



TriWest TRICARE West Region Provider Handbook

Effective for Dates of Service Starting January 1, 2025

TRICARE Managed Care Support Contract (T-5 West)

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1 Introduction to TriWest and TRICARE West Region

1.1 Welcome

Every day, health care providers in our communities are stepping up to care for military families. We thank these medical professionals for improving the lives of those we call heroes! On behalf of a grateful nation, we want every provider who has rendered care to the military or Veteran community to know – we are thankful for YOU.

This TRICARE Provider Handbook applies to the Department of Defense (DOD) TRICARE program for TriWest Healthcare Alliance (TriWest) network providers in the new 26-state TRICARE West Region. The West Region consists of the following states: Alaska, Arizona, Arkansas, California, Colorado, Hawaii, Idaho, Illinois, Iowa, Kansas, Louisiana, Minnesota, Missouri, Montana, Nebraska, New Mexico, Nevada, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Utah, Washington, Wisconsin, and Wyoming. **Note:** For T-5, six states moved from the TRICARE East Region to the West Region – Wisconsin, Illinois, Arkansas, Louisiana, Oklahoma, and Texas. See **Exhibit 2-1**.

Health care delivery in the new West Region begins January 1, 2025.

TriWest will continue to accept [interest forms](#) from providers who wish to join the TriWest network.

TriWest is looking for providers who are motivated by our mission to provide quality health care to active duty military, their families, and Veterans. By joining our network, you can help make a difference in the lives of our nation's heroes, doing Whatever It Takes![®] to increase access to care for those who deserve it most. Visit our [TRICARE Provider Contracting Q&A page](#) for more details or read on and then submit the online [Join Our Network form](#). TriWest's provider contracting team looks forward to working with you.

1.2 About TriWest Healthcare Alliance

Since our founding in 1996, TriWest has been On a Mission to Serve[®] our nation's military and Veteran communities. TriWest previously administered the Department of Defense (DOD) TRICARE program in the West Region from 1996 to 2013.

TriWest has also been the Department of Veterans Affairs (VA) third-party administrator for VA's Community Care Network (CCN) in Regions 4 and 5 since 2014. These regions include the following 14 states: Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Texas, Utah, Washington, and Wyoming, along with the U.S. Territories in the Pacific Islands to include Guam, American Samoa, and Northern Mariana Islands. If you are not currently a CCN network provider and are interested in joining TriWest's network to care for Veterans, visit [JoinOurNetwork.TriWest.com](#). More details about CCN can be found in the online [CCN Provider Handbook](#).

TriWest has a long history of superior customer service and dedication to doing what is right for our nation's heroes and those who care for them. Doing Whatever It Takes![®] not only is our corporate motto, but it is also a deep-rooted desire to go above and beyond for our customers, because we understand and honor them. We respect the military culture, we honor the sacrifices made, and we are committed to providing the service our customers deserve.

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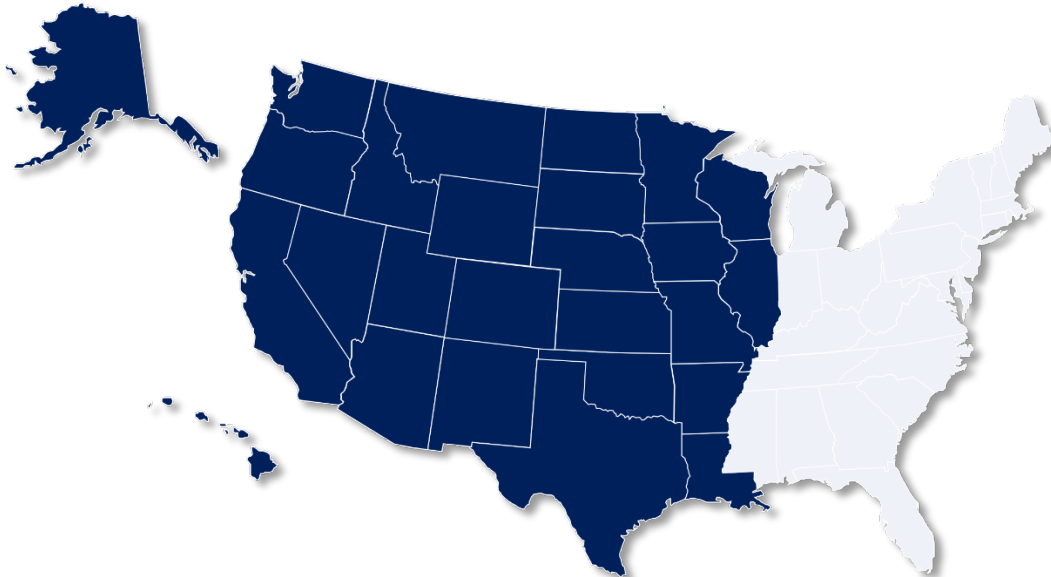
Our network health care providers and our business partners strive to continually support the military and Veteran communities and exceed customer expectations. Together, we are one team making a difference in the lives of our nation’s heroes!

1.3 TRICARE West Region for Next Generation of TRICARE

TRICARE is the Department of Defense’s (DOD) uniformed services health care program for active duty service members (ADSM), active duty family members (ADFM), National Guard and Reserve members and their families, retired Service members and their families, survivors, and certain former spouses. The Defense Health Agency (DHA) oversees the TRICARE program. TRICARE is managed by support contractors in two continental United States (CONUS) regions: TRICARE East and TRICARE West. DHA has contracted with TriWest as the support contractor for the new West Region.

This contract’s purpose is to provide Managed Care Support (MCS) to the DOD TRICARE program. For the West Region, TriWest assists the Military Health System (MHS) in operating an integrated health care delivery system combining resources of the military’s direct medical care system and our managed care support to provide health, medical, and administrative support services to TRICARE-eligible beneficiaries.

Exhibit 2-1: T-5 West Region Map



1.4 TRICARE Policy Resources

DHA provides TriWest with guidance as issued by the DOD for administering TRICARE-related services. DOD issues this direction through modifications to [Title 32 of the Code of Federal Regulations \(CFR\)](#), and TRICARE Manuals: [TRICARE Operations Manual \(TOM\)](#), [TRICARE Reimbursement Manual \(TRM\)](#), and [TRICARE Policy Manual \(TPM\)](#).

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This TriWest TRICARE Provider Handbook provides an overview of the TRICARE program regulations and requirements. These manuals are regularly updated to reflect changes made to the TRICARE Program.

For current information about policy changes, timelines, and implementation guidance, refer to:

- [TRICARE Manuals](#) (TOM, TRM, TPM, TSM)
- [TriWest’s provider training](#)
- [TriWest’s secure provider portal](#)
- www.tricare.triwest.com
- [Provider Pulse newsletters](#)

2 TRICARE Program

2.1 Beneficiary Types

TRICARE offers comprehensive medical and behavioral health benefits to all TRICARE beneficiaries. Beneficiary types include:

- Sponsors – active duty, retired, and Guard/Reserve Members
- Family members – spouses and children who are registered in Defense Enrollment Eligibility Reporting System (DEERS)

It is important to be aware of the TRICARE program plan options available according to beneficiary category. To view the most current information on these plans, please refer to the links below.

Plan	Link to More Information
TRICARE Prime	tricare.mil/Plans/HealthPlans/Prime
TRICARE Prime Remote	tricare.mil/Plans/HealthPlans/TPR
TRICARE Prime Overseas	tricare.mil/Plans/HealthPlans/TPO
TRICARE Prime Remote Overseas	tricare.mil/Plans/HealthPlans/TPRO
TRICARE Select	tricare.mil/Plans/HealthPlans/TS
TRICARE Select Overseas	tricare.mil/Plans/HealthPlans/TSO
TRICARE For Life	tricare.mil/Plans/HealthPlans/TFL
TRICARE Reserve Select	tricare.mil/Plans/HealthPlans/TRS
TRICARE Retired Reserve	tricare.mil/Plans/HealthPlans/TRR
TRICARE Young Adult	tricare.mil/Plans/HealthPlans/TYA
US Family Health Plan	tricare.mil/Plans/HealthPlans/USFHP

TRICARE Prime and TPR are managed care options offering the most affordable and comprehensive coverage. ADSMs must enroll in TRICARE Prime or TPR. ADFMs, retirees and their families, and others may choose to enroll in a TRICARE Prime or TRICARE Select option.

When on active duty orders for more than 30 consecutive days, National Guard and Reserve members are covered as ADSMs and must enroll in TRICARE Prime or TPR. During activation, their eligible family members are covered as ADFMs and may enroll in TRICARE Prime, TPR, or TRICARE Select.

The following table provides a summary of the TRICARE plans administered by TriWest for the West Region.

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Plans	Description	Availability	Provision of Care	Features
TRICARE Prime	A managed care option offering the most affordable and comprehensive coverage.	In the United States in Prime Service Areas	<ul style="list-style-type: none"> • Get most care provided by assigned Primary Care Manager (PCM) (military or network provider) • PCM refers to specialists for care they cannot provide 	<ul style="list-style-type: none"> • Enhanced vision coverage and preventive services • Time and distance access standards • Fewer out-of-pocket costs • Beneficiary does not file claims (in most cases)
TRICARE Prime Remote	A managed care option offering the most affordable and comprehensive coverage to active duty families in remote U.S. locations.	In designated remote U.S. locations, more than 50 miles from a Military Treatment Facility (MTF)	<ul style="list-style-type: none"> • Get most care provided by assigned PCM (network provider, if available, otherwise any TRICARE-authorized provider) • PCM refers to specialists for care they cannot provide 	<ul style="list-style-type: none"> • Enhanced vision coverage and preventive services • Time and distance access standards • Fewer out-of-pocket costs • Beneficiary does not file claims (in most cases)
TRICARE Select	A preferred provider network option available to eligible beneficiaries not enrolled in TRICARE Prime (except ADSMs and TRICARE For Life beneficiaries). Offers the most freedom of choice.	United States	<ul style="list-style-type: none"> • Get care from any TRICARE-authorized provider (network or non-network) • Referrals not required • Some services require prior authorization 	<ul style="list-style-type: none"> • Costs vary depending on type of provider • Beneficiary may have to pay for services when received and file for reimbursement
TRICARE Reserve Select	A preferred provider network option available for qualified National Guard and Reserve members.	Worldwide	<ul style="list-style-type: none"> • Get care from any TRICARE-authorized provider (network or non-network) • Referrals not required • Some services require prior authorization 	<ul style="list-style-type: none"> • Must qualify • Costs vary depending on type of provider • Beneficiary may have to pay for services when received and file for reimbursement
TRICARE Retired Reserve	A preferred provider network option available to qualified retired Reserve members.	Worldwide	<ul style="list-style-type: none"> • Get care from any TRICARE-authorized provider (network or non-network) • Referrals not required • Some services require prior authorization 	<ul style="list-style-type: none"> • Must qualify • Costs vary depending on type of provider • Beneficiary may have to pay for services when received and file for reimbursement
TRICARE Young Adult (Select)	A preferred provider network option available to qualified adult children of eligible sponsors.	Worldwide	<ul style="list-style-type: none"> • Get care from any TRICARE-authorized provider (network or non-network) • Referrals not required • Some services require prior authorization 	<ul style="list-style-type: none"> • Must qualify • Referrals are not required, but some care may require prior authorization • Beneficiary may have to pay for services when received and file for reimbursement
TRICARE Young Adult (Prime)	A managed care option offering the most affordable and comprehensive coverage available to qualified adult children of eligible sponsors.	In the United States in Prime	<ul style="list-style-type: none"> • Get most care from assigned PCM (military or network provider) 	<ul style="list-style-type: none"> • Must qualify • Enhanced vision coverage and preventive services • Time and distance access standards

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Plans	Description	Availability	Provision of Care	Features
		Service Areas	<ul style="list-style-type: none"> • PCM refers to specialists for care they cannot provide 	<ul style="list-style-type: none"> • Fewer out-of-pocket costs • Beneficiary does not file claims (in most cases)
TRICARE Young Adult (Prime Remote)	A managed care option offering the most affordable and comprehensive coverage in remote U.S. locations available to qualified adult children of eligible sponsors.	In designated remote U.S. locations, more than 50 miles from an MTF	<ul style="list-style-type: none"> • Get most care provided by assigned PCM (network provider, if available, otherwise any TRICARE-authorized provider) • PCM refers to specialists for care they cannot provide 	<ul style="list-style-type: none"> • Must qualify • Only available to children of active duty service members enrolled in TRICARE Prime Remote • Time and distance access standards • Fewer out-of-pocket costs • Beneficiary does not file claims (in most cases)

2.1.1 Beneficiary Rights

TRICARE beneficiaries have the right to:

- **Accurate, easily understood information** so they can make informed decisions about their TRICARE health plan, providers, and facilities.
- **A choice of health care providers** that ensures access to high-quality health care.
- **Emergency health care services** when and where they need it. Emergency services coverage is available without authorization if a beneficiary has reason to believe their life is in danger or they would be seriously injured or disabled without immediate care.
- **Understand their diagnosis, treatment, or prognosis**, as explained by their provider.
- **Fully participate in all decisions about their care.** If a beneficiary cannot make their own decisions, they have the right to be represented by someone else. This could be a family member or conservator.
- **Considerate, respectful care** from all health care system members. Beneficiaries are protected against discrimination based on:
 - Race
 - Ethnicity
 - National origin
 - Religion
 - Sex
 - Age
 - Mental or physical disability
 - Sexual orientation
 - Genetic information
 - Source of payment
- **Communicate confidentially with their health care team** and have their confidential information protected by law.
- **Review, copy, and request amendments** to their medical records.
- **A fair and efficient process for resolving differences** with their health plan, health care providers, and the institutions that serve them.

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Visit tricare.mil/ for more information about [beneficiary rights](#).

2.2 TRICARE Eligibility

TRICARE is a health program for Uniformed Service members and their families, National Guard/Reserve members and their families, survivors, former spouses, Medal of Honor recipients and their families, and others registered in DEERS. See page for more information.

2.2.1 *Verifying Benefit Coverage*

Civilian providers can use the TriWest online [Referral and Authorization Decision Support \(RADS\)](#) tool to determine if an approval from TriWest is required. The online tool also provides procedure codes, services, and procedure coverage information.

2.3 TRICARE Program Options

2.3.1 *TRICARE Pharmacy Program*

The TRICARE Pharmacy Program provides prescription drug coverage through safe, easy, and affordable options. TRICARE beneficiaries are eligible for the TRICARE Pharmacy Program managed through pharmacy contractor, Express Scripts® Pharmacy. For more information on how beneficiaries can sign up for secure services with Express Scripts, download the free mobile app, search the TRICARE formulary, and check pharmacy costs (refer to the [TRICARE Pharmacy Program](#) webpage).

TRICARE beneficiaries have the following options for filling prescriptions:

- [Military pharmacies](#)
- [TRICARE Pharmacy Home Delivery](#)
- [TRICARE retail network pharmacies](#)

For information on how beneficiaries may be able to get prescriptions filled from a non-network pharmacy, see the [Non-Network Pharmacy webpage](#).

2.3.2 *Transitional Health Care Benefits*

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

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

2.3.2.1 *Transitional Assistance Management Program (TAMP)*

[TAMP](#) provides 180 days of health care benefits after regular TRICARE benefits end. Beneficiaries do not have to pay any premiums for TAMP.

TAMP may cover beneficiaries and their family members if they are:

- Involuntarily separating from active duty under honorable conditions, including:
 - Members receiving a voluntary separation incentive (VSI) or
 - Members receiving a voluntary separation pay (VSP) and cannot receive retired or retainer pay upon separation

- A National Guard or Reserve member separating from a period of more than 30 consecutive days of active duty served for:
 - A pre-planned mission
 - Support of a contingency operation
 - Support of the government coronavirus (COVID-19) response
- Separating from active duty following involuntary retention (stop-loss) in support of a contingency operation
- Separating from active duty following a voluntary agreement to stay on active duty for less than one year in support of a contingency operation
- Receiving a sole survivorship discharge
- Separating from regular active duty service and agreeing to become a member of the Selected Reserve of a Reserve Component. The Service member must become a Selected Reservist the day immediately following release from regular active duty service to qualify

The Services determine TAMP eligibility and document eligibility in DEERS. TAMP eligibility can be [viewed online via milConnect](#).

Qualified Service Members and their families are eligible to use one of the following health plan options*[in addition to MTFs](#):

- [TRICARE Prime \(where locally available\)](#)
- [TRICARE Select](#)
- [US Family Health Plan \(if the beneficiary lives in a designated location\)](#)
- [TRICARE Prime Overseas](#)
- [TRICARE Select Overseas](#)

* Please see the **Section 3.1 table** that provides a summary of the TRICARE plans administered by TriWest for the West Region.

For more information about TAMP, visit [TRICARE's Transitional Assistance Management Program](#) webpage.

2.3.2.2 Transitional Care for Service-Related Conditions Program (TCSRC)

[TCSRC](#) extends TRICARE coverage to former active duty, Guard, and Reserve members for certain service-related conditions beyond their regular 180-day TAMP coverage period. The benefit is available worldwide.

Beneficiaries that are eligible for TAMP and have a newly diagnosed medical condition related to active duty service may qualify for TCSRC if the beneficiary's medical condition is:

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

Once the DOD validates a medical condition eligible for TCSRC, the beneficiary's coverage will show in DEERS.

To get started, beneficiaries should follow the instructions found on the [TCSRC webpage](#). These instructions include:

- Preparing a letter requesting coverage
- Collecting copies of documents showing the condition is service-related
- Completing the TCSRC Application Worksheet
- Completing the Provider Checklist & Instructions
- Submitting the letter and completed Application Worksheet

Beneficiaries should mail the letter and completed Application Worksheet and all other supporting documentation to the address found on the [TCSRC webpage](#).

2.3.2.3 Continued Health Care Benefit Program (CHCBP)

[CHCBP](#) is a premium-based health care program that offers temporary transitional health care coverage for 18-to-36 months after the TRICARE eligibility ends and acts as a bridge between military health care benefits and the beneficiary's new civilian health care plan. It provides the same coverage as [TRICARE Select](#), including prescriptions. It also gives the beneficiary minimum essential coverage as required by the Affordable Care Act.

For more information on eligibility, see the [CHCBP webpage](#).

Humana Military is the CHCBP contractor, providing enrollment, authorization, claims processing, and customer service services. For more information about CHCBP or to see if a beneficiary qualifies:

- Visit Humana's [CHCBP website](#)
- Call Humana Military at 1-800-444-5445

2.3.3 TRICARE Specialty Programs

2.3.3.1 TRICARE Extended Care Health Option (ECHO)

[ECHO](#) aids eligible beneficiaries with special needs for an integrated set of services and supplies beyond those offered by the basic TRICARE programs (e.g., Prime, TPR, Select).

Potential ECHO beneficiaries must first be enrolled in the [Exceptional Family Member Program \(EFMP\)](#) through the sponsor's branch of service to receive ECHO benefits. Under certain circumstances, this requirement may be waived. Beneficiaries can be referred to this program online in the [secure provider portal](#) or providers can call our dedicated ECHO phone line (833) 818-2402 and select the ECHO option to begin the registration process.

The following beneficiaries who are diagnosed with a moderate or severe intellectual disability, a serious physical disability, or an extraordinary physical or psychological condition may qualify for ECHO:

- ADFMs
- Family members of activated National Guard/Reserve members
- Family members covered under [TAMP](#)
- Children or spouses of former Service members who are [victims of abuse](#) and qualify for the Transitional Compensation Program

- Family members of deceased active duty sponsors while they are considered [“transitional survivors”](#)

The qualifying family member’s disability must be entered properly in DEERS to access ECHO services.

Children may remain eligible for ECHO beyond the usual [age limits](#) in some circumstances. Beneficiaries may call the dedicated ECHO line (833) 818-2402 and select the ECHO option to determine eligibility for ECHO benefits if they believe a qualifying condition exists.

2.3.3.1.1 ECHO Benefits

[ECHO benefits](#) can include:

- Training
- Rehabilitation
- Special education
- Assistive technology devices
- Institutional care in private non-profit, public, and state facilities (may include transport to and from)
- Home health care
- Respite care for the primary caregiver

Some services may be cost-shared under ECHO or the beneficiary’s basic TRICARE program. This includes services needed to establish or confirm the severity of a qualifying condition or measure functional loss. For more information, visit the [ECHO benefits](#) webpage.

Additional [ECHO benefits](#) include ECHO Home Health Care ([EHHC](#)) and Respite Care for Primary Caregivers. Beneficiaries must use resources such as public funds and other programs if they are available in their communities. These resources include training, rehabilitation, special education, assistive technology devices, and institutional care in private nonprofit, public, and state facilities (may include transport to and from). If these resources are not available or sufficient, beneficiaries may request ECHO benefits by providing a Public Facility Use Certificate along with an explanation of why the resources are not available or sufficient.

2.3.3.1.2 ECHO Costs

There are no enrollment fees for ECHO benefits, but beneficiaries must pay a monthly copayment based on the sponsor’s pay grade. This information can be found on the [ECHO Costs and Coverage Limits](#) webpage.

The coverage limit for the cost of combined ECHO services (excluding EHHC, see section 3.3.3.3) is \$36,000 per beneficiary per calendar year. Costs cannot be shared between family members.

Coverage for the EHHC benefit is capped annually and limited to the maximum fiscal amount TRICARE would pay if the beneficiary resided in a skilled nursing facility. This amount is based on the beneficiary’s geographic location.

For more information about TRICARE ECHO, refer to the [TRICARE Policy Manual \(TPM\), Chapter 9](#) or see the [Extended Care Health Option Fact Sheet](#).

2.3.3.1.3 ECHO Home Health Care Benefits

The [EHHC](#) benefit provides services or respite care to those ECHO-registered beneficiaries who:

- Are homebound
- Require skilled services beyond the coverage level that TRICARE Home Health Care Prospective Payment System provides
- Require frequent interventions that their primary caregiver normally provides
- Have a case manager who periodically assesses their needs and required services
- Have a physician-certified plan of care that details the services that are provided

Beneficiaries must obtain a referral or prescription before obtaining certain EHHC services. TRICARE Prime beneficiaries should contact their PCM and TRICARE Select beneficiaries should contact their family provider/primary care physician who will then:

- Decide eligibility for EHHC services
- Develop a plan of care

The physician, case manager, and/or TriWest must review the beneficiary's plan every 90 days or when there is a change in condition.

2.3.3.1.4 Respite Care

The EHHC respite care benefit provides a maximum of eight hours per day up to five days per week to give primary caregivers time to rest/temporary relief. EHHC cannot be used for child care services, sibling care, employment, deployment, or when pursuing education. It also cannot accumulate if unused. Only one respite care benefit (ECHO respite or EHHC respite) can be used in the same calendar month.

2.3.3.1.5 EHHC Benefit Cap

EHHC benefit coverage caps out on an annual basis and the amount is determined by the beneficiary's geographic location. TRICARE coverage caps at the maximum amount TRICARE would pay if the beneficiary resided in a skilled nursing facility.

For more information about EHHC, visit the [EHHC webpage](#).

2.3.3.2 Autism Care Demonstration

The [Autism Care Demonstration \(ACD\)](#) provides TRICARE reimbursement for Applied Behavior Analysis (ABA) services to TRICARE-eligible beneficiaries diagnosed with autism spectrum disorder (ASD). To qualify for ACD, beneficiaries must be enrolled in a TRICARE plan option and have a definitive ASD diagnosis from an approved ASD diagnosing provider (PCM or a specialized ASD diagnosing provider).

TriWest's online ACD provider directory includes ABA providers, parent-mediated programs, ASD diagnosing providers, respite care, speech language pathologist (SLP), OT, PT, etc.

Dependents of ADSMs diagnosed with ASD must be enrolled in the [Exceptional Family Member Program \(EFMP\)](#) and registered in [ECHO](#).

ACD program steps are available on the [ACD webpage](#). Assistance is available via the ACD information line at (833) 818-2525.

An Autism Services Navigator (ASN) is assigned to new beneficiaries and acts as a primary care coordinator. The ASN collaborates with the family and involved care providers to develop the Comprehensive Care Plan (CCP), to include setting goals, tracking timelines, connecting the beneficiary/family with clinical and non-clinical resources, and providing discharge, relocation, or transition support. The initial CCP shall be completed within 90 calendar days of the ASN assignment. For CCPs not completed within 90 calendar days as a result of family/beneficiary noncompliance, ASN and applicable ABA services shall be suspended through the duration of the existing authorization or until the CCP is complete, whichever comes first.

The ASN will ensure outcome measures are completed and submitted at baseline and by the respective repeated intervals (see [TOM Chapter 18, Section 3, Paragraph 6.3](#)) for:

- Pervasive Developmental Disorder Behavior Inventory (PDDDBI) (6 months)
- Parental Stress Index (PSI) (6 months)
- Stress Index for Parents of Adolescents (SIPA) (6 months)
- Vineland Adaptive Behavior Scales (Vineland) (annual)
- Social Responsiveness Scale (SRS) (annual)

ABA providers are required to adhere to the following requirements of [TOM Chapter 18, Section 3](#):

- Hold a bachelor's degree or higher in a relevant field recognized by the state licensure or certification authority. If no state licensure or certification is available, ABA providers must possess a degree in a field acknowledged by a DHA-approved certification organization.
- Maintain a valid, unrestricted state-issued license or state certification if they practice in a state that offers state licensure/certification. If no licensure/certification is offered, ABA providers must obtain state certification from either Behavior Analyst Certification Board (BACB) or the Qualified Applied Behavior Analysis (QABA).
- Complete ABA Provider Requirements pertaining to Certification/Credentialing including a training for Basic Life Support (BLS) or Cardiopulmonary Resuscitation (CPR) certification (see [TOM Chapter 18, Section 3, Paragraph 8.2](#))
- Participate in medical team conferences coordinated by the ASN
- Comply with and participate in any corrective action required based upon the following required audits (see [TOM Chapter 18, Section 3, Paragraph 8.9](#)):
 - Clinical and non-clinical documentation audits
 - Audits related to insufficient clinical documentation to review medical record documentation progress
- Documentation Requirements
 - Meet all ABA Service Documentation requirements ([TOM Chapter 18, Section 3 Paragraph 8.7](#))
 - Complete ABA Assessments and Treatment Plan (TP) documentation
 - Provide complete progress note documentation
 - Provide medical records to support ([TOM Chapter 18, Section 3 Paragraph 8.9.7](#))
 - Ensuring session documentation notes comply with all requirements
 - Correcting insufficiencies when identified by TriWest

- ASCP/Sole Provider groups will have a minimum of 30 records audited on an annual basis which includes a combination of administrative records and medical documentation review, and one medical team conference session note.
 - TriWest will conduct outreach and education to the ASCP/Sole Provider group with inconsistencies or errors identified in the audits. Additionally, TriWest will initiate progressively more severe administrative action, commensurate with the seriousness of the identified problems, consistent with [TOM Chapter 13](#), and 32 CFR 199.9.
 - All claims determined to be insufficient for claims payment, if already paid, shall be recouped.
- Follow timeline and authorization requirements for:
 - ABA services (see [TOM Chapter 18, Section 3, Paragraph 8.6.2](#))
 - Complete initial assessment and develop TP, including recommended Adaptive Behavior Treatment Current Procedural Terminology (CPT) code and number of units
 - Subsequent referrals and authorizations (see [TOM Chapter 18, Section 3, Paragraph 8.6.3](#))
 - For clinically indicated ongoing services, submit re-authorizations for ABA services before the expiration of each six-month treatment authorization period, as early as 60 calendar days in advance, but no later than 30 calendar days in advance
- Submit only authorized CPT codes and their units (see [TOM Chapter 18, Section 3, Paragraph 8.11.6](#) for ACD Approved CPT Codes)
- Submit claims electronically and comply with reimbursement rates provided in [TOM Chapter 18, Section 3, Paragraph 8.11.7](#))

Exclusions/non-covered services under the ACD include (See [TOM Chapter 18 Section 3 paragraph 8.10](#) for a full list.):

- Behavior Technicians (BTs) training
- ABA services for any other diagnoses other than ASD
- ABA services are not covered for symptoms and/or behaviors that are not part of the ASD core symptoms (i.e., impulsivity due to ADHD, reading difficulties due to learning disability, excessive worry due to anxiety disorder)
- Billing of direct and indirect supervision of BTs and assistant behavior analysts
- Billing for emails and phone calls
- Billing for mileage and drive time to and from ABA services appointments (i.e., beneficiary's house, clinic, or other locations).
- Rendering and billing for ABA services involving any aversive techniques or restraints
- Rendering and billing for custodian, personal care, and/or child care
- Billing for office supplies to include therapeutic supplies
- Billing for report writing outside of what is included in assessment CPT code 97151
- Educational/academic and vocational ABA services; all educational/academic and vocational goals must be removed from the treatment plan before approval
- TRICARE will authorize and reimburse only CPT code 97153 rendered by the authorized ABA supervisor (not delegated to the assistant or BT) in the school setting
- Authorizations for BTs in a school setting will not be approved

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- Autism schools are not TRICARE-authorized providers. If an autism school has a clinic setting as part of their offered services, the clinic must have a separate tax identification number (TIN) and is not owned by the child's responsible adult.
- Rendering or billing for any two ABA providers at the same time under one CPT code

Please review the ACD policy ([TOM Chapter 18 Section 3](#)) in its entirety for complete overview of TRICARE requirements to be a TRICARE-authorized provider and provide ACD services.

2.4 TRICARE Provider Types

TRICARE defines a provider as a person, business, or institution that provides health care. Beneficiaries must use TRICARE-authorized providers that are licensed by a state for independent practice, accredited by a national organization, or meet other standards of the medical community. For more information on provider types, refer to chart of provider types at tricare.mil/. TriWest contracts with network providers in the West Region to deliver health care to TRICARE beneficiaries.

TRICARE Authorized Providers. [Sec. 199.6](#) of the Title 32 National Defense Manual describes requirements for TRICARE providers and suppliers. This manual sets forth general policies and procedures that are the basis for the CHAMPUS cost-sharing of medical services and supplies provided by institutions, individuals, or other types of providers. Providers seeking payment from the federal government through programs such as CHAMPUS have a duty to familiarize themselves with, and comply with, the program requirements.

TRICARE-authorized providers must meet state licensing and certification requirements and are authorized by TRICARE to provide care to TRICARE beneficiaries. TRICARE-authorized providers include doctors, hospitals, urgent care centers, ancillary providers (nurse practitioners, physician assistants, and physical therapists), laboratory and radiology providers, and pharmacies.

TRICARE-authorized providers do not include any provider type not specifically named in [TPM Chapter 11](#). For providers in TriWest's Community Care Network (CCN) provider network for VA, please note that there are differences between the contracts. Beneficiaries are responsible for the full cost of care if they see providers who are not TRICARE-authorized.

2.4.1 Primary Care Managers

In TRICARE Prime, PCMs coordinate care for beneficiaries assigned as their patients and provide all non-emergency care within their capabilities. PCMs are responsible for maintaining beneficiary medical records and referring beneficiaries for urgent, emergent, and specialty care outside of their capabilities. This includes working with TriWest to obtain referrals and prior authorizations.

PCMs can be a part of an MTF or a civilian network provider. The following provider specialties are eligible to serve as PCMs in TRICARE:

- General practice
- Family practice
- Internal medicine
- Pediatrician
- Obstetrician/gynecologist
- Physician assistant

- Nurse practitioner
- Certified nurse midwife

PCMs are selected by TRICARE Prime beneficiaries at enrollment. TRICARE Prime beneficiaries must seek all non-emergency services from their PCM and obtain referrals to other providers before obtaining services.

PCMs are responsible for:

- Primary care services
- Following TRICARE procedures for obtaining necessary prior authorizations and referrals for non-emergency care
- Providing access to care 24 hours a day, seven days a week (including after-hours and urgent care services) or arrange for on-call coverage by another PCM
- Maintaining beneficiary medical records, including from referrals and emergency care
- Notifying TriWest of changes in capacity

During the performance of the contract, TriWest will adjust PCM enrollment capacity based on claims history and PCM feedback.

2.4.2 Behavioral Health Providers

The TRICARE behavioral health care outpatient network consists of TRICARE-authorized providers, such as:

- Advanced Practice Nurses
- Applied Behavior Analysis (ABA) licensed/certified providers
- Board Certified Behavior Analysts (BCBA)
- Board Certified Behavior Analysts-Doctoral (BCBA-D)
- Certified Clinical Social Workers
- Certified Marriage and Family Therapists (e.g., Licensed Professional Counselor, Licensed Marriage and Family Therapist (LMFT))
- Certified Psychiatric Nurse Specialists (CPNS)
- Clinical Psychologists
- Licensed Psychological Associates
- Psychiatrists and other Physicians
- Substance Abuse Counselors (e.g., Licensed Clinical Alcohol & Drug Abuse Counselor [LCDAC])
- Supervised Behavioral Health (BH) Counselors
- Supervised Licensed Pastoral Counselors TRICARE-Certified Mental Health Counselors (TCMHC)

To be a TRICARE-authorized provider and deliver care under the TRICARE program, providers must:

- Meet professional licensing and certification requirements for independent practice, with the exception of Supervised Behavioral Health Counselors and Supervised Licensed Pastoral Counselors TRICARE-Certified Mental Health Counselors.
- Be certified by TRICARE

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- Be licensed in the jurisdiction where they provide care ([Title 32, Code of Federal Regulations, Part 199.6](#))

2.4.3 Behavioral Health Care Network

The TRICARE behavioral health care network consists of:

- Hospitals
- Inpatient psychiatric units
- Opioid treatment programs (OTP)
- Substance use disorder rehabilitation facilities (SUDRF)
- Partial hospitalization programs (PHP)
 - A TRICARE-authorized psychiatric PHP can be a distinct part of an otherwise TRICARE-authorized institutional provider or a freestanding program.
 - For TRICARE certification, the PHP must be currently accredited by The Joint Commission (TJC), the Commission on Accreditation of Rehabilitation Facilities (CARF), the Council on Accreditation (CoA), or an accrediting organization approved by the DHA Director.
 - For acute care hospital-based PHPs, when a hospital is a TRICARE-authorized provider, the hospital's PHP is also considered a TRICARE-authorized provider.
- Intensive outpatient programs (IOP)
 - A TRICARE-authorized psychiatric IOP can be a distinct part of an otherwise TRICARE-authorized institutional provider or a freestanding program.
 - For TRICARE certification, the IOP must be currently accredited by TJC, CARF, CoA, or an accrediting organization approved by the DHA Director.
 - For acute care hospital-based IOPs, when a hospital is a TRICARE-authorized provider, the hospital's IOP is also considered a TRICARE-authorized provider.
- Residential treatment centers (RTC)
 - Must be currently accredited by TJC, CARF, CoA, or an accrediting organization approved by the DHA Director.
 - Must be licensed as an RTC to provide RTC services within the applicable jurisdiction in which it operates.
 - For more specific information regarding RTC standards, refer to the [TRICARE Policy Manual Chapter 11](#).

To become a network provider, these facilities must complete the TriWest contracting process, unless the facility is a VA facility. These facilities must sign a participation agreement to comply with all TRICARE policies before rendering services to TRICARE beneficiaries.

For information regarding PHPs, IOPs, RTCs, OTPs, and SUDRFs, refer to the [TRICARE Policy Manual Chapter 11](#).

2.4.4 Corporate Services Provider Class (CSP)

The [CSP class](#) comprises of institutional-based or freestanding corporations and foundations that render principally professional, ambulatory, or in-home care and technical diagnostic procedures. However, CSPs cannot be a professional corporation or professional association. A professional corporation is a form of corporation authorized by state statute for a specified list of licensed professions, often including doctors, lawyers, public accountants and engineers. State law defines

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a professional association. State law must be consulted for a determination of whether the entity is considered a professional corporation or professional association.

The provider types in this category may include:

- Cardiac catheterization clinics
- Comprehensive outpatient rehabilitation facilities
- Diabetic outpatient self-management education programs (American Diabetes Association accreditation required)
- Freestanding bone-marrow transplant centers
- Freestanding Magnetic Resonance Imaging (MRI) centers
- Freestanding sleep-disorder diagnostic centers
- Home health agencies (pediatric or maternity management required)
- Home infusion (Accreditation Commission for Healthcare accreditation required)
- Independent physiological laboratories
- Radiation therapy programs

For more information about Corporate Services Provider reimbursement, refer to [TPM, Chapter 11, Section 12.1](#).

2.5 TRICARE Medical Coverage

TRICARE medical coverage details can be found on the TRICARE [Types of Care website](#) and in the [TRICARE Policy Manual](#). Additional program information is included in the following sections.

2.5.1 *Primary Care*

TRICARE defines primary care as the initial medical care given by a health care provider to a patient, especially as part of regular ambulatory care, and sometimes followed by referral to other medical providers.

In TRICARE Prime, PCMs coordinate care for beneficiaries assigned as their patients and provide all non-emergency care within their capabilities. TRICARE Prime beneficiaries must seek all non-emergency services from their PCM, obtaining referrals to other providers before obtaining services. For more information, please reference the [Primary Care Managers \(PCM\) subsection](#) of this document.

Covered primary care services may include, but are not limited to:

- Asthma testing and treatment
- Blood pressure screening
- Body measurement
- Cardiovascular screening
- Pediatrics
- Certain physicals

2.5.2 *Preventive Care*

Preventive care services include diagnostic and other medical procedures not related directly to a specific illness, injury, or definitive set of symptoms, or obstetrical care, but rather performed as

periodic health screening, health assessment, or health maintenance. Covered preventive care services are applicable to beneficiaries 6 years of age or older.

[Per TRICARE Policy Manual Chapter 7, Section 2.2](#), TRICARE Prime enrollees may receive Prime clinical preventive services from any network provider within their geographic area of enrollment without a referral or authorization. If a TRICARE Prime clinical preventive service is not available from a network provider (e.g., a network provider is not available within prescribed access parameters), an enrollee may receive the service from a non-network provider with a referral from the PCM and authorization from the TriWest.

Covered preventive care services include but are not limited to:

- Cancer screening examinations and services
- Immunizations
- Health promotion and disease prevention (HP&DP) examinations
- Well Woman examinations
- Routine eye examinations
- Audiology screening

For more information, please refer to the [TRICARE Policy Manual Chapter 7 Section 2.1](#) and [TRICARE Policy Manual Chapter 7 Section 2.2](#).

2.5.3 Specialty Care

Specialty care is defined as specialized medical/surgical diagnosis, treatment, or services performed by a physician specialist that a PCP is not qualified to provide. In TRICARE Prime, a beneficiary's PCM refers to specialists for care they cannot provide. In TRICARE Select, referrals are not required for specialist providers. However, some services require prior authorization.

To determine if a specific service is a covered benefit or if referral/authorization is required, use the [Referral and Authorization Decision Support](#) (RADS) tool.

2.5.4 Behavioral Health

TRICARE covers services delivered by qualified, TRICARE-authorized behavioral health care providers practicing within the scope of their licenses, to diagnose and/or treat covered behavioral health disorders.

Only the types of providers listed in [TRICARE Policy Manual, Chapter 11, Sections: 3.6-3.11](#) are considered qualified providers of behavioral health services. All services and supplies provided by unauthorized providers or not considered medically or psychologically necessary are generally excluded. For information about the requirements for being a TRICARE-authorized provider, refer to the [TRICARE Policy Manual, Chapter 11, Sections: 3.6-3.11](#).

According to [TPM Chapter 7, Section 3.7](#) covered conditions must:

- Involve a clinically significant behavioral or psychological syndrome or pattern that is associated with a painful symptom, such as distress, and that impairs a patient's ability to function in one or more major life activities.
- The condition must be one of those conditions listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

To determine if a specific service is a covered benefit or if coverage is limited, use the [Referral and Authorization Decision Support \(RADS\)](#) tool.

2.5.4.1 Incident Reporting

All serious occurrences involving a TRICARE beneficiary while receiving services at a TRICARE-authorized treatment program (e.g., RTC, freestanding PHP, or SUDRF) must be reported to TriWest by phone at 1-888-TRIWEST (874-9378) within one business day.

2.5.4.2 Pre-Authorization and Referral Requirements

TRICARE pre-authorization and referral requirements vary according to beneficiary type, program option, diagnosis, and type of care. See the [RADS](#) tool or [Prior Authorization List \(PAL\)](#).

2.5.4.3 Clinical Documentation for Behavioral Health Care Services

TRICARE providers must keep sufficient clinical records to substantiate that care provided was actually and appropriately furnished and was medically or psychologically necessary.

Behavioral health care provider types must, at a minimum, maintain medical records in accordance with TJC, CARF, CoA, or an accrediting organization approved by the DHA Director.

Acceptable clinical documentation may include, but is not limited to:

- Psychiatric and psychological evaluations
- Physician orders
- Treatment plans
- Physician and/or integrated progress notes
- Discharge summaries

2.5.4.4 Standardized Measures

All behavioral health care settings must include assessments at treatment baseline, every 60-day intervals, and at discharge using the following standardized measures in the evaluation report for the following diagnosis:

- Post-Traumatic Stress Disorder (PTSD): PTSD Checklist (PCL-5)
- Anxiety Disorders: Seven-Item Generalized Anxiety Disorder (GAD-7)
- Depressive Disorders: Patient Health Questionnaire 9 (PHQ-9 or A for ages 11-17)

All providers participating in ACD care settings must clearly report scores for completed and valid outcome measures at treatment baseline (varies per assessment – see below) using the most current published version of the following standardized outcome measures in the treatment plan:

- Parenting Stress Index (PSI) ages 0-12, at baseline and every six months
- Stress Index for Parents of Adolescents (SIPA) for ages 11-19, at baseline and every six months
- Vineland Adaptive Behavior Scales (Vineland) at baseline and annually
- Social Responsiveness Scale (SRS) annually
- Pervasive Development Disorder Behavior Inventory (PDDBI) including all domain and composite scores, at baseline and every six months

[According to TPM Chapter 11, Section 12.3](#), Providers must notify the referring MTF when a TRICARE beneficiary in the provider’s clinical judgment meets any of the following criteria:

- Is a potential harm to self – The provider believes there is a serious risk of self-harm by the Service member either as a result of the condition itself or medical treatment of the condition.
- Is a potential harm to others – There is a serious risk of harm to others either as a result of the condition itself or medical treatment of the condition. This includes any disclosures concerning child abuse or domestic violence.
- Is a potential harm to mission – There is a serious risk of harm to a specific military operational mission. Such a serious risk may include disorders that significantly impact the beneficiary’s impulsivity, insight, reliability, and judgment.
- Is admitted or being discharged from any inpatient behavioral health or SUDRF.
- Is experiencing an acute medical condition or engaged in an acute medical treatment regimen that impairs the beneficiary’s ability to perform assigned duties.
- Has entered or is being discharged from an inpatient and outpatient Substance Use Disorder (SUD) programs.

2.5.4.5 Non-Covered Conditions and Treatment

A complete list of behavioral health care services that are excluded under TRICARE are provided on the [TRICARE Mental Health Exclusions](#) webpage. Before delivering care, network providers must notify TRICARE beneficiaries if services are not covered. The beneficiary must agree in advance in writing to receive and accept financial responsibility for non-covered services by signing a Request for Non-Covered Services.

To obtain specific information on TRICARE policy, benefits and coverage, please consult the [TRICARE Policy Manual](#), [TRICARE Reimbursement Manual](#), or the code look-up feature on the [RADS](#) tool.

2.5.5 Maternity Care

Maternity care includes the medical services related to conception and delivery as defined on the [TRICARE Maternity \(Pregnancy\) Care webpage](#) and [TRICARE Policy Manual \(TPM\) Chapter 4, Section 18.1](#).

TRICARE covers all medically necessary pregnancy care with limitations, including prenatal care, post-partum care (generally for six weeks after delivery), and treatment of any complications.

TRICARE Prime (TRICARE Prime, TPR, TRICARE Young Adult Prime) beneficiaries require a referral from TriWest for civilian professional maternity care services (e.g., obstetrician, gynecologist, or nurse midwife). The approved referral for Global OB care starts with the initial prenatal visit and remains valid through postpartum care, generally six weeks after the infant’s birth. It includes the hospital admission for a routine delivery. Hospital inpatient admission and birthing center delivery require notification to TriWest within 24 hours of admission or the next business day.

TRICARE Select beneficiaries can obtain all maternity care without a pre-authorization or referral from TriWest.

Birthing care centers must be TRICARE-certified.

See [TPM Chapter 8, Section 2.6](#) and our TriWest Quick Reference Guides for information on breast pumps and supplies and breastfeeding counseling.

To obtain specific information on TRICARE benefits and coverage, please consult the [RADS](#) tool.

2.5.6 Telemedicine

TRICARE covers [telemedicine visits](#) including secure video conferencing and audio-only (using a computer or a smartphone) through a secure connection with a beneficiary's provider. Beneficiaries pay cost-shares and copayments for telemedicine visits. TRICARE covers the following telemedicine visits:

- Office visits
- Preventive health screenings
- Telemental health services
 - A referral for telemental health services is required, more information can be found on the [Telemental Health Services webpage](#).

Beneficiaries can contact TriWest for a referral or pre-authorization for telemedicine visits, including telemental health services.

Audio-only telemedicine for TRICARE for Life (TFL) beneficiaries should be covered by Medicare. If not, TFL is the first payer. Refer to [the Medicare homepage](#) for information on Medicare coverage.

Refer to the [Telemental Health Services webpage](#) and [TRICARE Policy Manual \(TPM\), Chapter 7, Section 22.1](#) for more information on TRICARE's telemedicine benefit.

2.5.6.1 Originating Sites

TriWest monitors originating site location coverage across the TRICARE West Region. Originating site coverage is assessed through evaluation of our provider partners against Health Professional Shortage Areas (HPSA) and examination of provider locations submitting claims with the originating site CPT code (i.e., Q3014). This allows TriWest to determine where originating site location gaps exist so we can develop targets to expand access.

2.5.6.2 Provider-to-Provider Teleconsultations

TriWest providers can request provider-to-provider teleconsultations for challenging cases from expert specialists at institutions with nationally recognized specialty-specific accreditation in the appropriate medical field that are participating in the TriWest network (a "Consulting Provider"). Providers seeking a teleconsultation may use the TRICARE West provider directory to identify a Consulting Provider.

When a Consulting Provider offers asynchronous teleconsultation to another provider in the TriWest network, the following shall apply:

- (1) The Consulting Provider must provide a response within one business day,
- (2) The response must capture whether the Consulting Provider recommended a referral, and
- (3) The consulting provider must provide synchronous technical assistance (as needed) during business hours.

Providers must use secure HIPAA-compliant communication methods to undertake any teleconsultation. All Providers are expected to follow the claims submission process when teleconsultations are performed, leveraging applicable CPT codes (i.e., 99446, 99447, 99448, 99449, 99452, 99451).

2.5.6.3 Provider Requirements

TriWest ensures providers follow all telemedicine-specific regulatory, licensing, credentialing and privileging, malpractice/insurance laws, and compliance with required regulatory and accrediting agencies, in accordance with the [TRICARE Policy Manual, Chapter 7, Section 22.1](#). Providers must:

- Follow professional discipline and national practice guidelines when practicing via telemedicine. Any modifications to applicable clinical practice guidelines for the telemedicine setting shall ensure that clinical requirements specific to the discipline are maintained.
- Make arrangements for handling emergency situations at the outset of treatment to ensure consistency with established local procedures
 - For behavioral health services, this should include the processes for hospitalization or civil commitment within the jurisdiction where the patient is located if necessary.
- Implement means for verification of provider and patient identity for synchronous telemedicine services.
 - For telemedicine services where the originating site is an authorized institutional provider, the verification of both professional and patient identity may occur at the host facility.
 - For telemedicine services where the originating site does not have an immediately available health professional (e.g., the patient’s home), the telemedicine provider provides the patient (or legal representative) with the provider’s qualifications, licensure information, and, when applicable, registration number (e.g., National Provider Identifier) and the patient provides two-factor authentication.
- Document provider and patient location in the medical record as required for the appropriate payment of services for synchronous telemedicine services.
 - Documentation includes elements such as city/town, state, and ZIP code (or country for overseas services).
- Ensure that transmission and storage of data associated with asynchronous telemedicine services is conducted over a secure network and is compliant with Health Insurance Portability and Accountability Act of 1996 (HIPAA) requirements.
- Establish an alternate plan for communicating with the patient (e.g., telephone) in the event of a technological breakdown/failure.
 - This should be developed at the outset of treatment. In order for the telemedicine services to resume, all technological requirements of this policy must be restored, as telemedicine cannot be performed by telephone services alone.
- Apply HIPAA privacy and security requirements for the use and disclosure of Protected Health Information (PHI) to all telemedicine services.

2.5.6.4 Reimbursement for Telemedicine – Distant Site

For TRICARE payment to be authorized, the provider must be a TRICARE-authorized provider and the service must be within a provider's scope of practice under all applicable state(s) law(s) in which services are provided and or received. Telemedicine services are subject to the same authorization/referral requirements. Beneficiaries can contact TriWest for a referral or pre-authorization for telemedicine visits, including telemental health services.

Beneficiaries are responsible for any applicable copay or cost-share.

For technical requirements, connectivity, privacy and security, and other issues, refer to the [TRICARE Policy Manual, Chapter 7, Section 22.1](#).

2.5.7 Emergency Care

TRICARE covers [emergency care](#), including professional and institutional charges, services, and supplies that are ordered/administered in an emergency department. Emergency care is care for an illness or injury that is threatening to life, limb, sight, or safety and requires immediate medical attention.

Examples of conditions that require emergency care include:

- No pulse
- Severe bleeding
- Spinal cord or back injury
- Chest pain
- Severe eye injury
- Broken bone
- Inability to breathe

A medical emergency includes the sudden and unexpected onset of a medical condition or the acute exacerbation of a chronic condition that is life, limb, or eyesight threatening, requires immediate medical treatment, or manifests painful symptoms requiring immediate response to alleviate suffering.

This also includes pregnancy-related medical emergencies that involve sudden and unexpected medical complications that put the mother, the baby, or both at risk.

A psychiatric inpatient admission is an emergency when, based on a psychiatric evaluation performed by a physician (or other qualified behavioral health care professional with hospital admission authority), the beneficiary is at imminent risk of serious harm to self or others due to a behavioral disorder and requires immediate continuous skilled observation at the acute level of care.

To avoid penalties, providers must notify TriWest of any emergency admission using [Availity](#) online within 24 hours or by the next business day following admission and discharge. TriWest reviews admission information and authorizes continued care, if necessary. Please refer to the [TRICARE Referrals and Authorizations](#) section for more information.

TRICARE Prime beneficiaries must obtain all non-emergency primary health care from their PCM or from another provider to which the beneficiary is referred by the PCM or TriWest. If a TRICARE Prime beneficiary seeks treatment in an Emergency Department and there wasn't a

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referral by the PCM, and it is clearly a case of routine illness where the beneficiary's medical condition never was, or never appeared to be an emergency, the beneficiary may be responsible for paying Point of Service (POS) fees.

If a beneficiary requires emergency care, direct the beneficiary to call 911 or to go to the nearest emergency room.

2.5.8 Urgent Care

TRICARE covers [urgent care](#) for medically necessary services required for an illness or injury that would not result in further disability or death if not treated immediately but does require attention before it becomes a serious risk to health.

Examples of serious conditions (but not life-threatening) that should receive urgent treatment include:

- Sprains
- Scrapes
- Ear aches
- Sore throats
- A raised temperature

2.5.8.1 Urgent Care for TRICARE PRIME – Active Duty Service Members

According to the [TRICARE Operations Manual, Chapter 7, Section 5, Paragraph 2.1](#), ADSMs enrolled in TRICARE Prime require a referral from the MTF provider or through the MHS Nurse Advice Line (NAL). ADSMs enrolled to the TRICARE Overseas Program (TOP) or in TRICARE Prime Remote (TPR) do not need an urgent care referral, but they are still held to applicable DOD and Service requirements concerning authorization for private sector care.

TRICARE Prime's POS option does not apply to ADSMs, who may be responsible for the entire cost of their care if they seek urgent care without a referral when required.

2.5.8.2 Urgent Care for Other Beneficiaries

The following beneficiaries do not require a referral or authorization before seeking any urgent care services from a network or non-network provider, in accordance with [TRICARE Operations Manual, Chapter 7, Section 5.0](#); however, out-of-pocket costs may be more when seeking services from non-network providers:

- TRICARE Select
- TRICARE Reserve Select
- TRICARE Retired Reserve
- TRICARE Young Adult (Prime and Select)

These beneficiaries may self-refer for urgent care from a TRICARE network provider or a TRICARE-authorized (network or non-network) urgent care center (UCC) or convenience clinic (CC). If the enrollee seeks care from a non-network provider, the usual POS deductible and cost-shares shall apply.

2.5.8.3 Nurse Advice Line

Beneficiaries may contact the [Nurse Advice Line](#) 24 hours a day, seven days a week, 365 days per year at 1-800-TRICARE (874-2273). Registered nurses are available to help beneficiaries:

- Answer urgent care questions
- Give health care advice
- Help find a doctor
- Schedule next-day appointments at military hospitals and clinics

All TRICARE beneficiaries can access the Nurse Advice Line in the U.S. except those enrolled in the US Family Health Plan (USFHP). Beneficiaries who live overseas can call the Nurse Advice Line when traveling in the U.S., but must coordinate care with their [Overseas Regional Call Center](#).

2.5.9 Home Infusion Therapy

TRICARE covers [home infusion therapy](#). Home infusion therapy is a limited benefit that covers medicine taken in the home in a way other than swallowing, including:

- A shot in the muscles
- Injection beneath the skin
- Injection through veins
- Infused through a piece of [Durable Medical Equipment \(DME\)](#)

The medication type and length of administration determines whether the home infusion/injection medication will be paid by TriWest under the TRICARE medical benefit or by [Express Scripts®](#) through the TRICARE pharmacy benefit. Providers can use the [RADS](#) tool to determine if it is covered as a TRICARE medical benefit through TriWest.

Home infusion therapy requires pre-authorization from TriWest for all beneficiaries, except those with other health insurance (OHI) and when TRICARE is not the primary payer.

For more information, refer to [TRICARE Policy Manual, Chapter 8, Section 20.1](#).

2.5.10 Hospitalization

TRICARE covers [hospitalization services](#), including:

- Emergency services
 - Medical or psychiatric emergency
 - Immediate hospital admission
 - Mental health or SUD services include:
 - Management of withdrawal symptoms (detoxification)
 - Stabilization
 - Medical complications from the disorder
- Non-emergency services
 - Inpatient psychiatric hospitalization
 - Diagnosis and treatment of mental health
 - SUD

All scheduled hospitalizations require pre-authorization. For non-emergency inpatient psychiatric services, care may be provided in private psychiatric hospitals or local, state, or federal government psychiatric hospitals.

Inpatient psychiatric services may receive an approval if the beneficiary:

- Poses a serious risk of harm to themselves or others
- Needs specialized medication
- Needs psychological treatment
- Has a significant impairment in functioning
- Needs to be in a hospital full-time
- Is unable to maintain themselves in the community with only outpatient services

2.5.11 Skilled Nursing Facility Care

Per [TOM Chapter 7, Section 4](#), Skilled Nursing Facility (SNF) care must be preauthorized for all TRICARE beneficiaries to include dual eligible beneficiaries. For a SNF admission to be covered under TRICARE, the beneficiary must have a qualifying hospital stay of three consecutive days or more, not including the hospital discharge day, and the beneficiary must enter a Medicare-certified, TRICARE-participating SNF within 30 calendar days of discharge from the hospital. TRICARE has also adopted Medicare's Interrupted Stay Policy for SNF admission. For more information, please see [TRM Chapter 8, Section 2](#).

There is no day limit while medical necessity continues.

2.5.12 Hospice Care

Beneficiaries may receive [hospice care](#) if they are terminally ill. Hospice care helps manage beneficiaries' pain and symptoms, while helping them live as comfortably as possible. The benefit covers supportive services including pain control and counseling services, home health aide services, and personal comfort items.

Hospice care services require:

- A beneficiary to be referred for hospice care
- A beneficiary's doctor to submit orders for hospice care
- A beneficiary to complete and give an election statement to a hospice provider
 - The provider must file the election statement with TriWest

Beneficiaries who receive hospice care cannot receive curative treatment related to the terminal illness unless hospice has been revoked. Beneficiaries under age 21 are eligible for medically necessary curative treatment related to the illness in addition to palliative care.

TRICARE provides hospice care in three benefit periods:

- Period one: 90 days
- Period two: 90 days
- Period three: Unlimited 60-day periods

Beneficiaries need pre-authorization for each period and each 60-day period requires recertification of terminal illness.

Hospice levels of care include continuous home care, general hospice inpatient care, inpatient respite care, and routine home care. Types of care may include:

- Physician services
- Nursing care
- Counseling
- Medical equipment and supplies
- Medications
- Medical social services
- Physical and occupational services
- Short-term inpatient care
- Speech and language pathology

Hospice care requires pre-authorization from TriWest for all beneficiaries.

For more information about TRICARE's hospice coverage refer to [TRICARE Reimbursement Manual, Chapter 11, Section 3](#).

2.5.13 Laboratory, X-ray, and Laboratory Developed Test Services

TRICARE covers most laboratory and X-ray services that have been prescribed by a physician. There are certain exceptions for chemo-sensitivity assays and bone density X-ray studies for routine osteoporosis screening.

[The Laboratory Developed Test \(LDT\) Demonstration Project](#) allows TRICARE to review non-FDA approved LDTs to determine if they meet TRICARE requirements for safety and effectiveness according to the hierarchy of reliable evidence as referenced in [TRICARE Operations Manual, Chapter 18 Section 2](#).

A LDT is an In Vitro Diagnostic (IVD) test that is designed, manufactured, and used within a single laboratory.

For an LDT to be considered for coverage, the beneficiary must meet the following criteria:

- Meet the test's coverage guidelines
- Get pre-authorization from TriWest for all covered tests, except cystic fibrosis screening
- Get the test at an accredited clinical lab

2.5.13.1 LDT Authorization

Pre-authorization is required for all LDTs, except cystic fibrosis testing.

TriWest authorizes LDTs in accordance with the [TRICARE Operations Manual, Chapter 18 Section 2](#). Providers who perform LDT procedures more than once for the same beneficiary should use the appropriate modifiers and the claim will be processed accordingly. Claims submitted without pre-authorization will be denied.

2.5.14 Durable Medical Equipment (DME)

TRICARE covers [DME](#) or DME Prosthetics, Orthotics, and Supplies (DMEPOS) when prescribed by a physician that:

- Improves, restores, or maintains the function of a malformed, diseased, or injured body part, or can otherwise minimize or prevent the deterioration of the patient's function or condition
- Maximizes the patient's function consistent with the patient's physiological or medical needs
- Provides the medically appropriate level of performance and quality for the medical condition present
- Not otherwise excluded by the regulation and policy

If DME needs customization or repairs, TRICARE covers the following situations:

- Medically necessary customization or attachments to the DME to accommodate the medical disability when the physician has prescribed the equipment as medically necessary and appropriate
- Medically necessary covered accessories and attachments to a DME necessary to make the DME "serviceable" for a particular disability (e.g., a car lift that is a wheelchair accessory)
- Repairs to equipment that a beneficiary owns when needed to make the item serviceable
- Replacement of DME that a beneficiary owns when:
 - There is a change in the beneficiary's physical condition.
 - There is accidental damage to the DME.
 - The DME is inoperative and cannot be repaired.
 - The U.S. Food and Drug Administration (FDA) has declared the DME adulterated.
- Duplicate items (those that serve the same purpose, but may not be an exact duplicate, i.e., a portable oxygen concentrator as a backup for a stationary oxygen generator) that are essential to provide a fail-safe, in-home, life-support system.

Items that are not covered under the TRICARE benefit include:

- DME for a beneficiary who is a patient in a facility that ordinarily provides the same DME item to its patients at no additional charge in the usual course of providing its services is excluded
- DME available to the beneficiary from a military hospital or clinic
- DME with deluxe, luxury, or immaterial features, that will increase the item's cost to the government relative to a similar item without those features
- Routine periodic servicing, such as testing, cleaning, regulating, and checking, which the manufacturer does not require be performed by an authorized technician
- Duplicate items of otherwise allowable DME to be used solely as a back-up to currently owned or rented equipment
- Expendable items (e.g., incontinent pads, diapers, ace bandages, etc.)
- Non-medical equipment (e.g., humidifier, electric air cleaners, safety grab bars, etc.)

For more information, please reference [TRICARE Policy Manual, Chapter 8, Section 2.1](#) and [TRM Chapter 1, Section 11](#).

2.5.14.1 Upgraded DMEPOS (Deluxe, Luxury, and Immaterial Features)

An upgraded DE item, which otherwise meets the DE benefit requirement and is medically necessary, is covered if the prescription specifically states the medical reason why an upgrade is necessary. If the beneficiary prefers to upgrade a DE item, which otherwise meets the DE benefit requirements, the beneficiary will be solely responsible for the cost that exceeds the cost of what the Government would pay for the standard equipment. Refer to the [TRICARE Policy Manual, Chapter 8, Section 2.1](#) and [TRICARE Reimbursement Manual Chapter 1, Section 11](#) for more information.

2.5.14.2 DMEPOS Referral and Authorization Guidelines

Providers can use the TriWest [RADS](#) tool to look up codes to determine if a specific DME/DMEPOS is covered or if a referral or authorization is required.

3 Provider Information

The following sub-sections contain important information for providers to acknowledge and follow to provide health care services to TRICARE beneficiaries under the TRICARE program.

Providers must comply with applicable TRICARE requirements. Network providers sign a contract with TriWest to comply with all TRICARE and TriWest rules, requirements, policies, and procedures (please refer to the section on TRICARE Policy Resources). This handbook is not all-inclusive and is intended to present an overview of TRICARE and TriWest policies and procedures. In the event of a conflict between the contract and this handbook, the contract provisions supersede the handbook provisions.

For current information on TRICARE policy, please refer to the [Title 10 of the United States Code, Title 32 of the Code of Federal Regulations \(CFR\)](#), and TRICARE Manuals: [TRICARE Operations Manual \(TOM\)](#), [TRICARE Reimbursement Manual \(TRM\)](#), and [TRICARE Policy Manual \(TPM\)](#).

3.1 Provider Resources

3.1.1 Availity

[Availity](#) has a strong national presence connecting two million providers to health plans nationwide. Availity works with other clearinghouses, across other health plans, and is accessible through our [secure provider portal](#). Providers who already use Availity can use their existing log-in.

If a provider does not already have Availity, TriWest provides assistance to access this powerful tool. Through Availity, providers can:

- Update provider and office information
- Use the Availity Clinical Gateway Platform to deliver consultation reports and other clinical/medical documentation if they do not already have an existing electronic Health Information Exchange (HIE)
- Access secure transactions, including claims status, authorizations, and pharmacy data
- View communications regarding program updates, new training, and updated processes

TriWest has a full training program on Availity that utilizes various training methods that walk providers through TriWest's processes and procedures. The training methods include:

- Webinars – live, interactive virtual classes where providers can ask questions in real time
- Microlearning videos – short, bite-sized video snippets that cover various aspects of TRICARE
- eSeminar Learning Paths – Microlearning based on a variety of topics that, when viewed consecutively, form a complete eSeminar; think of microlearning as individual songs and the Learning Path as the playlist

Providers may contact Availity for basic user support and questions regarding HIE. Please visit www.availity.com or call Availity at 800-282-4548.

3.1.2 Electronic Health Information Exchange (HIE)

We know many providers have existing HIEs. During credentialing, we will confirm that a provider's HIE is compatible with the HIE the Defense Health Agency (DHA) utilizes.

If a provider does not already have a HIE, we can help them establish one.

3.1.3 Cultural Training

TriWest encourages providers to complete cultural training courses. Mental health care providers who have earned the DOD TRICARE Provider Readiness Designation (TPRD) as indicated by an icon, have knowledge of military culture and evidence-based treatments for mental health concerns common among members of the Armed Forces. To earn the TPRD, providers must complete the complete the six modules. Visit the [TRICARE Provider Readiness Training | Center for Deployment Psychology](#) to learn more about TPRD.

3.2 Privacy and Security

TriWest must ensure providers follow all privacy, security, and telemedicine-specific regulatory, laws, and rules for their profession in both the jurisdiction (site) in which they are practicing as well as the jurisdiction (site) where the beneficiary is receiving care, and compliance, as required, by appropriate regulatory and accrediting agencies. Our credentialing team will monitor provider offices during initial credentialing and thereafter during re-credentialing.

3.2.1 Health Insurance Portability and Accountability Act of 1996

TriWest requires all providers to follow the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA was enacted to:

- Combat fraud, waste, and abuse
- Improve portability of health insurance coverage
- Simplify health care administration

HIPAA requires individual health care providers and institutional providers such as hospitals, their workforce members, and their contractors, to use and disclose Protected Health Information (PHI) only as permitted or required by the HIPAA privacy rule. PHI includes beneficiary-identifiable health details, such as individually identifiable health information.

3.2.2 *Military Command Exception*

A provider may use and disclose the PHI of individuals who are service members for activities deemed necessary by appropriate military command authorities to ensure the proper execution of the military mission. Exceptions pertaining to disclosures to command authorities of PHI involving service members seeking behavioral health services and substance abuse education services are outlined on the [“Military Command Exception” page of the DHA Privacy and Civil Liberties Office website](#).

In the event of a disagreement between a commander and a DOD covered entity (including an affiliated health care provider) concerning disclosure of PHI, the DOD covered entity will, before making its determination, seek the advice of the cognizant legal advisor or command counsel, or the cognizant HIPAA privacy officer, or both, as appropriate. For more information in this area, please refer to Section 4 of [Department of Defense Manual 6025.18](#).

3.3 TRICARE Provider Authorization and Certification

TRICARE only reimburses appropriately covered services for eligible beneficiaries provided by TRICARE-authorized providers. TRICARE-authorized providers must comply with all TRICARE requirements, TriWest published policy and procedures, and the TriWest TRICARE Provider Handbook applicable to credentialing.

Providers who are contracted to the network must also be certified and credentialed. All network providers must accept the assignment (i.e., participate). Non-network providers have the option to accept the assignment on a case-by-case basis. If a non-network provider accepts assignment, they are recognized as a participating non-network provider, committing to accepting the TRICARE-allowable charge as complete payment for covered services and filing claims for TRICARE beneficiaries. When a beneficiary files a claim for services rendered by a non-participating individual professional provider who is legally practicing and eligible for TRICARE authorization, the provider will be certified, and payment will be issued to the beneficiary.

Providers can access certification forms necessary for providers to become TRICARE-authorized online.

Non-participating providers do not have to accept the TRICARE-allowable charge or file claims for beneficiaries. By federal law, if a non-network provider does not participate on a particular claim, the provider may not charge more than 15% above the TRICARE-allowable charge (115%).

National Provider Identifiers (NPI). TRICARE providers should already have NPIs. If a provider does not have an NPI, they can complete the [online NPPES application](#) or download the [National Provider Identifier Application/Update Form](#). Providers can find more information at [CMS.gov](#).

3.4 TRICARE Credentialing

To join the TRICARE West Region network, a TRICARE-authorized provider, if not already credentialed with us, must complete the credentialing process and sign a contract with TriWest. Providers who are already credentialed must meet TRICARE certification requirements per [TRICARE Operations Manual Chapter 4, Section 1, Paragraph 1.1](#). Please note that all network providers must accept Medicare on a claim-by-claim basis and must be Medicare participating providers. (Refer to [TRICARE Policy Manual Chapter 11, Section 1.2](#) for more information).

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The credentialing process requires verification of the provider's education, board certification, license, professional background, malpractice history, and other pertinent data. A fully executed contract copy is forwarded by TriWest to the provider. Please note that credentialing approval is sent separately from the fully executed contract.

Providers must have a signed contract with TriWest and have received credentialing approval from TriWest to be considered a network provider. TriWest monitors each network provider's quality of care and adherence to DOD, TRICARE, and TriWest policies. Network providers must be re-credentialed every three years.

Providers must meet VA-specific requirements as specified within the [TRICARE Policy Manual, Chapter 11](#).

3.4.1 Individual Providers

To meet the minimum credentialing criteria established by TriWest, individuals must have:

- Completed education and training required for the applicable specialty
- A current, active and unrestricted license
 - Provider licenses must allow for independent practice, with the exception of Pastoral Counselors and Supervised Mental Health Counselors.
- An unrestricted and active Drug Enforcement Agency (DEA) registration, as applicable to their license
- An unrestricted and active controlled substance registration, as applicable to their license per their state requirements
- Adequate malpractice or liability insurance per local requirements
- Providers cannot participate if they:
 - Are barred from participating in federal programs
 - Have a felony conviction
 - Have a physical or mental condition that would unreasonably limit their ability to render high quality care
 - Have a substance dependency that is untreated or unmanaged
 - Have gaps in work history of more than six months

Provider types that can participate subject to credentialing requirements are specified in [TRICARE Policy Manual, Chapter 11](#).

3.4.2 Institutional Providers

In order to participate, facilities must have:

- An active and unrestricted license
- Liability insurance that is active and adequate per state or locality requirements
- Proper accreditation as applicable for the facility type
- Facilities cannot participate if they are barred from participating in federal programs

For more information about becoming a network provider, visit TriWest's [Join Our Network](#) page. Providers can check credentialing status online.

3.5 Charging Administrative Fees

Providers may not charge TRICARE beneficiaries administrative fees. Per the [TRICARE Reimbursement Manual, Chapter 1, Section 19](#), providers may incur administrative expenses during the course of doing business. Most of these are normal expenses and payment for them is included in the payments made for the medical services rendered by the provider. Others are not covered because they are not medical services related to the treatment of an illness or injury. In either case, separate charges for administrative expenses are not allowed. Such expenses include:

- Penalty or interest charges imposed on a beneficiary by a provider because of failure to make timely payment on a bill are not covered.
- Provider administrative expenses such as charges for claims completion and furnishing medical records are not separately allowable.

3.6 Nondiscrimination Policy

All TRICARE-authorized providers agree not to discriminate against any TRICARE beneficiary on the basis of race, color, national origin, or any other basis recognized in applicable laws or regulations. To access the full TRICARE policy, refer to the [TRICARE Operations Manual Chapter 1, Section 5](#).

3.7 Office and Appointment Access Standards

TRICARE access standards are designed to ensure that beneficiaries receive timely health care services conveniently located within a reasonable distance from their homes. Network providers must adhere to the following appointment access standards:

- Preventive care appointment – Four weeks (28 days)
- Routine care appointment – One week (7 days)
- Specialty care appointment – Four weeks (28 days)
- Urgent care – One day (24 hours)
- Emergency care – Emergency services shall be available and accessible to handle emergencies within the service area 24 hours a day, seven days a week

3.8 Specialty Care Responsibilities

Pre-authorization for certain specialty care services is required. TRICARE Prime beneficiaries seeking specialty care require a referral from their PCM. PCMs and/or specialty care providers must coordinate with TriWest to obtain referrals and pre-authorizations. Please see the PCM section for more information.

[TRM, Chapter 1, Section 28, Paragraph 2.0](#) states that in the case of a provider's failure to obtain the required preauthorization, the provider's payment shall be reduced by 10% of the allowable amount. Under the managed care contracts, a network provider's payment can be subject to a greater than 10% reduction or a denial if the network provider has agreed to such a reduction or denial in the contract. These payment reduction penalties cannot be passed onto the beneficiary for payment. It is the provider's responsibility to obtain pre-authorization when required.

Network behavioral health care providers can request authorizations for non-office based, outpatient (e.g., Partial Hospitalization Program, Intensive Outpatient Program and Opioid Treatment Program) mental health services without requesting a PCM referral first.

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

- **TRICARE Prime:**
 - **ADSMs:** All civilian specialty care requires a referral from a beneficiary’s PCM and/or TriWest. In addition, pre-authorization from TriWest is required for certain services.
 - **Active Duty Family Members (ADFM):** Referrals to specialty care are required with the following exceptions:
 - Preventive care services from network providers
 - Urgent care services from network providers
 - Behavioral health care outpatient visits for medically necessary treatment for covered conditions
 - When using the POS option

Pre-authorization from TriWest is required for certain services.

- **TRICARE Select:** Referrals are not required to TRICARE-authorized specialty care providers
 - Pre-authorization from TriWest is required for certain services.
 - Providers can use the TriWest online [Referral and Authorization Decision Support \(RADS\)](#) tool to determine if TriWest approval is required.

Providers should submit referrals and pre-authorizations via the online referral management system on [Availity](#).

Any specialty care outside of the indicated referral scope requires an authorization request or communication back to the beneficiary’s PCM for necessary referrals.

3.9 Opioid Safety Initiative (OSI)

The DHA and the VHA developed and implemented the Opioid Safety Initiative (OSI) to improve quality of life, reduce suffering from chronic pain, decrease opioid prescribing practices associated with complications, and promote safer opioid-related prescribing for ADSMs, Veterans and their families.

The OSI addresses the challenges of opioid dependency and closely monitors DOD and VA dispensing practices system-wide, including care that occurs in the community. It coordinates pain management through patient and provider education, enhanced testing and safety monitoring, thoughtful tapering plans, the use of complementary integrated health modalities (i.e., acupuncture, massage therapy, yoga, etc.) and cognitive behavioral therapy for pain.

The current OSI guidance provides prescribers with a framework by which to evaluate, treat, and manage the individual needs and preferences of patients with chronic pain who are being considered for or are currently on long-term opioid therapy. Recommended actions for providers to take include:

- Perform a thorough assessment including all prior treatment approaches
- Set realistic expectations for pain management early and review often
- Request non-pharmacological/non-opioid treatment options when appropriate

- Proceed with opioid treatment with caution, as briefly as possible with the lowest dose immediate release option (not PRN long acting formulations)
- Reassess progress and safety at every visit. For example, drug screening or confirmation at least every six months, naloxone available, secure storage to protect others, consistently verify the state Prescription Drug Monitoring Program (PDMP) also known as Prescription Monitoring Programs – before prescribing any controlled substance each and every time a prescription is written, etc.
- Stop and reassess if concerns begin to occur
- Submit requests for substance abuse treatment when needed

3.10 Medical Documentation: Clear and Legible Reports (CLR)

Providers should return Clear and Legible Reports (CLR) for services rendered to ADSMs and MTF Prime beneficiaries. CLR's should be returned to the military hospital or clinic within 10 business days from the date of service for outpatient care. Inpatient discharge CLR's are due within 40 business days of discharge.

Outpatient CLR's should contain applicable information about the care provided such as:

- Specialty evaluations
- Lab and radiology reports
- Preventive services
- Clinical procedures
- Ancillary care
- Other clinical information obtained during the service

Inpatient CLR's should include:

- Consultation reports
- Operative reports
- Discharge summaries

Providers must follow the CLR instructions included on the referral/authorization confirmation from TriWest. Providers may submit CLR's using HIE networks that are connected to the Government's electronic health record system. If a provider does not have access to an HIE, they may submit CLR's online.

3.11 Updating Provider Information

Based on their TriWest contract, network providers are required to notify TriWest or their designated network subcontractor of any change in address, professional affiliation, tax identification number (TIN), or licensure status. TriWest often partners with a network subcontractor (e.g., Blue Cross Blue Shield plans) to develop and manage the provider network. Our provider contracts specify the designated network subcontractors that manage provider data, credentialing, and other functions as designated by TriWest. Some provider contracts may not have a designated network subcontractor. In such cases, providers should provide the updated information directly to TriWest.

Providers should make their best efforts to notify TriWest or their designated network subcontractor at least 60 days before the change date, or at the earliest opportunity if such prior

notice is impracticable. If advance notification is not possible, providers should notify TriWest or their network subcontractor no later than 10 business days after the effective change date.

Prompt notification to TriWest or their designated network subcontractor of changes in information allows beneficiaries seeking health care services and providers seeking to refer care to access the most accurate provider information. Additionally, it allows TriWest to send payments to the correct address and avoids PHI disclosures.

The Network Provider Directory, located at <https://tricare.triwest.com/en/beneficiary/>, helps beneficiaries and other providers locate TRICARE network providers. To confirm the accuracy of individual listings and information, network providers must visit the online Network Provider Directory at <https://tricare.triwest.com/en/beneficiary/>. To update demographic information, use Availity or submit a TRICARE Provider Roster at www.triwest.com.

If you are a network provider and do not see your practice listed in the Network Provider Directory, email TriWest providerservices@triwest.com or call the TriWest Customer Service line 1-866-690-0885 to inquire about being listed. Providers interested in joining the TriWest network should go to JoinOurNetwork.TriWest.com.

Non-network providers are not included in the Network Provider Directory. Doctors, hospitals, and other health care professionals who are TRICARE authorized and have submitted a claim over the past 14 months can be found on the online Non-Network Provider Directory. To update and verify demographic information, please visit <https://tricare.triwest.com/en/provider/>.

3.12 Provider Contract Provisions

The following provisions are applicable to services rendered pursuant to the TRICARE/CHAMPUS program requirements as administered by TriWest and will be incorporated by reference into the Provider’s contract as fully set forth therein. The Spanish version of the Provider Handbook is provided for convenience only; the English version of all contractual documents between TriWest and the provider, including but not limited to the TRICARE Provider Handbook, shall be exclusively used for legal interpretation. For avoidance of doubt, in the event of any ambiguity or disagreement between the terms of the Spanish version of the Provider Handbook and the original English version, the English version shall take precedence and control.

3.12.1 Definitions

Term	Definition
Adequate Medical Documentation, Medical Treatment Records	Adequate medical documentation contains sufficient information to justify the diagnosis, the treatment plan, and the services and supplies furnished. Under TRICARE/CHAMPUS, it is required that adequate and sufficient clinical records be kept by health care provider(s) to substantiate that specific care was actually and appropriately furnished, was medically necessary and appropriate, and to identify the individual(s) who provided the care. All procedures billed must be documented in the records. In determining whether medical records are adequate, the records will be reviewed under the generally acceptable standards such as the applicable Joint Commission (formally Accreditation of Healthcare Organizations) standards, the Peer Review Organization (PRO) standards, (and the provider’s state or local licensing requirements) and other requirements specified by TRICARE Requirements. In general, the documentation requirements for a professional provider are not less in the outpatient setting than the inpatient setting.

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Term	Definition
Authorized Provider	A hospital or institutional provider, physician, or other individual professional provider, or other provider of services or supplies specifically authorized to provide benefits under CHAMPUS pursuant to TRICARE Requirements. Provider shall be an Authorized Provider.
Balance Billing	A provider seeking any payment, other than any payment relating to applicable deductible and cost sharing amounts, from a beneficiary for TRICARE/CHAMPUS covered services for any amount in excess of the applicable TRICARE/CHAMPUS allowable cost or charge. Balance billing is prohibited.
Beneficiary Liability	The legal obligation of a beneficiary, his or her estate, or responsible family member to pay for the costs of medical care or treatment received. Specifically, for the purposes of services and supplies covered by TRICARE, beneficiary liability includes any annual deductible amount or cost-sharing amounts. Beneficiary liability also includes any expenses for medical or related services and supplies not covered by TRICARE.
Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)	A term also used for TRICARE and as referenced by the relevant authorities, including TRICARE Requirements. TRICARE and CHAMPUS shall be considered synonymous and interchangeable terms for the purpose of this TRICARE Provider Handbook.
CHAMPUS Maximum Allowable Charge (CMAC)	CMAC is a nationally determined allowable charge level that is adjusted by locality indices and generally, but not always, is equal to or greater than the Medicare Fee Schedule amount.
Defense Health Agency (DHA)	A joint, integrated combat support agency that enables the Army, Navy, Air Force, Marine Corps, Coast Guard, Space Force, and Coast Guard medical services to provide a medically ready force and ready medical force to combatant commands in both peacetime and wartime. DHA is considered part of the government.
Director	The Director of the Defense Health Agency, Director, TRICARE Management Activity, or Director, Office of CHAMPUS. Any references to the Director, Office of CHAMPUS, or OCHAMPUS, or TRICARE Management Activity, shall mean the Director, Defense Health Agency (DHA). Any reference to Director shall also include any person designated by the Director to carry out a particular authority. In addition, any authority of the Director may be exercised by the Assistant Secretary of Defense (Health Affairs).
Department of Defense (DOD)	The DOD is responsible for providing the military forces of the United States of America needed to deter war and protect the security of the country. DOD is also considered part of the government.
Medically (or Psychologically) Necessary Preauthorization (or prior)	A pre (or prior) authorization for payment for medical/surgical or psychological services based upon criteria that are generally accepted by qualified professionals to be reasonable for diagnosis and treatment of an illness, injury, pregnancy, and mental disorder. The term prior authorization is commonly substituted for preauthorization and has the same meaning. Provider reimbursement may be reduced or claims denied if services were provided without appropriate Preauthorization.
Military Health System (MHS)	The system that is operated by the DOD and is responsible for providing health services through both MTFs and private sector care to TRICARE eligible beneficiaries, composed of uniformed service members, military retirees, and family members. MHS is also considered part of the government.
Military Treatment Facility (MTF)	A military facility that operates within the MHS provide and directs care of TRICARE Beneficiaries. MTFs are also considered part of the government.
Network Subcontractor	The health plans with whom TriWest contracts to include providers in the TriWest provider network.

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Term	Definition
Preauthorization (or prior)	A decision issued in writing, or electronically by the Director, TRICARE Management Activity, TriWest, or a designee, that TRICARE benefits are payable for certain services that a beneficiary has not yet received. The term prior authorization is commonly substituted for preauthorization and has the same meaning. Provider reimbursement may be reduced or claims denied if services were provided without appropriate preauthorization. Preauthorization is not a guarantee of payment of a claim.
TRICARE Beneficiary/Beneficiaries/MHS Eligible Beneficiary	An individual who has been determined to be eligible for TRICARE/CHAMPUS benefits as set forth in TRICARE Requirements. TRICARE Beneficiary programs include TRICARE Prime and TRICARE Select.
TRICARE/TRICARE Program	A component of the MHS. The TRICARE Program is the means by which managed care activities designed to improve the delivery and financing of health care services in MHS are carried out.
TRICARE Covered Services	Services, items and supplies for which benefits are available to TRICARE Beneficiaries in accordance with the rules, regulations, policies and instructions of DHA and DOD.
TRICARE Requirements	Title 10, United States Code, Chapter 55; 32 CFR Part 199; TRICARE Policy Manual (TPM); TRICARE Reimbursement Manual (TRM); TRICARE Operations Manual (TOM); and TriWest TRICARE Provider Handbook and TriWest Policies and Procedures. As of the effective date of these TRICARE Terms and Conditions, TRICARE Manuals may be found at: https://manuals.health.mil/ .

3.12.2 Exclusions and Terminations

TriWest and Network Subcontractors have the right to immediately terminate Provider Agreements upon written notice to the provider for any of the events listed below:

- Provider’s state or federal license or authorization to do business is reduced, restricted, suspended, or terminated (either voluntarily or involuntarily), placed on probation, or provider’s other applicable license or accreditation is reduced, restricted, suspended, or terminated (either voluntarily or involuntarily).
- Provider’s professional liability coverage as required under Provider’s Agreement is reduced below required amounts or is no longer in effect.
- Provider fails to meet TriWest’s or Network Subcontractor’s credentialing, re-credentialing, quality management or utilization management criteria, or fails to comply with quality management or utilization management processes.
- Provider fails to provide material information or provides erroneous information on Provider’s credentialing application or re-credentialing application.
- Provider is no longer Medicare-eligible, Medicaid-eligible, or is not eligible to participate in another government program.
- Provider or any of its officers is arrested or indicted on felony charges that directly or indirectly relate to provisions of services under the Provider’s Agreement, and TriWest and Network Subcontractors make a reasonable and good faith determination that the nature of the charges is such that termination is needed to avoid unnecessary risk or harm to beneficiaries that could occur during the pendency of the criminal proceedings.
- The Director, DHA, or designee may exclude any provider based on 32 CFR § 199.9 provisions (fraud, abuse and conflict of interest). The exclusion period is at the discretion

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of DHA. DHA Program Integrity will send written notice to the Provider of the proposed exclusion, and the potential effect thereof. Provider may submit evidence and written argument regarding the proposed exclusion. DHA Program Integrity has sole authority to issue an Initial Determination of Exclusion. Written notice of this decision will include the basis for the exclusion, the exclusion length, and the effect of the exclusion. The determination also outlines the earliest date on which DHA Program Integrity will consider a request for reinstatement, the requirements for reinstatement, and appeal rights available. Exclusion of a Provider will be effective 15 calendar days from the date of the initial determination. The Director, DHA or designee has sole authority for approval of any request for reinstatement. Within 15 business days of DHA Program Integrity notifying TriWest of an exclusion action, TriWest will provide written notice, sent by certified mail, return receipt requested, that the Provider's agreement has been cancelled.

- TriWest will initiate termination action based on a finding that Provider fails to meet the qualifications to be an authorized TRICARE/CHAMPUS provider. The termination period will be indefinite and will end only after Provider has successfully met the established qualifications for authorized status under TRICARE and has been reinstated as outlined in [TOM Ch. 13 Section 5 Subsection 10.0](#).
- TriWest will initiate termination action based on a finding that the provider fails to meet the qualifications to be an authorized TRICARE/CHAMPUS provider. The termination period will be indefinite and will end only after Provider has successfully met the established qualifications for authorized status under TRICARE and has been reinstated as outlined in [TOM Ch. 13 Section 5 Subsection 10.0](#).
- TriWest and Network Subcontractor, in their sole discretion, have the right to immediately terminate or pursue other administrative action upon TriWest learning that Provider had not been credentialed in compliance with the TriWest Credentialing Committee Policy & Procedure.

3.12.3 Notification

All notices and other communications to a Party must be in writing, hand delivered, delivered by prepaid commercial courier services with tracking capabilities, faxed, or delivered by the U.S. mail to the address listed on the signature page of the Provider's Agreement. The Parties may change the address of record by notifying the other Party of the new address. Notice shall be complete upon the earlier of actual receipt or five (5) days after being deposited into the U.S. mail. Notices and other communications in writing need not be mailed either by registered or certified mail, although a signed return receipt received through the U.S. Post Office shall be conclusive proof between the Parties of delivery of any notice or communication and of the date of such delivery.

Provider shall notify TriWest or Network Subcontractor in writing immediately upon learning of any action, policies, determinations or internal or external developments that may have a direct impact on Provider's ability to perform its obligations under the Provider's Agreement. Such matters shall include, but are not limited to:

- Any change in ownership, specialty services provided, Medicare designation (including but not limited to sole community, critical access, etc.), or location of facilities
- Action against or lapse of Provider's license, certification, accreditation, or certificate of authority

- Loss of hospital privileges
- Arrest or indictment
- Reduction in insurance coverage below the required limits set forth for the applicable Program, or termination of insurance coverage
- Any activity that compromises the confidentiality and security of the beneficiaries' medical records
- Exclusion or any other penalty from Medicare, Medicaid, or any other federal health care program
- Provider shall complete TRICARE required training that will be determined at a later date and reflected in the next version of the TriWest TRICARE Provider Handbook.

3.12.4 Provider Directory

TriWest may periodically include the provider's name, gender, work address, work fax number, work telephone number, whether the provider is accepting new patients, specialty and sub-specialty, and willingness to accept beneficiaries in a network provider directory. The provider is responsible for notifying TriWest or network subcontractor of any changes of address, phone or fax number, or specialty services rendered within 10 business days.

3.12.5 Compliance

Providers must comply with all applicable state and federal laws as well as regulations and all rules, policies and procedures of the applicable program including without limitation to credentialing, peer review, referrals, utilization review/management, clinical practice guidelines, case management and quality assurance programs and procedures established by TriWest or the applicable health care program including submission of information concerning provider and compliance with Preauthorization requirements, care approvals, pharmacy, dental and DME utilization requirements, care approvals, concurrent reviews, retrospective reviews, discharge planning for inpatient admissions, critical event notifications, quality of care audits, return of medical records, and preauthorization of referrals.

3.12.6 Ancillary Providers

If laboratory tests billed by a non-network provider were performed outside the non-network provider's office, the place where the laboratory tests were performed must be provided for TriWest to approve arrangements for laboratory work submitted by network providers.

To be covered, the services must have been ordered by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) and the laboratory must meet the requirements to provide the services as required under the 32 CFR § 199 and DHA instructions.

For TRICARE Prime beneficiaries, ancillary services must be ordered by the PCM.

3.12.7 Credentialing and Certification Requirements

Providers cannot have had any state license terminated for cause, have relinquished any state license after being notified in writing by that state of potential termination for cause, or have relinquished any state license for any reason that would violate TRICARE requirements (as defined in the Provider TRICARE Terms and Conditions) whether or not provider had been notified by that state of potential termination for cause.

Providers who have not submitted a claim or whose services have not been submitted on a claim within the past two years may be moved from the active file to the inactive file. However, even if the provider remains on the active file, if a claim is received from a provider who has not submitted a claim or whose services have not been submitted on a claim within the past two years, the provider must be fully recertified. Providers who have been terminated or suspended shall not be deleted. Suspended, terminated, or excluded providers shall remain on the file as flagged providers indefinitely or until the flag is dropped because the suspended provider has been reinstated.

3.12.8 Professional Liability Coverage

Providers must provide and maintain professional liability insurance in an amount in accordance with the laws of the state in which the care is provided and TRICARE Requirements, including TriWest TRICARE Terms and Conditions.

4 TRICARE Referrals and Authorizations

If a necessary service or procedure cannot be provided by a MTF or the beneficiary's PCM, a referral to another provider for services can be required depending on the beneficiary program option (see below). Various procedures and services require pre-authorization from TriWest before they can be administered.

Referral and authorization requirements differ by TRICARE program option:

- TRICARE Prime: Referrals are required from a beneficiary's PCM before seeking care from other providers
- TRICARE Select: Referrals are not required to seek care from TRICARE authorized providers
- Certain services require pre-authorizations depending on the program option

Providers can check the [Referral and Authorization Decision Support](#) (RADS) tool to view the Pre-Authorization List to determine authorization requirements before performing services.

4.1 Referral and Pre-Authorization Requirements

Providers must comply with all referral and pre-authorization requirements contained in:

- TRICARE policy requirements
- TriWest published policy and procedures
- TriWest TRICARE Provider Handbook

Providers are encouraged to review these policies and procedures routinely as changes may occur due to contract modifications. Additionally, TriWest reviews pre-authorization requirements annually, ensuring adherence to TRICARE policy. To ensure appropriate utilization of care, TriWest also evaluates medical and behavioral health care trends.

Beneficiaries may be directed to receive care at a MTF if the specialty service requested is offered and the MTF accepts the beneficiary. If the MTF cannot provide the requested care, TriWest will find a network provider.

It is the provider/PCM's responsibility to obtain a pre-authorization for services that require them. Per [TRICARE Reimbursement Manual Chapter 1](#), network and non-network providers who do not obtain a pre-authorization and submit a claim for services that require them will receive a 10%

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payment reduction during claims processing. Network providers may have a greater penalty depending on the provider's network contract. Payment reduction penalties cannot be passed onto the beneficiary.

4.2 Submitting Referral and Pre-Authorization Requests

Referrals and pre-authorizations can be submitted to TriWest using the online referral management system on [Availity](#). Supporting clinical documentation must be attached to the request. If further documentation is needed, or if further instructions are required, TriWest will notify the PCM or referring provider.

MTFs can coordinate pre-authorizations and referrals with TriWest based on the specific guidelines established in the Memorandums of Understanding (MOU) between TriWest and their MTF.

The PCM or referring provider is responsible for providing the following information for services that require a pre-authorization or referral:

- Written explanation of the services that are being requested
- Sufficient clinical information to aid the beneficiary's treatment

The PCM or referring provider must also ensure the beneficiary is prepared for the appointment by ensuring they have the medical records, laboratory results or X-rays, etc., needed. If needed, TriWest will contact the provider's office for further information or clarification to process the pre-authorization or referral request.

Once the referral request or pre-authorization is approved, TriWest sends a notification to the beneficiary and referring provider/PCM that lists:

- Specialty provider's name
- Specialty services
- Dates and visits that are approved

TriWest also posts provider letters in the [online referral management system](#) online. Beneficiary letters are posted to the secure beneficiary portal that is accessible through <https://tricare-bene.triwest.com/signin>.

For outpatient services, the letter includes an authorization number for the approved services. Beneficiaries can use the information in the letter to schedule their first appointment. If they require assistance, providers are expected to help them schedule the service. For letters notifying the beneficiary of a denied authorization, guidance on how to submit an appeal is included.

For inpatient services, after TriWest is notified of a beneficiary's admission, the letter will include a tracking number for the pre-authorization request.

4.2.1 Required Clinical Documentation

Because TRICARE coverage of certain limited benefits is subject to specific clinical criteria review, TriWest may require providers to complete clinical information assessments. These assessments can be accessed via the [online referral management system on Availity](#). The provider must:

- Complete the beneficiary information

- Provide the diagnosis and medical necessity rationale for the requested services or supplies
- Electronically sign the assessment to confirm the accuracy of the clinical information

This assessment is submitted with a pre-authorization request.

4.3 MTF Optimization/KSA Referrals

Military hospitals and clinics, generally known as military treatment facilities (MTFs), are usually located on or near military installations. The TRICARE provider network supplements MTF resources to ensure that beneficiaries get the care they need.

MTFs are located on most military posts, bases, and installations with the goal of active duty readiness for military contingency operations. They also have primary responsibility for providing care to TRICARE beneficiaries within their capabilities and capacities. To provide care effectively and efficiently, MTFs retain the right to accept referrals for TRICARE beneficiaries when they have the capabilities and capacity to provide the required services. These referrals are known as Knowledge, Skills, and Abilities (KSA) referrals. Important reasons that MTFs may choose to deliver Prime-referred services include:

- To ensure all medical service forces are ready to perform by keeping their skills current
- To ensure MTF optimization, which helps to contain health care cost for TRICARE beneficiaries
- To assist in determining prevalent MTF specialty access and adequacy needs for a particular TRICARE population
- To enhance the military graduate medical education program
- To hone the skills of military providers rotating through the MTF

If the MTF cannot provide the requested services, the beneficiary will be referred to a TriWest network provider. However, if a TriWest network provider is selected before the MTF optimization determination and the MTF opts to provide the services, this overrides any prior network provider selection, and the beneficiary is required to be seen at the MTF.

TRICARE Prime beneficiaries who have received a referral for services will be referred by TriWest to an MTF first when the MTF indicates they have the capability to provide that type of care. The MTF has the right to accept or refuse the referral.

Providers are expected to refer TRICARE Prime beneficiaries to TRICARE network providers, except in an emergency or where the provider has obtained a referral or pre-authorization. If a Prime beneficiary chooses to receive a covered service from a non-network provider without a referral, the service will be covered under their [Point of Service \(POS\) option](#). ADSMs who do not coordinate care through their PCMs may be responsible for the entire cost of care.

Referrals to non-network providers for TRICARE Prime beneficiaries must include specific medical necessity and justifying information as to why a non-network provider must be used instead of a TRICARE network provider.

4.3.1 TRICARE Prime Referral Processing

When TRICARE Prime beneficiaries need specialty care referrals, the requesting provider must submit a referral/authorization request to TriWest for approval, which includes possible MTF Optimization/KSA referral processing.

Providers must request referrals using the TriWest online referral management system on [Availity](#) to include appropriate clinical information.

4.4 Processing Timelines for Pre-Authorization and Referral Requests

TriWest will process requests in the following time frames:

- **Routine referral requests** are processed within one-to-two business days of receiving the request from the provider.
- **Urgent referral requests** are processed within one business day.
- **Routine authorization requests** are processed within two-to-five business days of receiving the request from the provider and all required clinical documentation.
- **Urgent authorization requests** are processed in an accelerated manner for care that needs to be delivered within 72 hours. Processing time for both routine and urgent requests may be delayed if sufficient information is not provided.
- Requests are processed using the clinical information submitted by the provider

4.5 Appeals and Reconsideration

Beneficiaries have the right to file an appeal (also known as reconsideration) to dispute a denial of pre-authorization for services. TRICARE defines an appeal as a formal written request by a beneficiary, a participating provider, a provider denied authorized provider status under TRICARE, or a representative, to resolve a disputed question of fact.

Please see [TOM Chapter 12](#) for more information on TRICARE appeals requirements.

Depending on the situation, an appeal may be urgent, non-urgent expedited, or non-expedited. This depends on whether the care has already been received and the situation’s urgency. TriWest provides instructions for filing the request for reconsideration in the notification letter.

Type of Appeal	Instructions
Urgent Expedited	<ul style="list-style-type: none"> • Beneficiary must be inpatient • Submit appeal by noon next business day from initial determination decision
Non-Urgent Expedited	<ul style="list-style-type: none"> • Medical necessity denial of preadmission or pre-procedure • Received within three (3) calendar days from initial determination decision
Non-Expedited	<ul style="list-style-type: none"> • Medical necessity or factual reconsideration • Submit within 90 calendar days

TriWest can receive appeals via fax or email. These requests must include:

- Beneficiary’s name, address, phone number, and sponsor’s Social Security number (SSN) or DOD Benefits Number (DBN)
- Printed name of the person submitting the appeal and the relationship to the beneficiary
- Reason for disputing the denial (required)
- Copy of the initial denial letter and any other documents related to the issue
- Additional documents supporting the appeal

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4.5.1 Active Duty Service Member Reconsiderations

TRICARE Prime Remote (TPR) beneficiaries may have the right to a reconsideration if their request for services was denied. They can contact DHA-Great Lakes at 888-647-6676 for answers to questions or to initiate a reconsideration. Providers who submit reconsiderations on the behalf of a service member must obtain an Appointing a Representative for an Appeal form.

5 Medical Management

5.1 Peer Review Organization Agreement

In the TRICARE West Region, TriWest has peer review authority over health care services provided in network and non-network civilian facilities. Facilities must establish a Peer Review Organization (PRO) Agreement with TriWest in accordance with [32 Code of Federal Regulations](#) and [TRICARE Operations Manual \(TOM\)](#) to participate in our network. The PRO agreement is separate from a network contract. Both network and non-network facilities are required to sign a PRO, acknowledging that TriWest is the PRO for the TRICARE West Region.

If a corporation has multiple facilities, one signed agreement may cover all the facilities.

By signing the agreement providers confirm that they will cooperate with TriWest and our subcontractors by:

- Providing copies of medical records timely
- Providing accurate information on beneficiaries' conditions
- Informing beneficiaries of their rights and responsibilities
- Providing other assistance that may be required for TriWest to conduct comprehensive utilization and quality management programs for care of MHS beneficiaries who are facility patients

5.2 Emergency Admission

TRICARE providers must notify TriWest of an emergency room inpatient admission and discharge date within 24 hours or by the next business day following admission and discharge. Facilities can submit the admission notification by visiting the Emergency Inpatient Notification profile in [Availity](#) online.

Facilities must note the following items on the hospital admission request:

- Beneficiary demographic information including sponsor's Social Security number (SSN) or DOD Benefits Number
- Health plan information
- Admitting physician's name
- Admitting diagnosis and date

TriWest reviews admission information and authorizes continued care, if necessary.

5.3 Inpatient Notification Process

TriWest requires notification of all inpatient facility admissions and discharge dates by the next business day following the admission and discharge. We also conduct continued stay reviews for many services.

TriWest will send the medical facility an authorization number after we receive clinical information and the discharge date and we will request clinical records, as necessary. Clinical records should be submitted online before the beneficiary is discharged. This ensures that MTFs have insight into care being delivered.

5.4 Concurrent Review

Concurrent review ensures appropriate, efficient, and effective utilization of medical resources by evaluating continued inpatient stays. TriWest performs concurrent reviews to determine medical necessity, quality of care and appropriateness of the level of care being provided as well as the setting in which the treatment is being rendered or proposed. It applies to all levels of inpatient care and partial hospitalization programs. If an admission or an extended stay does not meet the required clinical criteria, TriWest will send a request to the medical director or peer review panel for further review.

When approving inpatient medical/surgical admissions, the number of days is assigned and the last covered date is set. If a beneficiary requires additional time in the facility and the facility does not request an extension by submitting necessary clinical information, a provider penalty is applied to the additional days.

When prospective review (pre-authorization) is initiated, TriWest will secure the necessary medical information to support the medical, surgical, or behavioral health care services. Utilization Management staff will perform a medical necessity and appropriateness of setting and treatment review with each concurrent review, utilizing InterQual[®] Level of Care Criteria or specific policy key criteria that incorporates specific TRICARE requirements. A TriWest medical management representative may contact the hospital at the time of admission notification to obtain initial clinical information and to discuss discharge planning needs. TriWest may make subsequent contacts to discuss goals for length of stay and/or confirm discharge.

Before or during discharge, facilities must arrange an aftercare appointment to occur within 7-10 days if the beneficiary is not being discharged to another facility. The facility must include this information with the final discharge information transmitted to TriWest.

5.5 Discharge Planning

TriWest initiates discharge planning for all admissions during the case's first review. Discharge planning begins upon admission review and continues throughout the beneficiary's stay. The intensity of services change when a beneficiary's illness decreases in severity and/or begins to stabilize. If care can be delivered in a less emergency-oriented setting, TriWest's medical management staff coordinates efforts with the physician directing the care (and the beneficiary and family members) to facilitate timely and appropriate discharge. These activities include:

- Arranging for services such as home health and DME needed after discharge
- Coordinating transfers to lower levels of care to minimize inappropriate use of hospital resources

5.6 Care Coordination

TriWest's Care Coordination Program is part of whole person clinical care support structure with its primary role to assist with:

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- Discharge planning, including assessment of the need for in-home case management visits, and coordinating the visits with network community case management resources
- Coordinating facility transfers
- Coordination of intraregional and interregional transition of care
- Assisting beneficiaries in their understanding on how to utilize, access, and navigate their TRICARE benefits
- Overseeing hospice benefit and requests
- Assisting with provider communication and collaboration when multiple providers are engaged in the care

Program participation for Care Coordination should be less than 60 days. TriWest will transfer the case to a Case Manager for longer term support if the complexity or the need is identified.

Providers can make referrals for Care Coordination through online referral management system on [Avality](#). [Avality](#) allows providers to see their referral status as well as the completed care plan once the beneficiary has agreed to participate. Care Coordination staff will reach out to providers for support as clinically indicated to ensure optimal outcomes and continuation of care for the beneficiary. Contact is multi-modal and will be made by phone, email, fax, etc., depending on the need.

5.7 Case Management

TriWest's Case Management program coordinates all aspects of medical and behavioral health treatment for at-risk beneficiaries who require extensive, complex, and/or costly services. TriWest case managers manage treatment by coordinating MTFs and TRICARE regional resources to provide high quality, cost-effective services targeted to address the beneficiaries' unique physical and behavioral health needs. TriWest case managers are nurses, licensed clinical social workers, or other health professionals that acts as a patient advocate, coordinating the beneficiary's health care between the MTF, PCM, specialists, and other health care providers.

Providers can refer beneficiaries who may benefit from case management for an evaluation to TriWest using the online referral management system on [Avality](#). [Avality](#) allows providers to see their referral status as well as the completed care plan once the beneficiary has agreed to participate. Case Management staff will reach out to providers for support as clinically indicated to ensure optimal outcomes and continuation of care for the beneficiary. Contact is multi-modal and will be made by phone, email, fax, etc., depending on the need.

Our case managers offer TRICARE beneficiaries and their families support in a personalized way throughout their health care experience. They also are equipped to identify relevant local, county, state and federal level resources to meet the beneficiary's needs in a quality and cost-effective manner. Case managers may consult with the beneficiary's providers regarding treatment plans.

Case Management staff have access to both clinical and non-clinical subject matter experts within our Disease Management team, supporting a multidisciplinary approach to address the unique needs of each beneficiary. This support includes:

- Access to findhelp.org for social determinant of health (SDoH) support.
- Health coaches with expertise in respiratory therapy.
- Dieticians, pharmacy, and counselor support.

Case Management staff can consult with these staff and/or coordinate interactions for the beneficiaries where indicated. Case Management staff also coordinate with community providers and MTF staff to facilitate a whole-person approach to care management.

5.7.1 In-Home Case Management Coordination

TriWest will provide in-home case management coordination for identified high-risk beneficiaries. During discharge planning, TriWest will partner with the hospital discharge planning team so that beneficiaries may be screened and assessed for the need for an in-home case management visit. TriWest uses a scoring tool to assess needs that drive a variety of interactions for the beneficiary and their family. TriWest will manage all notifications and act as a liaison to identify urgency and proper utilization of services needed to ensure successful transitions of care and help avoid readmissions. In-home visits will be scheduled within 48-72 hours of discharge.

5.8 Population Health Management

TriWest's Population Health management approach is to prevent, manage, and incorporate wellness measures for health optimization and disease management. To do this, TriWest provides support to beneficiaries through an integration of secure portals, online tools, and interactive programs developed to create greater autonomy for beneficiaries as they become more fluent in managing their own care needs and more confident in their treatment-seeking behaviors. TriWest offers several digital and interactive programs to support health and wellness, including:

- Wellness and Healthy Lifestyle Education
 - TriWest mobile app
 - Portal education and resources
- Targeted messaging
 - Wellness care for children and adults
 - HEDIS gaps in care
 - Cancer Screenings
 - Chronic disease support
 - Behavioral health challenges
- Disease management programs
 - Anxiety, Asthma, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Coronary Artery Disease/Post-Myocardial Infarction, COVID Long Haulers
 - Depression, Diabetes, Post-Traumatic Stress Disorder (PTSD)
 - Smoking and vaping cessation

5.8.1 Wellness and Healthy Lifestyle Education

TriWest provides a variety of health and wellness information to support our beneficiary's health journey as well as a mobile app option.

5.8.2 Targeted Messaging

Using data analytics and beneficiary program encounters, our targeted messaging will send personalized messages to our beneficiaries regarding:

- Gaps in care (e.g., HEDIS, cancer screening and absent wellness visits or immunizations) and how to close them
- Upcoming routine health care services that are age and gender appropriate

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- Opportunities for engaging in our clinical support programs
- General seasonal or wellness information

The messages will be sent utilizing beneficiary preferences for mail, email, text, and portal options.

5.8.3 *Disease Management Programs*

TriWest Disease Management programs are designed to improve the health of beneficiaries with newly identified diseases, or those that may be struggling with chronic conditions. TriWest has established programs for the following conditions:

- Anxiety
- Asthma
- Coronary artery disease with new myocardial infarctions
- Chronic Obstructive Pulmonary Disease (COPD)
- Congestive Heart Failure (CHF)
- Long-haul Coronavirus (COVID)
- Depression
- Diabetes

Beneficiaries that engage in our programs are provided education and resources to improve their health outcomes in collaboration with the providers.

Referrals for disease management can be made via the online referral management system on [Availity](#).

5.9 Retrospective Review

TriWest clinical staff collaborates with network claims processor PGBA when claims are submitted without a required authorization and require medical necessity review. Clinicians will obtain and utilize appropriate clinical criteria to confirm whether the care met clinical standards. This information is communicated to PGBA so that claims can be processed appropriately.

The clinical staff also support real-time and retrospective review of unlisted codes. Information is reviewed to determine if the unlisted code is appropriate to utilize, pricing meets TRICARE reimbursement requirements, or if another code is more appropriate for submission.

TriWest completes retrospective reviews on a statistical sample of paid claims as required by TRICARE program requirements on a quarterly basis. These reviews are completed to ensure documentation in the beneficiary's medical record support reimbursed services. Although retrospective reviews may be performed on any service, they are typically focused on:

- Diagnosis-related group (DRG) reimbursement
- Home health services
- Hospice services
- Other specified topics as identified by TRICARE

When reviewing claims as part of a retrospective review, TriWest requests medical records from the billing and/or rendering provider. Medical records are reviewed to:

- Assess the accuracy of information provided during the prospective review process
- Determine the medical or psychological necessity and quality of care provided

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- Validate the review determinations made by the utilization review staff
- Determine whether the diagnostic and procedural information and/or discharge status of the beneficiary matches the description of care and services documented in the medical record

TRICARE requires providers to comply with the request for records. Failure to do so could result in the recoupment of payment for the services rendered.

TriWest will initiate the following for all cases that are selected for focused retrospective review:

Review	Description
Admission review	Review to ensure medical records indicate that the inpatient hospital care was medically or psychologically necessary and provided at the appropriate level of care
Invasive procedure review (surgical or other procedure that affects DRG assignment)	Review medical records for surgical or other procedures that affects DRG assignment. Review ensures the medical records support the medical necessity of the procedure performed. The performance of unnecessary procedures may represent a quality and/or utilization problem.
Discharge review	Medical records are reviewed using appropriate criteria (i.e., InterQual®) to determine potential problems with questionable discharges, as well as other potential quality problems.
Home health prospective payment system review	A monthly retrospective review of medical records and claims, reviewed in accordance with the TRICARE Reimbursement Manual, Chapter 12 . This review evaluates whether services provided were reasonable and necessary, delivered, coded correctly, and appropriately documented.
DRG validation	This review determines if the diagnostic and procedural information and discharge status of the beneficiary, as reported by the hospital, matches the attending physician’s description of care and services documented in the beneficiary’s record. During this review, selected records receive focused and intensified reviews to ensure that medical documentation supports the services received.
Outlier review	Claims that qualify for additional payment as cost-outliers are reviewed to ensure costs were medically necessary, appropriate, and met all payment requirements. Claims that qualify as short-stay outliers are reviewed to ensure that the admission was medically necessary and appropriate and that the discharge was not premature or questionable. Procedures and services not covered by the DRG-based payment system International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) and Current Procedural Terminology (CPT) codes provide the basis for determining whether diagnostic and procedural information is correct and matches the information contained in the medical record

Additionally, TRICARE policy requires that every beneficiary admitted to a hospital receive and sign a copy of the An Important Message from TRICARE form, detailing the beneficiary’s rights concerning coverage and payment of hospital stays and post-hospital services. The form discusses the Notice of Non-Coverage typically used by hospitals to inform beneficiaries when their health insurance will no longer pay for hospital care. The signed document must be kept in the beneficiary’s file and a new document must be provided for each admission.

Under the rules of the [TRICARE Hold Harmless Policy](#), providers cannot bill TRICARE beneficiaries for non-covered services unless the beneficiary agrees in advance and in writing to pay for such services. Providers must have beneficiaries complete a Request for Non-Covered Services waiver if the beneficiary does not agree to be discharged from the hospital. If the beneficiary signs the form within the stated time frames, they will be responsible for the charges, otherwise, the hospital will be responsible for the beneficiary’s charges.

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5.10 Clinical Quality Management

TriWest's clinical quality management (CQM) program monitors quality of care and services rendered to TRICARE beneficiaries throughout the health care delivery system. The CQM program's goal is to create demonstrable quality improvement in the quality and value of health care provided to beneficiaries. To do this, TriWest's CQM program was developed to:

- Support with credentialing and provider quality activities, such as developing and implementing provider global and/or targeted education for suicide risk, mandated Autism Care Demonstration (ACD) program, and audits
- Support quality evaluations utilized in credentialing and clinical operations provider search selection
- Identify high-quality providers for the TriWest provider network
- Communicate expectations to network providers to ensure participation in the clinical quality process including but not limited to submission of requested records and completion of Corrective Action Plans.

To maintain high-quality options for our beneficiaries' care, TriWest's CQM utilizes data and analytics to measure provider and facility adherence to evidenced-based guidelines, and identify over- and under-utilization, identify gaps in care to provide an overall quality scoring methodology. These outcomes are provided to the Credentialing Committee and also used in our provider directory as a High Performing Provider (HPP) indicator.

The following committees are instrumental in ensuring high quality provider performance:

- Clinical Quality Management Committee (CQMC)
 - Reviews provider performance data and identifies and pursues collegial opportunities to improve the quality of clinical care provided to TRICARE beneficiaries and reviews timely access to quality care throughout the TRICARE West Region
 - Reviews reports on provider credentialing, grievances, clinical operations, patient safety, TRICARE Quality Monitoring Contractor (TQMC) findings, TQMC recommendations, quality projects, and staff audits
 - Adheres to the National Quality Forum (NQF) goals and monitors compliance with URAC guidelines for managing quality
 - Reviews health plan measures progress against corresponding benchmarks
 - Makes recommendations on reported findings
 - Approves quality studies to become Quality Improvement Projects (QIPs)
 - Receives CQMP Annual Plan and CQMP Annual reports that have been submitted to DHA for approval
- Credentialing Committee
 - Ensures that all TriWest direct contracted practitioners, including corporate and institutional providers, have the appropriate education, training, licensure, experience, and malpractice as required by TRICARE and URAC
 - Has authority to approve or deny any practitioner who does not meet TRICARE or URAC standards
 - Incorporates TriWest CQM's quality scoring methodology derived from provider performance data, complaints and grievances into decisions to credential or re-credential providers

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- Receives and reviews credentialing audits for delegated contracting processed by TriWest’s network subcontractors
- Communicates with the peer review committees to identify providers and facilities with quality of care issues, Corrective Action Plans (CAPs), and other findings and incorporate that information in decisions to credential or re-credential providers
- Adverse Action Subcommittee (AASC)
 - Acts as a quick response team to intervene rapidly with providers where beneficiary safety concerns or financial fraud are alleged
 - Triage urgent provider issues such as licensure, clinical and administrative quality concerns, civil and criminal matters and requests for removal from the network
 - Responds to urgent provider related concerns and makes recommendations to the Credentialing Committee regarding provider actions
- TRICARE Peer Review Committees – Behavioral Health (TPRC-BH)
 - Direct TriWest’s multi-functional PRO responsibilities for BH
 - Serve as the PRO that reviews individual provider and facility quality of care issues
 - In conjunction with TRICARE Peer Review Committee – Medical/Surgical (TPRC-MS), serves as the highest level of peer review within TriWest
 - Monitors trends
 - Recommends and reviews Corrective Action Plans (CAPs) and evaluates results of CAPs
 - Reviews provider PRO appeals
 - Recommends sanctions of network and non-network providers when warranted
 - Reviews sentinel events and makes the final determination on the severity level of individual quality of care issues
 - Communicates peer review outcomes (e.g., providers and facilities with quality of care issues, CAPs, and other findings) with the Credentialing Committee so they can incorporate that information in decisions to credential or re-credential providers
 - Collaborates with external peer reviewers when the expertise needed to review the case does not exist internally
- TRICARE Peer Review Committee – Medical/Surgical (TPRC-MS)
 - Direct TriWest’s multi-functional PRO responsibilities for medical care
 - Serve as the PRO that reviews individual provider and facility quality of care issues
 - In conjunction with TPRC-BH, serves as the highest level of peer review within TriWest
 - Monitors trends
 - Recommends and reviews CAPs and evaluates results of CAPs
 - Reviews provider PRO appeals
 - Recommends sanctions of network and non-network providers when warranted
 - Reviews sentinel events and makes the final determination on the severity level of individual quality of care issues
 - Communicates peer review outcomes (e.g., providers and facilities with quality of care issues, CAPs, and other findings) to the Credentialing Committee so they can incorporate that information in decisions to credential or re-credential providers
 - Collaborates with external peer reviewers when the expertise needed to review the case does not exist internally

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The CQM department investigates, receives, and actively searches for potential quality issues (PQI) and patient safety issues (PSI), resolves beneficiary and provider grievances, and performs clinical quality review studies. CQM also conducts studies and quality improvement projects on Healthcare Effectiveness Data and Information Set (HEDIS) measures or Department of Health and Human Services Agency for Healthcare Research and Quality PSI.

The CQM determines issues, analyzes potential improvements, and implements timely and appropriate corrective action, when needed. As part of its investigation, CQM may implement a CAP. TriWest's CQM department follows up on CAPs to ensure interventions have been implemented and remain effective. Corrective action includes, but is not limited to:

- Provider communication and education (e.g., through required further training), including provider office staff training
- Provider credentialing review by querying National Practitioner Data Bank (NPDB)
- Administrative policies and procedure revision
- Prospective or retrospective trend analysis of practice patterns
- Intensified review of practitioners or facilities, including but not limited to, requirements for second opinions for procedures, retrospective or prospective review of medical records, claims, or requests for pre-authorization
- Modification, suspension, restriction, or termination from the network

5.10.1 TRICARE Quality Monitoring Contractor

The TRICARE Quality Monitoring Contractor (TQMC) assists the DOD, DHA, MTF market managers, and the Health Plan West Region office by providing the government with an independent, impartial evaluation of the care provided to beneficiaries within the MHS. TQMC is part of TRICARE's Quality and Utilization PRO program, in accordance with [32 Code of Federal Regulations \(CFR\)](#) and reviews care provided by TRICARE network providers and subcontractors on a limited basis. To facilitate these reviews, TriWest may request providers' medical records on a monthly basis to comply with requirements detailed in the [TRICARE Operations Manual, Chapter 7](#). Records must be submitted in their entirety. Failure to do so will result in recoupment of payment for the hospitalization and/or any other services in accordance with [32 CFR 199.4\(a\)\(5\)](#).

5.10.2 Medical Records Documentation

TriWest reviews medical records to evaluate patterns of care and compliance with evidence-based standards of practice, and performance standards. TriWest requires each provider to maintain adequate medical documentation and medical treatment records, including contemporaneous clinical records that substantiate the clinical rationale for each course of treatment, periodic evaluation of the efficacy of treatment, and the outcome at completion or discontinuation of treatment. Medical records must include information that justifies admission and continued hospitalization, supports the diagnosis, and describes the beneficiary's progress and response to medications and services.

Providers must maintain clinical and other records related to individuals for whom TRICARE payment was made for services rendered for a period of 60 months from the date of service. Providers must provide copies of medical treatment records to TriWest within 10 business days of

its request so TriWest can conduct peer review, quality assurance activities, HEDIS, and utilization review.

TriWest will not pay (and provider agrees to waive) any costs associated with the required submission of medical treatment records, including but not limited to copying or handling fees, unless otherwise specified (e.g., TRICARE requirements, the TriWest TRICARE provider handbook, or the provider's contract with TriWest). We accept secure electronic medical records in a HIPAA-compliant, encrypted format.

Providers must adhere to Medical Treatment Record Guidelines. See the TriWest Medical Treatment Record Quick Reference Guide for details.

When requested, providers must transmit accurate, complete, and legible clinical records and information to the Government pertaining to the care delivered, pursuant to referrals or orders from MTF providers, in compliance with applicable privacy and confidentiality laws and regulations, and in accordance with the TRICARE Requirements and the TriWest TRICARE Provider Handbook.

6 Claims Processing and Billing Information

On behalf of the DOD, TriWest is the third party administrator (TPA) and payer for the TRICARE West Region.

TriWest partners with claims processor PGBA to process and pay claims to TRICARE providers who have rendered services to beneficiaries in accordance with TRICARE policies and procedures.

6.1 Claims Processing Standards and Guidelines

All claims for TRICARE-covered services must be submitted to PGBA for claims processing in accordance with the TriWest TRICARE Provider Handbook, no later than one year (365 days) after services are provided or one year from the date of discharge for an inpatient admission for facility charges billed by the facility or an ancillary provider participating in the inpatient care. To ensure timely submission and payment, TriWest strongly recommends filing claims within 30 days of the date of service. The claim must be submitted to PGBA within 90 calendar days from the OHI adjudication date.

TRICARE requires electronic claims be filed using the appropriate HIPAA-compliant and standard electronic claims format. If a non-network provider must submit paper claims, TRICARE requires use of either a CMS 1500 (professional charges) or a CMS UB-04 (institutional charges) claim form.

Completion of [claim forms and claim form requirement](#) information can be found online.

6.2 Electronic Claims Submission

Electronic claim submission is required for TRICARE network providers and encouraged for non-network providers. Claims submitted electronically are less likely to be rejected compared to paper claims. You can improve your claim submission accuracy and get your payments faster by signing up for electronic claim submission. You can do this by enrolling in Electronic Data Interchange (EDI) through PGBA.

The following options are available for electronic claims submission:

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- XPressClaim – A secure, full-service online claims submission tool. Claims clearinghouses – A third-party organization that acts as a middleman between healthcare providers and insurance companies, or other payers, to process medical claims electronically.
- Availity’s Basic Clearinghouse – The TriWest self-service [secure provider portal](#).

Network Providers – Submit Electronically: Use Payer ID 99726.

For more information on how to submit claims electronically using the options above, please go to <https://tricare.triwest.com>.

6.3 Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)

TriWest providers can enroll online for EFT and/or ERA through the [Availity Essentials Transaction Enrollment application](#). Your organization’s Availity administrator can set up user account access and assign roles and permissions to ensure you receive payments more quickly and avoid the hassle of paper checks and/or remits.

Enroll by following these steps:

- Log into [Availity](#) and navigate to Availity Essentials.
- Select My Providers > Enrollment Center > Transaction Enrollment
 - With Transaction Enrollment permission the user can enroll a single provider or providers in bulk (up to 500 at a time).

6.4 Claims Submission Addresses

Paper claims can be mailed or faxed to the address below:

TRICARE West Claims
P.O. Box 202160
Florence, SC 29502-2160
Fax Number 1-877-989-0070

6.5 TRICARE Billing Policies and Tips

Beneficiary Signature on File – Using the signature on file procedure is the provider’s indication that he or she agrees that verification of the beneficiary’s TRICARE eligibility at the time of admission or at the time care or services are provided is required before any TRICARE payment.

Please refer to the [TRICARE Operations Manual, Chapter 8, Section 4](#) to learn more about signature requirements.

Referrals – Network providers should hold beneficiaries harmless “held harmless” (i.e., considered not financially responsible for any charges) in cases where the provider fails to request a referral and the contractor either denies payment or applies Prime Point of Service (POS) option.

Claim Processing Timelines – 98% of retained and adjustment claims will be processed to completion within 30 calendar days from the date of receipt.

Other Health Insurance (OHI) – It is the provider’s responsibility to ask the beneficiary if they have OHI that is primary to TRICARE and submit the claim to primary payer before claim is filed with TRICARE. If TRICARE receives claim before OHI processes it, the claim will be denied.

National Provider Identifier (NPI): Providers in a Group should submit claims with their individual and group NPI:

- Enter Type 1 NPI in CMS 1500 form Field 24J
- Enter Type 2 NPI in Field 33A as billing provider
- Solo Practitioners: Use individual NPI in Field 33A only

Corrected/Void Claims – A corrected claim should be submitted when you need to replace or correct information on a claim that was previously submitted and/or processed by PGBA. Submitting a corrected claim will have the effect of completely replacing your previously filed claim with the information on the corrected claim.

Examples of a corrected claim include (but are not limited to):

- Providing a referral number or rendering NPI originally omitted
- Changing procedure or diagnosis codes, or the patient’s name or demographic information, or any other information that would change the way the claim was originally processed

Submit a void claim when you need to cancel a claim already submitted and/or processed by PGBA.

How to File a Corrected/Void Claim

Electronic submissions:

To submit a corrected claim or claim void electronically using forms 837I or 837P:

- Find Loop 2300 (Claim Information)
 - In segment CLM05-3, enter correct frequency code value:
 - 7 – Replacement of prior claim
 - 8 – Void/cancel prior claim
 - In segment REF01, enter F8
 - In segment REF02, enter original claim number

Complete all other claim fields as normal.

Paper submissions:

To submit a corrected claim or claim void by paper, follow the instructions below.

CMS 1500:

- Use the following frequency code in Box 22 and make sure it is left justified
 - Frequency code 7: Replacement of Prior Claim: Corrects a previously submitted claim.
 - Frequency code 8: Void/Cancel of Prior Claim: Indicates this bill is an exact duplicate of an incorrect bill previously submitted. This code will void the original submitted claims.

- In the Original Reference Number space, enter the original claim ID.

UB04:

- Find Box 4 - Type of Bill (top, right-hand corner). Enter the correct resubmission code below in the third digit of the bill type
 - Frequency code 7: Replacement of Prior Claim: Corrects a previously submitted claim.
 - Frequency code 8: Void/Cancel of Prior Claim: Indicates this bill is an exact duplicate of an incorrect bill previously submitted. This code will void the original submitted claims.
- Find Box 64 – Document Control Number and enter the original claim ID.

Billing duplicate services on same day: The same procedure code cannot be billed on multiple lines for the same date of service when no modifier is billed to distinguish the services because it is considered a duplicate procedure. Instead, please bill procedure code on one line with multiple units. If the same procedure was performed on different DOS, please bill each line separately instead of billing a date range on one line.

Emergency room charges with inpatient facility stay: Emergency room charges in conjunction with a DRG-reimbursed hospital stay must be billed on a separate outpatient CMS UB-04 form. In addition, ambulatory surgery room charges cannot be submitted on an inpatient facility claim and should be billed as a separate outpatient service on the CMS UB-04 form.

Interim claims: Interim bills are accepted when the beneficiary has been in the hospital at least 60 days. Please submit interim bills in chronological order.

Please refer to the [TRICARE Policy Manual \(TPM\)](#) to learn more about billing and policies surrounding specific types of care. The TPM is searchable by keyword.

6.6 Maximum Number of Services Limitation

TRICARE's maximum number of services per day that may be billed for specific procedure codes can be found on the [Rates and Reimbursement webpage](#), under *Limits on Number of Services without Override Code*. If the number of procedures performed in a day exceeds the limit, medical documentation will be required to support medical necessity.

6.7 Claims Status Check

Providers can check the status of claims through [Availity](#). The tool gives providers a more intuitive and robust workflow to check the claim status of a beneficiary. The Claim Status tool allows providers to check the status of a submitted claim and view remittances.

Providers can also search claims by:

- Member ID
- Tax ID Service date
- Claim number

If a claim cannot be found, there may have been errors with the submission. If a claim is visible, it is in process. Please do not resubmit claims showing as in-process claims.

For missing claims, please verify that:

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- It has been at least 10 business days since the claim was submitted electronically or 15 business days since the provider mailed the claim
- A paper claim was not handwritten and all information was typed correctly

6.8 Telemedicine Billing

Conditions of payment include:

- Synchronous telemedicine services
- Asynchronous telemedicine services

Synchronous. For a TRICARE payment to be authorized for synchronous telemedicine services between a provider and patient, interactive telecommunication systems, permitting real-time audio and video communication between the TRICARE-authorized provider (i.e., distant site) and the beneficiary (i.e., originating site) must be used.

As a payment condition for synchronous telemedicine services, both the patient and health care provider must be present on the connection and participating in the telemedicine service.

Asynchronous. TRICARE allows payment for asynchronous telemedicine services in which, under conventional health care delivery, do not require face-to-face or “hands-on” contact between patient and provider. For TRICARE payment to be authorized for asynchronous telemedicine services, interpretive services must be rendered by the consulting provider to the referring provider.

Please refer to [TRICARE Policy Manual \(TPM\) Chapter 7, Section 22.1](#) to learn more about telemedicine coverage and billing.

6.9 Eye Exam Coverage

TRICARE Select ADFMs are entitled to one annual routine eye examination. Prime ADFMs may receive their annual routine eye examination from any network provider without a referral, authorization, or pre-authorization from the PCM or any other authority (i.e., a Prime ADFM will be allowed to set up his or her own appointment for a routine eye examination with any network optometrist or ophthalmologist). TRICARE Select ADFMs may self-refer to any TRICARE authorized provider regardless of whether or not they are a network provider (i.e., they may set up their own appointment with either a network or non-network, TRICARE-authorized, optometrist or ophthalmologist).

Routine eye exams are covered once every two years for retirees and eligible family members who are enrolled in TRICARE Prime. Routine eye exams are not a covered benefit for retirees and eligible family members who are enrolled in TRICARE Select. ADFMs who are enrolled in TRICARE Prime or TRICARE Select may receive a routine eye exam annually.

Please refer to [TRICARE Policy Manual \(TPM\), Chapter 7, Section 6.1](#) to learn more about Ophthalmological services.

6.10 Billing for Mutually Exclusive Procedures

TriWest does apply editing to detect mutually exclusive procedures that cannot reasonably be performed at the same anatomic site or same beneficiary encounter.

6.11 Non-Covered Services

It is the provider's responsibility to ensure services are covered before delivering care. Non-covered services include:

- Services that appear on the [No Government Pay Procedure Code List](#)
- Services outside of the scope of TRICARE-covered services
- Services that currently have a temporary code or are considered experimental or investigational by the FDA.

If services are considered non-covered, providers must notify TRICARE beneficiaries in writing before delivering care.

In certain circumstances, ADSMs may be approved for non-covered services if authorized or a waiver is received from MTF.

6.12 Physician-Administered Drug and Vaccine Claim Filing

The National Drug Code (NDC) number, drug quantity, and unit of measure are required on drug and vaccine claims when there is no nationally established TRICARE-allowable charge. Please visit the [TRICARE Allowable Charges website](#) to determine if a TRICARE-allowable charge exists for specific drugs or vaccines.

Please see below for details on how to properly bill NDC number, drug quantity, and package unit fields.

Professional Paper Claim Guidelines (CMS-1500) – In the shaded portion of the line-item field 24A-24G on the CMS-1500, enter the qualifier N4 (left-justified), immediately followed by the NDC. Next, enter one space for separation, then enter the appropriate qualifier for the correct dispensing unit of measure (UN, ML, GR, or F2), followed by the quantity (number of NDC units up to three decimal places).

Institutional Paper Claim Guidelines (CMS UB-04) – In the line-item field 42-46, enter the appropriate drug-related revenue code in field 42. In field 43, report the NDC qualifier N4 (left-justified), immediately followed by the 11-character NDC in the 5-4-2 format (no hyphens). Immediately after the last digit of the NDC, enter the appropriate qualifier for the correct package size, NDC unit of measure (UN, ML, GR, or F2), followed by the quantity (number of NDC units up to three decimal places).

Please be sure to include the N4 before the 11-digit NDC number, but do not include drug name on the claim form. If the drug name is included on the claim form, this may result in the claim being denied.

Use the following data elements to submit the NDC information in the HIPAA-standard ASC X12N 837 electronic claims format.

- Loop 2400, segment SV101 = CPT/HCPCS code
- Loop 2400, segment SV104 = CPT/HCPCS units
- Loop 2410, segment LIN02 = N4 qualifier
- Loop 2410, segment LIN03 = 11-digit NDC number
- Loop 2410, segment CPT04 = NDC quantity

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- Loop 2410, segment CPT05 = NDC unit or basis for measurement code (UN, ML, ME, F2, GR)

6.13 Processing Claims for Out of Jurisdiction

For beneficiaries not enrolled in TRICARE Prime, the provider will submit claims to the contractor responsible for the jurisdiction using the beneficiary's home address on the claim regardless of where the service was received. (See the [TRICARE Systems Manual \(TSM\), Chapter 3, Section 4.2](#), if the beneficiary's home address on the claim differs from the home address on DEERS).

6.14 Extended Care Health Option (ECHO)

ECHO services reimbursement will be applied in accordance with the [TRM](#). Refer to the [TPM, Chapter 9](#) and the [TOM](#) to learn more about ECHO claims.

6.15 Autism Care Demonstration

ACD services reimbursement will be limited to the specific ACD CPT codes, rates are listed in the ACD Toolkit.

The Government will update ACD reimbursement rates at the same time as the annual CHAMPUS Maximum Allowable Charge (CMAC) update. ACD reimbursement rates are effective each May 1st.

Negotiated rates lower than those listed are not permitted.

6.16 TRICARE-Authorized Non-Network/Non-Participating Providers

Once an agreement is signed to become a TRICARE network provider, you agree to be paid the lesser of the TRICARE maximum allowable charge or your contracted rate. If you are a non-network TRICARE-authorized provider and have agreed to participate on a claim, this means you have agreed to accept the TRICARE-allowable charge as payment in full for this claim and you may not bill patients for any amount in excess of the TRICARE-allowable charge. Non-network providers who do not accept assignment are limited by federal balance billing laws on how much they can bill TRICARE beneficiaries.

By federal law, non-participating providers may not balance bill the beneficiary more than 15% above the allowable charge. When the billed amount is less than 115% of the allowed amount, the provider is limited to billing the billed charge to the beneficiary. The balance billing limit shall be applied to each line item on a claim.

See the [TRICARE-allowable charge schedules](#) for more information.

6.17 TRICARE Balance Billing and Collection Activities

Balance billing occurs when a provider bills a TRICARE beneficiary for any amount exceeding the TRICARE-allowable charge after TRICARE has processed the claim. This practice is limited by law. TRICARE prohibits the practice of balance billing. Balance billing requirements apply to both network and non-network providers who treat TRICARE beneficiaries. Noncompliance can impact your TRICARE and/or Medicare status.

Both network and non-network providers are encouraged to explore all available options to resolve claims issues. The involvement of a debt collection agency is strongly discouraged.

Beneficiaries are responsible for their out-of-pocket expenses reflected on the TRICARE Summary Payment Voucher/Remit, including deductible, cost-share and/or copayment amounts.

6.18 TRICARE and Other Health Insurance (OHI)

TRICARE is always the primary payer for ADSMs (including National Guard and Reserve members). For other beneficiary categories, TRICARE pays secondary to Medicare and other primary coverage.

If TRICARE is the secondary payer, the provider is required to submit claims to the primary payer before billing TRICARE. Provider must include the OHI EOB with paper claim submission, or fill out appropriate COB loops and segments on the electronic claim submission.

TRICARE requires an acceptable reason from OHI for non-payment before a claim can be considered payable. To coordinate benefits, the EOB/COB must reflect the beneficiary's liability (copayment, deductible and/or cost-share), original billed amount, allowed amount, and/or any discounts. The claim will be denied if there is indication of primary OHI and the claim is submitted without other payer EOB or COB payment information.

6.18.1 Other Health Insurance (OHI) Claims

The below services require a TRICARE pre-authorization regardless of OHI:

- Adjunctive dental care
- Advanced life support air ambulance in conjunction with stem cell transplantation
- All inpatient behavioral health and substance abuse disorder (SUD) services (inpatient services, SUD, substance use disorder rehabilitation facility, and RTC residential treatment center)
- All solid organ and stem cell transplants
- ABA services
- ECHO
- Electroconvulsive therapy
- Home health services, including home infusion
- Hospice
- Intensive outpatient programs
- Laboratory developed tests
- Low protein modified foods
- Medication-assisted treatment
- Non-emergency admissions, to include detoxification and rehabilitation services
- Open, arthroscopic, and combined hip surgery for the treatment of Femoroacetabular Impingement
- Opioid treatment programs (OTPs)
- Partial hospitalization program (PHPs)
- Psychoanalysis
- Psychological testing
- Residential Treatment Centers (RTC)
- Transcranial Magnetic Stimulation
- Transplants (solid organ and stem cell, not corneal transplant)

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Identify OHI in the claim form:

- Mark “Yes” in Box 11d (CMS 1500 claim form) or FL (CMS UB-04 claim form)
- Indicate the primary payer in Box 9 (CMS 1500 claim form) or FL 50 (CMS UB-04 claim form)
- Indicate the amount paid by the OHI in Box 29 (CMS 1500 claim form) or FL 54 (CMS UB-04 claim form)
- Indicate insured’s name in Box 4 (CMS 1500 claim form) or FL 58 (CMS UB-04 claim form)
- Indicate the allowed amount of the OHI in FL 39 (CMS UB04 claim form) using value code 44 and entering the dollar amount

Please refer to [TRICARE Reimbursement Manual, Chapter 4, Section 3](#) to learn more about how TRICARE coordinates benefits.

6.19 Durable Equipment (DE): Basic Program Billing Guidelines

Please refer to [TRICARE Policy Manual, Chapter 8, Section 2.1](#) to learn more about Durable Equipment (DE). This section includes coverage criteria and exclusions, as well as other relevant criteria.

6.20 Ambulatory Surgery Center Charges

All hospitals or freestanding ASCs must submit claims for ambulatory surgery procedures on a CMS UB-04 claim form.

Please refer to [TRICARE Policy Manual, Chapter 11, Sections 6.1 and 6.2](#) to learn more about Ambulatory Surgery and Freestanding Ambulatory Surgery Centers

6.21 TRICARE and Third-Party Liability Insurance

TriWest will identify claims with possible third party involvement and recover costs for medical care furnished, or paid for, on behalf of a TRICARE beneficiary.

Please refer to [TRICARE Operations Manual, Chapter 10, Section 4](#) to learn more about Third Party Recovery Claims.

6.22 TRICARE and Workers’ Compensation

TRICARE will not reimburse services covered under workers’ compensation programs.

6.23 TRICARE Claim Reconsiderations

Providers can submit a request for claim review when they need to dispute the outcome of a claim that was previously submitted and processed. It is appropriate to submit a request for claim review when a provider believes the information originally submitted was complete and accurate (to their knowledge), but they disagree with the claim determination and are requesting a secondary review.

If a provider is submitting additional or different information that was NOT included in the original claim submission which resulted in a denial or payment discrepancy, please DO NOT submit a request for claim review. Any changes to a previously submitted and or processed claim should be filed through the corrected claims process.

Examples of issues that are considered reviewable would include, but are not limited to:

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- Allowed amount disputes
- OHI issues
- Timely Filing denials
- Penalties for no authorization
- Denial Code(s)

6.23.1 *How to Request a Claim Review*

Submit claim reviews electronically by completing the online Provider Claims Reconsideration Form found at <https://tricare.triwest.com>.

The easy online form enables secure and efficient claims reconsideration submissions, eliminating the added tasks of printing and mailing the forms, *saving you time and money!*

The form can also be submitted by mail. Download and fill out TriWest's Provider Claims Reconsideration Form found at <https://tricare.triwest.com>, and mail or fax it and all supporting documentation to:

TRICARE West Provider Correspondence
P.O. Box 2748
Virginia Beach, VA 23450
Fax Number: 1-866-852-1969

Providers must submit separate reconsideration requests for each disputed item within 90 days of TRICARE PRA/ERA date.

Please refer to [TRICARE Operations Manual, Chapter 12, Section 3](#) to learn more about requesting claims review and appealable issues.

6.24 **Fraud and Abuse**

TriWest utilizes pre-payment and post-payment fraud detection tools and resources to monitor and analyze various beneficiary, provider, and claim data for potential fraud, waste, and abuse. Providers are responsible for submitting accurate and appropriate billing for all services billed to TRICARE. An example of fraud, waste and abuse includes billing for services, supplies or equipment not furnished or used by the beneficiary.

Please refer to [TRICARE Operations Manual, Chapter 13, Section 2](#) to learn more about TriWest responsibilities pertaining to Fraud, Waste and Abuse.

Providers can report suspected fraud, waste and abuse in one of the three ways listed below:

- 1) Call the Fraud Hot Line at 1-866-240-0382
- 2) Mail your report to:
TRICARE West Program Integrity
P.O. Box 8430
Virginia Beach, VA 23450
- 3) Fax your report to the Fraud Fax Number at 1-866-852-2009

The claim submission by a physician or supplier or their representative certifies that the services shown on the claim are medically indicated and necessary for the patient's health and were personally furnished by the physician/supplier or furnished incident to his/her professional service by his/her employee under his/her immediate personal supervision, except as otherwise permitted by Medicare or TRICARE regulations.

For services to be considered as "incident" to a physician's professional service, they must be rendered under the physician's immediate personal supervision by his/her employee; be an integral, although incidental part of a covered physician's service; consist of commonly furnished in physician's offices; and be included on the physician's bills for services of non-physicians.

The claim submission by a non-institutional network provider/supplier further certifies that he/she (or any employee) who rendered services is not an active duty member of the Uniformed Services or a civilian employee of the U.S. Government (refer to 5 USC 5536).

Anyone who misrepresents or falsifies essential information to receive payment from Federal funds may upon conviction be subject to fine and imprisonment under applicable Federal law.

Program Integrity

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

DHA has a specific office to oversee the fraud and abuse program for TRICARE. The TRICARE Program Integrity Office analyzes and reviews potential fraud referrals (intent to deceive or misrepresent to secure unlawful gain) and cases of potential fraud.

Some examples of fraud include:

- Agreements or arrangements between the provider and the beneficiary that result in billings or claims for unnecessary costs or charges to TRICARE.
- Billing for costs of non-covered or non-chargeable services, supplies, or equipment disguised as covered items.
- Billing for services, supplies, or equipment not furnished or used by the beneficiary.
- Duplicate billings (e.g., billing more than once for the same service, billing TRICARE and the beneficiary for the same services, submitting claims to both TRICARE and other third parties without making full disclosure of relevant facts or immediate full refunds in the case of overpayment by TRICARE).
- Misrepresentations of dates, frequency, duration, or description of services rendered, or the identity of the recipient of the service or who provided the service.
- Practicing with an expired, revoked, or restricted license. An expired or revoked license in any of the United States or its territories will result in a loss of TRICARE-authorized provider status.
- Reciprocal billing (i.e., billing or claiming services furnished by another provider or furnished by the billing provider in a capacity other than billed or claimed).

- Violation of the participation agreement that results in the beneficiary being billed for amounts that exceed the TRICARE-allowable charge or negotiated rate.

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

Some examples of abuse include:

- Inferior quality care (*does not meet accepted standards of care*).
- Charging TRICARE beneficiaries rates for services and/or supplies exceeding those charged to the general public, such as by commercial insurance carriers or other federal health benefit entitlement programs.
- Failure to maintain adequate clinical or financial records.
- A pattern of claims for services that are not medically necessary, or, if necessary, not to the extent rendered.
- A pattern of waiver of beneficiary (patient) copayment, cost-share, or deductible.
- Refusal to furnish or allow access to records.
- Unauthorized use of the term “TRICARE®” in private business, including in advertisements and website postings directed to TRICARE beneficiaries.

Providers are cautioned that unbundling, fragmenting, or code gaming to manipulate 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 practice can be considered fraudulent and abusive.

Fraudulent actions can result in criminal or civil penalties. Fraudulent or abusive activities may result in administrative sanctions, including suspension or termination as a TRICARE-authorized provider. The TMA Office of General Counsel works with TriWest’s Program Integrity department and the TRICARE Program Integrity Office to deal with fraud and abuse. The DOD Office of Inspector General and other agencies investigate TRICARE fraud.

To anonymously report suspected fraud and/or abuse, you can take one of the following actions:

- Call the TriWest Fraud Hotline at 888-584-9378
- Send an e-mail to PI@triwest.com
- Send a fax to 602-564-2171

Please provide as much information as possible, including:

- Who committed the fraud
- When the fraud occurred (time frame)
- Where the fraud occurred
- Detailed description of the fraudulent activity

7 Reimbursement Methodologies

Reimbursement rates and methodologies are established by DOD guidelines. TRICARE applies CMAC, which generally aligns with Medicare reimbursement rates and rules for similar services, as the maximum amount TRICARE will reimburse for nationally recognized procedure codes.

Please refer to the [TRICARE Reimbursement Manual \(TRM\)](#) to learn more about each specific claim type and specialty. The TRM includes details on payment methodology for the types of claims below:

- [Chapter 1, Section 9: Anesthesia](#)
- [Chapter 1, Section 11: Durable Medical Equipment \(DE\) and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies \(DMEPOS\)](#)
- [Chapter 1, Section 14: Ambulance Services](#)
- [Chapter 1, Section 17: Assistant Surgeons](#)
- [Chapter 3, Section 1: Individual Health Care Professionals and Other Non-Institutional Health Care Providers](#)
- [Chapter 3, Section 6: Home Infusion](#)
- [Chapter 6: Diagnosis Related Groups \(DRGs\)](#)
- [Chapter 7: Mental Health](#)
- [Chapter 8: Skilled Nursing Facilities \(SNFs\)](#)
- [Chapter 9: Ambulatory Surgery Centers \(ASCs\)](#)
- [Chapter 10: Birthing Centers](#)
- [Chapter 11: Hospice](#)
- [Chapter 12 Home Health Care \(HHC\)](#)
- [Chapter 13: Outpatient Prospective Payment System \(OPPS\)-Ambulatory Payment Classification \(APC\)](#)
- [Chapter 13, Section 2, 3.7: Partial Hospitalization Programs \(PHPs\) and Intensive Outpatient Programs \(IOPs\)](#)
- [Chapter 14: Sole Community Hospitals \(SCHs\)](#)
- [Chapter 15: Critical Access Hospitals \(CAHs\)](#)
- [Chapter 16: Long-Term Care Hospitals \(LTCHs\)](#)
- [Chapter 17: Inpatient Rehabilitation Facilities \(IRFs\)](#)
- [Chapter 18: Alternate Payment Models \(APMs\)](#)

Network participating providers must accept the TRICARE determined allowable payment combined with the cost share, deductible, and OHI amounts payable by, or on behalf of, the beneficiary, as full payment for TRICARE allowed services. The provider collects from the TRICARE beneficiary those amounts that the beneficiary has a liability to pay for the TRICARE deductible and cost share/copayment (this requirement does not apply to a State Vaccine Program or State Vaccine Program entity participation agreement).

Please refer to the [TRICARE Policy Manual, Chapter 11, Section 12.3](#) to learn more about Network Participating Agreement requirements.

7.1 Site of Service Pricing Categories

TRICARE CMAC payments are based on site of service. Payment based on site of service is a concept used by Medicare to distinguish between services rendered in a facility setting as opposed to a non-facility setting. The four categories of sites of services are:

- **Category one:** Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, certified nurse midwives, and audiologists provided in facilities, including hospitals (both inpatient and outpatient and billed with the appropriate revenue and procedure code for the outpatient department where the services were rendered), RTCs, ambulances, hospices, MTFs, behavioral health care facilities, community mental health centers (CMHC), SNFs, ASCs, etc.
- **Category two:** Services of MDs, DOs, optometrists, podiatrists, psychologists, oral surgeons, certified nurse midwives, and audiologists provided in non-facility settings, including provider offices, home settings and all other non-facility settings.
- **Category three:** Services of all other providers not included in Category one, that are provided in facilities, including hospitals (both inpatient and outpatient and billed with the appropriate revenue code for the outpatient department where the services were rendered), RTCs, ambulances, hospices, MTFs, behavioral health care facilities, CMHCs, SNFs, ASCs, etc. The non-facility CMAC rate applies to occupational therapy (OT), physical therapy (PT), and speech therapy (ST) regardless of the setting.
- **Category four:** Services, of all other providers not included in category two, that are provided in non-facility settings, including provider offices, home settings and all other non-facility settings. The non-facility CMAC rate applies to OT, PT and ST, regardless of the setting.

TriWest will reimburse services with a Locality-Based Reimbursement Rate Waiver at the rate that has been approved by DHA.

7.2 Accessing TRICARE CMAC Rates

To access the TRICARE CMAC rates, please visit the [CMAC rates webpage](#) and follow the online prompts.

7.3 TRICARE-Allowable Charge

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

The TRICARE payment will be limited to billed charge for professional services. Payment for both Inpatient (DRG) and Outpatient Facility (OPPS) claims can exceed billed charges.

7.4 TRICARE Deductible, Cost-Share, and Copayment Application and Collection

TRICARE Prime ADFMs and Retirees: Group A and Group B TRICARE Prime ADFMs and TRICARE Prime retirees have no deductible under TRICARE Prime for health care services obtained in accordance with TRICARE Prime rules and procedures. If otherwise covered health care services are not obtained in accordance with TRICARE Prime rules and procedures, the services may be covered under the POS option ([TRICARE Reimbursement Manual, Chapter 2, Section 5](#)) including a deductible of \$300 per individual or \$600 per family.

TRICARE Prime Group A and Group B ADFM Enrollees: TRICARE Prime enrollees have \$0 copayment for covered health care services obtained in accordance with TRICARE Prime rules and procedures. If otherwise covered health care services are not obtained in accordance with TRICARE Prime rules and procedures, the services may be covered under the POS option ([TRICARE Reimbursement Manual, Chapter 2, Section 5](#)), including a separate deductible of \$300 per individual or \$600 per family. This would include any non-emergency out of network care obtained by a TRICARE Prime beneficiary without following applicable referral requirements. Pharmacy copayments are in addition to any TRICARE Prime copayments.

All beneficiaries covered under TRS and TRR follow the applicable TRICARE Select cost-shares, copayments, deductibles, and catastrophic caps. TRS cost-shares follow the applicable cost-shares, deductibles, and catastrophic caps for ADFMs. TRR cost-shares, deductibles, and catastrophic caps match retiree cost-shares. Deductibles.

Collection of deductible amounts: Network providers are required to collect, at a minimum, the copayment at the time of service. The EOB shall inform the provider and beneficiary of additional amounts owed to satisfy the deductible. Additionally, TriWest may provide deductible information to network providers in advance so they may also be collected at the time of the service, at the discretion of both the contractor and network providers in their network contracts.

Cost-Shares and copayments: Care received from network providers – The cost-sharing amounts for covered health care services obtained from a network provider are fixed dollar amounts for each specified category of care and are set prospectively for each calendar year with the annual updates available the [Rates and Reimbursement](#) webpage.

Care received from non-network providers. The cost-sharing amounts for covered health care services obtained from a non-network provider are as provided in [32 CFR 199.4](#) and [TRICARE Reimbursement Manual \(TRM\) Chapter 2, Section 1](#).

CHAMPUS Maximum Allowable Charge (CMAC) impact on cost-sharing. In instances where the CMAC or allowable charge is less than the copayment established by this section and published on the DHA website, network providers may only collect the lower of the allowable charge or the applicable copayment.

Services with Set Copayments. Copayments apply only after any applicable deductibles have been satisfied, except for preventive care, which is available (when all conditions of coverage are met) with no copayment from network physicians, regardless of whether or not applicable deductibles have been satisfied.

Please refer to [TRICARE Reimbursement Manual, Chapter 2, Section 2](#) to learn more about deductibles, cost-shares and copayments for TRICARE services and how they are applied for TRICARE beneficiaries.

7.5 Bonus Payments Calculations

Bonus payments are provided to providers who are eligible and located in a Health Professional Shortage Area (HPSA).

Please refer to the [TRICARE Reimbursement Manual, Chapter 1, Section 33](#) to learn more about bonus payments.

7.6 Capital and Direct Medical Education Cost Reimbursement

Capital Costs – DHA will reimburse hospitals, through TriWest, for their capital costs as reported annually to TriWest. TriWest shall make annual payments for capital costs. Please refer to [TRICARE Reimbursement Manual, Chapter 3, Section 2](#) for more information about procedures that pay at capital costs.

Direct Medical Costs – DHA, through TriWest, will reimburse hospitals their actual direct medical education costs as reported annually to TriWest. Such direct medical education costs shall be for a teaching program approved under Medicare Regulation Section 413.85. TriWest shall make annual payments for direct medical education costs and those payments shall be calculated using the same steps required for calculating capital payments in the TRM link below. Allowable direct medical education costs are those specified in Medicare Regulation Section 413.85. Please refer to [TRICARE Reimbursement Manual, Chapter 3, Section 2](#) for the procedures for paying direct medical education costs.

Please refer to [TRICARE Reimbursement Manual, Chapter 6, Section 8](#) to learn more about Capital and Direct Medical Costs.

7.7 Diagnosis-Related Group Calculator

Providers can use the following [DRG calculator](#) to view rates within the TRICARE DRG-Based Payment system.

7.8 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies pricing

Please visit [DMEPOS pricing information](#) for reimbursement rates established for certain DMEPOS items and services, and Parenteral and Enteral Nutrition (PEN).

This site includes a link to [CMS DME POS Fee Schedule](#) to access DMEPOS and PEN reimbursement rates for certain items and services that begin with a HCPCS code of A, B, E, K, L, Q, or V.

7.9 Outpatient Prospective Payment System Exemptions

Providers excluded from Outpatient Prospective Payment System (OPPS) exemptions include:

- Outpatient services provided by hospitals of the Indian Health Service (IHS) will continue to be paid under separately established rates
- Certain hospitals that qualify for payment under the state's cost containment waiver, e.g., Maryland
- CAHs – See [TRICARE Reimbursement Manual, Chapter 15, Section 1](#)
- Hospitals located outside one of the 50 U.S. states, the District of Columbia, and Puerto Rico

Specialty care providers include:

- Freestanding Ambulatory Surgery Centers (ASC), also referred to as FASC
- Freestanding PHPs and Intensive Outpatient Programs (IOP) that offer psych and substance use treatments, Substance Use Disorder Rehabilitation Facilities (SUDRF), and freestanding Opioid Treatment Programs (OTP)
- Comprehensive Outpatient Rehabilitation Facilities (CORF)

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- Home Health Agencies (HHA)
- Hospice programs
- Community Mental Health Centers (CMHC)
- Other corporate services providers (e.g., Freestanding Cardiac Catheterization, Sleep Disorder Diagnostic Centers, and Freestanding Hyperbaric Oxygen Treatment Centers).
- Freestanding Birthing Centers
- Department of Veterans Affairs (DVA)/Veterans Health Administration (VHA) Hospitals
- Freestanding End Stage Renal Disease (ESRD) Facilities
- SNFs
- Psychiatric RTCs

Note: Antigens, splints, casts and hepatitis B vaccines furnished outside the patient’s plan of care in CORFs, HHAs and hospice programs will continue to receive reimbursement under current TRICARE allowable charge methodology.

Please refer to [TRICARE Reimbursement Manual, Chapter 13, Section 1](#) to learn more about OPPS exempt providers and scope of services excluded.

7.10 Present on Admission Code Indicators

Inpatient Prospective Payment System (IPPS) hospitals paid under the TRICARE DRG-based payment system are required to report a POA indicator for both primary and secondary diagnoses on inpatient discharges. POA is defined as present at the time the order for inpatient admission occurs.

The following hospitals are exempt from POA reporting for TRICARE:

- CAHs
- Long-term care hospitals
- Maryland waiver hospitals
- Cancer hospitals
- Children’s inpatient hospitals
- Inpatient rehabilitation hospitals
- Psychiatric hospitals and psychiatric units
- VA hospitals

POA indicators include:

- **Y** – Indicates that the condition was present on admission
- **W** – Affirms that the provider has determined, based on data and clinical judgment, that it is not possible to document when the onset of the condition occurred
- **N** – Indicates that the condition was not present on admission
- **U** – Indicates that the documentation is insufficient to determine whether the condition was present at the time of admission

A list of exempt ICD-10-CM diagnosis codes is available at [Coding | CMS](#).

7.11 State-Prevailing Rates

State-prevailing rates are established for codes that have no current available TRICARE-allowable charge pricing. Prevailing rates are those charges that fall within the range of charges most frequently used in a state for a particular procedure or service.

When no fee schedule is available, a prevailing charge is developed for the state in which the service or procedure is provided. In lieu of a specific exception, prevailing profiles are developed on:

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

For more details, please see the [TRICARE Reimbursement Manual, Chapter 5](#).

7.12 Reimbursement Discounts

Please refer to [TRICARE Reimbursement Manual, Chapter 1, Section 16](#) to learn about reimbursement discounts such as multiple surgery, bilateral and discounted procedures.

7.13 Updates to TRICARE Rates and Weights

Reimbursement rates and methodologies are subject to change per DOD guidelines. TRICARE rates are subject to change on at least an annual basis, which is consistent with Medicare. Please see the following link for [updated rates and weights](#).

8 Table of Acronyms and Abbreviations

Acronym	Meaning
ABA	Applied Behavior Analysis
ACD	Autism Care Demonstration
ADFM	Active Duty Family Member
ADI-R	Autism Diagnostic Interview, Revised
ADOS-2	Autism Diagnostic Observation Schedule, Second Edition
ADSM	Active Duty Service Member
APC	Ambulatory Payment Classification
ASC	Ambulatory Surgery Center
ASD	Autism Spectrum Disorder
BCaBA	Board Certified Assistant Behavior Analyst
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst – Doctoral
BT	Behavior Technician
CAC	Common Access Card
CAH	Critical Access Hospital
CARF	Commission on Accreditation of Rehabilitation Facilities
CARS-2	Childhood Autism Rating Scale, Second Edition
CC	Convenience Clinic
CCN	Community Care Network
CFR	Code of Federal Regulations
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHCBP	Continued Health Care Benefits Program
CLIA	Clinical Laboratory Improvement Amendments
CMAC	CHAMPUS Maximum Allowable Charge
CMHC	Community Mental Health Center
CMN	Certificate of Medical Necessity
CMS	Centers for Medicare & Medicaid Services
CNM	Certified Nurse Midwife
CoA	Council on Accreditation
COB	Coordination of Benefits
CONUS	Continental United States
CPNS	Certified Psychiatric Nurse Specialist
CPT	Current Procedural Terminology
CQM	Clinical Quality Management
CSP	Corporate Services Provider
DBN	Department of Defense Benefits Number
DCAO	Debt Collection Assistance Officer
DDS	Doctor of Dental Surgery
DEERS	Defense Enrollment Eligibility Reporting System
DHA	Defense Health Agency
DHA-GL	Defense Health Agency-Great Lakes
DM	Disease Management
DMD	Doctor of Dental Medicine
DMEPOS	Durable Medical Equipment, Prosthetics, Orthotics, and Supplies
DO	Doctor of Osteopathic Medicine
DOD	Department of Defense
DPM	Doctors of Podiatric Medicine
DRG	Diagnosis-Related Group
ECHO	Extended Care Health Option
EDI	Electronic Data Interchange
EFMP	Exceptional Family Member Program
EFT	Electronic Funds Transfer
EHHC	ECHO Home Health Care
EHR	Electronic Health Record
EIN	Employer Identification Number

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Acronym	Meaning
EOB	Explanation of Benefits
ePHI	Electronic Protected Health Information
ERA	Electronic Remittance Advice
Express Scripts	Express Scripts, Inc.
FDA	Food and Drug Administration
GAD	Generalized Anxiety Disorder
GARS-3	Gilliam Autism Rating Scale, Third Edition
H&P	History and Physical
HCPCS	Healthcare Common Procedure Coding System
HEDIS	Healthcare Effectiveness Data and Information Set
HHA	Home Health Agency
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMO	Health Maintenance Organization
HPSA	Health Professional Shortage Area
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification
ID	Identification
IDME	Indirect Medical Education
IOP	Intensive Outpatient Program
IRS	Internal Revenue Service
LDT	Laboratory Developed Test
LOD	Line of Duty
MD	Doctor of Medicine
MDD	Major Depressive Disorder
MHS	Military Health System
MTF	Military Treatment Facility
MUE	Medically Unlikely Edit
NATO	North Atlantic Treaty Organization
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Code
NOC	Not Otherwise Classified
NP	Nurse Practitioner
NPI	National Provider Identifier
NPDES	National Plan and Provider Enumeration System
OD	Doctor of Optometry
OHI	Other Health Insurance
OPPS	Outpatient Prospective Payment System
OT	Occupational Therapy
OTP	Opioid Treatment Program
PA	Physician Assistant
PCL	PTSD Checklist
PCM	Primary Care Manager
PDDBI	Pervasive Developmental Disorder Behavior Inventory
PDMP	Prescription Drug Monitoring Program
PGBA	PGBA, LLC
PH	Population Health
PHI	Protected Health Information
PHP	Partial Hospitalization Program
PHQ-8	Patient Health Questionnaire 8
PII	Personally Identifiable Information
PMP	Prescription Monitoring Program
POA	Present On Admission
POC	Point of Contact
POS	Point of Service
PPS	Prospective Payment System
PQI	Potential Quality Issue
PRO	Peer Review Organization
PSA	Prime Service Area

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Acronym	Meaning
PSI	Parental Stress Index
PT	Physical Therapy
PTSD	Post-Traumatic Stress Disorder
QASP-S	Qualified Autism Service Practitioner – Supervisor
RADS	Referral and Authorization Decision Support
RTC	Residential Treatment Center
RVU	Relative Value Unit
SAS	Specified Authorization Staff
SCH	Sole Community Hospital
SHCP	Supplemental Health Care Program
SIPA	Stress Index for Parents of Adolescents
SMCM	Specialty Medication Care Management
SNF	Skilled Nursing Facility
SRS	Social Responsiveness Scale
SSN	Social Security Number
ST	Speech Therapy
STAT	Screening Tool for Autism in Toddlers and Young Children
SUD	Substance Abuse Disorder
SUDRF	Substance Use Disorder Rehabilitation Facility
T-5	TRICARE next generation contract beginning 2025
TAMP	Transitional Assistance Management Program
TCMHC	TRICARE-Certified Mental Health Counselor
TCSRC	Transitional Care for Service-Related Conditions
TDEFIC	TRICARE Dual-Eligible Fiscal Intermediary Contract
TFL	TRICARE For Life
THHCPPS	TRICARE Home Health Care Prospective Payment System
TIN	Tax Identification Number
TJC	The Joint Commission
TOM	TRICARE Operations Manual
TOP	TRICARE Overseas Program
TPL	Third Party Liability
TPM	TRICARE Policy Manual
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote for Active Duty Family Members
TQMC	TRICARE Quality Monitoring Contractor
TriWest	TriWest Healthcare Alliance
TRM	TRICARE Reimbursement Manual
TRR	TRICARE Retired Reserve
TRS	TRICARE Reserve Select
TYA	TRICARE Young Adult
UCC	Urgent Care Center
VA	Department of Veterans Affairs

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