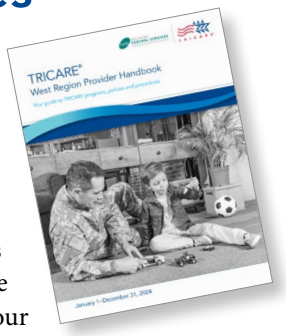
January 2024

TRICARE® Provider NEWS

ISSUE HIGHLIGHTS

2024 TRICARE Provider Handbook and Quick Reference Guides



The **2024 TRICARE West Region Provider Handbook** (Handbook) is now available online. We developed the Handbook to provide you with a comprehensive guide to TRICARE program specifics and TRICARE West Region contract requirements, policies, and procedures that affect the way you deliver and coordinate services. We encourage all providers who care for TRICARE West Region beneficiaries to review the Handbook. If you are a network provider, please review the Handbook in its entirety as it is a component of your TRICARE Provider Agreement.

While we update the Handbook annually, TRICARE program changes and updates may occur throughout the year. We will communicate changes via TRICARE Provider News or other notifications. Be sure to visit **www.tricare-west.com** for the latest program information.

Don't forget! We offer printable reference guides on topics such as authorizations and referrals, updating demographics, claims, benefits, eligibility, mental health care, and active duty/National Guard and Reserve. Check out our latest suite of materials at **www.tricare-west.com**.

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TRICARE

A Review of TRICARE Select

At the end of last year, TRICARE beneficiaries had the opportunity to review health plan choices for 2024 during TRICARE Open Season. As a provider, it's important to understand the plan options offered to TRICARE patients. One of the plan options available is TRICARE Select, which may be the right choice for those who live in an area where they can't use TRICARE Prime, have other health insurance (OHI), or want to see a non-network TRICARE-authorized provider. The following Q&A covers frequently asked questions about TRICARE Select, a self-managed, preferred provider organization (PPO) plan for eligible non-active duty service members.

How do I verify patient eligibility and TRICARE plan enrollment?

Refer to our "Check Patient Eligibility in the New Year" article in this newsletter for information on how to verify patient eligibility.

How do patients get care?

With TRICARE Select, beneficiaries can see any TRICARE-authorized provider for covered services.

Are there out-of-pocket costs?

Beneficiaries may pay a deductible and copays or cost-shares based on the services received. They can save on costs by seeing TRICARE network providers. TRICARE Select costs also depend on the sponsor's military status. Refer to our **Benefits and Copays** and **Copayment and Cost-Share Information** pages for details.

Are referrals required for specialty care?

Beneficiaries using TRICARE Select do not have primary care managers. Referrals are not required for most primary and specialty appointments. However, some services may require pre-authorization. Check pre-authorization requirements using our **Prior Authorization, Referral & Benefit** tool.

How do I submit a pre-authorization or check authorization status?

Submit pre-authorizations and check authorization statuses online using our **Submit an Authorization** and **Authorization Status** tools (login required).

How do I find more information regarding reimbursement or claims-related questions or issues?

Take advantage of our website's secure tools to **check claim status** (login required), or review helpful reimbursement information with our **billing tips** pages.

If a patient has OHI, how does that work with TRICARE Select?

As with all TRICARE plans, non-active duty service members who have OHI must use their OHI before TRICARE. Pre-authorization is only required for applied behavior analysis services. Visit our **Claims** page for more information.

Check Patient Eligibility in the New Year

Health Net Federal Services, LLC (HNFS) reminds you to verify which plan your TRICARE patients are enrolled in for 2024, as it may have changed. TRICARE Prime and TRICARE Select have different referral requirements and cost structures. For example, if you have a patient who had TRICARE Select last year, but enrolled in TRICARE Prime this year, a referral for specialty care may now be required. Verify TRICARE patient eligibility one of three ways:

- Log in at **www.tricare-west.com**. Be sure to retain a printout of the eligibility verification screen for your files.
- Use the self-service prompt when calling 1-844-866-WEST (1-844-866-9378).
- Submit an electronic data interchange (EDI) transaction.

Learn more about checking eligibility through our self-paced online course, **Checking TRICARE Eligibility in the TRICARE West Region.**

Certified Nurse Midwives and Birth Centers

Beneficiaries must use TRICARE-authorized providers for TRICARE to cover health care services. To be certified as TRICARE authorized, providers must meet specific licensing and certification requirements. Health Net Federal Services offers the following reminders about TRICARE requirements for birthing center and midwife provider types.

TRICARE requires birthing centers to meet TRICARE licensing requirements and be accredited by one of these three accrediting bodies:

- The Joint Commission
- The Accreditation Association for Ambulatory Health Care (AAAHC)
- The Commission for the Accreditation of Birth Centers (CABC)

TRICARE allows for the following provider types to offer midwifery services:

- Certified nurse midwives (CNM) who have local licensing (when required) and certification from the American Midwifery Certification Board
- Registered nurses (RN) who are not CNMs if referred by a licensed physician and under physician supervision

It's important to note that non-CNMs and non-RN midwives cannot be TRICARE-authorized providers. This includes certified professional midwives (CPM).

Find complete details in the TRICARE Policy Manual (TPM) at **https://manuals.health.mil**:

- Midwives – TPM, Chapter 11, Section 3.12.
- Birthing centers – TPM, Chapter 11, Section 2.3.

Mental Health Providers and Medicare Participation

As of Jan. 1, 2024, Medicare will cover mental health care services provided by marriage and family therapists (MFT), mental health counselors (MHC) and licensed professional counselors (LPC).

What does this mean for TRICARE network providers?

Per Health Net Federal Services' (HNFS) TRICARE Provider Participation Agreement, network providers eligible to participate in Medicare must have a signed **Medicare CMS-460 Agreement** or agree to participate with Medicare on a claim-by-claim basis for dual-eligible beneficiaries (those eligible for TRICARE and Medicare).

HNFS will look for Medicare enrollment or per-claim agreement for MFTs, MHCs and LPCs as part of its credentialing process moving forward.

TRICARE's Right of First Refusal

When a TRICARE Prime beneficiary is referred for specialty care, TRICARE requires Health Net Federal Services (HNFS) to first attempt to coordinate care at a military hospital or clinic, even if the beneficiary is enrolled to a civilian primary care manager. This process is known as TRICARE's right of first refusal. Providers should include as much clinical documentation or as many details as possible when submitting referrals to HNFS, as this will help military hospitals and clinics to reasonably determine if they can effectively treat the beneficiary.

Be sure to review the details of approval letters issued by HNFS with your TRICARE patients. Each letter will specify the approved specialty provider. If a beneficiary sees a provider other than who was approved, point-of-service charges may apply. Beneficiaries and providers can access copies of approval letters through our secure **Authorization Status** tool (log in required).

2024 Beneficiary Costs and Fees

Effective Jan. 1, 2024, certain TRICARE copayments, cost-shares and other beneficiary out-of-pocket costs have changed. Updates include, but are not limited to, minor increases to the outpatient primary, specialty, urgent care, and emergency room copayments, and inpatient admission costs. The annual deductible and catastrophic cap amounts also increased slightly for certain plans. View complete **copayment and cost-share details** on our website.

Enhanced Specialty Drug Benefits and Lower Costs for TRICARE Beneficiaries

Active duty service members, military retirees, and their families deserve the highest quality pharmacy care. To enhance the delivery of specialty services, the Department of Defense (DOD) is expanding TRICARE Home Delivery, which includes specialty pharmacy services provided by Accredo, a nationally accredited specialty pharmacy.

Beginning March 1, 2024, TRICARE beneficiaries who take TRICARE-defined[1] specialty medications will gain access to expanded specialty pharmacy services at no additional cost beyond TRICARE cost-shares. In addition, some beneficiaries will benefit from lower mail-order copays for certain medications. Expanded specialty pharmacy services include:

- 24/7 beneficiary access to specialty-trained pharmacists, nurses and clinicians who are trained to provide personalized clinical care to patients
- Individualized support from Accredo's Therapeutic Resource Centers, which consist of dedicated staff who specialize in different health conditions, including:
  - Advanced pulmonary conditions
  - Asthma and allergy
  - Blood disorders
  - Cystic fibrosis
  - Endocrine disorders
  - Fertility
  - Hepatology
  - Immune and complex conditions
  - Neurology and multiple sclerosis
  - Oncology
  - Rare diseases and gene therapy
  - Rheumatoid arthritis and inflammatory conditions
- Lower mail-order copayments and up to 90-day refills for TRICARE-defined specialty drugs when beneficiaries choose TRICARE Home Delivery
- Access to social workers, patient care advocates and dietitians who can provide holistic support to patients navigating **specialty conditions**
- Convenient new digital tools and apps that allow beneficiaries to customize their care when and how they need it, including order tracking and online payments, selecting specific delivery dates, refills by text, and dose reminders

For more information, visit **www.accredo.com/dodspecialty**.

[1] TRICARE, through the DOD P&T Committee process defines what is considered a "specialty medication" and maintains the specialty drug list. The TRICARE specialty drug list can be found at https://tricare.mil/CoveredServices/IsItCovered/SpecialtyDrugs

Addressing Perinatal Depression

Depression during and after pregnancy occurs more often than people may realize. Perinatal depression, a depressive disorder occurring during pregnancy or in the first 12 months after delivery, affects as many as **one in seven women**, and is one of the most common complications of pregnancy and the postpartum period.

Why screen for perinatal depression?

It's important to identify pregnant and postpartum women with depression. Left untreated, perinatal and other mood disorders can have devastating effects, including poor infant care and developmental issues.

Risk factors for developing perinatal depression include:

- Personal or family history of depression
- History of physical or sexual abuse
- Unplanned or unwanted pregnancy
- Current stressful life events
- Pregestational or gestational diabetes
- Complications during pregnancy

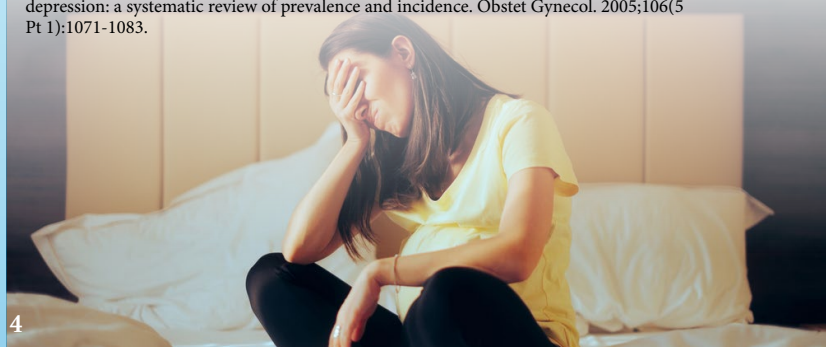
In addition, social factors such as low socioeconomic status, lack of social or financial support, and adolescent parenthood have also been shown to increase the risk of developing perinatal depression.

Several **screening instruments** have been validated for use during pregnancy and the postpartum period. **American Family Physicians** recommends the Edinburgh Postpartum Depression Scale or the Patient Health Questionnaire. It's recommended obstetrician-gynecologists and other obstetric care providers screen patients at least once during the perinatal period for depression and anxiety symptoms. Providers are also encouraged to complete a full assessment of mood and well-being, including screening for postpartum depression and anxiety during the comprehensive postpartum visit. Additionally, well-child visits provide yet another opportunity to screen for postpartum depression. Patients with elevated screening scores should be directed, as appropriate, to mental health care providers for maximum benefit.

Visit our Provider Toolkit section – **Pregnancy and Postpartum Care** – for printable handouts, patient resources and links to evidenced-based provider screening tools and resources.

Reference

Gavin NI, Gaynes BN, Lohr KN, Meltzer-Brody S, Gartlehner G, Swinson T. Perinatal depression: a systematic review of prevalence and incidence. Obstet Gynecol. 2005;106(5 Pt 1):1071-1083.



Blood Pressure Monitors

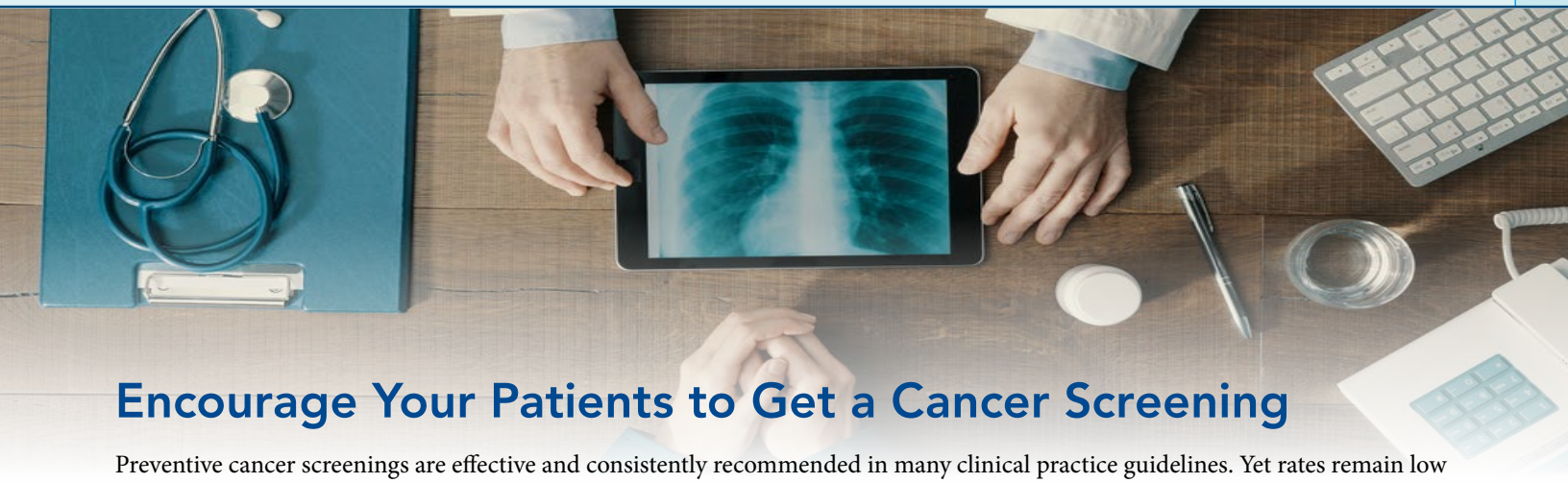
TRICARE now covers automatic blood pressure monitors prescribed for patients receiving covered remote physiologic monitoring (RPM) services. RPM is a form of telehealth that allows providers to monitor and manage their patients' chronic conditions. Previously, TRICARE excluded automatic blood pressure monitors from coverage. Manual blood pressure monitors remain excluded. Refer to TPM, Chapter 8, Section 2.8.

Find additional details on RPM and blood pressure monitors on our **www.tricare-west.com** Benefits A-Z pages.

Mobile Medical Applications

Mobile medical applications (MMA) – also called mHealth apps, software-as-a-medical devices, and digital therapeutics – are accessed using smartwatches, tablets, smartphones, and other mobile platforms. TRICARE recently defined coverage guidelines for condition-specific health MMAs. Currently, no MMAs meet TRICARE's requirements for coverage.

TRICARE will only cover MMAs that meet the definitions for durable medical equipment (DME) detailed in TRICARE Policy Manual (TPM), Chapter 8, Section 2.1. If at any point an MMA meets these requirements, the Defense Health Agency will update the TPM. Important: TRICARE does not cover mobile platforms (smartwatches, tablets, etc.) that do not meet DME guidelines.



Encourage Your Patients to Get a Cancer Screening

Preventive cancer screenings are effective and consistently recommended in many clinical practice guidelines. Yet rates remain low for many screening procedures, such as mammography, Pap smears (also known as Pap tests) and colonoscopies. Barriers such as patient refusal, forgetfulness or a lack of time, can all lead to missed opportunities for prevention and early detection.

Review the following tips to help increase patient screenings:

- **Recommend:** Your recommendation is the most influential factor in whether a person decides to get screened. Patients are 90% more likely to get a screening when their provider recommends it. Engage patients in one-on-one conversations that explain the importance of prevention services.
- **Create an office policy:** Make sure staff are aware of the policy and know how to implement it. Policies should include information about local health care resources, as well as steps for follow-through on diagnostic tests with positive findings.
- **Have a reminder system:** Reminder systems may include electronic flags, chart prompts or labels, audits, ticklers, logs or staff assignments, and they may be directed at patients, providers and office staff.
- **Educate:** Build trust with your patients by educating and engaging with them. Assess a patient's stage of readiness, participate in shared decision making and be respectful of patient preferences.
- **Reduce barriers:** Make it easy for patients to schedule appointments by having convenient test locations, making phone calls to arrange services or allowing patients to make appointments via the Internet.

Note: These tips are not intended to provide specific guidance as to which intervention or set of interventions is most appropriate for a given population or setting, nor do they guarantee interventions will be effective under all circumstances.

Visit our **Cancer Prevention** web page for resources on various cancers.

Sources
http://thecanceryoucanprevent.org/wp-content/uploads/14893-80_2018-PROVIDER-PHYS-4-PAGER-11-10.pdf
Sarfaty, Mono, MD. How to Increase Screening Rates in Practice: A Primary Care Clinician's Evidence-Based Toolbox and Guide (2008).
S. McPhee, J. Bird, D. Fordham, J. Rodnick and E. Osborn. Promoting cancer prevention activities by primary care physicians. JAMA 1991; 266: 538-544.
D.K.Litzelman, R.S. Dittus, M.E. Miller, W.M. Tierney. Requiring physicians to respond to computerized reminders improves their compliance with preventive care. J. Gen Intern Med. 1993; 8: 311-317.

Consider Quest Diagnostics for Your Patients' Lab Tests

We know as a health care provider you have options for where to send patients to get lab work completed. We also understand the health and well-being of your patients depend on the results of these tests to guide treatment plans and improve patient outcomes. Health Net Federal Services (HNFS) has designated Quest Diagnostics as a high-value provider and preferred laboratory in the TRICARE West Region network.

Here are some reasons why your TRICARE patients may benefit from going to Quest for diagnostic testing.

Multiple locations throughout the TRICARE West Region

- To find a Quest Patient Service Center, go to **www.tricare-west.com/go/directory** and click on the Quest icon.
- ***Note:*** For other network lab facilities, search for "Laboratory – Medical/Clinical" in our directory.

Extensive test menu

- Access a variety of testing options.
- Support coordination of care.

Commitment to quality and accuracy

- Meets Defense Health Agency and HNFS network standards.
- Meets Clinical Laboratory Improvement Amendments (CLIA) standards.

Investment in cutting-edge technology and research

- Collaborates with leading hospitals and health systems.
- Creates custom solutions to help you get the most from their laboratory resources.

The next time you order diagnostic testing for a TRICARE patient, remember Quest as HNFS' high-value, preferred network lab provider. To find more information about Quest's mission and goals, visit **www.questdiagnostics.com**.

As a reminder, most ancillary services only require a doctor's order. Search our **Ancillary Services Requirements** tool for guidelines.

Quest Diagnostics™

Autism Care Demonstration: Documenting Medical Team Conferences

Under TRICARE's Autism Care Demonstration (ACD), qualified health care professionals (QHP) may hold medical team conferences to discuss patient care and progress for individuals with autism spectrum disorder. These conferences must be documented by the QHPs to comply with TRICARE requirements.

Health Net Federal Services' medical documentation reviewers look for specific criteria in the progress notes, including the use of appropriate Current Procedural Terminology (CPT®) codes, the presence of an authorized applied behavior analysis (ABA) supervisor, the attendance of at least three different QHPs who have seen the patient in the last 60 days, and the attendance of the patient's assigned Autism Services Navigators (ASN). Additionally, the conference must be conducted in-person or through a HIPAA-compliant telehealth platform, and all participants must stay throughout the entire medical team conference.

Remember, TRICARE excludes the following under the ACD:

- Teacher or Individualized Education Program (IEP) meetings billed as medical team conferences.
- Telephone-only medical team conferences.
- Non-health care professionals (such as school officials) documented as QHPs.

Some common errors found in progress notes include fewer than three QHPs attending the conference and a lack of detail about the ABA provider's role and treatment recommendations.

Visit our **ACD page** for more information on medical team conferences and progress notes.

Learn the Basics About Submitting Consult Reports to Referring Military Providers

If you are treating a TRICARE patient who was referred by a military hospital or clinic, you will need to submit consult documentation – also known as patient encounter reports or clear and legible reports (CLRs) – to the referring provider within required time frames. Consult documentation includes consultation reports, care notes, operative reports, and discharge summaries.

We encourage you and your staff to check out our online module, "**Returning Consult Documentation for Your TRICARE Patients.**" The module, which takes less than 10 minutes to complete, covers:

- Why consult reports are important
- The patient continuum of care
- Timeliness standards for returning consult documentation
- Where and how to submit consult documentation to military hospitals and clinics.

As a reminder, once you have rendered care, the "clock" for returning consultation or initial assessment documentation begins.

Consultation Type	Consultation Standard
Emergent care	Send within **24 hours**
Urgent care	Send within **48 hours**
All others (*except mental health)	Send within seven **business days**
Mental health assessment	Mental health care providers: Submit brief initial assessments within seven **business days**.

Visit our **Consultation Reports** page to learn more.

CONTACTS

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1-844-866-WEST (1-844-866-9378)
www.tricare-west.com

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