

Understanding TRICARE's School Physical Benefit

Summer is still in full swing, but the first day of school will be here before you know it, and parents will be making appointments for their children's school physicals.

TRICARE Prime and TRICARE Standard cover required back-to-school physicals for children ages 5–11 years as a clinical preventive service. Sports physicals are **not** a TRICARE-covered benefit.

A child's school physical may be one of the only times throughout the year that you see some of your young patients. Because of this, the American Academy of Pediatrics suggests that providers use a child's yearly school physical as an opportunity to build and add to his or her complete medical history. This can help you and other health care providers monitor a child's progress and development over time and detect emerging problems.

School physicals often require confirming the child's immunizations are up-to-date. TRICARE covers age-appropriate vaccines per Centers for Disease Control and Prevention (CDC) guidelines to immunize children against common childhood diseases. The CDC's recommended vaccination schedule may be found at www.cdc.gov/vaccines.

A beneficiary using TRICARE Prime or TRICARE Prime Remote for Active Duty Family Members does not need a referral or prior authorization from his or her primary care manager to see a network provider for school physicals, immunizations or other clinical preventive services. In addition, no copayment is required for these services.

Referrals for school physicals are also not necessary if a beneficiary uses TRICARE Standard or TRICARE Extra; however, cost-shares and deductibles will apply.

Remember, TRICARE coverage is only for school physicals required for enrollment, not for sports physicals. If the child's parent requests a sports physical only, you should have the parent complete a *Waiver of Non-Covered Services* form. By completing this form, the parent acknowledges that he or she will be paying for the non-covered service. The *Waiver of Non-Covered Services* form may be found at www.triwest.com/provider. You may also advise beneficiaries to check if their MTFs offer sports physicals, as some sites may offer this service.

For more information about TRICARE-covered school physicals, well-child care and immunizations, refer to Chapter 7, Sections 2.2 and 2.5, of the *TRICARE Policy Manual*, available at <http://manuals.tricare.osd.mil>. ■

Change for Non-DRG Acute Care Medical/Surgical Admissions

TriWest Healthcare Alliance Corp. (TriWest) now requests clinical documentation for medical review upon notification of urgent/emergent non-Diagnosis Related Group (DRG) acute care medical/surgical admissions.

TriWest will contact facilities and ask them to provide clinical information for admissions by telephone or fax. The clinical information requested will include the reason for admission and discharge plan.

If the requested clinical information is not received within the time frame specified in the request, the facility will receive approval for a one-day admission.

The prior authorization process for nonemergent/nonurgent admissions and continued stay reviews remains unchanged.

As always, TriWest appreciates your participation with the TRICARE program. If you have any questions, please call 1-888-TRIWEST (1-888-874-9378). ■



Referrals and Prior Authorizations

For correct TRICARE beneficiary care coordination and appropriate claims payment, it is important to understand the difference between a referral and prior authorization and the requirements and processes for each.

When Is a Referral Needed?

When a TRICARE Prime beneficiary requires medical or surgical services that are beyond your scope of practice, you must request a referral from TriWest Healthcare Alliance Corp. (TriWest). TRICARE Prime beneficiaries must first seek care from their primary care manager (PCM) or the military treatment facility (MTF). TriWest will approve a referral for specialized medical services from a civilian professional or ancillary provider **only** if the services are not available from the PCM or MTF. The MTF is always the primary source of care and has the “right of first refusal.”

Exceptions to the referral requirement for TRICARE Prime beneficiaries are emergency care, preventive care services from TRICARE network providers or when using the point of service (POS) option. **Note:** When treating active duty family members enrolled in an overseas TRICARE Prime option (e.g., TRICARE Global Remote Overseas), referrals and authorizations for care are not required when traveling in the United States, and POS fees do not apply. The exception is for nonemergency inpatient behavioral health care; authorization is required and POS fees will apply if it is not obtained.

It is important to remember that active duty service members (ADSMs) **always** need a referral from their MTF before seeking civilian care (except in a true emergency). ADSMs enrolled in TRICARE Prime Remote can receive routine primary care services from their primary care providers or TRICARE-authorized civilian providers without a referral; however, specialty care requires a referral from their regional contractor and service point of contact.

Referrals are not applicable to TRICARE Standard and TRICARE Extra beneficiaries.

When Is Prior Authorization Needed?

Prior authorization is required for requested services, procedures or admissions that require medical necessity review before services are rendered. Prior authorization may be required for various services and care, including adjunctive dental care, durable medical equipment and hospice care. This applies to TRICARE Prime, TRICARE Standard and TRICARE Extra beneficiaries.

To determine if prior authorization is needed for your patient, refer to TriWest’s prior authorization list, available at www.triwest.com/provider. **Note:** For ADSMs, prior authorization is required for all inpatient and outpatient services from a civilian provider.

How Do I Request Referrals and Prior Authorizations?

The new preferred way to submit a referral or authorization request to TriWest is online at www.triwest.com. To use the referral/authorization submission tool, you must become a registered user of the secure provider portal. Just go to the “Register Today!” section at www.triwest.com/provider to sign up.

continued on page 3



Referrals and Prior Authorizations

continued from page 2

Once registered, you can log in to the secure portal by clicking on “My Account,” then go to the “Referrals & Authorizations” section and click on “Learn to Submit Requests.” There is a brief online tutorial to assist you with getting started and answer common questions about using the tool. Additional online help is also available.

You may also go to www.triwest.com/provider and find the *TRICARE Patient Referral/Authorization Form* in the “Forms” section. There is also a “Fill & Print” version of the form. All you have to do is click on the “Fill & Print” icon and you will be directed to a form where you can type the necessary information in the appropriate fields online, and then print the form and fax it to TriWest. This way illegible handwriting, which could delay approval of the authorization request, is avoided. TriWest will review the request to determine the patient’s eligibility and whether

the service requested is a TRICARE-covered benefit that is medically necessary and at the appropriate level of care. Medically necessary services will be directed to the MTF first. If the service is not available at the MTF, TriWest will refer the beneficiary to a network civilian provider or authorize a non-network provider if a network provider is not available. Once the referral process is complete, TriWest will notify you, the servicing provider, the facility (when applicable) and the beneficiary.

Requesting and servicing providers can check the real-time status of referrals and authorizations on TriWest’s Web site. **Note:** Receipt of a referral or prior authorization does **not** guarantee payment.

To learn more about referrals and prior authorizations in the TRICARE West Region, visit www.triwest.com/provider. ■

Important Reminder about Balance Billing

It is important to remember that TRICARE prohibits the practice of balance billing. Balance billing requirements apply to both network and non-network providers who treat TRICARE beneficiaries, and noncompliance with these requirements can impact your TRICARE and/or Medicare status.

What Is Balance Billing?

Balance billing is when a provider bills a TRICARE beneficiary for any amount in excess of the TRICARE-allowable charge after TRICARE has processed the claim. This practice is limited by law.

Network versus Non-network Provider Responsibilities

Once you’ve signed a contract to become a TRICARE network provider, you’ve agreed to be paid at your contractual rate. If you are a non-network TRICARE-authorized provider and have agreed to participate on a particular claim, this means you have agreed to accept the TRICARE-allowable charge as payment in full and 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 in how much they can bill TRICARE beneficiaries.

What if the Patient Has Other Health Insurance?

When other health insurance (OHI) is involved, a provider may not collect more than the billed charges from the OHI (primary payer) and TRICARE (secondary payer) combined. In addition, a provider may not collect any out-of-pocket payments from the beneficiary after processing a TRICARE and OHI claim, unless TRICARE and the OHI combined have failed to pay one of the following:

- The contracted rate to a network provider
- The TRICARE-allowable charge or the billed amount (whichever is lower) to a non-network provider

If the patient’s financial responsibility with the OHI is more than the TRICARE-allowable charge, the additional money cannot be collected. The amount paid by the OHI and TRICARE is the full payment.

If a provider participates with the primary OHI, then all OHI rules and requirements must be followed or TRICARE will not pay the claim.

Failure to comply with the balance billing laws is a violation of federal law and is considered fraudulent under the federal laws governing TRICARE. For more information about balance billing, refer to Section 2 of your *TRICARE Provider Handbook* or visit www.tricare.mil. ■

TRICARE Provider News

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

CONTACTS

TriWest Customer Service
1-888-TRIWEST
www.triwest.com

TRICARE Alaska Office
1-907-743-1800

Wisconsin Physicians Service
(Electronic claims set up)
1-800-782-2680
www.wpsic.com

Express Scripts, Inc. (ESI)
(Pharmacy inquiries)
1-866-DoD-TRRX
1-866-DoD-TMOP
www.express-scripts.com/TRICARE



Change in Urgent Request Process

We at TriWest Healthcare Alliance Corp. (TriWest) know that taking care of our TRICARE beneficiaries in a timely manner is of the utmost importance to you as well as us. However, there is a difference between an urgent referral/authorization request and a routine request.

Urgent care is defined as medically necessary services required for an illness or injury that would not result in further disability or death if not treated immediately, but that requires professional attention and has the potential to develop into such a threat if treatment is delayed longer than 24 hours. Please do not indicate “urgent” on a referral or authorization request unless the beneficiary truly needs care urgently. Administrative urgency or convenience is not considered urgent.

When you indicate on the *TRICARE Patient Referral/Authorization Form* that the medically necessary services are needed urgently, TriWest processes it as an urgent request. However, referral/authorization requests are sometimes submitted as urgent without sufficient clinical information to support that the services are medically urgent. This can delay the processing of other requests for services that truly are needed urgently.

TriWest has therefore changed the urgent request process. If the request does not include the clinical information supporting that the services are needed urgently and a medical necessity review is required for the particular services requested, TriWest will now contact the provider’s office to request the supporting clinical information. This will ensure that truly urgent requests are processed more quickly. If the requested clinical information is not provided, the medical necessity review will be completed on the urgent request as originally submitted by the provider.

As always, TriWest appreciates the care you provide to our TRICARE West Region beneficiaries. If you have any questions, please call 1-888-TRIWEST (1-888-874-9378). ■