

Understanding TRICARE's Ambulance Coverage

When an Ambulance Is Covered

Ambulance transfers are covered in the following circumstances:

- Emergency transfers to or from a beneficiary's home, accident scene or other location to a civilian hospital, military treatment facility (MTF) or Department of Veterans Affairs (VA) hospital
- Emergency transfers between MTFs, VA hospitals and civilian hospitals
- Transfers from a hospital-based emergency room to an MTF, VA hospital or civilian hospital that is more capable of providing the care
- Transfers from an MTF/civilian hospital/skilled nursing facility to a freestanding or other hospital-based outpatient therapeutic or diagnostic department/facility
- Transfers to and from a skilled nursing facility and a civilian hospital/MTF/VA hospital when medically necessary

When It's by Boat, Airplane or Helicopter

Ambulance services using "other-than-land" vehicles such as a boat, airplane or helicopter are covered only when:

- The pick-up point is inaccessible by a land vehicle
- Great distance or other obstacles are involved in transporting the patient
- The patient's medical condition warrants speedy admission to an emergency room

If the ambulance service received a call and dispatched Advanced Life Support (ALS) even though Basic Life Support (BLS) was available, then BLS will be paid if the patient's condition could have been managed by BLS service.

There must be justification on the claim supporting the use of ALS in areas where both ALS and BLS ambulances are available and no state laws or local ordinances mandate ALS as the minimum standard transport.

When an Ambulance Is Not Covered

TRICARE does not cover ambulance services for the following:

- Nonemergency ambulance services used instead of a taxi service or other normal transportation means when the patient's condition would permit use of regular transportation
- Transport or transfer of a patient primarily for the purpose of having the patient closer to home, family, friends or a physician
- Any type of medicabs or ambicabs, which function as public passenger services transporting patients to and from their medical appointments

Please be aware that transportation may be covered in certain circumstances for beneficiaries using the TRICARE Extended Care Health Option (ECHO). Contact Humana Military for details. ■

Billing for Ambulance Services

Be certain to use a modifier code with two characters indicating the origination and destination of the ambulance transport.

- H - Hospital
- R - Residence
- P - Physician's office
- S - Scene
- E - Extended care facility

For example, the modifier HH indicates a trip from one hospital to another, while PH stands for a trip from physician's office to hospital. These modifiers help Humana Military process ambulance claims accurately.



TRICARE Reference Room: Outpatient Treatment for Substance Abuse

TRICARE covers detoxification, rehabilitation and outpatient care for treatment of alcohol or drug abuse disorders, as long as the care is medically necessary. The following is an overview of the outpatient rehabilitative services covered by TRICARE.

- **Outpatient rehabilitative care** is recommended for individuals who do not need detoxification and who are medically or psychologically stable. It is also helpful for patients who have been through rehabilitation in the past and just need additional support.
- **A hospital-based setting** is more appropriate for rehabilitation of patients who are unstable. A hospital-based rehabilitation program provides an interdisciplinary model for those with a medical or psychological condition.

If your patients are not medically compromised, it may be appropriate to refer them to outpatient care at a freestanding substance abuse disorder rehabilitation facility.

Outpatient Rehabilitation Coverage

Outpatient care for substance abuse must be provided by a TRICARE-authorized/certified substance abuse disorder rehabilitation facility, whether freestanding or hospital-based. Otherwise, beneficiaries will not be eligible for cost-sharing. Certified addiction rehabilitation counselors or certified alcohol counselors employed by the facility may provide the care.

TRICARE covers outpatient care for substance abuse rehabilitation in a group setting only. Beneficiaries are

covered for up to 60 facility-based, group therapy visits per 365-day benefit period.

Patients needing rehabilitation, who also present with a coexisting mental health diagnosis (DSM-IV) like depression, can continue to seek individual therapy. In these cases, the treating therapist may submit claims using the mental health diagnosis as primary and the substance abuse diagnosis as secondary.

Family therapy is available as part of substance abuse rehabilitation. TRICARE allows 15 family therapy sessions for the substance abuse diagnosis.

Prior authorization is required for outpatient group therapy. Providers can fax in a treatment request. The form is available on the Humana Military Web site at www.humana-military.com. Go to “Provider Resources,” click on “Behavioral Health,” and then click on “ValueOptions Forms.”

For more information about substance abuse disorder treatment coverage, visit the Humana Military Web site or call ValueOptions at 1-800-700-8646. ■

Substance Abuse Treatment Not Covered by TRICARE

- Methadone maintenance
- Group homes
- Outpatient detoxification
- Aversion therapy (except Antabuse)
- Half-way houses
- Therapy-related smoking cessation programs

Consult Reports Required within 10 Working Days

Consult reports are required to be returned to the primary care manager or initiating provider within 10 working days of the patient encounter. For routine specialty referrals for initial office visits, all outpatient services and inpatient services, you must provide complete and legible documentation for these reports to be accurate and useful.

Returning consult reports, operative reports and discharge summaries to the initiating provider is important for timely follow up and continuity of care. Please be responsive to the request when asked to return a consult report for TRICARE beneficiaries.

Providers who treat TRICARE beneficiaries coming from the local military treatment facility may receive a faxed reminder to return a consult report for a recent visit/service. Your office should return the requested report and use the designated fax reminder as the cover sheet. Please use the fax number listed in the upper right corner of the reminder page.

This fax number is shown only on the reminder fax to providers for each beneficiary consult return request. This is to avoid having providers send documentation on all other TRICARE beneficiaries. ■

A Closer Look: Balance Billing Q&A

Non-compliance with balance billing requirements may affect your TRICARE and/or Medicare status. Here's a closer look at those requirements.

What is balance billing?

Balance billing is when a provider bills a TRICARE beneficiary for more than their payment responsibility after TRICARE has processed the claim. Network providers sign a contract to be paid at a negotiated rate. Non-network providers who accept assignment, i.e., participate in TRICARE, agree to accept the TRICARE allowable charge as payment in full. Collecting the beneficiary's copayment, deductible, or cost-share is not considered balance billing.

All providers are **prohibited** from balance billing.

What if a TRICARE beneficiary has other health insurance (OHI)?

When OHI is involved, network and participating non-network providers may receive no more than the TRICARE allowable charge through payment by the other health insurer and TRICARE combined.

- Network providers must accept the TRICARE negotiated rate as payment in full. If the OHI pays more than the TRICARE allowed amount, no additional TRICARE payment will be made.
- Participating, non-network providers may not collect any amount from a beneficiary after payment of the claim unless TRICARE and the OHI combined have failed to pay the allowable charge.
- Nonparticipating, non-network providers who participate in the OHI may receive TRICARE payment up to the OHI allowable charge. If the provider **does not** participate in TRICARE or the OHI, then the provider may bill up to 15 percent above the TRICARE allowable charge. The beneficiary should not be charged a cost-share when the Explanation of Benefits shows no patient responsibility.

What charges are beneficiaries required to pay?

In most cases, the patient is not required to pay the copayment, cost-share or deductible when TRICARE is a

secondary payer. Beneficiary charges appear in the "deductible" or "cost-share" column on the TRICARE Summary Payment Voucher or remittance.

Network and non-network providers who sign participation agreements with "hold harmless" provisions may not bill the beneficiary for non-covered services, **unless the beneficiary has agreed in advance and in writing to pay for those services.** Some of these providers include hospices, certified marriage and family therapists, partial hospitalization programs, residential treatment centers, substance use disorder rehab facilities and birthing centers.

TRICARE Prime beneficiaries must read and sign the Request for Non-Covered Services form to be considered financially responsible for non-covered services. You can obtain the form in the Provider section of the Humana Military Web site at www.humana-military.com.

Additionally, beneficiaries are only responsible for a copayment when receiving primary or emergency care, or when the care is referred or prior authorized by Humana Military regardless of whether the provider is network or non-network.

Note: Active duty service members and their family members enrolled in TRICARE Prime and TRICARE Prime Remote/TRICARE Prime Remote for Active Duty Family Members do not have a copayment, except when using the pharmacy benefit, the point-of-service option, or if receiving benefits through the TRICARE Extended Care Health Option. ■



TRICARE Provider News

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 1-800-444-5445
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PGBA (claims)
 1-800-403-3950

ValueOptions (behavioral health)
 1-800-700-8646

Pharmacy Customer Service
 1-866-DoD-TRRx (retail)
 1-866-DoD-TMOP (mail order)
www.express-scripts.com/TRICARE

National TRICARE Web Sites
www.tricare.osd.mil
www.tricareonline.com

Update DEERS
 1-800-538-9552
www.tricare.osd.mil/DEERS

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TRICARE Prime Access Standards

Our Commitment to Timely Health Care

The Military Health System is committed to providing TRICARE Prime beneficiaries with timely access to providers within specific time frames and certain drive times from their homes. We ask for your commitment to these access standards.

Appointment Wait Time

TRICARE policy requires network providers to meet the following access standards for appointments for beneficiaries enrolled in TRICARE Prime:

Type of care ...	Patients must not wait more than ...
Urgent care or acute illness	24 hours for an appointment (1 day)
Routine visits	One week for an appointment (7 days)
Specialty or wellness care	Four weeks for an appointment (28 days)

Patient wait times in nonemergency situations must not exceed 30 minutes, except when you are providing emergency care to other patients and the normal schedule is interrupted. You should notify patients of the cause for the delay and the length of delay anticipated, and then offer to

reschedule the appointment. Patients may choose to stay and keep their scheduled appointment.

Drive Time

Primary care managers (PCMs) accepting new patients should understand beneficiaries are entitled to a drive time that does not exceed 30 minutes from their home to your office under normal circumstances.

When helping patients with referrals to specialists, PCMs should also be aware in most cases TRICARE Prime beneficiaries do not have to travel more than an hour from their home to access specialty care. TRICARE Prime beneficiaries residing outside of a Prime Service Area (a geographic area where TRICARE Prime is offered) have waived their drive time standards and are required to use network PCMs and specialists regardless of distance.

Verifying the Standards

Meeting TRICARE Prime access standards is essential for network providers. Network providers must notify Humana Military within 10 days of any change to demographics, panel status or ability to meet appointment standards. ■