TRICARE Prime® Demo by CareSource Military & Veterans™

Partner is an affiliate of CareSource Network Partners, LLC

TRICARE Prime Demo Competitive Plans Demonstration (CPD) Provider Manual

TRICARE®

CareSource™ MILITARY & VETERANS

This content has been reviewed; however, changes and/or revisions occur frequently. Providers should check our website at CareSourceMilitary.com for the most current version of this manual.


PALMER
AIRBORNE

Dear TRICARE Prime® Demo by CareSource Military & Veterans™ provider,

Thank you for your participation. CareSource Military & Veterans values our relationships with our providers, and we are actively working to make it easier for you to deliver quality care to our beneficiaries.

This manual is a resource for working with our health plan. It communicates policies and programs and outlines key information such as claims submission, reimbursement processes, authorizations and beneficiary benefits to make it more efficient for you to do business with us.

This manual will be made available on **CareSourceMilitary.com** > Providers > Tools & Resources > Provider Manual. You may also request a hard copy of the manual by calling Provider Services at **1-833-230-2170**. CareSource Military & Veterans communicates updates to our provider network regularly at **CareSourceMilitary.com** > Providers > Tools & Resources > Updates & Announcements. To better support our providers and offer an immediate response to questions, concerns and inquiries, we offer claims, policy and appeals assistance through our call center.

To support our providers, we have dedicated Customer Care teams specialized with each plan to help assist with questions and concerns. Additionally, an external team of specialists is available to provide onsite training and work with our providers in their communities.

We know great health care begins with you. Together we can help attain better outcomes for our TRICARE Prime Demo beneficiaries.

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TRICARE Prime Demo – Mission-Driven Support for Military Families

CareSource Military & Veterans is dedicated to serving service members, veterans, and their families. As a beneficiary-centric organization, CareSource Military & Veterans' mission is to improve health care access, delivery, and outcomes for the military community. Guided by CareSource's ethos of prioritizing people over profits, CareSource Military & Veterans reinvests resources into its beneficiaries, providers, and communities—ensuring military families receive the focused support they deserve.

Introducing the TRICARE Competitive Plans Demonstration (CPD)

CareSource Military & Veterans has been awarded the TRICARE Competitive Plans Demonstration (CPD) contracts for the Atlanta and Tampa regions, marking a historic opportunity to support military families through an innovative TRICARE pilot program. Beginning January 1, 2026, the Defense Health Agency's (DHA) CPD will test a new managed care model for TRICARE. For the first time, approximately 146,000 eligible TRICARE CPD beneficiaries (active-duty family members, retirees, and their families in the demonstration regions) can choose TRICARE Prime Demo as their managed care plan during the 2025 TRICARE Open Season. This demonstration introduces choice into TRICARE, allowing families to opt in to a comprehensive managed care plan designed to increase access to care, provide personalized support, and improve health outcomes and quality of life.

TRICARE Prime Demo uses the TRICARE Pharmacy vendor, Express Scripts (ESI), to manage pharmacy services and fill prescriptions. Dental coverage will continue to be provided by the TRICARE dental contractor, United Concordia. TRICARE Prime Demo will coordinate data exchanges with both ESI and United Concordia to stay abreast of all CPD beneficiary health needs.

Key Items to Know

TRICARE CPD offers TRICARE PRIME benefits. However, there are some unique components that providers should be aware of.

- Enrollment Fees Waived (First Year): Beneficiaries pay no enrollment fees in year one. Standard TRICARE Prime fees apply after.
- Care Through TRICARE Prime Demo Network Only: All services are delivered exclusively through the TRICARE Prime Demo provider network.
- No Referrals Needed for In-Network Care: Beneficiaries can see in-network specialists without a referral.
- No First Right of Refusal (FROR): Military treatment facilities do not have priority over civilian network care. Military facilities remain available for emergency needs only.

- TRICARE Prime Demo Supports PCM Selection and Care Coordination: Includes disease management, virtual care, and a 24 hour, seven days a week nurse advice line.
- Pharmacy Access Remains the Same: Beneficiaries use the TRICARE Pharmacy program – military and retail options still apply. Medical pharmacy (i.e., provider-administered injectables) are managed and reimbursed by CareSource Military & Veterans.

Operational Excellence and Experience

Backed by CareSource's decades of managed care experience serving over two million members nationwide, CareSource Military & Veterans delivers operational excellence in every aspect of health plan management. Leveraging proven solutions and robust infrastructure, CareSource Military & Veterans is well-equipped to administer TRICARE benefits efficiently and effectively. The organization's nonprofit, mission-driven approach means that operational decisions are guided by what's best for beneficiaries and the mission rather than shareholders. CareSource Military & Veterans' team brings deep expertise in coordinating care and navigating military health needs, ensuring a smooth implementation of the TRICARE CPD and a high-quality experience for all participants.

Through its mission-driven philosophy and commitment to operational excellence, CareSource Military & Veterans is redefining how military families experience health care. By leading the TRICARE CPD in the two designated service areas, TRICARE Prime Demo is bringing innovation and choice to TRICARE while remaining steadfast in its nonprofit, beneficiary-first values. This unique role as a TRICARE CPD partner allows CareSource Military & Veterans to honor and support those who serve our nation — providing them and their families with the quality care, support, and peace of mind they deserve.

Benefits for Military Families, Government, and Providers

By combining its mission-focused philosophy with operational strength, TRICARE Prime Demo creates value for all stakeholders in the TRICARE community.

- **TRICARE CPD Beneficiaries (Military Families, Retirees and Survivors):** Military families gain a new choice in their health coverage through TRICARE Prime Demo's plan. They can expect high-quality care tailored to their unique needs, improved access to providers, and personalized care coordination. TRICARE Prime Demo's support services are designed to engage beneficiaries in their health, resulting in better health outcomes and an enhanced quality of life for those who serve and their loved ones.
- **Government Partners (Defense Health Agency):** CareSource Military & Veterans serves as a trusted mission partner to the DHA by executing the CPD with excellence. As a nonprofit focused on service rather than profit, TRICARE Prime Demo aligns with the government's goals of improving care while managing costs. The demonstration will provide critical insights for the DHA — testing how a competitive managed care model can enhance TRICARE. CareSource Military & Veterans reliable operations and innovative approaches help ensure the pilot meets its objectives, potentially shaping the future of TRICARE and benefiting the military health system.
- **Provider Partners:** CareSource Military & Veterans works closely with health care providers to build a strong, supportive network for TRICARE CPD beneficiaries. Providers benefit from streamlined administration, timely reimbursements, and collaboration with an organization that values their role in caring for military families. By reinvesting in provider support and community health programs,

TRICARE Prime Demo fosters positive partnerships that enable doctors, hospitals, and clinics to deliver services. This collaborative approach helps expand access to services and improve care coordination across the board.

TRICARE Authorized Provider

A TRICARE provider is a health care professional or facility authorized to deliver medical services to individuals covered under the TRICARE health insurance program. Providers within TRICARE are categorized into two main types: network and non-network providers. Network providers have agreements with TRICARE to offer CPD services at negotiated rates, ensuring lower out-of-pocket costs for beneficiaries. An authorized provider is any individual, institution/organization, or supplier that is licensed by a state, accredited by national organization, or meets other standards of the medical community, and is certified to provide benefits under TRICARE.

Enrollment and Eligibility

TRICARE CPD Enrollment and Eligibility

TRICARE CPD is available to active-duty family members (ADFMs), retirees, their families, and survivors residing in the CPD designated service areas. They may voluntarily elect to enroll in CPD, which would disenroll them from other TRICARE programs.

Active-Duty Service Members (ADSMs), Guard/Reserve Service Members, and beneficiaries who are eligible for Medicare are ineligible to enroll in the CPD. Beneficiaries participating in the following benefit programs are also not eligible to enroll in the CPD:

- TRICARE For Life (TFL)
- TRICARE Reserve Select (TRS)
- TRICARE Reserve Retired (TRR)
- TRICARE Young Adult (TYA)

Due to CPD program design and the government's desire to maintain beneficiary continuity of care, beneficiaries participating in or receiving benefits under the following special programs are not eligible to enroll into the CPD:

- Autism Care Demonstration (ACD)
- Extended Care Health Option (ECHO) Program
- Wounded Warrior Program
- Continued Health Care Benefits Program (CHCBP)

If a beneficiary opts to move into the ACD, ECHO, Wounded Warrior, or CHCBP program, they will disenroll from CPD.

Beneficiary Eligibility Verification

Providers are expected to verify beneficiary eligibility each time a service is rendered.

Providers may use the Provider Portal to verify beneficiary eligibility. Upon logging into the provider portal, providers will be able to view beneficiary eligibility with:

- 24 months of history
- Beneficiary span information
- Multiple beneficiary look-up (up to 500)

Beneficiary ID Cards

Beneficiaries will be issued a TRICARE Prime Demo ID card once enrolled in TRICARE Prime Demo CPD. The TRICARE Prime Demo ID card will include the TRICARE Prime Demo system generated ID. This is the card CPD network providers will leverage for claims submission.

Providers may use our secure Provider Portal or call Provider Services at **1-833-230-2170** to check beneficiary eligibility.

Beneficiaries are asked to present an ID card each time services are accessed. If you are not familiar with the person seeking care and cannot verify the person as a beneficiary of our health plan, please ask to see photo identification.

CPD beneficiaries registered in the Defense Enrollment Eligibility Reporting System (DEERS) will be issued a uniformed services identification (ID) card. The ID card is used to identify a beneficiary only as it applies to CPD. It does not guarantee eligibility or benefits coverage and should not be used to verify their CPD eligibility. Therefore, it is important to verify beneficiary eligibility using their TRICARE Prime Demo ID card and our provider portal prior to each service rendered.

New Beneficiary Kit Elements

- A welcome letter
- Beneficiary ID card
- A quick start guide for how to get started with TRICARE Prime Demo
- Health Needs Assessment form
- TRICARE Prime Demo's Notice of Privacy Practices as required by HIPAA
- Other preventive health education materials and information, including how to select a PCM and how to complete an initial health screening

Finding a Doctor

Beneficiaries are generally encouraged to use our online **Find a Doctor** directory tool. The online Provider Directory, which lists network providers and facilities within a certain radius of the beneficiary's residence, provides the latest information on our provider network, including availability of telehealth services. A current list of providers can be found at any time on TRICARE Prime Demo's website, **CareSourceMilitary.com**.

Beneficiaries can call Beneficiary Services at 1-833-230-2080 to request a printed directory. As the contents of the printed directory are subject to change, we encourage beneficiaries to call TRICARE Prime Demo or to use the online provider directly to confirm they are in network.

Newborn Enrollment & Adoption

Unmarried biological children, adopted children, and stepchildren are eligible for TRICARE until age 21. Beneficiaries must first register newborns or adopted children in the Defense Enrollment Eligibility Reporting System (DEERS) before enrolling the child in TRICARE Prime Demo. Beneficiaries have 90 days

to register the child in DEERS from the date of birth or date an adoption is finalized. Some beneficiaries' children may be auto enrolled depending on their beneficiary category. If auto-enrolled, beneficiaries have 90 days from the auto-enrollment date to change to a different plan and the new plan is backdated to the date of birth.

Beneficiary Disenrollment

Beneficiaries don't have to re-enroll every year to continue TRICARE Prime Demo coverage. Certain events will cause beneficiaries to be disenrolled. TRICARE's Eligibility, Enrollment, and Encounter (EEE) contractor will process all TRICARE Prime Demo and CPD disenrollment requests. Beneficiary disenrollment requests can be submitted via telephone, surface mail, internet, facsimile and in person.

Please contact 1-833-230-2080 for questions about beneficiary disenrollment from CPD.

Reasons for Disenrollment

1. Enrollment in a different TRICARE plan not included in CPD (e.g., TRICARE for Life, Humana TRICARE Prime, TRICARE Reserve Select, or TRICARE Young Adult).
2. Beneficiaries choosing to participate in or receive benefits under the following special programs:
   a. Autism Care Demonstration (ACD)
   b. Extended Care Health Option (ECHO) Program
   c. Wounded Warrior Program
   d. Continued Health Care Benefits Program (CHCBP)
3. Relocation outside of the CPD designated service area.
4. Loss of eligibility for CPD due to other reasons, such as sponsor separation from active duty, divorce, etc.
5. The enrollee no longer satisfies the criteria to participate in the CPD, e.g. beneficiary has become eligible for Medicare.
6. Beneficiary violates the Direct Care (DC) system/Military Medical Treatment Facility (MTF) lockouts (i.e., repeatedly accessing MTFs for other than emergency services or pharmacy benefits).
7. Fraudulent or abusive use of services.
8. Beneficiary has died.

Visit **https://tricare.mil/Plans/Eligibility** for more information about eligibility and reasons for disenrollment.

Disenrollment Initiated by the Beneficiary

A beneficiary may request disenrollment without cause at any time.

Reasons for disenrollment initiated by the beneficiary, include, but are not limited to, poor quality of care, lack of access to services covered under the contract or lack of providers experienced in addressing the beneficiary's health care needs.

Disenrollment Initiated by TRICARE Prime Demo

TRICARE Prime Demo may request disenrollment if:

- The enrollee violates the Direct Care (DC) system/Military Medical Treatment Facility (MTF) lockouts (i.e., repeatedly accessing MTFs for other than emergency services or pharmacy benefits).
- The beneficiary's utilization of services is fraudulent or abusive.
- The enrollee no longer satisfies the criteria to participate in the CPD.
- The beneficiary has died.

Provider-Initiated Requests for Beneficiary Reassignment

The TRICARE Prime Demo programs encourage positive and continuous relationships between beneficiaries and Primary Care Managers (PCMs). In rare instances, a PCM may request reassignment of a beneficiary to another PCM within TRICARE Prime Demo. CareSource Military & Veterans must approve and document these situations. The reasons for these situations include the following:

- Missed appointments (with appropriate documentation and criteria).
- Beneficiary fraud (upper-level review required).
- Uncooperative or disruptive behavior on the part of the beneficiary or beneficiary's family (upper-level review required).
- Medical needs that could be better met by a different PCM (upper-level review required).
- Breakdown in physician and patient relationship (upper-level review required).
- Beneficiary accesses care from providers other than the selected or assigned PCM (upper-level review required).
- Previously approved termination.
- Beneficiary insists on medically unnecessary medication.

CareSource Military & Veterans' medical director or a committee appointed by the medical director performs an upper-level review – a thorough review of the individual case – to determine whether the cause and documentation are sufficient to approve a reassignment. The upper-level review includes monitoring to improve the overall quality of the program and to ensure that TRICARE Prime Demo's guidelines and policies are consistent with those of the program.

The following provides guidelines for situations outlined previously:

- **Missed appointments** – A beneficiary may miss at least three scheduled appointments without defensible reasons before a PCM may request beneficiary reassignment. The PCM or staff is responsible for educating the beneficiary, on the first occurrence, about the problems and consequences associated with missed appointments. Beneficiaries are not penalized for an inability to leave work, for lack of transportation, or for other defensible reasons. Missed appointments must be documented in the beneficiary's chart that is accessible to the PCM and staff. On documentation of the third missed appointment for non-defensible reasons, CareSource Military & Veterans may approve the PCM's request for the beneficiary's reassignment within TRICARE Prime Demo. CareSource Military & Veterans has procedures in place to assist beneficiaries and PCMs with missed appointments and may intervene to resolve issues, while supporting the overall goals of the program.

- **Beneficiary fraud** – This reason for beneficiary reassignment must be restricted to cases referred to TRICARE Prime Demo. To learn more about beneficiary fraud, please see the section on *Fraud, Waste and Abuse* in the **Administrative Processes** chapter of this manual.
- **Threatening, abusive or hostile actions by beneficiaries** – The PCM can request a beneficiary's reassignment when the beneficiary or the beneficiary's family becomes threatening, abusive, or hostile to the PCM or to the office staff after attempts at conflict resolution have failed. The request must be consistent with the PCM's office policies and with criteria used to request reassignment of commercial patients.
- **Beneficiary's medical needs may be better met by another PCM** – A PCM may request beneficiary reassignment because the PCM believes a beneficiary's medical needs would be better met by a different PCM. This request must be documented as to the severity of the condition and must be reviewed by CareSource Military & Veterans' medical director. CareSource Military & Veterans' medical director must review the request based on the specific condition or severity of the condition as a PCM scope-of-practice matter, not based on a bias against an individual beneficiary.
- **Breakdown of physician and patient relationship** – CareSource Military & Veterans must conduct an upper-level review, as defined previously, to ensure that the breakdown in the relationship between the PCM and the beneficiary is mutual.
- **Beneficiary accessing care from other than the selected or assigned PCM** – CareSource Military & Veterans must conduct beneficiary education about the health plan and the PCM selection process. If the beneficiary does not initiate a PCM change and continues to access primary care services from a provider other than the PCM, the PCM may request the beneficiary's reassignment. Misuse of the emergency room is not a valid reason for requesting a beneficiary's reassignment.

Most of these situations can be resolved by facilitating the beneficiary's selection of another PCM within the health plan. Beneficiaries who require services of providers not available within the health plan generally are not disenrolled but remain in TRICARE Prime Demo, with CareSource Military & Veterans managing and reimbursing for non-network services.

Unacceptable reasons for PCM-initiated beneficiary reassignment requests:

- **For good cause** – This term is used for beneficiary-initiated PCM change requests.
- **Noncompliance with mutually agreed-to treatment** – Beneficiaries are not reassigned for being noncompliant or refusing treatment. A patient has the right to refuse treatment.
- **Demand for unnecessary care** – A PCM-initiated request for beneficiary reassignment is not approved for this reason unless there is documentation of threatening, abusive or hostile behavior, as described in this section of the manual.
- **Language and cultural barriers** – PCMs who have difficulty with a beneficiary's language or other cultural barriers must request assistance from CareSource Military & Veterans to address the problem.
- **Unpaid bills incurred before TRICARE Prime Demo enrollment** – PCMs may not initiate beneficiary transfer requests because of unpaid medical bills incurred before TRICARE Prime Demo enrollment. PCMs can pursue charges outstanding before TRICARE Prime Demo enrollment through the normal collection process.

Avoiding Collection Activities

Both network and non-network providers are encouraged to explore every possible means to resolve claims issues without involving debt-collection agencies. Before sending a beneficiary's claim to a collection agency, providers should do one or both of the following:

- Submit an administrative review request
- Request an adjustment on an allowable charge review

Please wait at least 45 days after submitting a claim before contacting CareSource Military & Veterans.

Beneficiaries are responsible for their out-of-pocket expenses, unless the outstanding amount is the beneficiary's deductible, cost-share, or copay amount reflected on the provider remittance advice.

TRICARE's Debt Collection Assistance Officer (DCAO) Program

DCAOs are located at military hospitals or clinics to assist TRICARE beneficiaries in determining the validity of collection agent claims and/or negative credit reports received for debts incurred as a result of receiving health care under the TRICARE program ("health care" includes medical and adjunctive dental care under TRICARE).

DCAOs cannot provide beneficiaries with legal advice or fix their credit ratings, but DCAOs can help beneficiaries through the debt-collection process. DCAOs also cannot assist with claim concerns that are not in collections or have not resulted in an adverse credit rating. For claim concerns not related to a collection issue, customer service representatives are available to assist beneficiaries Monday through Friday, 8 a.m. to 6 p.m. (ET) at 1-800-444-5445.

Beneficiaries must take or submit documentation associated with a collection action or adverse credit rating to the DCAO. This documentation will include a completed and signed DCAO form and either a collection notice, a copy of the credit report or both showing a debt.

The DCAO will research the beneficiary's claim with the appropriate claim's processor or other agency points of contact. Then, the DCAO will provide the beneficiary with a verbal resolution, or if the beneficiary cannot be reached, a written resolution to the collection problem. The DCAO will notify the collection agency that action is being taken to resolve the issue. In some instances, the beneficiary may owe the billed amount as part of their health plan copays, cost shares and deductibles.

Coverage Policies

Covered Services

Our Provider Services include:

- Provider relations
- Beneficiary eligibility/enrollment information
- Claims processing
- Credentialing/recredentialing
- Decision-support informatics
- Quality improvement
- Regulatory/compliance
- Special investigations for fraud, waste and abuse
- Beneficiary services, including a beneficiary call center within CareSource Military & Veterans

In addition to the functions above, our Care Management programs include the following:

- Low, medium and high-risk/complex case management
- Telephonic case management
- Transition of care program
- Disease management
- Maternal health program
- Preventive health and wellness assistance with focused health needs assessment
- 24-Hour Nurse Advice Line

Please visit **CareSourceMilitary.com** for information on services, the beneficiary's coverage status, and other information about obtaining services. Prior authorization requirements for beneficiaries enrolled with TRICARE Prime Demo are determined and enforced by CareSource Military & Veterans. Please refer to our website and the "Prior Authorizations" section in this manual for more information about prior authorization procedures.

Additional covered services information is available on TRICARE's website: **https://tricare.mil/CoveredServices**.

Emergency Room Copayments for TRICARE Prime Demo

A copayment might apply when a TRICARE Prime Demo beneficiary uses the emergency room (ER), depending on the beneficiary's sponsor status and group. The copayment is on a per visit basis, meaning one payment applies to the entire ER episode, regardless of the number of providers involved in the patient care and regardless of their status as network providers. Providers will collect the copayment from the beneficiary at the time of service. TRICARE Prime Demo includes the beneficiary's copayment information on the beneficiary's ID card. For additional copayment information, visit **https://tricare.mil/Costs/Compare**.

Emergency services are covered subject to the prudent layperson standard of an emergency medical condition. Emergency services are those that are necessary to prevent death or serious impairment of health and, because of the danger to life or health, require the use of the most accessible hospital available and equipped to furnish those services. Visit **https://tricare.mil/CoveredServices/IsItCovered/** EmergencyCare for more information about emergency care.

Urgent care services are covered when medical care is necessary for a condition that is not life threatening, but requires treatment that cannot wait for routine care by a regularly scheduled clinical appointment. This would be in the case that the condition would worsen without timely medical intervention. Visit **https://tricare.mil/CoveredServices/IsItCovered/UrgentCare** for more information about urgent care.

Benefit Limits

In general, most benefit limits for services and procedures follow federal guidelines. Benefits limited to a certain number of visits per year are based on a calendar year (January through December). Please check that the beneficiary has not already exhausted benefit limits before providing services by checking our provider portal or calling Provider Services at **1-833-230-2170**.

Any services rendered in excess of the benefit limits will be denied. The Military Health System (MHS) publishes limits on number of services without an override code. This list contains Maximum Numbers of Services Per Day for Procedure Codes. More information can be found on MHS' site: **https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/TRICARE-Health-Plan/Rates-and-Reimbursement/Limits-on-Number-of-Services-without-Override-Code.**

Medical Necessity Standards and Practice Guidelines

"Medically reasonable and necessary service" is a covered service that is required for the care or well-being of the beneficiary and is provided in accordance with generally accepted standards of medical or professional practice. For a service to be reimbursable, it must:

- Be medically reasonable and necessary, as determined by CareSource Military & Veterans, which shall, in making that determination, utilize generally accepted standards of medical or professional practice; and
- Not be listed as a non-covered service or otherwise excluded from coverage.

Some services require prior authorization. If a request for authorization is submitted, CareSource Military & Veterans will notify the provider and beneficiary in writing of the determination. Authorizations can

also be requested retroactively. For more information about our authorization procedures, see the "Prior Authorizations" section in this manual.

If a service cannot be covered, providers and beneficiaries may have the right to appeal the decision. The letter will include the reason that the service cannot be covered and how to request an appeal if necessary. Please see the "Administrative Processes - Grievances and Appeals" section for information on how to file an appeal.

Services Excluded from TRICARE Prime Demo

In general, TRICARE excludes services and supplies that aren't medically or psychologically necessary for the diagnosis or treatment of a covered illness (including mental disorder), injury, or for the diagnosis and treatment of pregnancy or well-child care.

Additionally, all services and supplies (including inpatient institutional costs) related to a non-covered condition or treatment, or provided by an unauthorized provider, are excluded. Please see TRICARE's online list of excluded services, keeping in mind that the list is not all inclusive: **https://tricare.mil/CoveredServices/IsItCovered/Exclusions**.

Beneficiary Support Services and Benefits

TRICARE Prime Demo provides our beneficiaries a wide variety of support and educational services and benefits to:

- facilitate their use and understanding of our plan's services,
- promote preventive health care and
- encourage appropriate use of available services.

We are always happy to work in partnership with you to meet the health care needs of our beneficiaries.

TRICARE Prime Demo's Beneficiary Services

Beneficiary Services Representatives are available by telephone at 1-833-230-2080 Monday through Friday, 8 a.m. to 6 p.m. ET, except on certain holidays. After-hours callers can use the Interactive Voice Response (IVR) or speak to someone at the Nurse Advice Line.

Please visit **CareSourceMilitary.com** > About Us > Contact Us for the holiday schedule or contact Provider Services for more information.

Nurse Advice Line

For Physical and Behavioral Health Services, beneficiaries can call our Nurse Advice Line 24 hours a day, seven days a week. With our Nurse Advice Line, beneficiaries have unlimited access to talk with a caring and experienced staff of registered nurses about symptoms or health questions.

Nurses assess beneficiaries' symptoms using the Schmitt-Thompson Clinical Content to determine the urgency of the complaint and direct beneficiaries to the most appropriate place for treatment. Schmitt-Thompson is the "gold standard" in telephone triage, offering evidence-based triage protocols and decision support. CSMV Nurse Advice Line nurses educate beneficiaries about the benefits of preventive care and connect beneficiaries to our case management programs, as needed. The nurses promote

the relationship with the Primary Care Manager (PCM) by explaining the importance of their role in coordinating the beneficiary's care. For improved care coordination with PCMs, summaries of the call are posted on the provider portal, including a record of why the beneficiary called and what advice the nurse gave.

Key features of this service include nurses who:

- Assess beneficiary symptoms
- Advise on the appropriate level of care
- Assist with locating urgent or emergency care facilities in the area and when traveling, as applicable
- Answer health-related questions and concerns
- Provide information about other services
- Encourage the PCM-beneficiary relationship

Beneficiaries may access the 24-Hour Nurse Advice Line anytime night or day. The phone number is on the beneficiary's ID card.

Crisis Line

Beneficiaries may call our Behavioral Health Crisis line at 1-833-227-3111 during a mental health or substance use crisis. The crisis line is available 24 hours a day, seven days a week and is staffed by licensed professionals with behavioral health training.

988 Suicide & Crisis Lifeline

The national 988 Suicide & Crisis Lifeline offers a direct connection to compassionate, accessible care and support for anyone experiencing mental health-related distress – whether that is thoughts of suicide, mental health or substance use crisis, or any other kind of emotional distress.

Health Needs Assessment

CareSource Military & Veterans asks that all beneficiaries complete the Health Needs Assessment (HNA) within 30 days of enrollment. Through a few questions about their health and well-being, CareSource Military & Veterans can help identify health, housing, education and employment concerns where we may be able to help.

Completing the HNA is simple! Beneficiaries can complete the HNA in one of the following ways:

1. Beneficiaries can complete the HNA by visiting MyLife.CareSource.com/Assess or accessing the mobile app.
2. New beneficiaries can complete the printed copy of the HNA included with their new beneficiary packet. It can be returned in the enclosed self-addressed, postage paid envelope
3. Call our Beneficiary Assessment team at **1-844-206-6188** Monday through Friday, 7 a.m. to 6 p.m. ET.

Case Management

Case management can provide a broad spectrum of educational and follow-up services for your patients. It can be especially effective for reducing admission and readmission risks, managing anticipatory transitions, encouraging treatment adherence, reinforcing medical instructions, and assessing social and safety needs, as well as educating pregnant patients and first-time mothers on the importance of prenatal care, childbirth, postpartum and infant care. We also offer individualized education and support for many conditions.

The role of the Case Manager includes:

- Assisting beneficiaries in completed the Health Needs Assessment and other condition specific assessments
- Coordinating the development of a care plan
- Providing education and support for the beneficiary's health condition
- Linking beneficiaries to available benefits and resources
- Connecting beneficiaries with community support services to address social needs
- Assisting beneficiaries in closing gaps in care
- Assisting with transitions of care
- Removing barriers to care

Providers can connect beneficiaries to Case Management services by phone 1-844-206-6188 or by fax 937-396-3673. Electronic case management requests can also be completed on the Provider Portal.

Population Health and Case Management Services

At TRICARE Prime Demo, we believe it is vital to deliver targeted and integrated care coordination services that are beneficiary-centric, collaborative, and supported by evidence-based care to facilitate improved beneficiary outcomes, enhanced beneficiary satisfaction and optimal resource utilization.

The focus of the TRICARE Prime Demo Case Management program is to provide a dynamic, beneficiary-centric model of service delivery. The model, designed as a population health management approach with care coordination for beneficiaries, utilizes a multidisciplinary care team to address the beneficiaries' holistic needs.

As a population health management model, the ultimate goals are to:

- Improve the beneficiary experience of care (including clinical quality and satisfaction);
- Improve the health of populations;
- Reduce health disparities between communities;
- Improve Clinician Experience; and
- Reduce the per capita cost of health care.

The Case Management program is designed to support the care and treatment you provide and recommend to your patient. We stress the importance of establishing a PCM, identifying barriers and

keeping appointment, and we can assist in arranging transportation to the provider's office. This one-on-one personal interaction with Case Managers helps provide a comprehensive safety net to support your patient through initial and ongoing assessment activities, coordination of care, education to promote self-management and healthy lifestyle decisions. In addition, we help connect your patient with additional needed community resources, such as assistance with housing and food.

CareSource Military & Veterans encourages you to take an active role in your patient's case management program through the Patient Profile feature on the Provider Portal. This profile provides beneficiary-specific information on pharmacy, inpatient and Emergency Department (ED) utilization, and scheduled or planned services. This information provides you with critical information necessary to make informed decisions pertaining to your patient. In addition, we invite and encourage you to direct and provide input into patient assessment activity and participate in the development and monitoring of a care plan individualized to the needs of your patient. We believe communication, coordination, and collaboration are integral to ensure the best care for your patients.

Case Management of High-Risk Beneficiaries

TRICARE Prime Demo applies a multidisciplinary approach for our high-risk beneficiaries. We integrate the Case Management Society of America (CMSA) Standards of Practice and the National Academy for State Health Policy (NASHP) Standards into key processes to help ensure implementation of a best-practice program. The case management team helps patients overcome health care access barriers and strengthen our provider and community resource partnerships through collaboration.

Typical high-risk beneficiaries served by this model may have multiple medical issues, socioeconomic challenges, and behavioral health care needs.

Participating beneficiaries receive targeted health literacy and beneficiary education programs to address underlying acute or chronic conditions through either guided or self-service platforms. Care coordination efforts may include:

- Care transition planning
- Identifying gaps in care and collaborating with the care team to close gaps
- Facilitating beneficiary access to appropriate care and services
- Providing connections to appropriate medical, behavioral, social, and community resources to address identified beneficiary needs
- Coordinating planned interventions, driven by a care coordination plan, consistent with evidence-based clinical guidelines

To support the idea of you having an active role in your patient's case management journey, our case management staff may call you to coordinate and develop a care plan that addresses the beneficiary's current needs. Together, we can make a difference.

Transitions of Care (TOC) Planning

CareSource Military & Veterans identifies beneficiaries who require assistance as they transition from an inpatient stay (level of care setting change). Our team works with beneficiaries and their families to coordinate care needs and make the transition to home or a lower level of care as successful as possible.

Our Transitions of Care (TOC) program has focused outreach and discharge planning activities based on the Coleman Model, utilizing a team approach to coordinate post-discharge care needs for beneficiaries at

risk for readmission. Through these efforts, we strive to empower and educate beneficiaries to help ensure all components of the beneficiary's discharge plan are in place.

When an at-risk beneficiary is discharged from an inpatient stay, our TOC team reaches out to ensure the beneficiary has a clear path to recovery, free from barriers to care. We can coordinate home care and medical equipment needs, assist with obtaining prescribed medications and coordinate other medical care and services as needed.

We believe in the importance of partnership. That is why we collaborate with PCMs to provide our beneficiaries with the services they need along the continuum of care.

For beneficiaries transitioning to a new location or program and receiving case management services or requiring case management assistance with transition of care, the Case Management (CM) and Utilization Management (UM) teams will work to coordinate transition of services with the Department of Veterans Affairs/Veterans Health Administration (DVA/VHA), Global Defense Agency (GDA), or private sector care provider(s) upon the beneficiary or GDA request. Assistance will begin within three (3) business days of beneficiary or GDA notification. The team ensures that the beneficiary continues to have access to all appropriate providers and services to prevent gaps in care.

Perinatal and Neonatal Case Management

TRICARE Prime Demo's perinatal and neonatal case management program utilizes a multi-disciplinary team with extensive obstetrics and neonatal intensive care unit (OB/NICU) clinical experience. Specialized nurses are available to help manage high-risk pregnancies and medically complex newborns by working in conjunction with providers and beneficiaries. This includes a focus on patient education and care coordination and involves direct telephone contact with beneficiaries and providers.

All pregnant beneficiaries receive educational materials throughout their pregnancy and in the immediate postpartum period. Pregnant beneficiaries in case management will receive one-to-one perinatal education throughout pregnancy.

Neonatal Intensive Care Unit (NICU) Program

The Neonatal Intensive Care Unit (NICU) Integrated Care Management program works to improve the health status and decrease clinical complications in our youngest and most fragile beneficiaries. The best outcomes are achieved by supporting and advocating for evidence-based medicine solutions to guide decisions in clinical care. By synergistically coordinating care between case management, utilization management, discharge planning, and our beneficiaries' families, we achieve our mission. For more information about this program or to enroll beneficiaries in this case management program call 1-844-206-6188.

Mom & Baby Beginnings™ Program

The Mom & Baby Beginnings (MBB) program utilizes a population health approach to improve the health of our pregnant and postpartum beneficiaries, which promotes the decrease of complications in pregnancy and postpartum period while improving birth outcomes. MBB utilizes a holistic approach that addresses physical, behavioral, and social needs that complicate beneficiaries' lives and potentially their prenatal and postpartum courses. Let us know if your patient becomes pregnant so that we may offer case management services throughout their pregnancy. For more information about this program or to enroll beneficiaries in this case management program, call 1-844-206-6188.

Disease Management Program

Our free Disease Management program helps our beneficiaries find a path to better health through information, resources, and support. Beneficiaries with specific disease conditions are identified by criteria or triggers such as emergency room visits, hospital admissions, and the health assessment by our proprietary risk stratification algorithm. CPD beneficiaries of all ages are eligible.

We help our beneficiaries through:

- Providing beneficiaries with digital health education and self-management tools to help manage chronic conditions and improve their overall health.
- One-to-one case management (if qualified).

Any beneficiary may self-refer or be referred into the disease management program to receive condition-specific information or outreach. If a beneficiary does not wish to receive disease management education, they can contact CareSource Military & Veterans to update their contact preferences.

If you have a patient with a chronic condition who you believe would benefit from this program and is not currently enrolled, please call Case Management at 1-844-206-6188.

Healthy Behaviors Program

Our Healthy Behaviors program consists of an important beneficiary support program including medically approved tobacco/vaping cessation.

Tobacco/Vaping Cessation

CareSource Military & Veterans reminds providers of resources available for tobacco/vaping cessation and wants to help beneficiaries maintain a healthy lifestyle. This includes not using tobacco/vaping products as well as prevention. The tobacco/vaping cessation program includes:

- Beneficiary participation in a toll-free Tobacco Quitline.
- Promoting the availability of behavioral counseling.
- Informing beneficiaries on how to obtain prescribed medications from their providers for assistance with quitting.
- Links to resources to assist beneficiaries are available at: **CareSourceMilitary.com** > Beneficiaries.
- TRICARE Resources: Tobacco Cessation Services and Tobacco Cessation
- You Can Quit 2 resources

Interpreter Services

Non-Hospital Providers

TRICARE Prime Demo offers sign and other language interpreters for beneficiaries who are hearing impaired, do not speak English, or have limited English-speaking ability. We can also provide some printed materials in other languages or formats, such as large print, or we can explain materials orally. These services are available at no cost to the beneficiary or provider. As a provider, you are required to identify the need for interpreter services for your TRICARE Prime Demo patients and offer assistance to them appropriately. Providers who have 24-hour access to health care-related services in their service

area or via telephone must provide beneficiaries with 24-hour language interpreter services. This can be done either through in-person, video remote or telephone interpreter services. To arrange services, please contact our Provider Services department. To request an ASL sign language interpreter, five business days' notice is needed before the scheduled appointment while any other language interpreter services require four business days' notice before the scheduled appointment. We ask that you let us know of beneficiaries in need of interpreter services, as well as any beneficiaries that may receive interpreter services through another resource.

Hospital Providers

TRICARE Prime Demo requires hospitals, at their own expense, to offer sign and other language interpreters for beneficiaries who are hearing impaired, do not speak English, or have limited English-speaking ability. We can provide some printed materials in other languages or formats, such as large print, or we can explain materials orally. These services should be available at no cost to the beneficiary. You are also required to identify the need for interpreter services for your TRICARE Prime Demo patients and offer assistance to them appropriately. If you do not have access to interpreter services, contact Provider Services at **1-833-230-2170**. We ask that you let us know of beneficiaries in need of interpreter services, as well as any beneficiaries that may receive interpreter services through another resource.

Telehealth/Telemedicine

Telehealth technology makes health care more accessible, cost-effective, and can increase patient engagement. CareSource Military & Veterans wants to support your telehealth program by covering select telehealth services you provide to our beneficiaries. If you do not have a telehealth program or if you need help servicing your patients during busy times, CareSource Military & Veterans has partnered with Teladoc® to offer the convenience of telehealth to our beneficiaries. General medical services are available to all beneficiaries, and mental health services are available for beneficiaries 18 years and older.

TRICARE Prime Demo covers the use of telehealth systems to provide diagnostic and treatment services that are medically or psychologically necessary and appropriate. These services may include, but are not limited to:

- Routine and urgent encounters
- Primary care
- Specialty care
- Behavioral health
- Telehealth services may be synchronous (information exchange in at least two directions at a time, such as a provider and patient talking on a video call) or asynchronous (storing or forwarding medical information in one direction at a time, such as a provider sending a message to a patient portal). Services otherwise excluded under the TRICARE CPD are also excluded from being delivered via telehealth.

Telemedicine Requirements for Providers

For payment to be authorized, the provider shall be a TRICARE authorized provider, and the service shall be within a provider's scope of practice under all applicable state(s) law(s) in which services are provided and or received.

In addition, providers rendering telemedicine services are required to:

- Follow telehealth-specific regulatory, licensing, credentialing and privileging, malpractice and insurance laws and rules for their profession in both the jurisdiction (site) in which they are practicing as well as the jurisdiction (site) where the patient is receiving care and shall ensure compliance as required by appropriate regulatory and accrediting agencies.
- Follow professional discipline and national practice guidelines when practicing via telehealth, and any modifications to applicable clinical practice guidelines for the telehealth setting shall ensure that clinical requirements specific to the discipline are maintained.
- Determine arrangements for handling emergency situations at the outset of treatment to ensure consistency with established local procedures.
- Establish an alternate plan at the outset of treatment for communicating with the patient (e.g., telephone) in the event of a technological breakdown/failure and only resume telehealth services if all the technological requirements of this policy are restored.

Privacy and Security

HIPAA privacy and security requirements for the use and disclosure of PHI apply to all telehealth services.

- Providers of telemedicine services shall ensure that transmission and storage of communications and data whether synchronous or asynchronous is conducted via a secure network and is compliant with HIPAA requirements as well as all applicable privacy and security laws, regulations and guidance.
- Providers of telemedicine services shall ensure that audio and video transmissions used are secured using point-to-point encryption that meets recognized standards.
- Providers of telemedicine services shall not use videoconference software that allows multiple concurrent sessions to be opened by a single user. While only one session may be open at a time, a provider may include more than two sites/patients as participants in that session with the consent of all participants (i.e., group psychotherapy).
- For synchronous telehealth services providers must implement a means for verification of provider and patient identity. For telehealth services where the originating site is an authorized institutional provider, the verification of both professional and patient identity will occur at the host facility. For telehealth services where the originating site does not have an immediately available health professional e.g., the patient's home), the telehealth provider shall provide the patient (or legal representative) with the provider's qualifications, licensure information, and, when applicable, registration number (e.g., NPI). The patient will provide two-factor authentication.
- Protected Health Information (PHI) and other confidential data shall only be backed up to or stored on secure data storage locations that have been approved for this purpose. Cloud services unable to achieve compliance shall not be used for PHI or confidential data.

Health Education

TRICARE Prime Demo beneficiaries receive health information through a variety of communication vehicles including easy-to-read health guides, an interactive health library, and phone calls. CareSource Military & Veterans sends preventive care reminder messages to beneficiaries via mail and automated outreach messaging. CareSource Military & Veterans also encourages the use of Medline Plus® a web site developed and maintained by the U.S. National Library of Medicine (NLM) and the National Institutes of

Health (NIH). This site provides health professionals and beneficiaries with information on diseases and conditions, clinical trials, drugs, and the latest health information. You can visit the Medline Plus® site at http://medlineplus.gov.

Online Health Engagement

TRICARE Prime Demo uses innovative technology to engage beneficiaries to manage their own health. We provide personalized wellness tools for all TRICARE Prime Demo beneficiaries. Through these tools, TRICARE Prime Demo beneficiaries have access to resources to help them manage health topics specific to their needs. Resources include:

- Interactive health assessment
- Condition specific digital health tools
- Multi-dimensional daily wellness tracker
- Small steps interactive guides

These tools are accessible via web or mobile through our MyLife app.

Consent Form Requirements

Per MHS requirements, information about SUD treatment and HIV/AIDS should only be released if you have obtained beneficiary consent. See https://www.health.mil/Military-Health-Topics/Privacy-and-Civil-Liberties/HIPAA-Compliance-within-the-MHS/Notice-of-Privacy-Practices for more information.

Advanced Directives

An advance directive is a written instruction, such as a living will or durable power of attorney for health care including mental health, recognized under the applicable state law, relating to the provision of health care when a beneficiary is incapacitated.

Providers delivering medical care to TRICARE Prime Demo beneficiaries shall not, as a condition of treatment, require a beneficiary to execute or waive an advance directive. In addition, providers shall not discriminate against TRICARE Prime Demo beneficiaries based on whether or not the beneficiary has executed an advance directive.

Benefits Grid

The benefits grid outlines covered services, cost share information, and whether or not a prior authorization is required. A copy of the TRICARE CPD benefits grid is located on **CareSourceMilitary.com**.

Provider Responsibilities

Primary Care Managers

Primary Care Manager Concept

All TRICARE Prime Demo beneficiaries will be assigned or may choose a Primary Care Manager (PCM) upon enrollment in the plan. PCMs should help facilitate a medical home for beneficiaries. This means that PCMs will help coordinate health care for the beneficiary and provide additional health options to the beneficiary for self-care or care from community partners.

Beneficiaries select a PCM from our online Provider Directory available at **CareSourceMilitary.com** > Beneficiaries > Tools & Resources > Find a Doctor. Beneficiaries have the option to change to another network PCM as often as needed. Beneficiaries initiate the change by calling Beneficiary Services, using the portal, or using the mobile app.

Primary Care Manager Roles and Responsibilities

PCM care coordination responsibilities include at a minimum, the following:

- Assisting with coordination of the beneficiary's overall care, as appropriate for the beneficiary.
- Serving as the ongoing source of primary and preventive care.
- Connecting beneficiaries to specialists, as required.
- Triaging beneficiaries.
- Participating in the development of case management care treatment plans and notifying TRICARE Prime Demo of beneficiaries who may benefit from case management. Please see the "Beneficiary Support Services and Benefits" section of this manual to learn how to refer beneficiaries for case management.

PCMs are Responsible For:

- Treating TRICARE Prime Demo beneficiaries with the same dignity and respect afforded to all patients. This includes high standards of care and the same hours of operation.
- Identifying the beneficiary's health needs and taking appropriate action.
- Providing phone coverage for handling patient calls 24 hours a day, seven days a week.
- Following all prior authorization policies and procedures as outlined in this manual.
- Complying with the quality standards of our health plan providing 30 days of emergency coverage to any TRICARE Prime Demo patient dismissed from the practice.

- Maintaining clinical records, including information about pharmaceuticals, inpatient history, etc.
- Obtaining patient records from facilities visited by TRICARE Prime Demo patients for emergency or urgent care if notified of the visit.
- Use best commercial efforts to collect required copayments for services rendered to applicable beneficiaries.
- Ensuring demographic and practice information is up to date for directory and beneficiary use.
- Reporting suspected fraud and/or abuse.
- PCMs disenrolling from TRICARE Prime Demo must provide continuation of care for TRICARE Prime Demo beneficiaries for a minimum of 30 calendar days or until the beneficiary's link to another PCM becomes effective.

In addition, TRICARE Prime Demo PCMs play an integral part in coordinating health care for our beneficiaries by providing:

- Availability of a personal health care practitioner to assist with coordination of a beneficiary's overall care, as appropriate for the beneficiary.
- Continuity of the beneficiary's total health care.
- Early detection and preventive health care services.
- Elimination of inappropriate and duplicate services.

Primary Care Manager Selection

TRICARE Prime Demo allows for PCMs to include more than traditional provider types that have historically served as PCMs. PCMs are licensed and credentialed healthcare providers privileged to provide primary and preventive care services and to facilitate connections to other services, including specialty services, for all TRICARE Prime Demo enrollees. PCMs may include physicians specialized in Family Practice, Internal Medicine, Pediatrics, and Obstetrics and Gynecology. Certified and privileged Adult, Family, Pediatric or Women's Health Nurse Practitioners, Nurse Midwives, and Physicians Assistants may also serve as PCMs.

If a beneficiary does not select a PCM, CareSource Military & Veterans will assign them one.

Provider Rights

TRICARE Prime Demo shall not prohibit or otherwise restrict a health care professional, acting within his or her lawful scope of practice, from advising or advocating on behalf of a beneficiary who is his or her patient regarding the following:

- The beneficiary's health status, medical care or treatment options, including any alternative treatment that may be self-administered, regardless of whether benefits for such care are provided under the TRICARE CPD program;
- Any information the beneficiary needs to decide among all relevant treatment options;
- The risks, benefits, and consequences of treatment or non-treatment; and
- The beneficiary's right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Medical Records

Health care providers shall prepare, maintain, and retain as confidential the health records of all beneficiaries receiving health care services and beneficiaries' other personally identifiable health information received from TRICARE Prime Demo, in a form and for time periods required by applicable state and federal laws, licensing requirements, accreditation and reimbursement rules and regulations to which physicians and providers are subject, and in accordance with accepted practices.

Providers are required to maintain beneficiary records on paper or in an electronic format. Beneficiary medical records shall be timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review.

Complete medical records include, but are not limited to, medical charts, applicable directives, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records and other documentation sufficient to disclose the quantity, quality, appropriateness and timeliness of services provided under the contract. Medical records shall be signed by the provider of service.

The PCM also must maintain a primary medical record for each beneficiary that contains sufficient medical information from all providers involved to ensure quality of care.

The medical chart organization and documentation shall, at a minimum, require the following:

- Beneficiary/patient identification information, on each page
- Personal/biographical data, including date of birth, age, gender, marital status, race or ethnicity, mailing address, home and work addresses and telephone numbers, employer, school name and telephone numbers (if no phone, contact name and number) of emergency contacts, consent forms, identification of language spoken and guardianship information
- Date of data entry and date of encounter
- Provider identification by name
- Allergies, adverse reactions and known allergies noted in a prominent location
- Past medical history, including serious accidents, operations and illnesses [for children, past medical history includes prenatal care and birth information, operations and childhood illnesses (e.g., documentation of chickenpox)]
- Identification of current problems
- The consultation, laboratory and radiology reports in the medical record shall contain the ordering provider's initials or other documentation indicating review
- Documentation of immunizations
- Identification and history of nicotine, alcohol use or substance abuse
- Documentation of reportable diseases and conditions submitted to the local health department serving the jurisdiction in which the patient resides or the Department for Public Health
- Follow-up visits provided and (secondary) reports of emergency room care
- Hospital discharge summaries
- Advance medical directives, for adults
- All written denials of service and the reason for the denial

- Record legibility to at least a peer of the writer (records judged illegible by one reviewer shall be evaluated by another reviewer)

A beneficiary's medical record shall include the following minimal detail for individual clinical encounters:

- History and physical examination for presenting complaints containing relevant psychological and social conditions affecting the patient's physical/behavioral health, including mental health and substance abuse status
- Unresolved problems, results from diagnostic tests including results and/or status of preventive screening services addressed from previous visits
- Plan of treatment including:
  - Medication history, medications prescribed, including the strength, amount, directions for use and refills
  - Therapies and other prescribed regimen
  - Follow-up plans including consultation and directions, including time to return
- A beneficiary's medical record shall include the following minimal detail for hospitals and mental hospitals:
- Identification of the beneficiary
- Physician name
- Date of admission and dates of application for and authorization of TRICARE CPD benefits, if application is made after admission
- Plan of care
- Initial and subsequent continued stay review dates
- Reasons and plan for continued stay, if applicable
- Other supporting material the committee believes appropriate to include
- For non-mental hospitals only:
  - Date of operating room reservation
  - Justification of emergency admission, if applicable

A beneficiary's medical record shall include the medical record total score results at treatment baseline, every 60-day intervals, and at discharge for the following diagnoses:

- PTSD -> PTSD Checklist (PCL-5)
- Anxiety Disorders -> Seven-item Generalized Anxiety Disorder (GAD-7)
- Depressive Disorders -> Patient Health Questionnaire (PHQ-9 or A for ages 11-17)

Note: Consistent with National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2016, Section 729 and Veterans Health Administration (VHA)/Department of Defense (DoD) Clinical Practice Guidelines.

CareSource Military & Veterans' Commitment to Access to Care

At CareSource Military & Veterans', we are dedicated to the communities we serve and to making a positive impact in the lives of our beneficiaries through the elimination of health disparities and partnering with community stakeholders to carry out this work.

CareSource Network Partners, LLC and its Affiliates, including TRICARE Prime Demo participates in efforts to promote the delivery of services in a way that provides all our beneficiaries necessary access to care. Network providers must also meet the requirements of this mandate and any applicable state and federal laws or regulations pertaining to provision of services and care. We prohibit our providers or partners from refusing to treat, serve or otherwise discriminate against an individual because of race, color, national origin, disability, age, religion, or sex (which includes discrimination on the basis of sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes) marital status, health status, or public assistance status.

We will not discriminate against providers who practice within the permissions of existing protections in provider conscience laws, as outlined by the United States Department of Health and Human Services (HHS).

Military Awareness

Cultural competency within CareSource Military & Veterans is defined as "the willingness and ability of a system to value the importance of culture in the delivery of services to all segments of the population." It is the use of a system's perspective which values differences and is responsive to diversity at all levels in an organization.

Military families form a unique subculture marked by frequent relocations, deployments, and a strong sense of community. This culture emphasizes resilience, adaptability, and a shared experience of military life. Military families often experience a heightened sense of purpose and patriotism, often reflected in their values and beliefs.

Military retirees and their families carry many of the values and beliefs developed during the active-duty phase of life into their retirement years. The retiree may have service-related injuries or conditions for which they need care after retiring. Some of these conditions, such as traumatic brain injury (TBI), have a higher prevalence in the military community than the general population.

DHA places sensitivity towards this population at a high priority and expects CareSource Military & Veterans and providers to do the same. We offer courses via PsychArmor around military cultural awareness via our Provider Portal.

Utilization Management

Utilization Management (UM) helps maintain the quality and appropriateness of health care services provided to TRICARE Prime Demo beneficiaries. The Utilization Management department performs all utilization management activities including prior authorization, concurrent review, discharge planning, and other utilization activities. We monitor inpatient and outpatient admissions and procedures to ensure that appropriate medical care is rendered in the most appropriate setting using the most appropriate resources. We also monitor the coordination of medical care to ensure its continuity. The TRICARE Prime Demo Care Management team is also engaged, when appropriate. For more information on peer-to-peer, refer to the "Requests for Peer-to-Peer Review" section.

TRICARE Prime Demo makes its UM criteria available in writing by mail, fax and online through the Provider Portal, as follows:

- Mail:
  TRICARE Prime Demo
  Attn: Medical Management Department
  P.O. Box 1598
  Dayton, OH 45401
- Fax: 844-824-5582
  Sick Newborn Fax: 937-396-3499

Accessibility of UM Staff

To request authorization for an inpatient admission or ask a question about post-stabilization services, please call Provider Services at **1-833-230-2170**. When calling, tell our IVR system that you are requesting post-stabilization. Your call will be answered by our UM department. If calling after regular business hours, the call will be answered by CSMV Nurse Advice Line.

Authorization requests are completed within the time frames noted below.

Authorization Type	Decision	Extension
Concurrent	48 hours from receipt of request	May extend the time frame once, by up to 14 calendar days, under the following conditions: • The beneficiary requests an extension, or • TRICARE Prime Demo needs additional information, provided it documents at least one attempt to obtain the necessary information.

Authorization Type	Decision	Extension
Urgent Preservice	1 business day	If an urgent pre-service request is incomplete and requires additional information, CareSource Military & Veterans must request the additional information within 2 business days. Health care providers then have 48 hours to respond to the request.
Standard Preservice	5 business days	CareSource Military & Veterans may extend the time frame once, by up to 14 calendar days if a beneficiary requests the extension or CareSource Military & Veterans needs additional information, provided it documents at least one attempt to obtain the necessary information.
Retro (Post service)	30 calendar days	None

Inpatient

TRICARE Prime Demo does not require prior authorization and/or pre-certification for:

- Emergency services,
- Post-stabilization services, or
- Urgent care services.

TRICARE Prime Demo requires notification of an emergent admission within one business day of the admission.

Post-stabilization care services are covered services related to an emergency medical condition that a treating physician views as medically necessary after an emergency medical condition has been stabilized to maintain the stabilized condition. Prior authorization is not required for coverage of post-stabilization services when these services are provided in any emergency department or for services in an observation setting by a network provider.

Peer-To-Peer

Providers may request a peer-to-peer consultation when TRICARE Prime Demo denies an authorization request. TRICARE Prime Demo provides the opportunity for providers to request a discussion of the adverse determination with a Medical Director/Behavioral Health Medical Director or designee within five business days of the notification of the determination. The peer-to-peer process is independent of the appeal process and does not impact the time frame a beneficiary and/or provider has to appeal. To initiate the peer-to-peer process, please call 1-833-230-2168.

Prior Authorizations

Please visit **CareSourceMilitary.com** > Providers > Provider Resources > Prior Authorization for the most up-to-date information of services that require prior authorization, including details on second opinions,

and prior authorizations by service type. You can also review prior authorization information on our Provider Look-up Tool. Copies of prior authorization forms can be found on **CareSourceMilitary.com** > Providers > Forms.

Services are provided within the benefit limits of the beneficiary's enrollment. Beneficiaries may go to non-network providers for emergency or urgent care without an authorization. If a necessary service is not available from the beneficiary's Primary Care Manager (PCM), a request to see a non-network provider or a specialty provider will be required. Some procedures and services, including hospitalization require prior authorization from TRICARE Prime Demo. Any provider who is not a network provider with TRICARE Prime Demo must obtain prior authorization for all non-emergency services.

The provider portal is the preferred method to request prior authorizations for health care services. Upon submission, you will obtain an immediate decision or pend status. Email us at CiteAutoAssistance@CareSource.com for portal login assistance.

Alternate methods to request prior authorization:

- Phone: **1-833-230-2170**
- Fax: 844-824-5582
  NICU Fax: 937-396-3499
- Surface Mail:
  TRICARE Prime Demo
  P.O. Box 1307
  Dayton, OH 45401-1307
- Surface Mail – Behavioral Health:
  TRICARE Prime Demo
  Attn: Behavioral Health Utilization Management Department
  P.O. Box 1307
  Dayton, OH 45401

When requesting a prior authorization, please provide the following information:

- Beneficiary name and TRICARE Prime Demo Beneficiary ID number
- Provider name, address and NPI/TIN
- Anticipated date of service
- Diagnosis code and narrative
- Procedure, treatment or service requested
- Number of visits requested, if applicable
- Reason for referring to an out-of-plan provider, if applicable
- Clinical information to support the medical necessity for the service
- If inpatient surgery is planned, please include the date of surgery, surgeon and facility, admit date, admitting diagnosis and presenting symptoms, plan of treatment, and any appropriate clinical and anticipated discharge needs.
- If the request is for outpatient surgery, please include the date of surgery, surgeon and facility, diagnosis, procedure planned and anticipated discharge needs.

Ordering physicians must obtain a prior authorization for the following outpatient, non-emergent diagnostic imaging procedures:

- MRI/MRAs
- CT/CTA scans
- PET scans

Providers can obtain prior authorization from NIA Magellan for an imaging procedure in the following ways:

- Online – www.radmd.com
- By phone – 1-800-424-4883 (follow the options to obtain a prior authorization and select the option for advanced radiology prior authorization), Monday through Friday, from 8 a.m. to 8 p.m. ET.

Please Note: Imaging procedures performed during an inpatient admission, hospital observation stay, or emergency room visit are not included in this program.

Authorizations are not a guarantee of payment. Authorizations are based on medical necessity and are contingent upon eligibility and benefits (and other factors). Benefits may be subject to limitations and/or qualifications and will be determined when the claim is received for processing.

Autofax Confirmation

Providers are encouraged to use provider self-service to view approved authorizations. The detail page specifies the services authorized, the number of visits and the period in which the visits must occur. An automatic fax may be sent, and providers should program their office fax number into their fax machine to ensure the number appears on their requests. The beneficiary will also receive notification of the approved authorization. Requesting providers are responsible for notifying the beneficiary of urgent approval requests.

Retrospective (Post-Service)

Post-service review requests greater than 30 calendar days past the date of service or date of retrospective enrollment will be administratively denied.

A retrospective/post-service review is performed under the following circumstances:

- When a TRICARE Prime Demo beneficiary is unable to advise the provider what plan they are enrolled in due to a condition that renders them unresponsive or incapacitated.
- The beneficiary is retrospectively enrolled and covers the date of service.
- When urgent service(s) requiring authorization was/were performed and it would have been to the beneficiary's detriment to take the time to request authorization.
- The new service was not known to be needed at the time the original prior authorized service was performed.
    - The need for the new service was revealed at the time the original authorized service was performed.
    - The service was directly related to another service for which prior approval has already been obtained and that has already been performed.

TRICARE Prime Demo as Secondary Payer

If TRICARE Prime Demo requires prior authorization for a service, and the beneficiary has additional insurance coverage that is primary, the provider must follow the primary insurance requirements for obtaining prior authorization.

Other Health Insurance (OHI) refers to any additional health coverage beneficiaries have besides TRICARE. This could be through an employer, a spouse's employer, or a private insurance program. Here's how TRICARE and OHI work together:

Primary and Secondary Coverage: OHI is considered primary, meaning it pays medical claims first. TRICARE acts as secondary coverage, paying any remaining costs only after a claim has been filed with the other plan and a payment determination issued.

Coordination of Benefits: Beneficiaries should inform their healthcare providers about their OHI. This ensures that claims are processed correctly. If TRICARE receives a claim before the OHI processes it, TRICARE will deny the claim.

Exceptions: There are a few exceptions where TRICARE pays first, such as Medicaid enrollment or certain federal programs.

Billing for Services Denied Prior Authorization

TRICARE Prime Demo may permit billing beneficiaries for services that require authorization, but for which authorization is denied, if certain safeguards are in place and are followed by the provider:

- The provider must establish that authorization has been requested and denied before rendering the service.
- The provider can request CareSource Military & Veterans review of the authorization decision. CareSource Military & Veterans must inform providers of the contact person, the means for contact, the information required to complete the review and procedures for expedited review, if necessary.
- If CareSource Military & Veterans maintains the decision to deny authorization, the provider must inform the beneficiary that the service requires authorization, and that the authorization has been denied.
- The beneficiary must be informed of the right to contact CareSource Military & Veterans to file an appeal if the beneficiary disagrees with the decision to deny authorization.
- The provider must inform beneficiaries of beneficiary responsibility for payment if the beneficiary chooses to or insists on receiving the service without authorization.

If the provider chooses to use a waiver to establish beneficiary responsibility for payment, use of such a waiver must meet the following requirements:

- The waiver is signed only after the beneficiary receives the appropriate notification stated in requirements three and four.
- The waiver does not contain any language or condition to the effect that if authorization is denied, the beneficiary is responsible for payment.
- Providers must not use nonspecific patient waivers. A waiver must be obtained for each encounter or patient visit that falls under the scenario of non-covered services.

- The waiver must identify the specific procedure to be performed, and the beneficiary must sign the consent before receiving the service.
- The provider must maintain documentation that the beneficiary voluntarily chose to receive the service, knowing that CareSource Military & Veterans did not authorize the service.

The waiver must include the right to appeal any denial of payment by CareSource Military & Veterans for denial of authorization.

Billing for Activities that Improve Health Care Quality

Providers are prohibited from billing enrolled beneficiaries for activities that improve health care quality as described in § 422.2430.

§ 422.2430 Activities that improve health care quality.

(a) ***Activity requirements.***

(1) Activities conducted by an MA organization to improve quality must either—

(i) Fall into one of the categories in paragraph (a)(2) of this section and meet all of the requirements in paragraph (a)(3) of this section; or

(ii) Be listed in paragraph (a)(4) of this section.

(2) ***Categories of quality improving activities.*** The activity must be designed to achieve one or more of the following:

(i) To improve health outcomes through the implementation of activities such as quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical homes model as defined for purposes of section 3602 of the Patient Protection and Affordable Care Act, for treatment or services under the plan or coverage.

(ii) To prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post-discharge reinforcement by an appropriate health care professional.

(iii) To improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence-based medicine, and health information technology under the plan or coverage.

(iv) To promote health and wellness.

(v) To enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology. Such activities, such as Health Information Technology (HIT) expenses, are required to accomplish the activities that improve health care quality and that are designed for use by health plans, health care providers, or enrollees for the electronic creation, maintenance, access, or exchange of health information, and are consistent with meaningful use requirements, and which may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current quality improving activities or make new quality improvement initiatives possible.

(3) The activity must be designed for all of the following:

(i) To improve health quality.

(ii) To increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.

(iii) To be directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees.

(iv) To be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.

(4)

(i) For an MA contract that includes MA-PD plans (described in § 422.2420(a)(2)), Medication Therapy Management Programs meeting the requirements of § 423.153(d) of this chapter.

(ii) Fraud reduction activities, including fraud prevention, fraud detection, and fraud recovery.

(b) ***Exclusions.*** Expenditures and activities that must not be included in quality improving activities include, but are not limited to, the following:

(1) Those that are designed primarily to control or contain costs other than those that are related to fraud reduction.

(2) The pro rata share of expenses that are for lines of business or products other than those being reported, including but not limited to, those that are for or benefit self-funded plans.

(3) Those which otherwise meet the definitions for quality improving activities but which were paid for with grant money or other funding separate from premium revenue.

(4) Those activities that can be billed or allocated by a provider for care delivery and that are reimbursed as clinical services.

(5) Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities (and that are not related to fraud reduction activities under paragraph (a)(4)(ii) of this section) or to meet regulatory requirements for processing claims, including ICD-10 implementation costs in excess of 0.3 percent of total revenue under this part, and maintenance of ICD-10 code sets adopted in accordance with to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended.

(6) That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality.

(7) All retrospective and concurrent utilization review.

(8) [Reserved]

(9) The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason.

(10) Provider credentialing.

(11) Marketing expenses.

(12) Costs associated with calculating and administering individual enrollee or employee incentives.

(13) That portion of prospective utilization review that does not meet the definition of activities that improve health quality.

(14) Any function or activity not expressly permitted by CMS under this part.

Pharmacy

CPD uses the TRICARE Pharmacy program, which offers comprehensive prescription drug coverage and several options for filling prescriptions. All TRICARE beneficiaries are eligible for the TRICARE Pharmacy Program, administered by Express Scripts®. To fill prescriptions, beneficiaries need a valid prescription and a valid uniformed services ID card or Common Access Card (CAC).

TRICARE beneficiaries using the TRICARE Prime Demo CPD plan have the same options for filling prescriptions: military hospitals or clinic pharmacies, home delivery through Express Scripts Pharmacy, TRICARE retail network pharmacies, non-network retail pharmacies, and E-Prescribe.

Learn more about the TRICARE Pharmacy Program at **https://tricare.mil/CoveredServices/Pharmacy**.

Prescription Drug Coverage

Information about the TRICARE Formulary and pharmacy drug coverage for beneficiaries can be found at **https://tricare.mil/CoveredServices/Pharmacy/Drugs**.

Specialty Pharmacy Program

To improve medication compliance, disease state and side effect management, we work with the TRICARE Pharmacy provider, Express Scripts®. For more information about the TRICARE Pharmacy specialty care drug list, visit **https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Pharmacy-Operations/TRICARE-Formulary/Specialty-Care-Drug-List**.

Provider Administered Drugs

Provider administered drugs/medications that are administered in a professional setting (such as a physician office, hospital, outpatient department, clinic, dialysis center, or infusion center) will be billed to TRICARE Prime Demo.

Please Note: Prior authorization requirements exist for many **provider-administered** medications.

TRICARE Prime Demo Pharmacy Clinical Policies will be utilized for provider administered drugs requiring prior authorization. CareSource Military & Veterans will process prior authorization requests in accordance with TRICARE requirements and will utilize Pharmacy Clinical Policies for reviewing provider administered drug prior authorization requests.

In addition, any provider who is not a network provider with TRICARE Prime Demo must obtain prior authorization for all non-emergency services provided to a TRICARE Prime Demo beneficiary.

Requests for provider-administered drugs which require prior authorization may be submitted on our secure Provider Portal. The Provider Portal is the preferred method to request prior authorization for pharmacy services under the medical benefit. Providers will be required to submit pertinent medical/drug history, prior treatment history and any other necessary supporting clinical information with the request.

Online
Visit **CareSourceMilitary.com** > Login > Provider.

Email us at CiteAutoAssistance@CareSource.com for portal login assistance.

Alternate methods include:
Fax: 888-399-0271

Questions about physician administered drug prior authorization requests may be directed to **1-833-230-2170**.

Behavioral Health

Behavioral Health Overview

Behavioral health is critical to each beneficiary's overall health, and CareSource Military & Veterans provides behavioral health benefits to our TRICARE CPD beneficiaries. TRICARE Prime Demo ensures that all beneficiaries have access to behavioral health resources and that behavioral health is integrated across all interventions. Behavioral health providers (BHPs) are expected to assist beneficiaries in accessing emergent, urgent and routine behavioral services as expeditiously as the beneficiary's condition requires.

Beneficiaries may self-request behavioral health services within our provider network without a request from their primary care manager (PCM).

Screening & Evaluation

CareSource Military & Veterans requires that PCMs and specialists have screening and evaluation procedures for the detection and treatment of any known or suspected behavioral health problems and disorders. PCMs and specialists may provide clinically appropriate behavioral health services within the scope of their practice.

CareSource Military & Veterans provides training to network PCMs on how to screen for and identify behavioral health disorders and encourages universal screening of Post-Traumatic Stress Disorder (PTSD), anxiety disorders and depression through standardized clinical tools. Recommended standardized clinical tools can be located on the provider website.

For beneficiaries engaged in Case Management, assessments completed by the Case Manager may be accessed and reviewed by providers via the portal at any time.

Coordination of Care

CareSource Military & Veterans requires that behavioral health providers connect beneficiaries with known or suspected and untreated physical health problems or disorders to their PCM for examination and treatment, with the beneficiary's or the beneficiary's legal guardian's consent. Behavioral health providers may only provide physical health care services if they are licensed to do so.

CareSource Military & Veterans encourages communication and care coordination between PCMs and behavioral health providers to achieve optimal health for our beneficiaries. Communication is necessary to ensure continuity of care and beneficiary safety.

CareSource Military & Veterans encourages behavioral health providers to send initial and at least quarterly status reports to PCMs, with the beneficiary's or the beneficiary's legal guardian's consent.

CareSource Military & Veterans requires every provider to ask and encourage beneficiaries to sign a consent permitting release of substance use disorder information to TRICARE Prime Demo and to the PCM or BHP. The consent form can be found on **CareSourceMilitary.com** > Providers > Tools & Resources > Forms.

Scope of Practice

BHPs may provide physical health care services within their scope of practice. PCMs and specialists may provide clinically appropriate behavioral health services within the scope of their practice. Behavioral health providers are required to use DSM-5 when assessing the beneficiary for behavioral health services. Behavioral health providers are required to document the DSM-5 diagnosis and outcome of assessment information in the beneficiary's medical record.

Billing and Claims Instructions

Claims Submission

As with other commercial health plans, TRICARE Prime Demo's TRICARE CPD plan beneficiaries are responsible for any applicable copays or cost shares. Providers are responsible for collecting the appropriate payments. Please note that the provider cannot bill a beneficiary for activities that improve health care quality.

In general, CareSource Military & Veterans follows the claim reimbursement policies and procedures set forth by the relevant regulations and regulating bodies. These can be found at **CareSourceMilitary.com** > Providers > Provider Policies. For expedited claims processing and payment delivery, please confirm addresses and phone numbers on file with TRICARE Prime Demo are up to date. You can update this information on the Provider Portal at **CareSourceMilitary.com** > Login > Provider Portal or email ProviderMaintenance@CareSource.com.

Claims must be submitted within 365 calendar days of the date of service or discharge. We will not pay a claim with incomplete, incorrect or unclear information. If this happens, providers have 90 calendar days from the date of explanation of benefits. Corrected claims should not be submitted through appeal.

Billing Methods

CareSource Military & Veterans accepts claims in a variety of formats, including paper and electronic claims. We encourage providers to submit claims electronically to take advantage of the following benefits:

- Faster claims processing
- Reduced administrative costs
- Reduced probability of errors or missing information
- Faster feedback on claims status
- Minimal staff training or cost

Submit Claims Online Through Provider Portal

Providers may submit claims through the secure, online Provider Portal. Online submission saves you money by eliminating the costs associated with printing and mailing paper claims. Using the portal for claims submission also provides additional benefits:

- Improves accuracy by decreasing the opportunities for transcription errors and missing or incorrect data

- Allows tracking and monitoring of claims through a convenient online search tool
- Includes attachments up to 100 MB that may be necessary for claim processing
- Allows uploading of a completed claim forms up to 50 MB
- Allows corrections and re-submissions

Who Can Submit Claims Via the Provider Portal?

TRICARE Prime Demo's traditional providers, community partners and delegates, and health homes – specifically health care providers using the UB-04 or CMS-1500 claim form – can submit claims through the Provider Portal.

What Types of Claims Can Be Submitted?

1. Professional medical office claims (CMS 1500 and 837P)
2. Institutional claims for Inpatient and Outpatient Services Inpatient and Outpatient Services (UB-04 and 837I)

Note: For more information on the TRICARE Dental Program, please refer to https://www.tricare.mil/CoveredServices/Dental.

Electronic Claim Submission

Electronic Data Interchange (EDI) is the computer-to-computer exchange of business data in ANSI ASC X12 standard formats. EDI transmissions must follow the transaction and code set format specifications required by the Health Insurance Portability and Accountability Act (HIPAA). CareSource Military & Veterans has invested in an EDI system to enhance our service to network providers. Our EDI system complies with HIPAA standards for electronic claims submission.

Clearinghouse

CareSource Military & Veterans prefers electronic claim submission. To submit claims electronically, providers must work with an electronic claims clearinghouse. CareSource Military & Veterans currently accepts electronic claims from providers through the clearinghouse listed below. Contact the clearinghouse to begin electronic claims submission.

Clearinghouse	Phone	Website
Availity	1-800-282-4548	https://www.availity.com/

Please provide the clearinghouse with the TRICARE Prime Demo payer ID MVCS1.

File Format

CareSource Military & Veterans accepts electronic claims in the 837 ANSI ASC X12N (005010X ERRATA version) file format for professional and institutional claims.

5010 Transactions

In 2009, the U.S. Department of Health and Human Services released a final rule that updated standards for electronic health care and pharmacy transactions. This was in preparation to implement ICD-10 CM codes in 2015. The new standard is the HIPAA 5010 format. All trading partners and payers should be 5010 compliant.

Transactions Covered Under the 5010 Requirements

- 837 Health Care Claim/Encounter
- 276/277 Health Care Claim Status Request and Response
- 270/271 Health Care Eligibility Benefit Inquiry and Response

Please include the full physical address for billing 5010 transactions. P.O. boxes are no longer accepted for the billing address. However, a P.O. box or lock box can be used for the pay-to address (Loop 2010AB).

National Provider Identifier and Tax ID Numbers

Your National Provider Identifier (NPI) number and Tax Identification Number (TIN) are required on all claims. Claims submitted without these numbers will be rejected. Contact your EDI vendor to find out where to use the appropriate identifying numbers on the forms you are submitting to the vendor.

Electronic Payment Processing

CareSource Military & Veterans has partnered with ECHO Health, Inc. to offer electronic funds transfer (EFT) as a payment option. Visit the Provider Portal for more information about the program and to enroll in EFT. Providers who elect to receive EFT payment will receive an Electronic Data Interchange (EDI) 835 (Electronic Remittance Advice), the 835 file will be sent to the preferred clearinghouse. Providers can also download their Explanation of Payment (EOP) from the Provider Portal or request a hard copy via the mail.

Benefits of EFT:

- **Simple** – Receive fully reconciled remittances electronically; eliminate paper checks and EOPs, which will increase efficiency with payment processing.
- **Convenient** – Available 24/7; free training is also offered for health partners.
- **Reliable** – Claim payments electronically deposited into your bank account.
- **Secure** – Access your account through the secure Provider Portal to view (and print if needed) remittances and transaction details.

To enroll in EFT, complete the enrollment form, available on **CareSourceMilitary.com** > Providers > Claims and fax it back to our payment processing vendor, ECHO Health Inc. If you prefer to receive Virtual Card Payment or Paper Check payments, call ECHO Health support at 1-888-834-3511.

**Payment processing fees are what you pay your bank and credit card processor for use of payment via credit card.*

Paper Claims

For the most efficient processing of your claims, CareSource Military & Veterans recommends you submit all claims electronically. For more information on electronic claims, refer to the "Electronic Claims Submission" section of this manual.

All claims (EDI and paper) must include:

- Patient (beneficiary) name.
- Patient address.
- Insured's ID number – Be sure to provide the complete ID beneficiary ID number of the patient. This number is located on the TRICARE beneficiary's government issued ID card. For the most efficient processing of your claims, CareSource Military & Veterans recommends you submit all claims electronically.
- Patient's birth date – Always include the beneficiary's date of birth. This allows us to identify the correct beneficiary in case we have more than one beneficiary with the same name.
- Place of service – Use standard CMS (HCFA) location codes.
- ICD-10 diagnosis code(s).
- HIPAA-compliant CPT or HCFA Common Procedure Coding System (HCPCS) code(s) and modifiers, where modifiers are applicable.
- Units, where applicable (anesthesia claims require minutes).
- Date of service – Please include dates for each individual service rendered. A date range cannot be accepted, even though some claim forms contain from/to formats. Please enter each date individually.
- Prior authorization number, where applicable – A number is needed to match the claim to corresponding prior authorization information. This is only needed if the service provided required prior authorization.
- National Provider Identifier (NPI) – Please refer to sections for professional and institutional claim information.
- Federal tax ID number or physician Social Security Number – Every provider practice (e.g., legal business entity) has a different Tax ID number.
- Signature of physician or supplier – The provider's complete name should be included, or if we already have the physician's signature on file, indicate "signature on file" and enter the date the claim is signed in the date field.

When submitting claims for telemedicine services, the provider may indicate "Signature not required – distance telemedicine site" in the required patient signature field.

Global Maternity Claims

Maternity services are reimbursed as a single global maternity fee that covers professional services typically provided for routine prenatal care, vaginal delivery (including any episiotomy, forceps, or breech delivery), and postpartum care. The technical component of a diagnostic or laboratory test is covered outside of the global maternity fee.

The maternity care benefit includes, but is not limited to, the following prenatal screening tests:

- Anemia Screening
- Asymptomatic Bacteriuria, Urinary Tract, or Other Infection Screening. Screen with urine culture for women 12-16 weeks gestation, or at first prenatal visit, if later.
- Gestational Diabetes Mellitus Screening. Screen women 24-28 weeks pregnant and those at high risk of developing gestational diabetes.
- Hepatitis B Screening. Screen pregnant women for Hepatitis B Surface Antigen (HBsAG) during the prenatal period.
- Human Immunodeficiency Virus (HIV) Infection Screening.
- Rh Incompatibility Screening. Screen all pregnant women and provide follow-up testing for pregnant women at high risk.
- Syphilis Infection Screening. Progesterone therapy for the prevention of preterm birth is covered only for weekly injections of 17 alpha-hydroxyprogesterone caproate between 16 and 36 weeks of gestation for pregnant women with a documented history of a previous spontaneous birth at less than 37 weeks of gestation.

National Drug Code (NDC)

What to include on claims that require National Drug Code:

- NDC and unit of measure (e.g., pill, milliliter - cc, international unit or gram)
- Quantity administered – number of NDC units
- NDC unit price – detail charge divided by quantity administered
- HCPCS codes that will require NDCs on professional claims (submitted on the 837P format)

Instructions for National Drug Code on Paper Claims

The following information is required for each applicable code required on a claim:

- In the shaded area of 24A, enter the N4 qualifier (only the N4 qualifier is acceptable)
- 11-digit NDC (this excludes the N4 qualifier)
- A unit of measurement code – F2, GR, ML or UN (only acceptable codes)
- The metric decimal or unit quantity that follows the unit of measurement code
- Do not enter a space between the qualifier and the NDC, or qualifier and quantity
- Do not enter hyphens or spaces with the NDC
- Use three spaces between the NDC number and the units on paper forms

Telemedicine Billing

Synchronous Telemedicine Services

Synchronous telemedicine services involve an interactive, electronic information exchange in at least two directions during the same time period. For payment to providers for synchronous telemedicine services both the patient and provider shall be present on the connection and participating. When billing for synchronous telehealth services, providers must bill with CPT or HCPCS codes with a GT or 95 modifier for distant site and Q0314 for originating site to distinguish telehealth services. In addition, when billing Q0314 for the originating site, the provider should report a Place of Service (POS) code 02. When the patient's home is the originating site, code Q0314 shall not be billed, but the Place of Service billed should be 10. By coding and billing the GT or 95 modifier with a covered telehealth procedure code, the distant site provider certifies that the beneficiary was present at an eligible site when the telehealth service was furnished. Payment of the originating site facility fee is limited to facilities where an otherwise authorized TRICARE provider normally offers medical or psychological services, such as the office of a TRICARE-authorized individual professional provider (i.e., physician's office), or a TRICARE-authorized institutional provider.

Asynchronous Telemedicine Services

Asynchronous telemedicine services involve storing, forwarding and transmitting medical images or other medical information from telemedicine encounters in one direction at a time. For payment to be authorized for asynchronous telehealth services, the consulting provider must have rendered interpretive and other clinical services to the referring provider. Providers must conduct transmission and storage of data associated with asynchronous telemedicine services over a secure network in compliance with HIPAA requirements. When billing for asynchronous telehealth services, providers must bill with CPT or HCPCS codes with a GQ modifier. In addition, the provider should report a Place of Service (POS) code 02.

Telephonic Office Visits

A telephonic (audio only) office visit is a covered service provided via a telephone call between a beneficiary who is an established patient and a CSMV network provider, for otherwise covered medically necessary and appropriate care which does not require face-to-face, hands-on treatment or visual evaluation. When billing for covered telephonic office visits Current Procedure Terminology (CPT) codes 98966-98968, 99441-99443 and Healthcare Common Procedure Coding System (HCPCS) G2012 should be used.

Tips for Submitting Paper Claims

For the most efficient processing of your claims, CareSource Military & Veterans recommends you submit all claims electronically.

CareSource Military & Veterans uses an optical/intelligent character recognition (OCR/ICR) system to capture claims information, which increases efficiency, improves accuracy and results in faster turnaround time.

To Ensure Optimal Claims Processing Timelines:

- First consider submitting EDI claims. They are generally processed more quickly than paper claims.
- When submitting paper claims, we require the most current form version as designated by CMS and NUCC.
- Do not submit handwritten (including printed claims with any handwritten information) claims or SuperBills. They will not be accepted.
- Use only original claim forms; do not submit claims that have been photocopied or printed from a website.
- Ensure fonts are 10 to 14 point (capital letters preferred) with printing in black ink.
- Do not use liquid correction fluid, highlighters, stickers, labels, or rubber stamps.
- Ensure that printing is aligned correctly so that all data is contained within the corresponding boxes on the form.
- NPI, GNPI (is applicable) and federal TIN or physician SSN is required for all claim submissions.

Please send all paper claim forms to TRICARE Prime Demo at the following address:

TRICARE CPD
TRICARE Prime Demo Attn: Claims Department P.O. Box 608 Dayton, OH 45401-0608

Claim Submission Timely Filing

For providers, claims must be submitted within one year the date of services were rendered or date of discharge. We will not be able to pay a claim if there is incomplete, incorrect, or unclear information on the claim, as the claim will be denied. If this happens, a corrected claim may be submitted with corrected information, but this is still considered an initial claim and will be subject to the one year from the date of service, date of discharge, or 90 calendar days from the date they were notified by CareSource Military & Veterans, whichever is later.

Claims Filing Guidelines

If an initial claim is filed timely and is denied, the provider has the following options:

1. If a claim denial is due to a provider's incorrect or inaccurate claim information, the provider may resubmit the claim with corrections.
2. For adjudication purposes, a denied claim that is resubmitted with corrected information is considered to be an initial claim and, as such, is subject to the one year timely filing limit.
3. For adjudication purposes, a denied claim resubmitted without corrected information is considered to be a duplicate claim and will continue to deny for the same reasons. Resubmitted claims with no correction will be subject to the one year timely filing limit and will not be accepted as "reasonable and continuous attempts to resolve a claim problem" for consideration to waive or extend the timely filing limit.

4. If a claim denial is not due to a provider's incorrect or inaccurate claim information, but the provider disagrees with the denial, the provider should refer to the provider appeal section of this manual for further information.
5. If a line item on a claim is denied, that line item should be resubmitted separately, unless the claim details are dependent on one another for payment. For example, all surgical services for the same beneficiary, same date and same provider must be submitted on one claim form and cannot be separately processed. To rebill a surgical procedure, a claim adjustment must be requested.

If an initial claim is **filed timely** and is **paid**, including claims **partially paid**, or **paid at zero**, the provider has the following options:

- If a claim paid incorrectly due to the provider's incorrect or inaccurate claim information, the provider may submit a corrected claim. The corrected claim must be filed within one year from the date of service or discharge.
- If a claim payment disagreement is not due to a provider's error, refer to the provider appeal section of this manual.
- If a beneficiary has other health insurance (OHI) and TRICARE Prime Demo is secondary, the provider may submit for secondary payment in accordance with the TOM, Chapter 8, Section 2.
- If a claim is denied for Coordination of Benefits (COB) information needed, the provider must submit the primary payer's Explanation of Benefits (EOB) for paper claims or primary carrier's payment information for EDI claims within the remainder of the initial claims timely filing period.
- If the initial timely filing period has elapsed, a statement indicating the original date of submission to the primary health insurance, and date of adjudication, together with any relevant correspondence and an EOB or similar statement must be submitted to us within 90 calendar days from the primary payer's EOB date. If the relevant correspondence and EOB is not submitted within the required time frame, the claim will be denied for timely filing.
- When the patient is discharged, the provider will be required to submit a final bill, which includes the entire bill from date admitted to date discharged. CareSource Military & Veterans is not able to determine correct payment unless the full, final bill is submitted. The provider will have one year from the date of discharge to submit the complete bill. If this information is not submitted within the timely filing guidelines, the claim will be denied, and previous payments will be recouped.
- Claims for newborns or newly adopted children must be submitted using the CSMV ID. In the case of multiple births, separate claims must be submitted for each newborn. Do not submit newborn/adoptee claims using the parent's beneficiary ID; the claim will deny. The same timely filing guidelines apply for newborns. Newborns receiving **retroactive** eligibility are an exception to timely filing requirements.

Claims Status

To check you claims status, log into the Provider Portal at **CareSourceMilitary.com** > Login > Provider.

Claim status is updated daily on our Provider Portal. You can search by Beneficiary ID, beneficiary name and date of birth, claim number, check number, or patient number.

You can find the following claim information on the Provider Portal:

- Claim history available
- Submit claim appeal and disputes

- Reason for payment or denial
- Check numbers and dates
- Procedure/diagnostic
- Claim payment date
- Submission of attachments for denied claims
- Easy submission for corrected claim when the claim was submitted online via the portal
- Accessibility to claim recovery letters

Claims Procedure and Diagnosis Codes Standards

- TRICARE Prime Demo requires HIPAA-compliant codes on electronic and paper claims. Adopting a uniform set of medical codes is intended to simplify the process of submitting claims and reduce administrative burdens on providers and health plans. HIPAA specifies that the health care industry use the following four code sets when submitting health care claims. International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM) (Available) from the U.S. Government Printing Office at 202-512-1800, 202-512-2250 (fax) and from many other (vendors)
- Current Procedural Terminology, 4th Edition, (CPT-4). Available at ama-assn.org.
- HCFA Common Procedure Coding System (HCPCS). Available at cms.gov.
- National Drug Codes (NDC). Available at fda.gov.

Procedures That Do Not Have a Corresponding Code

- If a procedure is performed which cannot be classified by a CPT or HCPCS code, please include the following information with an unlisted CPT/HCPCS procedure code on the claim form:
  - A full, detailed description of the service provided.
  - A report, such as an operative report or a plan of treatment.
  - Providers should also include any relevant information on the claim form, such as the specific nature of the procedure, the reason for its necessity, and any other supporting details that can help justify the use of the unlisted code.
- Medical claims that include drug injections which do not have specific J code (J3490, unclassified drug code) and any assigned HCPCS J code that is not listed on the Medicare ASP file require the NDC number, name of the drug and the dosage administered to the patient. The unit of measure billed must be defined.
- Claims for services that include a modifier 22 and claims for unlisted procedures must be accompanied by an operative report or supporting documentation. This documentation should explain why the unlisted code is being used and provide sufficient information for CareSource Military & Veterans to evaluate the claim. The claims will be evaluated based on the provided documentation to determine if the service is eligible for reimbursement.
- Coordination of Benefits (COB) claims require a copy of the Explanation of Payment (EOP) from the primary carrier or required dollar amounts billed via the HIPAA 837 claim transaction. If you have questions on how to bill COB claims electronically, please contact your EDI vendor.

Code Editing

CareSource Military & Veterans uses code auditing software to help evaluate the accuracy of diagnosis and procedure codes on all submitted claims to ensure claims are processed consistently, accurately, and efficiently.

CareSource Military & Veterans' code editing software helps evaluate the accuracy of the procedure code only, not the medical necessity of the procedure.

Corrected Claims Submissions

Accepted standards for corrected claim submissions require that the original claim number is populated on both EDI 837 transactions and paper forms. Including the original claim number allows your corrected claim to auto adjudicate, resulting in the fastest payment.

CareSource Military & Veterans will reject both EDI and paper form corrected claims that are received without the original claim number.

Electronic Data Interchange Billing Instructions

We strongly encourage use of electronic claim submission for all standard claim transactions, including corrected claims.

- Submit the corrected claim in the nationally recognized Electronic Data Interchange (EDI) 837 file format.
- Use an EDI 837 Loop 2300 CLM 05-3 value of "7" (Replacement).
- Carry over the Original Reference No. /Claim No. (12-character data) on the REF 02 data element with a Qualifier "F8" on Loop 2300.

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

Paper Form Billing Instructions:

Professional Claims:

For professional claims (CMS 1500 claim form), the provider must include the original TRICARE Prime Demo claim number and a frequency code of "7" per industry standards. When submitting a corrected claim, enter a "7" in the left-hand side of Box 22 and the original claim number in the right-hand side of that box.

Institutional Claims:

For institutional claims (UB-04 claim form), the provider must include the original TRICARE Prime Demo claim number in Box 64 and frequency code 7 as the last digit in Box 4 per industry standards.

Please Note: If a corrected claim is submitted without this information, the claim will be processed as an original claim and rejected or denied as a duplicate. Additionally, this process is for correcting denied claims only, not for resubmission of rejected claims (rejected claims are defined as EDI claims not accepted by TRICARE Prime Demo).

Provider Coding and Reimbursement Guidelines

CareSource Military & Veterans strives to be consistent with all TRICARE, Medicaid, Medicare and national commercial standards regarding the acceptance, adjudication and payment of claims. These standards apply to the code or code set(s) submitted and related clinical standards for claims received either as a paper copy or electronically. We apply HIPAA standards to all electronically received claims.

Accordingly, we accept only HIPAA-compliant code sets (HCPCS, CPT, ICD-10, and NDC). Specific contract language stipulating the receipt, processing and payment of specific codes and modifiers is honored as would be any aspect of a provider contract. Generally accepted commercial health insurance rules regarding coding and reimbursement are also used when appropriate. CareSource Military & Veterans strives to follow the prevailing National Correct Coding Initiative (NCCI) edits as maintained by CMS.

CareSource Military & Veterans uses coding industry standards, such as the American Medical Association (AMA) Current Procedural Terminology (CPT) manual, CCI and input from medical specialty societies to review multiple aspects of a claim for coding reasonableness, including, but not limited to:

- Bundling issues
- Diagnosis to procedure matching
- Gender and age appropriateness
- Maximum units of a code per day
- Currently valid CPT/HCPCS code or modifier usage

CareSource Military & Veterans seeks to apply fair and reasonable coding edits. We maintain a provider appeals function, refer to the provider appeal section of this manual for more information.

Emergency Department Reimbursement Guidelines

CareSource Military & Veterans covers emergency department visits. For emergency care obtained on an outpatient basis in network or non-network facilities, the TRICARE Prime Demo copayment requirement for Emergency Department (ED) services is on a PER VISIT basis; this means that only one copayment is applicable to the entire ED episode, regardless of the number of providers involved in the patient's care and regardless of their status as network providers. See the TRM Chapter 2, Section 2.

Point of Service charges do not apply to emergency care. See the TOM, Chapter 8, Section 5 for more details.

Copayment

TRICARE Prime Demo beneficiaries are responsible for any applicable copayments or cost shares as established by the program. For more information, visit: https://www.tricare.mil/Costs/Compare.

Increased Cost-Share for Point of Service (POS) Claims

The POS option allows non-active-duty service members enrolled in TRICARE Prime or TPRADFM to seek non-emergency healthcare services from any TRICARE-authorized provider. The POS cost-share applies when:

- The patient receives clinical preventive services from a non-network provider
- The patient self-advocates to a non-network specialty provider for non-emergency specialty or inpatient care

The POS option does not apply to the following:

- Newborns and newly adopted children in the first 60 days after birth or adoption
- Emergency care
- Clinical preventive care received from a network provider
- Beneficiaries with Other Health Insurance (OHI)

When using the POS option, beneficiaries may be expected to pay a deductible and 50 percent of the TRICARE-allowable charge. POS costs do not apply to the catastrophic cap.

POS deductible and cost-share amounts for TRICARE Prime enrollees:

- Enrollment or calendar year deductible for outpatient claims (deductible amounts do not apply to inpatient claims): $300 per individual; $600 per family.
- Beneficiary cost-share for inpatient and outpatient claims: 50 percent of the allowable charge after the deductible has been met.
- Additional charges by non-network providers beneficiary is fully responsible. Up to 15 percent above the TRICARE allowable charge is permitted by law.

Notification

If a TRICARE Prime Demo beneficiary presents to the emergency department for services, the provider must notify CareSource Military & Veterans to allow for case management services, preparation for admission, or discharge planning. Calls to CareSource Military & Veterans with the notification should be made to Provider Services. If the call occurs after hours, CareSource Military & Veterans will return the call within 24 hours. If an inpatient admission is expected, a prior authorization is needed. Additional information along with instructions to submit a request can found at **CareSourceMilitary.com**.

Explanation of Payment

An Explanation of Payments (EOPs) is statements of the status of your claims that have been submitted to TRICARE Prime Demo and entered into our system. EOPs are generated weekly. However, you may not receive an EOP each time they are generated, depending on your claim submission activity. Providers who receive EFT payments will receive an Electronic Remittance Advice (ERA) and can access it on the Provider Portal.

Information Included on EOPs

EOPs include paid and denied claims. Denied claims appear on the EOP with a HIPAA compliant remark code indicating the reason the claim was denied. It is the provider's responsibility to resubmit claims with the correct or completed information needed for processing.

Check Claim Status Online

You can track the progress of your submitted claims at any time through our Provider Portal.

Providers and their support staff can also track the status of claims using our Clearinghouse Availity. A Search can be completed using the website or through a connection in the Providers Electronic Health Records (EHR) system. This connection can be established if the EHR system is configured for X12 5010 276 Claim Status Inquiry output and able to receive a 277 Claim Status Response.

CareSource Military & Veterans is responsible for resolving any pended claims, not the provider. The report may be sent to you merely to acknowledge receipt. Please do not resubmit pended claims; this may further delay processing. A Pended Claim Explanation Report may be sent on the first and third check write of the month.

Explanation of Benefits

TRICARE Prime Demo beneficiaries receive an Explanation of Benefits (EOB) that informs beneficiaries of their deductible and out-of-pocket status and shows copays and coinsurance they have paid when care is denied of partially denied. The EOB outlines the amount the provider billed, the amount CareSource Military & Veterans reimbursed and the remaining amount for which the beneficiary is responsible.

Coordination of Benefits

CareSource Military & Veterans collects Coordination of Benefits (COB) information for our beneficiaries. This information helps us to ensure that we are paying claims appropriately.

While we try to maintain information as accurately as possible, we rely on numerous sources of information that are updated periodically, and some information may not always be fully reflected on our Provider Portal. Please ask TRICARE Prime Demo beneficiaries for all health care insurance information at the time of service.

Search Coordination of Benefits on the Provider Portal By:

- TRICARE Prime Demo beneficiary ID number
- TRICARE Prime Demo case number
- Beneficiary name and date of birth
- TRICARE CPD Sponsor ID

You can check COB information for beneficiaries who have been active with TRICARE Prime Demo within the last 12 months.

Claims involving COB will not be paid until an EOB/Payment or EDI payment information has been received indicating the amount the primary carrier paid. Claims indicating that the primary carrier paid in full (zero balance) must still be submitted to TRICARE Prime Demo for processing. This is due to regulatory requirements.

Coordination of Benefits Overpayment

If a provider receives a payment from the beneficiaries Other Health Insurance (OHI) after receiving payment from TRICARE Prime Demo for the same items or services, this is considered an overpayment. Adjustments to the overpayment will be made on subsequent reimbursements to the provider, or the provider can issue refund checks to TRICARE Prime Demo for any overpayments.

Workers' Compensation

Claims indicating that a beneficiary's diagnosis, illness, or injury was caused by their employment will not be paid. The provider will be advised to submit the charges to workers' compensation for reimbursement.

Balance-Billing

In-network providers may not bill enrolled beneficiaries for "activities that improve health care quality" as that term is defined in 42 CFR 422.2430. To charge the beneficiary for non-covered services, providers must inform beneficiary of his or her responsibility to pay for services that are not covered by TRICARE Prime Demo, and document in the recipient's file that the recipient was informed of his or her liability, prior to rendering each service. The provider must disclose the following in writing:

- That the service to be rendered is not covered by TRICARE Prime Demo.
- Whether there are procedures or treatments covered by TRICARE that are available to the beneficiary in lieu of the non-covered procedure or treatment. If there are covered procedures or treatments available to the beneficiary, the beneficiary must indicate on the disclosure form his or her willingness to accept the non-covered service.

The requirements and documentation must be signed prior to providing any service. Beneficiaries in emergent situations cannot be billed for services. Beneficiaries cannot be billed if the provider fails to bill TRICARE Prime Demo correctly and in a timely manner.

In accordance with 32 CFR 199, non-network providers may not balance bill the beneficiary more than 115% of the allowable charge.

Hold-Harmless Policy for Network Providers

A network provider may not bill a TRICARE CPD beneficiary for excluded or excludable services (i.e., the beneficiary is held harmless), except in the following circumstances:

- If the beneficiary did not inform the provider that he or she was a TRICARE CPD beneficiary
- If the beneficiary was informed that services were excluded or excludable and agreed in advance and in writing to pay for the services
- If the beneficiary has been notified, in writing, that the service would not be covered for any reason

A TRICARE CPD beneficiary is held harmless from financial liability for noncovered services. If the beneficiary has agreed in writing (using the TRICARE Non-Covered Services Waiver form) in advance of the service/care being performed, the provider may bill the beneficiary directly.

If there is not a TRICARE waiver on file for the patient and the specified date of service and care, then the network provider has no recourse and must uphold the hold harmless provision according to *Title 10 of the Code of Federal Regulations* on TRICARE.

TRICARE network providers must file patients' claims, even when the patient has Other Health Insurance (OHI).

It is never appropriate to balance bill a CPD beneficiary for a CPD covered service. A beneficiary must be given an option, with the ability, to leave and find an alternative option prior to rendering consent for direct billing.

Administrative Processes

Compliance and Ethics

We serve a variety of audiences – beneficiaries, providers, government regulators, community partners, and each other. We serve them best by working together with honesty, respect, and integrity. Our corporate compliance plan, along with state and federal regulations, outline the personal, professional, ethical, and legal standards we must all follow.

TRICARE Prime Demo complies with applicable state and federal civil rights laws. We do not discriminate, exclude people, or treat them differently because of race, color, national origin, disability, age, religion, or sex (which includes discrimination on the basis of sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation; gender identity; and sex stereotypes), marital status, health status, public assistance status, or veteran status.

Our Corporate Compliance Plan is an affirmation of CareSource Military & Veterans' ongoing commitment to conduct business in a legal and ethical environment. It has been established to:

- Formalize CareSource Military & Veterans' commitment to honest communication within the company and within the community
- Develop and maintain a culture that promotes integrity and ethical behavior
- Facilitate compliance with all applicable local, state, and federal laws and regulations
- Implement a system for early detection and reporting of noncompliance with laws, regulations, or company policy

This allows us to resolve problems promptly and minimize any negative impact on our beneficiaries or business, such as financial losses, civil damages, penalties, and criminal sanctions.

Our Corporate Compliance Plan is a formal company policy that outlines how everyone who represents TRICARE Prime Demo must conduct himself or herself. This includes how we do our work and how we relate to each other in the workplace. It also includes the conduct of those we have business relationships with, such as providers, consultants, and vendors. All providers are required to review and comply with our corporate compliance plan, located at **CareSourceMilitary.com** > About Us > Legal > Corporate Compliance.

General Compliance and Ethics Expectations of Providers

- Act according to the standards of our compliance plan.
- Notify us about suspected violations or misconduct.
- Contact us if you have questions.

For questions about provider expectations, please call Provider Services at **1-833-230-2170**.

If you suspect potential violations, misconduct or non-compliant conduct that affects TRICARE Prime Demo or our beneficiaries, please leverage one of the following methods to communicate the issue to TRICARE Prime Demo:

Ethics and Compliance Hotline: 844-784-9583 or CareSource.ethicspoint.com. Any issues submitted to the Ethics and Compliance Hotline may be submitted anonymously.

The Corporate Compliance Plan is posted for your reference on **CareSourceMilitary.com** > About Us > Legal > Corporate Compliance.

Please let us know if you have questions regarding the Corporate Compliance Plan. We appreciate your commitment to corporate compliance.

Personally Identifiable Information (PII)

In the day-to-day business of patient treatment, payment and health care operations, TRICARE Prime Demo and its providers routinely handle large amounts of personally identifiable information (PII). In the face of increasing identity theft, there are various standards and industry best practices that guide that PII be appropriately protected wherever it is stored, processed and transferred in the course of conducting normal business. As a provider, you should be taking measures to secure your sensitive provider data, and you are mandated by the HIPAA to secure protected health information (PHI). There are many controls you should have in place to protect sensitive PII and PHI.

Here are a few important places to start:

1. Utilize a secure message tool or service to protect data sent by email.
2. Limit paper copies of PHI and PII left out in the open in your workspace and shred this content when it is no longer needed.
3. Ensure conversations involving patient information cannot be overheard by others.
4. Ensure all employees complete a HIPAA training program and understand the importance of safeguarding patient information.

There may be times when we share patient information with you or ask you to share with us. CareSource Military & Veterans, like you, is a Covered Entity under HIPAA. It is permissible for covered entities to share patient information when necessary for treatment, payment or health care operations.

For more information about HIPAA Compliance within the Military Health System (MHS), refer to the TOM Chapter 19 or visit the DHA's Privacy & Civil Liberties Office's webpage.

Beneficiary Consent

When you check eligibility on the Provider Portal, you can also determine if a beneficiary has granted consent to share their health information with their past, current and future treating providers. A message displays on the Beneficiary Eligibility page if the beneficiary has not consented to sharing their health information.

Please encourage TRICARE Prime Demo CPD beneficiaries who have not consented to complete our HIPAA Authorization Form so that all providers involved in their care can effectively coordinate their care.

The HIPAA Authorization Form can also be used to designate a person to speak on the beneficiary's behalf. This designated representative can be a relative, a friend, a physician, an attorney or some other person that the beneficiary specifies.

Accreditation

CareSource Military & Veterans is currently in the process of achieving various accreditations from the National Committee for Quality Assurance (NCQA).

Communicating with CareSource Military & Veterans

CareSource Military & Veterans communicates with our provider network through a variety of channels, including phone, fax, Provider Portal, newsletters, **CareSourceMilitary.com**, and network notifications. We encourage you to reach out to your assigned Provider Engagement Representative with any questions.

TRICARE Prime Demo Hours of Operation

Provider Services 1-833-230-2170		
TRICARE Prime Demo	Monday to Friday	8 a.m. to 6 p.m. Eastern Time (ET)
Beneficiary Services 1-833-230-2080		
TRICARE Prime Demo	Monday to Friday	8 a.m. to 6 p.m. ET

Representatives are available by telephone Monday through Friday, except on observed holidays. If the call occurs after hours, CareSource Military & Veterans will return the call within 24 hours.

Please visit **CareSourceMilitary.com** > About Us > Contact Us for the holiday schedule or contact Provider Services for more information.

Phone

Our IVR system will direct your call to the appropriate professional for assistance. We also provide telephone-based self-service applications that allow you to verify beneficiary eligibility.

Provider Services	1-833-230-2170
Prior Authorizations	1-833-230-2170
Claim Inquiries	1-833-230-2170
Credentialing	1-833-230-2170
Beneficiary Services	1-833-230-2080
Case Management	1-844-206-6188
24-Hour Nurse Advice Line	1- 833-687-7376
Crisis Line	1-833-227-3111

Substance Use Disorder Line	1-844-607-2838
Fraud, Waste and Abuse Hotline	1-833-230-2170
TTY for the Hearing Impaired	711
EyeMed Beneficiary Services	1-833-337-3129

Fax

Case Management Requests	937-396-3673
Credentialing	937-396-3168
Fraud, Waste and Abuse	1-800-418-0248
Medical Prior Authorization	937-396-3052
Sick Newborn Fax	937-396-3499
Outpatient Drugs Covered Under Medical Benefit Prior Authorization Form	1-888-399-0271
Provider Appeals	937-531-2398
Provider Maintenance	937-396-3076

Provider Representative Information

Our goal is to build collaborative and mutually supportive relationships with our network. TRICARE Prime Demo's Provider Representatives are dedicated to helping your practice.

You can find your assigned Provider Representative here and by visiting **CareSourceMilitary.com** > Providers > Provider Overview > Contact Us.

Website

Accessing our website, **CareSourceMilitary.com**, is quick and easy. On the Provider section of the site, you will find commonly used forms, newsletters, updates and announcements, our Provider Manual, claims information, frequently asked questions, clinical and preventive guidelines and much more.

Provider Portal

Our secure online Provider Portal gives you instant access at any time to valuable information. You can access the Provider Portal at **CareSourceMilitary.com** > Login > Provider Portal. Enter your username and password (if already a registered user) or submit your information to become a registered user. Assisting you is one of our top priorities to deliver better health outcomes for our beneficiaries.

In accordance with federal and state regulations concerning HIV/AIDS/SUD consent requirements, beneficiary data on the Provider Portal may be incomplete unless a consent is on file. Contact Provider Services at **1-833-230-2170** if additional information is needed.

Provider Portal Benefits

- Easy access to a secure online (encrypted) tool with time-saving services and critical information
- Availability 24 hours a day, seven days a week
- Secure, convenient access to time-saving services and critical information
- Accessible on any web browser without any additional software

Provider Portal Tools

We encourage you to take advantage of the following time-saving tools:

- **Payment history** – Search for payments by check number or claim number.
- **Claims Features**
  - Submit Claims – Submit claims using online forms or upload a completed claim. Claim submission through the portal is available to traditional providers, community partners, delegates, and health homes. For more information about submitting claims online, visit the "Claims Submissions" chapter of this manual.
  - Claim Status – Search for status of claims.
  - Claims Attachments – Submit documentation needed for claims processing.
  - Rejected Claims – Find claims that may have been rejected so that you can resubmit them.
  - Claim Dispute and Appeals – Submit and search for claim appeals and disputes.
- **Coordination of Benefits (COB)** – Confirm if the TRICARE beneficiary has other health insurance (OHI). If so, health care bills must be submitted first to the beneficiary's OHI plan for processing and payment. Once that is completed, a claim indicating the OHI allowed, and payment amounts may be submitted to TRICARE Prime Demo for secondary payment (if appropriate).
- **Prior authorization** – Request authorization for medical and behavioral inpatient/outpatient services, as well as pharmacy authorizations.
- **Eligibility termination dates** – View the beneficiary's termination date (if applicable) under the eligibility tab.
- **Benefit limits** – Track benefit limits electronically in real time before services are rendered.
- **Care plans** – View care plans for patients on our Provider Portal.
- **Clinical Practice Registry (CPR)** – Review beneficiary gaps in care. View and sort TRICARE Prime Demo beneficiaries into actionable groups for improved focus on preventive care (e.g., well-baby visits, diabetes, asthma and more). Look on the "Beneficiary Eligibility" page for alerts to notify you what tests a patient needs.
- **Recovery Letters** – View and download letters.
- **Beneficiary Profile** – Access a comprehensive view of patient medical/pharmacy utilization.
- **Beneficiary financial status and information** – View beneficiary payment responsibilities (such as deductible, copay, and coinsurance) and monthly premium status.
- **Monthly beneficiary lists** – View and download current monthly beneficiary lists.

- **Case management requests** – Submit automated case management forms on our Provider Portal for efficiency in enrolling beneficiaries.
- **Information exchange** – Share relevant beneficiary information to facilitate better integration of behavioral health, dental and medical care.
- **File a Grievance**

Portal Registration

If you are not registered with our Provider Portal, follow these easy steps:

1. Visit the Provider Portal. Click "Sign Up" to establish your account by entering your email address and creating your password*
2. For added security, set up multifactor authentication
3. To connect your account, you will need information provided in your Welcome Letter including your Provider Type, Provider Name, Tax ID, TRICARE Prime Demo Provider ID and your Zip Code
4. Review and accept the agreement

**Please note that your first registered account will become the account administrator and may add additional users.*

For more information, see our Provider Portal Key Features Overview on the Quick Reference Materials page.

Once registered, access our Provider Portal by clicking the Login button at the top of any page.

Forms

Providers may access plan forms at **CareSourceMilitary.com** > Providers > Tools & Resources > Forms.

Mailing Addresses

For mailing addresses, see the Provider Portal for the most current updates.

Provider Communications

Newsletters

Our provider newsletter contains operational updates, clinical articles, and new initiatives underway at TRICARE Prime Demo. We will also share updates to adopted Evidence Based Guidelines through our newsletters.

Provider Education Materials

The Office of the Inspector General (OIG) has created free materials for providers to assist you in understanding the federal laws designed to protect program beneficiaries from fraud, waste and abuse (FWA). This brochure can be found on the Office of Inspector General's website at https://oig.hhs.gov/compliance/physician-education/.

Network Notifications

We regularly communicate policy and procedure updates to TRICARE Prime Demo providers via network notifications. Network notifications are found on our website at **CareSourceMilitary.com** > Providers > Tools & Resources > Updates & Announcements.

Provider Demographic Changes and Updates

Advance written notice of status changes, such as a change in address, phone or adding or deleting a physician to your practice helps us keep our records current and beneficiaries able to find you when searching for a provider. Your current information is critical for efficient claims processing.

The Provider Portal is the preferred method to submit changes. Log in to the Provider Portal by visiting **CareSourceMilitary.com** > Login > Provider Portal, entering your login credentials and selecting "Provider Maintenance" from the left-hand navigation.

Demographic Change Submission Options	
Online/Provider Portal* *Preferred Method	**CareSourceMilitary.com** > Providers > Provider Portal Log-In
Email	ProviderMaintenance@CareSource.com
Fax	937-396-3076
Mail	TRICARE Prime Demo Attn: Provider Maintenance P.O. Box 8738 Dayton, OH 45401-8738

Questions? Email ProviderMaintenance@CareSource.com.

Provider Policies

TRICARE Prime Demo maintains medical, pharmacy, reimbursement, and administrative policies on our website. Approved policies may be found at **CareSourceMilitary.com** > Providers > Tools & Resources > Provider Policies. Policies are regularly reviewed, updated, withdrawn or added, and therefore subject to change. TRICARE Prime Demo provides notice to providers regarding a change in policy at least 30 calendar days prior to implementation.

Provider Responsibilities

Network providers have contracts with TRICARE Prime Demo and must comply with all TRICARE program rules and regulations and TRICARE Prime Demo policies. This handbook is not all-inclusive and provides an overview of TRICARE program rules and regulations and TRICARE Prime Demo policies and procedures.

Nondiscrimination policy

All TRICARE-authorized providers agree not to discriminate against any TRICARE beneficiary on the basis of his or her 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.

Provider Training

CareSource Military & Veterans' dedicated provider education team uses provider and state feedback to create and update a market-specific suite of provider resource materials. CareSource Military & Veterans offers live, educational opportunities through in-person, on-site informational meetings and scheduled webinars with Q&A sessions. On-demand, educational opportunities are highlighted on our website and within our Provider Portal. Visit **CareSourceMilitary.com** > Providers >Training & Events to learn more.

Providers may also contact their assigned Provider Representative for additional live training support. You can find your assigned Provider Representative by visiting **CareSourceMilitary.com** > Providers > Provider Overview > Contact Us.

Credentialing and Recredentialing

CareSource Military & Veterans credentials and recredentials all licensed independent practitioners, including physicians, facilities, and non-physicians with whom it contracts and who fall within its scope of authority and action. Through credentialing, CareSource Military & Veterans checks the qualifications and performance of physicians and other health care practitioners. Our Vice President/Senior Medical Director is responsible for the credentialing and recredentialing program.

Credentialing Process

CareSource Military & Veterans has partnered with Verisys to complete credentialing requirements. Verisys may contact you on behalf of CareSource Military & Veterans if additional information is required for credentialing to be completed.

Verisys offers a web-based credentialing application tool that streamlines the credentialing process for health care professionals. Updates in the Council for Affordable Quality Healthcare's (CAQH) web platform allow for the information to be shared directly with Verisys and CareSource Military & Veterans for primary source verification.

Provider Credentialing Rights

- Practitioners have the right to review information submitted to support their credentialing application upon request to the CareSource Military & Veterans Credentialing department. CareSource Military & Veterans keeps all submitted information locked and confidential.
- Practitioners have the right to correct incomplete, inaccurate or conflicting information by supplying corrections in writing to the Credentialing department prior to presenting to the credentialing committee. If any information obtained during the credentialing or recredentialing process varies substantially from the application, the practitioner will be notified and given the opportunity to correct this information prior to presenting to the credentialing committee.
- Providers have the right to be informed of the status of their credentialing and recredentialing application upon request. An automated email is sent to the providers once their application is submitted via the Provider Portal. This email directs them to contact Provider Services at **1-833-230-2170** to obtain application status updates. Provider services representatives are able to inform providers if their application is complete and they are showing as participating in the CSMV network, or if their application is still in process while referencing state-specific time frames.

Council for Affordable Quality Healthcare (CAQH) Application

CareSource Military & Veterans is a participating organization with the CAQH. Please make sure that we have access to your provider application prior to submitting your CAQH number.

1. Log on to the CAQH website at www.CAQH.org, utilizing your account information.
2. Select the "Authorization" tab and ensure CareSource Military & Veterans is listed as an authorized health plan (if not, please check the "Authorized" box to add).

Please also include copies of the following documents:

- Malpractice insurance face sheet
- Drug Enforcement Administration (DEA) certificate (current) or Controlled Substance Registration (CSR)
- Clinical Laboratory Improvement Amendment (CLIA) certificate, if applicable
- Standard collaborative care arrangement (if an advanced practice nurse or a physician assistant)

It is essential that all documents are complete and current, or CareSource Military & Veterans will discontinue the contracting and credentialing process.

Debarred and Criminal Conviction Attestation

CareSource Military & Veterans verifies that its providers and the providers' employees have not been debarred or suspended by any state or federal agency. CareSource Military & Veterans also requires that its providers and the providers' employees disclose any criminal convictions related to federal health care programs. "Provider employee" is defined as directors, officers, partners, managing employees, or persons with beneficial ownership of more than five percent of the entity's equity.

Providers must offer a list that identifies all of the provider employees, as defined above, along with the employee's tax identification or social security numbers. Providers and their employees must execute the attestation titled, "TRICARE Prime Demo Debarment/Criminal Conviction Attestation" (in addition to being subject to and cooperating with TRICARE Prime Demo verification activities) as a part of the credentialing and recredentialing process.

Who Is Credentialed

Contracted providers listed in the Provider Directory and the following are credentialed:

- Providers who have an independent relationship with TRICARE Prime Demo. This independent relationship is defined through contracting agreements between TRICARE Prime Demo and a provider or group of providers and is defined when CareSource Military & Veterans selects and directs its enrollees to a specific provider or group of providers.
- Providers who see beneficiaries outside the inpatient hospital setting or outside ambulatory free-standing facilities.
- Providers who are hospital-based but see the organization's beneficiaries as a result of their independent relationship with the organization.
- Dentists who provide care under the organization's medical benefits.
- Non-physician providers who have an independent relationship with the organization, as defined above, and who provide care under the organization's medical benefits.

- Covering providers (locum tenens).
- Medical directors of urgent care centers and ambulatory surgical centers.
- Providers are Medicare participating providers (unless they are not eligible to be participating providers under Medicare).

The following providers listed in the Provider Directory do not need to be credentialed:

- Providers who practice exclusively within the inpatient setting and who provide care for an organization's beneficiaries only as a result of the beneficiaries being directed to the hospital or other inpatient setting.
- Providers who practice exclusively within free-standing facilities and who provide care for organization beneficiaries only as a result of beneficiaries being directed to the facility and who are not listed separately in the TRICARE Prime Demo Provider Directory.
- Providers who do not provide care for beneficiaries in a treatment setting (e.g., board-certified consultants).

For more information about TRICARE Prime Demo's credentialing and selection processes, refer to the Provider Portal.

Providers are monitored on an ongoing basis to ensure continuing compliance with participation criteria. TRICARE Prime Demo will initiate immediate action if the participation criteria are no longer met. Providers are required to inform CareSource Military & Veterans of changes in status, such as being named in a medical malpractice suit, involuntary changes in hospital privileges, licensure or board certification or any event reportable to the National Practitioner Data Bank (NPDB).

Recredentialing

Providers are recredentialed a minimum of every three years. As part of the recredentialing process, CareSource Military & Veterans considers information regarding performance to include complaints and safety and quality issues collected through the quality improvement program, in addition to information regarding sanctions collected from the NPDB, and Medicaid Sanctions and Reinstatement Report, Medicare Opt-Out, and the HHS/OIG. Providers will be considered recredentialed unless otherwise notified. CareSource Military & Veterans will remove from the active file any provider who has not submitted a claim or whose services have not been submitted on a claim within the past two years. If a claim is received from an active provider who has not submitted a claim or whose services have not been submitted on a claim within the past two years, they will be recertified at that time. Providers will be informed of the credentialing committee decision within 30 business days of the committee meeting. Providers will be considered recredentialing unless otherwise notified.

Board Certification Requirements

Effective as of January 1, 2003, physicians applying to become participating providers network must be either board certified in their primary specialty or pursuing the pathway to certification as defined by their specialty board.

Effective as of September 10, 2010, Primary Care Managers (PCMs) may be exempted from the board certification requirement if they have successfully completed a primary care residency program, and their education and training is consistent with their intended scope of practice.

Physicians who are pursuing certification must be certified within the time frame specified by their respective board. Failure to become certified may result in termination as a participating network provider.

Physicians whose boards require periodic recertification will be expected but not required to be recertified, although failed attempts at recertification may be reason for termination. At the time of recredentialing, if board certification status has expired, a letter will be sent to the physician to request explanation. If the response indicates quality concerns as a reason, the VP, Senior Medical Director or designated Medical Director will contact the physician and investigate directly.

To be credentialed as a subspecialist, physicians must:

- Complete an approved fellowship training program in the respective subspecialty, and
- Be board certified by a board recognized and approved by the Credentialing Committee. If no subspecialty board exists or the board is not a board recognized and approved by the Credentialing Committee, then subspecialty recognition will be determined based on education, training and experience requirements of the fellowship training program and/or other suitable board certification recognition.

Delegation of Credentialing/Recredentialing

CareSource Military & Veterans will only enter into agreements to delegate credentialing and recredentialing if the entity that wants to be delegated is NCQA-accredited for these functions, utilizes an NCQA-accredited Credentials Verification Organization (CVO) and successfully passes a pre-delegation audit demonstrating compliance with NCQA, federal and state requirements.

A pre-delegation audit must be completed prior to entering into any delegated agreement. All pre-assessment evaluations will be performed utilizing the most current NCQA and regulatory requirements. The following will be included (at a minimum) in the review:

- Credentialing and recredentialing policies and procedures
- Credentialing and recredentialing committee meeting minutes from the previous year
- Credentialing and recredentialing provider file review

CareSource Military & Veterans may also choose to outsource the credentialing and recredentialing function at any time to an NCQA-accredited CVO. Providers will be notified of this and must adhere to the requests from the chosen CVO.

Reconsideration and Appeals of Credentialing/Recredentialing Decisions

CareSource Military & Veterans may decide that an applying or participating network provider may pose undue risk to our beneficiaries and should be denied participation or be removed from TRICARE Prime Demo's network. If this happens, the applying or participating network provider will be notified in writing. Reconsideration and appeal opportunities are available unless an exception applies. Exceptions are set forth in the Provider Participation Plan. To submit a request, the following steps apply:

Step 1

The participating network provider must request such a hearing, in writing, within 14 days of receipt of the Notice of Action. The request must be addressed to the Chair of the Credentialing Committee or his or her designee as referenced in the Notice of Action and must be sent via certified mail, return receipt requested. Failure to file such a request within the required time period shall constitute the participating

network provider's complete and final waiver of any right to a hearing, any appellate review, and/or any other procedural due process rights associated with the Action at issue.

Step 2

Upon receipt of a participating network provider's request for a hearing, the Chair of the Credentialing Committee or his or her designee will promptly arrange for and schedule the hearing. Promptly after the hearing is scheduled, the Chair of the Credentialing Committee or his or her designee will send a notice to the participating network provider, via certified mail, return receipt requested, of the date, time and place of the hearing, which may be held virtually or in-person.

Step 3

Within seven business days of the conclusion of the hearing, the PHP shall render its decision which shall be deemed full and final and not subject to appeal. A three-business day extension may be granted by the PHP Chairperson. The PHP decision will be sent to the Chair of the Credentialing Committee. The Chairperson of the Credentialing Committee will, within five business days of receipt of the PHP Decision, send notice via certified mail, return receipt requested, to the participating network provider, of the PHP decision.

Applying providers may submit additional documents for reconsideration by the credentialing committee to the address above. An application rejection due to the provider's failure to submit a complete application is not subject to reconsideration or appeal.

If you would like to review the Provider Participation Plan, please visit **CareSourceMilitary.com** > Documents > Fair Hearing Plan.

Provider Disputes

Provider disputes for issues **related to quality, professional competency or conduct** should be sent to:

TRICARE Prime Demo
Attn: Quality Improvement
P.O. Box 8738
Dayton, OH 45401-8738

Provider disputes for issues that are **contractual or non-clinical** should be sent to:

TRICARE Prime Demo
Attn: Provider Appeals Department
P.O. Box 2008
Dayton, OH 45401

Summary Suspensions

CareSource Military & Veterans reserves the right to immediately suspend or summarily dismiss, pending investigation, the participation status of a network provider who, in the opinion of the Vice President/ Senior Medical Director, is engaged in behavior or who is practicing in a manner that appears to pose a significant risk to the health, welfare or safety of our beneficiaries. Any network provider that is subject to a suspension or termination may appeal the action and request a hearing through the Provider Participation Plan unless an exception applies. Exceptions are set forth in the Provider Participation Plan.

Beneficiary Grievance and Appeals

The grievance process allows the beneficiary, or the beneficiary's authorized representative acting on behalf of the beneficiary (or provider acting on the beneficiary's behalf with the beneficiary's written consent) to file a grievance in writing. A grievance is defined as an expression of dissatisfaction about any matter other than an "adverse action."

Grievances may be filed at any time. In accordance with TRICARE standards as outlined in the TOM Chapter 1, Section 3, grievances are acknowledged within three business days and resolved within 30 calendar days from the date of receipt. All grievances must be submitted in writing.

Beneficiary Grievances

Beneficiaries have the right to file a grievance or appeal a decision made by TRICARE Prime Demo. As a TRICARE Prime Demo provider, we may contact you to obtain documentation when a beneficiary has filed a request for one of these reviews. TRICARE Prime Demo does not retaliate or discriminate against any beneficiary or provider for utilizing the grievance and appeals process.

Beneficiaries are encouraged to write to CareSource Military & Veterans to let us know of any grievance regarding TRICARE Prime Demo or the health care services they receive. Beneficiaries or providers, when designated as the authorized representative by the beneficiary and with beneficiary written consent, may file a grievance or appeal with CareSource Military & Veterans. Detailed grievance and appeal procedures are explained in the Beneficiary Handbook. Beneficiaries can contact CareSource Military & Veterans at **1-833-230-2080** (TTY: 711) to learn more about these procedures. Beneficiaries must exhaust CareSource Military & Veterans' internal appeals process before requesting an external review.

Time Frames and Requirements

The beneficiary can file a grievance at any time in writing. CareSource Military & Veterans responds to beneficiary grievances within 30 calendar days of the receipt of the request and this period may be extended up to 30 calendar days if resolution of the matter requires additional time. A letter notifying the beneficiary of this extension is required.

Beneficiary Appeals

CareSource Military & Veterans notifies beneficiaries in writing when a decision is made to:

- Deny or limit authorization of a requested service, including the type or level of service.
- Reduce, suspend or terminate services prior to the beneficiary receiving the services previously authorized.
- Deny, in whole or part, of payment for a service.
- Fail to provide services in a timely manner.
- Fail to act within the resolution time frame.

Beneficiaries and providers, as outlined in the Tricare Operations Manual (Chapter 12, Sections 2, 1.1 and 3, 1.3.1), have the right to appeal the actions listed in the letter if they contact CareSource Military & Veterans in writing within 90 calendar days from the date on the determination communication. If the amount of time necessary to resolve a standard pre-admission or pre-procedure appeal could jeopardize the beneficiary's life, health or ability to attain, maintain or regain maximum function, the beneficiary may

request an expedited appeal within three calendar days after the date of the receipt of the initial denial determination. CareSource Military & Veterans will review the request and determine if the request meets the expedited criteria, if the expedited request is denied, CareSource Military & Veterans will transfer the request to a standard appeal for resolution and make a reasonable effort to give the beneficiary prompt oral notice and follow up within two calendar days with a written notice of the decision.

Appeals will be decisioned within the time frames outlines below:

APPEAL TYPE	TIME FRAME
Standard appeal	30 calendar days
Expedited Appeal	3 business days

All determination communications include next level review rights, as available.

Formal Review and Hearings

Written appeal determination notices will advise of further rights to appeal, including the right of the beneficiary (or representative) and the non-network participating provider to request an appeal to the TQMC contractor for a second reconsideration if the plan's reconsideration determination is denied in whole or in part, and $50 or more remains in dispute. The beneficiary's timeframe to file with the TQMC for expedited pre-admission or pre-procedure reconsideration is three calendar days after the date of receipt of the initial reconsideration determination, considered to be five calendar days after the date of mailing, unless the receipt date is documented.

If a request for reconsideration is filed with the TQMC contractor by the beneficiary more than three calendar days after the date of receipt but within 90 calendar days from the date of the initial reconsideration determination, it will be addresses as a non-expedited reconsideration.

Non-expected reconsiderations may be requested by the beneficiary or non-network participating provider with the TQMC contractor within 90 calendar days after the date of the initial reconsideration determination.

The TQMC contractor shall include a statement explaining the right of the beneficiary (or representative) and the non-network participating provider to file a request for hearing with DHA, if the reconsideration determination issued the TQMC contractor is denied in whole or in part and $300 or more remains in dispute. A request for hearing must be postmarked or received by DHA within 60 calendar days from the date of the notice on the reconsideration determination issued by the TQMC contract. This request should be in writing and sent to the Chief, Appeals and Hearing, OCHAMPUS, and should be mailed within 60 calendar days after the date of the notice of the initial determination or formal review determination being appealed.

TRICARE Prime Demo beneficiaries can request a formal review by submitting a written request to TRICARE.

Continuation of benefits while the appeal and the state fair hearing are pending:

In certain beneficiary appeals, TRICARE Prime Demo is required to continue the beneficiary's benefits pending the appeal. Beneficiaries may be required to pay the cost of services provided while the appeal or state hearing is pending.

Provider Appeals Procedure

Denials based on medical necessity review can be appealed with beneficiary written consent from the beneficiary. A participating provider is not authorized to enter an appeal for a beneficiary unless the provider has been designated by the beneficiary, in writing, to act as his or her representative in the appeal process. Appeal requests must be received within 90 days from the date of the action notice.

Valid appeal requests are reviewed by licensed clinicians and physicians. Determinations of the appeal are communicated to the provider within the time frames outlined below:

APPEAL TYPE	TIME FRAME
Standard Appeal	30 calendar days
Expedited Appeal	3 business days

All determination communications include next level review rights, as available.

Provider Claim Disputes and Provider Claim Appeals

Claim Dispute and Claim Appeal Process for Providers:

If you believe the claim was processed incorrectly due to incomplete, incorrect, or unclear information on the claim, you should submit a corrected claim. You do not need to file a dispute.

Network and non-network providers must submit claim disputes and claim appeals within 90 days after the provider's receipt of the written determination of the claim. They must submit the dispute or appeal in writing using one of the following methods:

- Provider Portal: The Provider Portal is the preferred method of submission to ensure timely receipt and resolution of the dispute. In the portal, click the "Claims" tab and select "Dispute."
- In writing, by submitting the claim dispute/claim appeal form using one of the following methods:
  - Fax: 937-531-2398
  - Mail:
    TRICARE Prime Demo
    Attn: Claim Appeals Department
    P.O. Box 2008
    Dayton, OH 45401

If you are submitting a timely filing dispute or appeal, you must send proof of original receipt of the claim by fax or Electronic Data Information (EDI) for reconsideration.

For additional information, contact Provider Services at **1-833-230-2170**.

Requests for Peer-to-Peer Review

TRICARE Prime Demo peer-to-peer review is a process where a beneficiary's treating physician discusses a case with a TRICARE Prime Demo medical expert. This review is typically requested when there is a disagreement about the medical necessity or appropriateness of a proposed treatment or service.

When is it used?

- **Medical Necessity Disputes:** If TRICARE Prime Demo denies coverage for a service or treatment, citing medical necessity concerns, a peer-to-peer review can be requested.
- **Treatment Plan Disagreements:** When there's a difference of opinion between the treating physician and TRICARE Prime Demo regarding the best course of treatment.

How does it work?

1. **Request:** The beneficiary or their treating physician initiates the request for a peer-to-peer review. This is usually done in writing, outlining the specific concerns and reasons for the request.
2. **TRICARE Review:** TRICARE Prime Demo reviews the request and determines if a peer-to-peer review is warranted.
3. **Peer Selection:** If approved, TRICARE Prime Demo selects a medical expert in the relevant field to participate in the review.
4. **The Review:** The treating physician and the TRICARE Prime Demo medical expert discuss the case, sharing medical information and treatment plans. The goal is to reach a mutual understanding and agreement on the best course of action.
5. **Decision:** Following the discussion, TRICARE Prime Demo issues a decision regarding the disputed treatment or service. This decision can be to approve, deny, or modify the original decision.

Important Considerations:

- **Time Frame:** TRICARE Prime Demo aims to complete the peer-to-peer review process within a specific timeframe, typically within a few business days.
- **Documentation:** It's crucial to have detailed medical records and supporting documentation to present during the review.
- **Beneficiary Involvement:** While the review is primarily between the physicians, beneficiaries may be involved to provide additional information or clarify questions.
- **Appeal Rights:** If the outcome of the peer-to-peer review is unsatisfactory, beneficiaries may have the option to appeal the decision through TRICARE Prime Demo's appeals process.

Additional Information: TRICARE Prime Demo can provide specific guidance and assistance with the peer-to-peer review process and the TRICARE website provides detailed information about the appeals process, including peer-to-peer reviews.

TRICARE Prime Demo Beneficiary Rights and Responsibilities

As a TRICARE Prime Demo provider, you are required to respect the rights of our beneficiaries. TRICARE Prime Demo beneficiaries are informed of their rights and responsibilities via their Beneficiary Handbook. The list of our beneficiaries' rights and responsibilities are available at tricare.mil/PatientResources/RightsResponsibilities. All beneficiaries are encouraged to take an active and participatory role in their own health and the health of their family.

An Important Message from TRICARE

Inpatient facilities are required to provide each TRICARE beneficiary with a copy of the *An Important Message from TRICARE* form. This document details the beneficiary's rights and obligations on admission to a hospital. The signed document must be kept in the beneficiary's file. A new document must be provided for each admission.

HIPAA Notice of Privacy Practices

Beneficiaries are notified of TRICARE Prime Demo's privacy practices as required by HIPAA. The Notice of Privacy Practices includes a description of how and when beneficiary information is used and disclosed within and outside of the TRICARE Prime Demo organization. The notice also informs beneficiaries how they may obtain a statement of disclosures or request their medical claim information. TRICARE Prime Demo takes measures across our organization internally to protect oral, written and electronic personally identifiable health information, specifically, protected health information (PHI) of beneficiaries. A copy of the Notice of Privacy Practices can we viewed at https://www.health.mil/Military-Health-Topics/Privacy-and-Civil-Liberties/HIPAA-Compliance-within-the-MHS/Notice-of-Privacy-Practices.

As a provider/covered entity, please remember that you are obligated to follow the same HIPAA regulations as TRICARE Prime Demo and only make reasonable and appropriate uses and disclosures of protected health information for treatment, payment and health care operations.

Please remember that disclosures of a patient's personal health information are permitted for treatment, payment or health care operations in compliance with the HIPAA regulation 45 CFR 164. For example, providers may disclose patient information to CareSource Military & Veterans for quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, or case management and care coordination, among others.

When a patient has a sensitive health diagnosis (e.g., treatment for drug/alcohol use, genetic testing, HIV/AIDS, or sexually transmitted diseases), you should verify if the patient has granted consent to share health information.

Log in to the Provider Portal at **CareSourceMilitary.com** > Login > Provider Portal and search for the TRICARE Prime Demo patient using the "Beneficiary Eligibility" option. A message displays if the patient has not consented to sharing sensitive health information. If the patient has not consented, you may not have access to all the patient's health information on the Provider Portal.

Please encourage your TRICARE Prime Demo patients who have not consented to complete a Beneficiary Consent/HIPAA Authorization Form so that all providers involved in their care can effectively coordinate their care. This form is located on **CareSourceMilitary.com** > Members/Beneficiaries > Tools & Resources > Forms. The Beneficiary Consent/HIPAA Authorization Form can also be used to designate a person who can speak on the patient's behalf. This designated representative can be a relative, a friend, a physician, an attorney or some other person that the patient specifies.

Clinical Quality Management Program

Participation in CQMP

TRICARE Prime Demo's Clinical Quality Management Program (CQMP) results in demonstrable quality improvement in the quality and value of health care provided to beneficiaries, and in the process and services delivered by the contractor. This CQMP is designed to achieve the efficient and effective

provision of timely access to high quality, high value health care. Network providers are expected and encouraged to participate in TRICARE Prime Demo's CQMP.

Quality Management/Quality Improvement Program

CareSource Military & Veterans is dedicated to delivering high-quality care and services to its beneficiaries through its Quality Management (QM)/Quality Improvement (QI) program. This program focuses on improving health outcomes, optimizing processes, and ensuring the highest level of care for beneficiaries. TRICARE Prime Demo leverages managed care best practices to address the unique needs of the military community, helping beneficiaries navigate healthcare complexities, maximize benefits, and maintain continuity of care.

TRICARE Prime Demo's QM/QI program aims to improve health outcomes, streamline processes, promote consistency in care, identify care barriers, and apply Continuous Quality Improvement (CQI) principles. The program covers both administrative and clinical services, ensuring responsiveness to beneficiary needs, provider feedback, healthcare best practices, industry standards, and regulatory requirements.

Health Effectiveness Data and Information Set (HEDIS)

TRICARE Prime Demo uses HEDIS as one measure to determine the quality of care delivered to beneficiaries. HEDIS is one of the most widely used means of health care measurement in the United States. HEDIS is developed and maintained by NCQA. The HEDIS tool is used by America's health plans to measure important dimensions of care and service and allows for comparisons across health plans in meeting performance measures and HEDIS benchmarks. HEDIS measures are based on evidence-based research and address significant health priorities in the United States. TRICARE CPD aspires to improve the health of CPD beneficiaries and envisions CareSource Military & Veterans and our network providers to work together to improve HEDIS scores.

Patient Safety Program

CareSource Military & Veterans prioritizes patient safety as a fundamental aspect of high-quality healthcare, aiming to reduce avoidable harm. The program evaluates safety trends through retrospective reviews of Potential Quality Issue (PQI) concerns and real-time claims data. Continuous monitoring, regulatory adherence, and improvement plans are key components. Case analysis helps identify and address risks via Performance Improvement Plans (PIPs) or Corrective Action Plans (CAPs).

Quality of Care Reviews

CSMV investigates PQIs, such as inappropriate treatment or delays in care, to ensure safe and high-quality care. The organization requests medical records from providers to assess PQIs, ensuring compliance with policies and contracts, that allow the use of protected health information for quality reviews.

Provider Advisory Committee (PAC)

The PAC facilitates collaboration between healthcare providers and CSMV staff to address challenges, share information, and improve care delivery. The committee reviews PQIs, safety, and welfare data and participates in quality care discussions. The committee makes recommendations, including initiating Provider PIPs or CAPs, and may refer issues to the Credentialing Committee.

Clinical Practice Guidelines (CPGs)

CSMV adopts evidence-based CPGs to guide providers in delivering quality care. These guidelines are accessible to providers and beneficiaries. CPGs are updated quarterly and focus on chronic diseases, preventive health measures, and screenings for both medical and behavioral health. They are reviewed and approved by the PAC.

Access Standards

CareSource Military & Veterans has a comprehensive quality program to help ensure our beneficiaries receive the best possible health care services. It includes evaluation of the availability, accessibility and acceptability of services rendered to patients by participating providers.

CareSource Military & Veterans expects network to have procedures in place to see patients within these time frames and to offer 8 a.m. to 7 p.m. Monday through Friday to their TRICARE Prime Demo patients that are no less (in number or scope) than the 8 a.m. to 7 p.m. Monday through Friday offered to non-TRICARE Prime Demo beneficiaries.

Please keep in mind the following access standards for differing levels of care.

Primary Care Managers

Type of Visit	Should be seen…
Emergency needs	Immediately upon presentation
Urgent care	Not to exceed 24 hours
Regular and routine care	Not to exceed 1 week
Well-patient visit	Not to exceed 4 weeks

For Primary Care Managers (PCMs) only: Provide 24-hour availability to your TRICARE Prime Demo patients by telephone. Whether through an answering machine or a taped message used after hours, patients should be given the means to contact their PCM or a back-up provider to be triaged for care. **It is not acceptable to use a phone message that does not provide access to you or your back-up provider and only recommends emergency room use for after hours.**

Non-Primary Care Managers (Specialists)

CareSource Military & Veterans is committed to maintaining compliance with the TRICARE access to care standards described in 32 CFR 199.17(p)(5).

Type of Visit	Should be seen…
Emergency needs	Immediately upon presentation
Regular and routine care	Not to exceed 4 weeks

Behavioral Health Providers

Type of Visit	Should be seen…
Emergency needs	Immediately upon presentation
Non-Life-Threatening Emergency	Within 6 hours
Urgent care*	Not to exceed 48 hours
Initial visit for routine care	Not to exceed 10 business days

*A beneficiary should be seen as expeditiously as the beneficiary's condition warrants based on severity of symptoms.

It is expected that if a provider is unable to see the beneficiary within the appropriate time frame, CareSource Military & Veterans will facilitate an appointment with a network or a non-network provider, if necessary.

Services included in the TRICARE contract must be available 24 hours a day, seven days a week, when medically necessary. Providers may find information about medically necessary services that must be available 24/7 by visiting **CareSourceMilitary.com** > Tools & Resources > Provider Policies.

For the best interest of our beneficiaries and to promote their positive health care outcomes, CareSource Military & Veterans supports and encourages continuity of care and coordination of care between medical care providers as well as between medical care providers and behavioral health providers.

Advance written notice of status changes, such as a change in address, phone, or adding or deleting a provider to your practice helps us keep our records current and are critical for claims processing. Additionally, it ensures our directories are up-to-date, and reduces unnecessary calls to your practice.

CareSource Military & Veterans continually assesses and analyzes the quality of care and services offered to our beneficiaries. This is accomplished by using objective and systematic monitoring and evaluation to implement programs to improve outcomes.

Identifying Beneficiary Abuse and Neglect

Given the diverse populations we serve, as an TRICARE Prime Demo provider, there is great potential for victims of abuse and neglect to encounter you or your facility. It is important to recognize the signs of abuse and neglect and to know what to do when you suspect an issue.

Required Training

TRICARE Prime Demo requires all providers to receive and attest to receiving abuse, neglect, and exploitation training. To attest to receiving this training, please visit https://www.healthplanresources.com/learn.

Abuse and Neglect Education: The National Children's Advocacy Center provides helpful information for providers caring for children. Resources can be found on their website at nationalcac.org. The U.S. Department of Justice offers information for providers caring for elderly patients. Resources can be found on their website at ojp.gov/feature/elder-abuse/training.

Reporting

TRICARE Prime Demo requires all staff and providers to report adverse incidents to the TRICARE Prime Demo Abuse Hotline at 1-800-962-2873 for Florida, or to contact Beneficiary Services at **1-833-230-2080**. Reporting should occur immediately but not more than 24 hours after the incident in known. Reporting should include:

- Beneficiary's identity
- Description of the incident
- Status of the beneficiary

For beneficiaries who present with an immediate health and/or safety concern, our case managers will arrange to move or transition to a provider of the beneficiary's choice to ensure the beneficiary's safety and well-being.

All information related to the suspected abuse, neglect, or harm, including the reporting of such, must be kept separately and confidentially from the beneficiary's case file. Such file shall be made available to the Agency upon request. Any quality-of-care (QOC) issues should be reported to our Quality Management department.

Mandated Reporters

State law requires certain professionals to report abuse or evidence of abuse. These professionals may also be referred to as "mandatory reporters." The below list provides descriptions of mandatory reporters for the relevant state:

- Physicians, osteopaths, medical examiners, nurses, or hospital personnel
- Other healthcare or mental health professionals
- Practitioners who rely solely on spiritual means for healing
- Teachers or other school officials or personnel
- Social workers, daycare center workers, or other professional childcare, foster care, residential, or institutional workers
- Law enforcement officers or judges
- Animal control officers

Key Contract Provisions

This section outlines key components of your contract. These key components strengthen our partnership with you and enable us to meet or exceed our commitment to improve the health care of the underserved. We appreciate your cooperation in carrying out our contractual arrangements and meeting the needs of underserved consumers.

Additional Provider Responsibilities

Network providers are expected to treat beneficiaries with respect. TRICARE Prime Demo beneficiaries should not be treated any differently than patients with any other health care insurance. Please reference our "Beneficiary Rights & Responsibilities" section.

Network providers are responsible for providing CareSource Military & Veterans with advance written notice of any intent to terminate an agreement with us. A 60-day notice is required if you plan to close your practice to new patients. If we are not notified within this time period, you will be required to continue accepting TRICARE Prime Demo beneficiaries for a 60-calendar day period following notification.

For PCMs only:

- Provide 24-hour availability to your TRICARE Prime Demo patients by telephone. Whether through an answering machine or a taped message used after hours, patients should be given the means to contact their PCM or a back-up provider to be triaged for care. It is not acceptable to use a phone message that does not provide access to you or your back-up provider and only recommends emergency room use for after hours.

- Be available to see beneficiaries at least three days per week for a minimum of 20 hours per week, or any combination of visits at no more than two locations.
- Provide beneficiaries telephone access to the PCM (or appropriate designate) in English and Spanish 24/7.

These are just a few of the specific terms of our agreement. In addition, we expect providers to follow standard practice procedures even though they may not be spelled out in our provider agreement.

For example:

- Network providers, or their designee, are expected to make daily visits to their patients who have been admitted as inpatient to an acute care facility or arrange for a colleague to visit.
- PCMs are expected to have a system in place for following up with patients who miss scheduled appointments.

Timeline of Provider Changes

Type of Visit	Notice Required (Please notify TRICARE Prime Demo of the change prior to the time frames listed below)
New providers or deleting providers	30 business days
Providers leave the practice	30 business days
Phone number change	30 business days
Address change	30 business days
Change in capacity to accept beneficiaries	30 business days
Intent to terminate Provider Agreement	90 calendar days

Why is it Important to Give Changes to TRICARE Prime Demo?

This information is critical to process your claims. In addition, it ensures our provider directories are up-to-date and reduces unnecessary calls to your practice. This information is also reportable to TRICARE.

Marketing Activities and Standards

Only with approval from the DHA Communications Division is TRICARE Prime Demo allowed to distribute marketing materials related to TRICARE CPD. Examples include displaying posters or other materials in common areas, such as a waiting room, advertisements announcing affiliations between providers and a specific plan.

It is important to note the following guidelines.

The TRICARE Prime Demo TRICARE CPD program may not permit providers to:

- Offer marketing/appointment forms.
- Make phone calls or direct, urge, or attempt to persuade potential enrollees to enroll or enrollees to remain enrolled in TRICARE Prime Demo based on financial or any other interests of the provider.
- Mail marketing materials on behalf of TRICARE Prime Demo.
- Offer anything of value to retain enrollees or persuade potential enrollees to select them as their provider or to enroll in a particular plan.
- Accept compensation directly or indirectly from CareSource Military & Veterans for marketing activities.

Americans with Disabilities Act (ADA) Standards:

Additionally, providers will remain compliant with ADA standards, including but not limited to:

- Utilizing waiting room and exam room furniture that meet needs of all enrollees, including those with physical and non-physical disabilities
- Accessibility along public transportation routes, and/or provide enough parking
- Utilizing clear signage and way finding (e.g., color and symbol signage) throughout facilities

For more information on these ADA standards and how to be compliant, please see the ADA section of this manual.

Fraud, Waste and Abuse

Health care fraud, waste and abuse hurts everyone, including beneficiaries, providers, taxpayers and TRICARE Prime Demo. As a result, TRICARE Prime Demo has a comprehensive Fraud, Waste and Abuse program in our Program Integrity department. Please help us by reporting questionable activities and potential fraud, waste and abuse situations. You can find more information, education and examples on fraud, waste and abuse online at **CareSourceMilitary.com**.

Options for reporting anonymously:

- Call: 1-833-230-2170 and follow the appropriate menu option for reporting fraud
- Write: TRICARE Prime Demo
  Attn: Program Integrity
  P.O. Box 1940
  Dayton, OH 45401-1940

Options for reporting that are not anonymous:

- Fax: 800-418-0248
- Email: Fraud@CareSource.com

Or you may choose to use the Fraud, Waste and Abuse Reporting Form located on **CareSourceMilitary.com** > Providers > Tools & Resources > Forms.

When you report fraud, waste, or abuse, please give as many details as you can, including names and phone numbers. You may remain anonymous, but if you do, we will not be able to call you back for more information. Your reports will be kept confidential to the extent permitted by law. Thank you for helping CareSource Military & Veterans keep fraud, waste and abuse out of health care.

*Most email systems are not protected from third parties. Please do not use email to send confidential information. If you will be sending confidential or health information, please use the form or phone number to report your concerns to help protect your privacy.

Thank you for helping CareSource Military & Veterans keep fraud, waste, and abuse out of health care.

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