July 2018: West Region Transition Provider Issues

Frequently Asked Questions

Issue: Primary Care Manager (PCM) Changes

Question	Answer
Why did Health Net Federal Services, LLC (HNFS) remove patients from PCM rosters?	TRICARE Prime enrollees are required to seek all primary care from PCMs who are TRICARE-authorized providers in the TRICARE network. Following TRICARE Prime guidelines, HNFS is ensuring Prime enrollees are appropriately assigned to providers in the TRICARE network.
Why am I not a PCM in the HNFS network when I was one in UnitedHealthcare Military & Veterans' (UnitedHealthcare) network?	Providers in UnitedHealthcare's West Region network did not automatically transfer to HNFS' West Region network. HNFS is required to conduct a credentials review on each network provider to determine if the provider meets the minimum requirements of the Defense Health Agency, HNFS and URAC. HNFS reached out to UnitedHealthcare's network providers beginning in September 2016 to encourage them to start the credentialing process with HNFS, as this process can take up to 90 days to complete.
I completed the HNFS credentialing process but still am not listed in the network directory. Why?	HNFS experienced a delay in moving provider data from its provider data repository to the network directory due to a change in requirements of provider elements needed (such as Social Security number). This resulted in a workaround to what would normally be an automated process. HNFS is working daily to ensure providers get loaded properly and timely. We encourage beneficiaries and providers to check the directory often, as updates are made daily.
If I join the HNFS network, will my patients be reassigned back to me?	Beneficiaries who are part of HNFS' automatic enrollment reversal efforts in July 2018 will be assigned back to their PCM with a June 30, 2018, effective date (or the date the provider contract was signed, if after June 30). Beneficiaries will receive PCM change letters once the reassignment is complete. The original UnitedHealthcare PCMs will be contacted by HNFS via provider relations representative outreach notifying them of the patient panel move. Outside of the automatic enrollment reversal efforts in July 2018, beneficiaries can request a PCM change back to you with an effective date no earlier than the start of your contract with HNFS (other date limitations may apply). Keep in mind back-dated enrollment could impact claims processing and should be taken into consideration with any retro-PCM change request.
Will my TRICARE Prime patients be charged Point of Service (POS) if they continue to see me?	As part of the TRICARE contract transition, DHA allowed TRICARE Prime beneficiaries to seek care from their UnitedHealthcare PCMs without incurring additional POS fees. This allowed HNFS additional time to contract providers and develop the TRICARE network. As of July 1, 2018, PCM assignments have completed and TRICARE Prime enrollees must seek care from their assigned PCM. Referral guidelines will be enforced and POS charges will be applied as appropriate. Keep in mind, if a beneficiary sees a network PCM provider type who is not his/her assigned PCM, the claim will process the same as if the beneficiary went to urgent care (POS will not apply).

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Issue: Point of Service Deviation

Question	Answer
My patients weren't charged POS when they saw me before. Why are they now?	As part of the TRICARE contract transition, DHA allowed TRICARE Prime beneficiaries to seek care from their UnitedHealthcare PCMs without incurring additional POS fees. This allowed HNFS additional time to contract providers and develop the TRICARE network. As of July 1, 2018, PCM assignments have completed and TRICARE Prime enrollees must seek care from their assigned PCM. Referral guidelines will be enforced and POS charges will be applied as appropriate. Keep in mind, if a beneficiary sees a network PCM provider type who is not his/her assigned PCM, the claim will process the same as if the beneficiary went to urgent care (POS will not apply).
I have a valid authorization from UnitedHealthcare, but my patient chose to see a different doctor of the same specialty. Will he/she be charged POS?	HNFS continues to honor referrals/authorizations from UnitedHealthcare through their expiration dates. Some beneficiaries choose to see providers of the same specialty, rather than the providers listed on their approval from UnitedHealthcare. Due to the POS deviation, prior to July 1, 2018, these beneficiaries were not charged POS, even if the doctor was not in the HNFS network. As of July 1, 2018, TRICARE Prime patients will not be charged POS if they are seeking care under a valid UnitedHealthcare authorization and the doctor is not in the HNFS network. But, if they choose to see a different doctor than the one approved, Prime guidelines will be enforced. That doctor must be part of the HNFS to avoid POS costs.

Issue: West Region Provider Network Directory Accuracy

Question	Answer
Why am I not a PCM in the HNFS network when I was one in UnitedHealthcare's network?	Providers in UnitedHealthcare's West Region network did not automatically transfer to HNFS' West Region network. HNFS is required to conduct a credentials review on each network provider to determine if the provider meets the minimum requirements of the Defense Health Agency, HNFS and URAC. HNFS reached out to UnitedHealthcare's network providers beginning in September 2016 to encourage them to start the credentialing process with HNFS, as this process can take up to 90 days to complete.
Why is it taking so long for providers to be credentialed?	The credentialing process on average takes 60–90 days. HNFS is currently averaging a 20-day turnaround time on credentialing providers from the time of submission of a completed application.
I completed the HNFS credentialing process but still am not listed in the network directory. Why?	HNFS experienced a delay in moving provider data from its provider data repository to the network directory due to a change in requirements of provider elements needed (such as Social Security number). This resulted in a workaround to what would normally be an automated process. HNFS is working daily to ensure providers get loaded properly and timely. We encourage beneficiaries and providers to check the directory often, as updates are made daily.
If a patient relies on the directory data and seeks care from a physician they believe to be network, but turns out to be non-network, will HNFS process the claim based on the directory data at the time of service?	The claim will process based upon what is in the provider database at the time the claim is processed. Beneficiaries or providers who believe a claim processed incorrectly may request a claims review within 90 calendar days of the date on the provider remittance or beneficiary Explanation of Benefits.

Issue: Challenges related to provider contracting and credentialing

Question	Answer
HNFS used various vendors to assist with its network contracting efforts. One of these vendor contracts terminated in August 2017. What was the impact?	We are aware that some contracts and or credentialing packets have been delayed due to the vendor change. We are currently reviewing all provider contract and credentialing applications received that have not yet completed and working to expedite those through completion.
Is HNFS able to obtain any of the contracting information from the previous contracting vendor?	Yes. The previous vendor provided HNFS with its files.
If a physician has documentation to support he/she was in process with one of the contracting vendors, will HNFS accept that as proof and expedite the completion of the process?	Yes. HNFS can assist with expedited processing, but HNFS must have a completed contract and credentialing documents from the provider.
Can the effective date of the contract be back-dated to ensure the physician is paid for services he/she provided during the period where he/she reasonably believed he/she was in network?	URAC rules do not allow for back-dating prior to completion of credentialing. Claims are processed per TRICARE guidelines.
Will HNFS honor the date the contract was counter-signed by the provider, assuming he/she has a copy to share with HNFS?	If a provider has a copy of a fully executed contract, HNFS will review and take appropriate action. Keep in mind, the credentialing process must complete before a provider under the contract can be deemed in-network.
How can providers check credentialing status?	Providers can check their credentialing status online at **www.tricare-west.com** > *Provider* > *Public Tools* > *Check Credentialing Status*. If they need assistance beyond what the online tool provides, they should contact our call center at **1-844-866-WEST**.
What is the current contracting turnaround time (start to finish)?	The credentialing process on average takes 60–90 days. HNFS is currently averaging a 20-day turnaround time on credentialing providers from the time of submission of a completed application.
How will claims pay if beneficiary sees a non-network provider that is part of a network group?	The claims will pay as network. TRICARE Prime rules apply.

Issue: West Region providers who do not meet the requirements to be a TRICARE-authorized provider

Question	Answer
I've been notified by HNFS that I don't qualify as a non-network TRICARE authorized provider? Why? My claims paid when UnitedHealthcare was the West Region contractor.	TRICARE-authorized providers must meet specific licensing and certification requirements, and be certified by TRICARE to provide care under the TRICARE program. HNFS is obligated to attest providers meet the requirements at the time of their credentialing and process subsequent claims from those providers according to TRICARE guidelines.

Issue: Prime Referral Waiver/Care valid through June 30, 2018

Question	Answer
How do we determine referral/authorization effective dates for those issued during the waiver period?	The waiver approval letter allowed for care through June 30, 2018 (or through postpartum care for outpatient maternity referrals). For care referred during the waiver period that extends beyond June 30, 2018, providers must submit a request to HNFS for approval (for TRICARE Prime patients, if approval is required).
Will HNFS' online tools reflect referrals and authorizations issued during the waiver period?	Except for ABA, LDT and ECHO services, HNFS' online tools at www.tricare-west.com will not reflect referrals/orders for outpatient services given to TRICARE beneficiaries by civilian and military providers during the waiver period. The TRICARE West Region Referral Waiver Approval Letter is your verification of approval.
What happens if I continue with my treatment beyond June 30, 2018, and I don't have an approval from HNFS?	TRICARE Prime beneficiaries who seek specialty care without an approved referral from HNFS are subject to higher POS costs. Not all specialty care requires a referral. HNFS offers a Prior Authorization, Referral and Benefit tool at www.tricare-west.com to help you understand Prime referral guidelines.
Why does HNFS issue approvals for "evaluate and treat" only? What about the related services, such as testing?	We authorize the evaluation and treat codes only, as many diagnostic tests do not require an authorization. If additional services are needed that require an authorization, the servicing provider should request approval for the needed codes. Providers can use the Prior Authorization and Benefit Tool and the Benefits A-Z pages at www.tricare-west.com to determine prior authorization requirements.

Issue: Increased copayments/cost-shares with new contract

Question	Answer
Why does HNFS charge more than UnitedHealthcare for specialty care?	TRICARE copayments/cost-shares are determined by the Defense Health Agency, and not the regional contractors who administer the program. HNFS must adhere to the program guidelines defined in the TRICARE manuals.
Why did the copays change?	TRICARE cost changes vary and may change annually. Near the end of 2017, with the help of several military and veteran service organizations, DHA was able to recalculate and correct costs before Jan. 1, lowering 2018 patient costs for several types of care by $3 to $8. Other costs increased, like the retiree specialty mental health outpatient copayment, which changed from $12 to $30. As always, TRICARE costs depend on plan type and beneficiary status (for example, active duty family member or retiree). To make managing your health costs more predictable and transparent, DHA introduced more copayments (versus cost-shares) under the new TRICARE Select program when using a TRICARE network provider.

Issue: Online-only authorization/referral notifications and individual EOBs

Question	Answer
Can a beneficiary opt out of receiving referral and authorization notices online?	This option is not available as HNFS must adhere to the TRICARE program guidelines defined in the TRICARE manuals.
What if my patient doesn't have internet access?	TRICARE beneficiaries may contact HNFS' customer service department to request an individual authorization or referral notice be mailed to them, or they can ask their provider for a copy. They must do this for each referral/authorization determination letter needed. However, they can request monthly EOB summaries be mailed to them.