Humana Military | TRICARE®

TRICARE provider news

Up-to-the-minute information for TRICARE® providers in the East Region

ISSUE #4 | 2025

Supporting your patients with chronic care management

Humana Military offers a free disease management program for eligible beneficiaries. This program features an experienced disease management clinician who helps beneficiaries improve their self-care, reduce the risk of disease progression and support prevention and wellness strategies for targeted conditions, such as:

- Asthma
- Coronary Artery Disease (CAD)
- Congestive Heart Failure (CHF)
- Diabetes
- Anxiety
- Depression

The program provides:

- A dedicated disease management clinician, who is knowledgeable about chronic condition management, and can provide one-on-one support about chronic condition management, treatment adherence and prevention and wellness information.
- Motivational coaching to encourage the beneficiary to set health goals and focus on improvements in quality of life and whole health outcomes.
- Healthcare navigation and resource education to close knowledge deficits, and address treatment barriers and gaps in non-medical factors that influence an individual's health and well-being.

The program also offers beneficiaries an opportunity to register for the live, educational webinars or take advantage of the library of on-demand webinars found on TRICARE.mil/East.

Please encourage your TRICARE patients to learn more about this program on TRICARE.mil/eastdm or call a disease management clinician at (800) 881-9227. You can also send us a care management referral form, which you can find in provider self-service.

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Important update to TRICARE coverage of weight loss medications

As of August 31, 2025, the Defense Health Agency (DHA) has implemented regulatory controls that affect how TRICARE covers weight loss medication. TRICARE only covers these medications for TRICARE Prime and Select when obesity is the sole or major condition treated. As a reminder:

- Beneficiaries with TRICARE Prime or Select are still covered with a previously approved prior authorization.
- Beneficiaries NOT enrolled in TRICARE Prime or Select, who previously had an approved prior authorization for weight loss drugs, are no longer covered as the prior authorization is no longer valid. They'll need to see their provider to discuss their options.

Glucagon-Like Peptide 1 (GLP-1) for the treatment of type 2 diabetes continues to be covered for all beneficiaries with a diagnosis of diabetes when prior authorization requirements are met. Cost-shares for these medications remain unchanged.

Please note: Certain prescriptions require prior authorization. Beneficiaries may need prior authorization for a prescription if it:

- Is specified by the Department of Defense (DoD) Pharmacy & Therapeutics Committee
- Is a brand-name prescription drug with a generic substitute
- Has age limits
- Is prescribed for an amount more than the normal limit

To learn more and see a list of impacted groups, check out this article, "TRICARE Coverage of Weight Loss Medications: What To Know."

Check prescription drug cost and coverage on the TRICARE Formulary Search Tool which contains a list of generic and brand-name prescription drugs we cover. TRICARE covers most prescription drugs approved by the US Food and Drug Administration.

BetterDoctor® information: A tool to enhance accuracy in TRICARE East directories

BetterDoctor® is a tool from Quest Analytics® that helps providers keep their directory information accurate with less effort. By checking your data, you make sure TRICARE East beneficiaries get timely and accurate information. This saves you time so you can focus more on caring for your patients.

Please review the information and resources below to help you with this new platform:

- Humana Military network providers will receive a request via email, fax, direct mail and/or phone to verify their information every 90 days. Email requests will come from validation@betterdoctor.com.
- After verifying the first time, your information will automatically save, making ongoing verification a seamless process.
- Groups of 20+ providers, or five or more facility locations, will have the option to attest by roster instead of updating providers individually in the BetterDoctor® portal, saving time and improving accuracy.
- General BetterDoctor® FAQs
- Roster Solution FAQs
- Contact the BetterDoctor® support team at support@betterdoctor.com or (844) 668-2543, Monday-Friday, 8 AM – 5 PM CT.

Visit the TRICARE formulary search tool to learn more about copayment and coverage details for your medication or view the specialty drug list to see TRICARE-eligible specialty medications.

If you have additional questions about home delivery, visit the Home Delivery page or contact us at (877) 363-1303.

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Reminder: Medical record submission requirements for Autism Care Demonstration (ACD) audits

As a reminder, participation in our audit process is a contractual requirement of the TRICARE Operations Manual (TOM) which states that the contractor is required to conduct an annual audit that includes a minimum of 30 records for each Applied Behavior Analysis (ABA) service provider/sole provider group. This audit must consist of a combination of administrative records and medical documentation review [1].

If a provider fails to submit adequate medical records during this audit, the contractor shall recoup all claims determined to be insufficient per supporting documentation for claims payment [1].

If no records are submitted for a required audit, the provider will be placed on noncompliant prepayment review and all requested claims for that audit will be submitted for recoupment [2].

1: Chapter 18 - Department Of Defense (DoD) Comprehensive Autism Care Demonstration (ACD) - TOM 6010.62-M, April 2021 8.9-8.9.8

2: Chapter 13 - Anti-Fraud Controls And Contractor Actions - TOM 6010.62-M, April 2021 3.4-3.8.1

Make sure your appeals process correctly!

We've found some appeals are being sent to the wrong location, delaying the resolution process. To more accurately and efficiently process appeals requests, please ensure you are sending the correct appeals to the correct location.

Appeals and allowable charge reviews are different types of requests related to denials and payment amounts. To more accurately and efficiently process these types of requests, we've provided clarity on the definitions of each and where written requests should be submitted.

Find out more about appeals processing.

Claims processing and payment—no need to resubmit

We are experiencing delays in processing times for claims payments. We understand how important timely and accurate claim processing is to your practice. Please be assured that if your claims were impacted by the issues described below, you do not need to resubmit claims or supporting documentation—we are actively working on corrections to process the claims as quickly as possible.

Certificate of Medical Necessity (CMN): Due to an influx of submissions, we are experiencing a delay in processing CMNs. Please allow up to 90 days before resubmitting duplicate documentation. This gives us time to process the forms and make any needed corrections to the claims.

Claims without medical records: Claims that were submitted without supporting medical record documentation are being delayed due to a removal of claims from the system. Please allow up to 90 days from the date you submitted the claims before submitting any duplicate documentation.

Returned checks: Some providers may have experienced return payments due to an error in provider data. We are actively reissuing these payments. If you enroll, or are enrolled, in Electronic Funds Transfer (EFT), electronic payments will be sent electronically in 30 days. Providers not enrolled in EFT will still receive reissued payments automatically, no action is required.

We understand these delays may cause inconvenience, and we truly appreciate your patience and understanding as we work to complete all requests.

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New code editing rules for diabetic supply codes

Providers must indicate if the supply code is for insulin-dependent or non-insulin-dependent types when submitting claims. The modifier KX (insulin) or KS (non-insulin) is used to distinguish between the two. While the modifier requirement is unique to Medicare, the allowed frequencies are based on industry standard packaging practices and derived from various health plan policies.

Please see the below codes for reference:

KX – (insulin)
KS – (non-insulin)

For example, with a traditional tethered insulin pump, you will need to change the infusion set (which includes the needle) every two to three days. This means you will need approximately 10 to 15 sets per month. Tubeless pumps, such as the Omnipod, also require a new set every two to three days.

The HCPCS code, A4230, refers to "Infusion set for external insulin pump, non-needle cannula type." This code does not specify a particular manufacturer or packaging, so the number of infusion sets per box may vary by supplier and product brand. Most commercial infusion set boxes contain 10 sets per box.

TRICARE Coverage of Chemotherapy Drugs

This change removes outdated information and clarifies that chemotherapy drugs, including paclitaxel, are covered. This change is consistent with FDA-labeled indications, or off-label use. It's also consistent with the National Comprehensive Care Network recommendations for the treatment of cancer.

See more at: TRICARE Policy Manual (TPM), Ch. 7, Sec 16.3

Check us out on Facebook!

Be sure to follow us on Facebook to get all the latest from Humana Military and TRICARE East: Facebook.com/HumanaMilitary

Digital Breast Tomosynthesis for Breast Cancer Screening

TRICARE recently updated its policy to remove frequency limitations and make digital breast tomosynthesis, also known as DBT or 3D mammography, a covered clinical preventive services benefit for breast cancer screening for eligible TRICARE beneficiaries.

Screening mammography, whether digital mammography or Digital Breast Tomosynthesis (DBT) (3D mammography), is covered for all persons assigned female at birth between the ages of 40 and 74 who are at an average or increased risk of breast cancer. The frequency of breast cancer screening may be at the discretion of the patient and the clinician; however, screening mammography should not be performed less frequently than once every two years. For patients 75 and older, screening mammography will be at the discretion of the patient and physician.

See more at: TRICARE Policy Manual (TPM), Ch. 7, Sec. 2.1.

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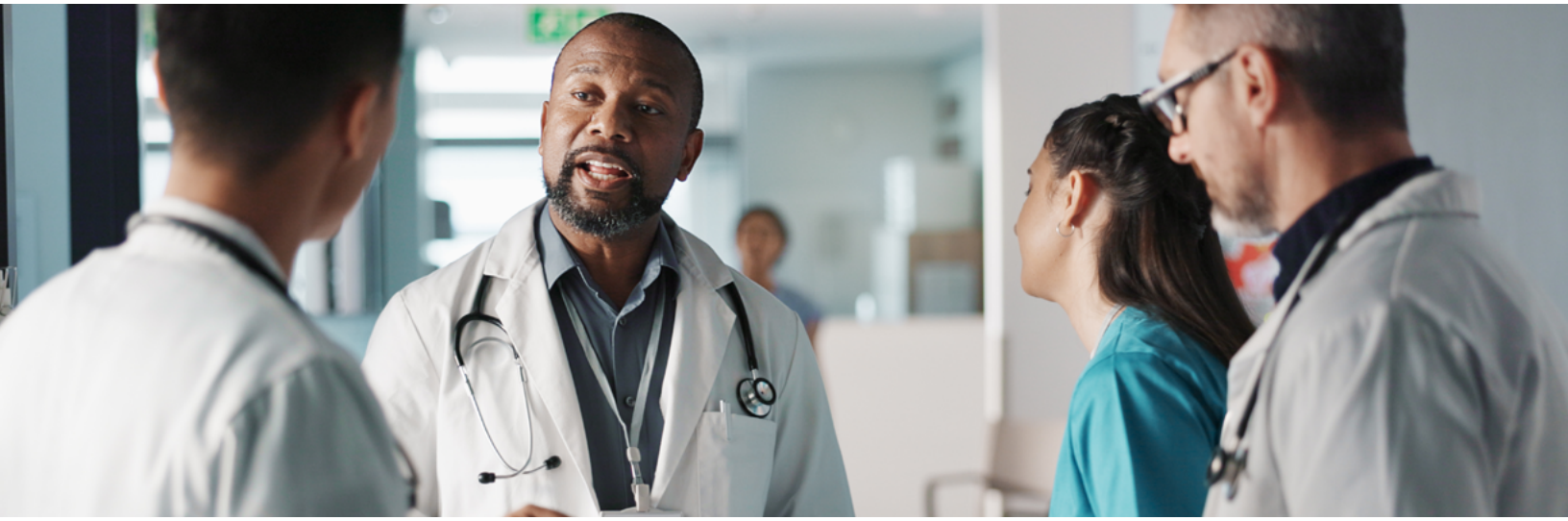

TRICARE Prime and TRICARE Select HIV Pre-Exposure Prophylaxis (PrEP)

This change allows cost-sharing of Pre-Exposure Prophylaxis (PrEP) for the prevention of HIV as a covered preventive care service for TRICARE Prime and Select beneficiaries.

HIV PrEP: Provide FDA-approved AntiRetroviral Therapy (ART) as PrEP for the prevention of HIV acquisition to:

- Sexually active adults and adolescents who weigh at least 35 kilograms (77 pounds) who do not have HIV and are at an increased risk of HIV; and
- Persons who inject drugs and share injection equipment or have a drug-injecting partner who has HIV.

Persons who are prescribed PrEP should receive regular HIV screening and risk reduction counseling at the following intervals:

- At one month and three months after starting medication, then every three months, if prescribed daily, oral medications Tenofovir Disoproxil Fumarate/ Emtricitabine (TDF/FTC) or Tenofovir Alafenamide/ Emtricitabine (TAF/FTC);
- At one month and two months after starting medication, then every other month, if given the injectable cabotegravir.

Note: PrEP services shall be provided and cost-shared in accordance with United States Preventive Services Task Force guidelines as they are updated.

See more at: TRICARE Policy Manual (TPM), Ch.7, Sec 2.2.

Recent CPT code changes to covered and excluded services

TRICARE made changes to CPT codes that are newly covered or excluded. Please review the following code updates and implement their use in claims.

New coverage

CPT codes 98012-98016

Telephonic office visits have been added to coverage with these specifications: The provider must be TRICARE authorized and hold the visit via telephone call with a beneficiary who is an established patient. The visit must be for covered, medically necessary and appropriate care which does not require face-to-face, hands-on treatment or visual evaluation (e.g., evaluation of a skin lesion or intensive outpatient programs).

CPT code 0932T

Noninvasive heart failure detection is covered to confirm diagnosis of Heart Failure with Preserved Ejection Fraction (HFpEF) when augmentative analysis of an echocardiogram demonstrated preserved ejection fraction.

CPT codes 38225-38228

Chimeric Antigen Receptor T-cell (CAR-T) cell therapy for is now covered.

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Code replacement

CPT code 61715 replaced 0398T

Unilateral thalamotomy using Magnetic Resonance Image Guided Focused Ultrasound Surgery (MRgFUS) for treatment of medication-refractory essential tremor may be covered. It must be provided with Food and Drug Administration-approved (FDA-approved) devices and in accordance with the American Society for Stereotactic and Functional Neurosurgery (ASSFN) coverage criteria.

Clarification

CPT codes 77046-77047

Breast MRI are covered for the following indications, which is not inclusive:

- To detect breast implant rupture if the implantation procedure was, or would have been, covered by TRICARE (e.g., related to a covered mastectomy and reconstruction and not a solely cosmetic procedure)
- For detection of occult breast cancer in the setting of axillary nodal adenocarcinoma with negative physical exam and negative mammography
- For presurgical planning of locally, advanced breast cancer (before and after completion of neoadjuvant chemotherapy) to permit tumor localization and characterization
- For presurgical planning to evaluate the presence of multicentric disease in patients with localized or locally, advanced breast cancer who are candidates for breast-conservation treatment
- To evaluate suspected cancer recurrence
- To determine the presence of pectoralis major-/minor- muscle, chest-wall invasion in patients with a posteriorly located tumor
- For guidance of interventional procedures such as vacuum-assisted biopsy and preoperative wire localization for lesions that are occult on mammography or sonography and are demonstrable only with MRI

Other indications may be covered when Humana Military determines it to be medically necessary and appropriate.

Exclusions

CPT codes 77046-77047

MRIs are excluded from coverage for the following indications:

- To screen for breast cancer in asymptomatic women considered to be at low or average risk
- For diagnosis of suspicious lesions to avoid biopsy
- To evaluate response to neoadjuvant chemotherapy
- To differentiate cysts from solid lesions
- To assess implant integrity or confirm implant rupture, if implants were not originally covered or coverable

CPT code 77058

MRIs are excluded for assessment of implant integrity or to confirm implant rupture, if implants were not originally covered or coverable.

CPT codes 77048-77049

Computer-Aided Detection (CAD) with breast MRI is unproven and excluded from coverage.

CPT code 96041

Medical genetics and genetic counseling services (30 minutes) from genetic counselors who are not TRICARE-authorized providers are excluded from coverage.

New covered treatment for hypertrophic scarring and keloids.

Treatment for hypertrophic scarring and keloids resulting from burns, surgical procedures or traumatic events is covered as cost-share only with evidence of impaired function. Previously, only topical treatments were covered.

See more at: TRICARE Operations Manual (TOM)

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