Chapter 1 Section 16.1

TRICARE Coverage and Payment for Certain Services in Response to the Coronavirus Disease 2019 (COVID-19) Pandemic

Issue Date: December 24, 2020
Authority: 10 USC Chapter 55, Section 1073 (a)(2)

1.0 DESCRIPTION

Changes in TRICARE coverage and payment necessitated by the COVID-19 pandemic.

2.0 POLICY

The Assistant Secretary of Defense (Health Affairs) (ASD(HA)) issued an Interim Final Rule (IFR) with comment in the **Federal Register** on May 12, 2020, temporarily amending the TRICARE regulation to encourage social distancing and prevent the spread of COVID-19 by incentivizing the use of telemedicine services.

The ASD(HA) issued a second IFR with comment in the **Federal Register** on September 3, 2020, temporarily amending the TRICARE regulation to expand the COVID-19 therapies available to TRICARE beneficiaries while doing so in settings that ensure informed consent of the beneficiary, and that the benefits of treatment outweigh the potential risks. This IFR also expands TRICARE coverage of acute care facilities during the COVID-19 pandemic.

The ASD(HA) issued a third IFR with comment in the **Federal Register** on October 30, 2020, temporarily amending the TRICARE regulation to cover National Institute of Allergy and Infectious Disease-sponsored clinical trials for the treatment or prevention of COVID-19. See Chapter 7, Section 24.2.

The ASD(HA) issued a final rule in the **Federal Register** on June 1, 2022, finalizing certain temporary provisions of the IFRs published in 2020 in response to the COVID-19 pandemic. The Final Rule finalized without change the temporary relaxation of state professional licensing requirements (see paragraph 2.2). The Final Rule finalized coverage of temporary hospitals, with modifications (see paragraph 2.4). The Final Rule made permanent coverage of audio-only telephone services (renamed telephonic office visits) (see Chapter 7, Section 22.1).

2.1 Temporary Coverage of Audio-Only Telephone Services

Existing regulations exclude TRICARE coverage of telephone services (audio-only) except for biotelemetry. Given the Centers for Disease Control and Prevention (CDC) guidelines for social distancing and some states governors' orders for residents to stay at home, an exception to the

regulatory exclusion is permitted. TRICARE-authorized providers are allowed to render medically necessary care and treatment to beneficiaries over the telephone, when face-to-face, hands-on treatment is not medically necessary.

2.1.1 Telephone services (audio-only) are not excluded when otherwise covered TRICARE services are provided to a beneficiary through this modality, if the services are medically or psychologically necessary and appropriate.

2.1.2 Telephone services involving evaluation and management visits shall be reported utilizing Current Procedural Terminology[1] (CPT) code 99441-3; 98966-8; Healthcare Common Procedure Coding System (HCPCS) code G2012.

2.1.3 Other authorized telephone services (e.g., psychotherapy services) shall be reported with the appropriate CPT or HCPCS code and with the appropriate modifier or place of service code (e.g., 02) to report that the care was delivered via telephone.

2.1.4 Audio-only care is inappropriate where a visual connection would be required to ensure appropriate medical care; e.g., evaluation of a skin lesion by a dermatologist or intensive outpatient programs.

Note: See TRICARE Reimbursement Manual (TRM), Chapter 2, Section 7 for information on copayments and cost-shares in response to the COVID-19 pandemic.

2.2 Temporary Relaxation of State Professional Licensing Requirements

2.2.1 In the United States, if applicable federal or state law permits providers to operate within a jurisdiction without obtaining a license in that state, services provided to beneficiaries by an otherwise authorized TRICARE provider may be cost-shared if that provider holds an equivalent license from any state in the United States, complies with provisions for interstate practice in the state where the beneficiary is receiving care, and is not affirmatively barred or restricted from practicing in any state in the United States. This temporary change does not supplant state authority to regulate licensure, but assures that if licensure requirements are relaxed by any state or the federal government during the period of the COVID-19 pandemic, that providers caring for TRICARE beneficiaries in compliance with applicable state or federal law will be eligible for reimbursement under TRICARE.

2.2.2 For overseas locations, if the host-nation permits providers to operate within that nation without obtaining a license in that nation, services provided to beneficiaries by a TRICARE-authorized provider may be cost-shared if the provider holds an equivalent license in the nation in which they normally practice and meets all requirements for practice under the host nation.

2.2.3 Providers listed on the Department of Health and Human Services (HHS) sanction list remain ineligible to provide care under TRICARE.

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2.3 Coverage of Treatment Use of Investigational Drugs Under Expanded Access

2.3.1 Treatment use of investigational drugs under expanded access shall be cost-shared under the medical program under the following circumstances:

2.3.1.1 The investigational drug is for the treatment of a serious or life-threatening case of COVID-19 or its associated sequelae.

2.3.1.2 The United States Food and Drug Administration (FDA) has approved the investigational drug for treatment use under expanded access.

2.3.1.3 The investigational drug is administered in a setting approved by the FDA (i.e., individual patient access, emergency individual patient access, intermediate access, and widespread access).

2.3.2 For care provided overseas, drugs without formal marketing approval in a nation are permitted to be cost-shared in that nation when the following conditions are met:

2.3.2.1 Use of the investigational drug is permitted in that nation.

2.3.2.2 The investigational drug is intended to treat a serious or life-threatening case of COVID-19 or its associated sequelae.

2.3.2.3 There is no satisfactory or comparable alternative available.

2.3.2.4 The potential patient benefit justifies the potential risks of treatment use.

2.3.2.5 Providing the investigational drug will not compromise the potential development or interfere with clinical investigations that could support marketing approval of the investigational drug for the use.

2.3.3 Investigational drugs shall not be cost-shared when provided as part of a clinical trial.

2.3.4 Coverage of investigational drugs in this section supersedes the exclusion of treatment investigational new drugs under Chapter 8, Section 9.1.

2.3.5 Coverage of investigational drugs in this section does not apply to drugs administered under the TRICARE Pharmacy program.

2.4 Temporary Hospital Expansion Sites

2.4.1 Temporary hospitals, freestanding Ambulatory Surgical Centers (ASCs), and other entities that enroll with Medicare as hospitals for the duration of Medicare's "Hospitals without Walls" initiative are exempt from certain institutional requirements for acute care hospitals listed in 32 CFR 199.6(b)(4)(i). The contractor shall temporarily change the status of these providers to a hospital status when the provisions of this paragraph 2.4, are met.

2.4.2 Temporary hospitals, including temporary hospital expansion locations such as the patient's home, shall meet the following requirements:

2.4.2.1 Centers for Medicare and Medicaid Services (CMS) must approve the location or site to receive payment for Medicare services.

2.4.2.2 The location or site must meet all criteria required by CMS for Medicare coverage of inpatient or outpatient hospital services.

2.4.3 Freestanding ASCs shall meet the following requirements:

2.4.3.1 Enrollment with and approval by CMS as a hospital. The contractor shall obtain a copy of the facility's approval letter before reimbursing services and supplies.

2.4.3.2 If a freestanding ASC temporarily enrolls as a hospital, but later changes or loses its enrollment status with Medicare, then the contractor shall no longer reimburse that ASC as a hospital, effective on the date of the enrollment status change under Medicare.

2.4.4 Other entities (not including temporary hospitals and freestanding ASCs) shall meet the following requirements:

2.4.4.1 Enrollment with and approval by CMS as a hospital. The contractor shall obtain a copy of the facility's approval letter before reimbursing services and supplies.

2.4.4.2 If an entity other than a temporary hospital or freestanding ASC temporarily enrolls as a hospital, but later changes or loses its hospital enrollment status with Medicare, then the contractor shall no longer reimburse that entity as a hospital, effective on the date of the enrollment status change under Medicare.

2.4.4.3 The contractor shall ensure that services and supplies provided in these facilities are otherwise covered under the TRICARE program.

2.4.4.4 The contractor shall reimburse otherwise covered services and supplies (provided in facilities that meet the requirements in paragraph 2.4) using the existing applicable TRICARE reimbursement methodologies for hospitals.

2.5 Temporary Waiver of Certain Critical Access Hospital (CAH) Participation Requirements

Under 32 CFR 199.6(b)(4)(xvi), CAHs must meet all conditions of participation under 42 CFR 485.601 through 485.645 in relation to TRICARE beneficiaries in order to receive payment under the TRICARE program. If Medicare temporarily waives a condition of participation for CAHs, TRICARE has the legal authority to continue to authorize the CAH as a TRICARE provider as long as Medicare does not revoke the CAH's status as a Medicare provider. TRICARE has exercised this legal authority to recognize Medicare's emergency waiver issued under Section 1135(b) of the Social Security Act (42 United States Code (USC) § 1320b-5), for the following requirements for CAH participation:

- The requirement that CAHs make available 24-hour emergency care services and provide

not more than 25 beds for acute (hospital-level) inpatient care or swing beds used for Skilled Nursing Facility (SNF)-Level care.

- The requirement that CAHs maintain a length-of-stay (LOS), as determined on an annual average basis, of no longer than 96 hours.

2.6 Temporary Waiver of Certain Hospice Participation Requirements

Under 32 CFR 199.6(b)(4)(xiii), Hospice programs must be Medicare approved and meet all Medicare conditions of participation (42 CFR part 418) in relation to TRICARE patients in order to receive payment under the TRICARE program. A hospice program may be found to be out of compliance with a particular Medicare condition of participation and still participate in the TRICARE program as long as the hospice is allowed continued participation in Medicare. TRICARE has exercised this legal authority to recognize Medicare's emergency waiver issued under Section 1135(b) of the Social Security Act (42 USC § 1320b-5), for the following requirements for Hospice participation:

- The requirement to provide non-core services such as Physical Therapy (PT), Occupational Therapy (OT), and Speech-Language Pathology (SLP).

- The requirement to conduct on-site nurse visits every two weeks.

2.7 Temporary Waiver Of The Referral Requirement For TRICARE Prime Enrollees, Not Including Active Duty Service Members (ADSMs), So They May Receive COVID-19 Vaccines From Any TRICARE Authorized Non-Network Provider Without Incurring Point-of-Service (POS) Charges Where Applicable

2.7.1 Due to the widespread need for COVID-19 vaccines and the possibility that one day these vaccines may not be free-of-charge, on February 23, 2021, a notice was published in the **Federal Register** (86 FR 10942) advising TRICARE Prime enrollees, not including ADSMs, of a waiver to the referral requirement so they may receive COVID-19 vaccines, a clinical preventive service, from any TRICARE Basic (medical) program authorized non-network provider without incurring POS charges where applicable.

2.7.2 Although there is no separate copayment/cost-share for clinical preventive services, there may be a copayment/cost-share or POS charge if the vaccine is administered as part of a primary or specialty care visit for a reason other than preventive care or for other services received during the office visit.

2.7.3 For information on TRICARE coverage of vaccines as clinical preventive services, see Chapter 7, Sections 2.1 and 2.2.

2.7.4 This waiver does not apply to ADSMs as they are governed by the requirements of the Supplemental Health Care Program (SHCP) which allows for payment of claims for civilian services rendered pursuant to a referral by a provider in a Market/Military Treatment Facility (MTF) as well as for civilian health care. For information on the SHCP, see the TRICARE Operations Manual (TOM), Chapter 17.

3.0 EFFECTIVE DATES

3.1 May 12, 2020, for temporary exception to the prohibition on telephone services in the United States.

3.2 May 12, 2020, for the provision relaxing professional licensing requirements to allow interstate and international licensing.

3.3 September 3, 2020, for treatment use of investigational drugs under expanded access.

3.4 September 3, 2020, for temporary hospitals and freestanding ASCs enrolled with Medicare as hospitals.

3.5 For overseas, the effective date is March 10, 2020 for the provisions identified above.

3.6 March 1, 2020, for the temporary waiver of the CAH participation requirements.

3.7 March 1, 2020, for the temporary waiver of the Hospice participation requirements.

3.8 December 13, 2020, for the temporary waiver of the TRICARE Prime referral requirement for COVID-19 vaccines.

3.9 June 1, 2022, for other entities (not including temporary hospitals and freestanding ASCs) enrolled with Medicare as hospitals.

4.0 EXPIRATION

4.1 Unless otherwise specified in this section, for services provided in the United States, these provisions expire upon expiration of the President's national emergency for the COVID-19 outbreak.

4.2 Unless otherwise specified in this section, for services provided outside the 50 United States, District of Columbia, and U.S. Territories including the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands, these provisions expire upon conclusion of the COVID-19 pandemic, as determined by the ASD(HA).

4.3 Coverage of temporary hospitals, freestanding ASCs, and other entities enrolled with Medicare as hospitals expires upon expiration of Medicare's "Hospitals without Walls" initiative.

4.4 Under section 319 of the Public Health Service (PHS) Act, a Public Health Emergency (PHE) declaration lasts until the Secretary of HHS declares the PHE no longer exists, or upon the expiration of the 90-day period beginning on the date the Secretary declared a PHE exists, whichever occurs first. The Secretary may extend the PHE declaration for subsequent 90-day periods for as long as the PHE continues to exist, and may terminate the declaration whenever he determines the PHE has ceased to exist. The manual provisions related to the waiver of the CAH and

hospice participation requirements terminate upon expiration of the COVID-19 PHE declared by the Secretary of HHS.

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