

New Member Choice Center Saves Your Patients Time and Money

TRICARE beneficiaries who have been thinking about signing up for TRICARE's mail-order pharmacy now have another reason to make the switch from retail purchases to the convenience of ordering by mail.

With the introduction of the Member Choice Center (MCC) in August 2007, all it takes for TRICARE beneficiaries to start receiving prescription medications by mail is a phone call or a click of the mouse. Also, military family members and retirees can use the MCC to update prescription information and get answers to pharmacy questions.

TRICARE is always looking for ways to improve customer service and add value. Beneficiaries don't have to download forms or wait to have forms mailed; they can log on to www.express-scripts.com/TRICARE and complete the registration form or call the MCC at 1-877-363-1433 to switch from the retail program to the mail-order pharmacy. It's that easy.

When a TRICARE beneficiary calls the MCC, a patient care advocate from Express Scripts, Inc., TRICARE's pharmacy contractor, will verify their information and walk them through the conversion process. To help facilitate the process, Express Scripts may contact you to have the beneficiaries' prescriptions transferred to the mail-order program.

On the MCC Web site, beneficiaries can also fill out an online enrollment form and convert their existing medications to home delivery.

The mail-order pharmacy can save TRICARE beneficiaries as much as 66 percent on maintenance medications for conditions such as high blood pressure, asthma or diabetes. The beneficiary receives up to a 90-day supply of their generic medications for \$3, which is what they would pay for a 30-day supply at a retail pharmacy. If you prescribe a brand-name medication, the copayment for a 90-day supply is just \$9.

continued on page 2

Non-Formulary Drugs Covered ... When Medically Necessary

It is Department of Defense policy to fill prescriptions with generic drugs when available. You are urged to prescribe both generic and brand-name medications which are on the approved formulary. However, TRICARE will cover a non-formulary medication at the formulary copayment if you can provide information demonstrating medical necessity for the non-formulary medication.

In order for a non-formulary medication to be considered medically necessary, it must meet one or more of the criteria listed below for **all** of the available formulary alternatives:

- The formulary alternative is contraindicated.
- The patient is reasonably expected to have a more favorable outcome with the non-formulary alternative.

- The formulary alternative causes therapeutic failure.
- The patient previously responded to a non-formulary medication and changing to a formulary medication would pose a non-favorable clinical risk.
- There is no formulary alternative available.

continued on page 2



Non-Formulary Drugs Covered ... When Medically Necessary

continued from page 1

Military treatment facilities (MTFs) are able to fill a patient's request for a non-formulary medication if both of these conditions are met:

- The prescription is written by an MTF provider.
- Medical necessity has been established for the medication.

Furthermore, MTFs have the option of filling a non-MTF provider's prescription for a non-formulary medication if medical necessity has been established; however, the MTF is not required to do so.

Active duty service members pay no copayments for non-formulary medications through any pharmacy; however, they may only fill prescriptions for non-formulary medications when deemed medically necessary.

Non-formulary medications are also available to non-active duty service members and their families. Once medical necessity has been established, these spouses, dependents and retirees may fill their non-formulary prescriptions at retail network pharmacies or through TRICARE's mail-order pharmacy for the applicable \$9 formulary copayment.

To view the complete list of TRICARE non-formulary medications or to learn more about how to establish medical necessity, please log on to www.tricare.mil/pharmacy/medical-nonformulary.cfm. ■

File Your Claims Electronically It's Required and It's Beneficial

If you are a TRICARE network provider you must file all your claims electronically. By filing your claims electronically you'll receive your money much faster than if you filed them on paper.

Here are some things to remember:

- Correctly populating your electronic claim with your service address (as opposed to your "pay to" address) will eliminate possible payment delays.
- You are required to use your NPI as your identifier on all electronic claims. Although TRICARE, like the majority of other payers, will not deny claims for failure to include the provider's NPI on the HIPAA-standard electronic

transaction immediately, providers are encouraged to use their NPIs as their primary provider identifier as soon as possible.

- For help filing your claims electronically, refer to PGBA, LLC's XPressClaimSM service at www.myTRICARE.com. XPressClaim is HIPAA-compliant, it's free, payment results are returned instantly and you can use XPressClaim to file your claims where TRICARE is the secondary payer.

Start filing electronically and experience a much faster processing time! ■

New MCC Saves Your Patients Time and Money

continued from page 1

Some of the benefits of using TRICARE's mail-order pharmacy include:

- Free standard shipping of medications directly to beneficiaries' homes
- Ordering refills online, by phone or by mail
- Each prescription checked by a pharmacist for accuracy and potential drug interactions
- Pharmacists available 24 hours a day, every day, to answer beneficiaries' questions

The Department of Defense (DoD) saves money when beneficiaries use the mail-order pharmacy. The DoD pays 30 percent to 40 percent

less for prescriptions filled through the mail-order service versus retail pharmacies. The savings can be substantial. By transferring just one percent of prescriptions from the retail pharmacy to the mail-order pharmacy, the DoD would save \$24 million a year. Savings like this help keep the benefit affordable for military families.

As with all health benefits, there are things beneficiaries can do to reduce costs. Having prescriptions filled by mail saves time and lowers the cost for the entire military health system. ■

Balance Billing: What You Should Know

When caring for TRICARE beneficiaries, it is important to keep TRICARE's policies on balance billing in mind. Noncompliance with these requirements can impact your TRICARE and/or Medicare status.

What is balance billing?

Balance billing is when a provider bills a TRICARE beneficiary for more than their payment responsibility after TRICARE has processed the claim. Both network and non-network providers are **prohibited by law** from balance billing TRICARE beneficiaries.

If you are a network provider, you've signed a contract to be paid at the contractual rate. For non-network providers who accept assignment (i.e., agree to participate in TRICARE), you've agreed to accept the TRICARE-allowable charge as payment in full.

Collecting the beneficiary's copayment, deductible or cost-share is not considered balance billing.

What if a TRICARE beneficiary has other health insurance?

When other health insurance (OHI) is involved, network and participating, non-network providers may receive no more than the TRICARE-allowable charge through the combined payments of TRICARE and the OHI.

- Network providers must accept the TRICARE contractual rate as payment in full. If the OHI pays more than the TRICARE-allowable charge, no additional TRICARE payment is made.
- Participating, non-network providers may not collect any amount from a beneficiary after payment of the claim unless TRICARE and the OHI payments combined have failed to pay the TRICARE-allowable charge.
- Nonparticipating, non-network providers who participate in the OHI may receive TRICARE payments up to the OHI allowable charge.

What charges are beneficiaries required to pay?

In most cases, the patient is not required to pay the copayment, cost-share or deductible when TRICARE is a secondary payer. Beneficiary charges appear in the "deductible" or "cost-share" column on the TRICARE Summary Payment Voucher or remittance.

Network and non-network providers who sign participation agreements with "hold harmless" provisions may not bill the beneficiary for non-covered services, **unless the beneficiary has agreed in advance and in writing to pay for those services.**

It is highly recommended that TRICARE Prime beneficiaries read and sign the waiver of *Non-Covered Services* form to acknowledge financial responsibility for non-covered services. You can find the form under "Materials/Resources" in the Provider Resources section of the Humana Military Web site at www.humana-military.com.

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



Humana Military Healthcare Services, Inc.
P.O. Box 740044
Louisville, KY 40201-7444

CONTACTS

Humana Military
1-800-444-5445
www.humana-military.com

PGBA, LLC (claims)
1-800-403-3950

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

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

National TRICARE Web Site
www.tricare.mil

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

.....
TRICARE Provider News is published by the TRICARE Management Activity. Please provide feedback at www.tricare.mil/evaluations/feedback.



Prior Authorizations Required for Certain Services

A prior authorization is a process of reviewing certain medical, surgical and behavioral health services to ensure medical necessity and appropriateness of care prior to services being rendered.

If your patient needs a service or procedure that requires prior authorization, the request must be submitted to Humana Military prior to services being rendered. Inpatient or specialty care services require prior authorization from Humana Military and the service point of contact (SPOC). When prior authorizations for medical and surgical services are approved they will have a begin date and an end date. Authorizations are valid only for care that begins within 30 days of receiving authorization. Prior authorizations approved for behavioral health services are valid for the number of visits specified and will have a beginning and an end date.

Network and non-network providers must obtain prior authorization for all required services, as defined by Humana Military. Network provider claims submitted for services rendered without obtaining a required authorization are subject to a 10 percent penalty of the negotiated rate. In addition, some services may be excluded or have limited coverage under TRICARE.

Prior authorization requirements may change, so providers should refer to the HMHS Referrals and Authorization System at www.humana-military.com. Simply log on and click "Online Provider Services." In this section you can:

- Enter a new referral/authorization.
- Enter a new hospital admission notification.
- Check the status of an existing referral/authorization request.

- Check to see how a diagnosis code (ICD-9) is classified by TRICARE or look for a specific code using the appropriate CPT-4 code.

To view a complete prior authorization listing in the South Region, visit www.TRICARE.mil.

Requests for authorization may be submitted in one of three ways:

- Submit your request online at www.humana-military.com.
- Fax a completed *Patient Referral Authorization Form* to Humana Military at 1-877-548-1547.
- Call Humana Military at 1-800-444-5445.

Note: At this time, behavioral health providers are not able to use the referral/authorization portion of this online tool. ■