

Navigating HIPAA and PHI

Providers have asked what types of protected health information (PHI) they should and shouldn't share with Humana Military. As a TRICARE regional contractor, Humana Military requires beneficiaries' PHI for a variety of purposes, including medical necessity review, case management, claims review, etc. Here are answers to commonly asked questions about PHI.

What information is considered to be protected health information under HIPAA?

PHI is information that is created and obtained as you deliver services to beneficiaries. PHI may include documentation of symptoms, examination and test results, diagnoses and treatments. Certain personal information is also considered to be PHI under the Health Insurance Portability and Insurance Accountability Act (HIPAA), including, but not limited to:

- Home address
- Home telephone number
- Race
- Social Security number
- Medical records

- Photographs
- Any information that may compromise the privacy of or prove harmful to the beneficiary

Do I need a patient's written authorization to send a copy of the patient's medical record to a specialist or other health care provider who will treat the patient?

No. Providers may disclose PHI to another health care provider for treatment purposes.

If a patient is a minor or is not competent to make health care decisions, may I release information to the parent or guardian?

Providers may not release minors' information to parents or guardians without a minor's consent when the services are related to alcoholism, abortion, drug abuse, behavioral health, venereal disease or HIV. If the patient is incompetent, whether a minor or not, the guardian or other person authorized to act on the patient's behalf may give the consent.

May I release patient information to Humana Military, TMA or health

care insurance companies for payment purposes?

Yes. Providers are permitted to disclose PHI as necessary to obtain payment for health care. However, the Privacy Rule requires providers to reasonably limit the amount of information disclosed for such purposes to the minimum necessary.

Are the following types of insurance covered under HIPAA: long/short-term disability, workers' compensation, and automobile liability that includes coverage for medical payments?

No, the listed types of policies are not health plans as defined by HIPAA. HIPAA specifically excludes any policy, plan or program that provides for or pays for benefits other than health benefits or that are secondary or incidental to other insurance benefits. Therefore, providers are not required to release PHI to these plans or programs.

TRICARE offers training in HIPAA compliance. For more information about PHI and other HIPAA issues, visit www.tricare.osd.mil/HIPAA. ■

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FDA Approvals and TRICARE

TRICARE covers only those drugs, devices, treatments and procedures whose safety and efficacy have been established and proven by the Food and Drug Administration (FDA). As a provider, you should be familiar with the process by which the FDA approves new medical therapies. The following is an overview of that process.

- **Drug company or sponsor applies for FDA approval of a specific drug, device, treatment or procedure.**
Before applying for approval, the company/sponsor conducts extensive laboratory testing and research (sometimes several years worth), which they then provide to the FDA with the application for approval.
- **FDA reviews data and gives approval for clinical trials.**
After reviewing the submission, the FDA will determine whether or not the benefits of the new medical therapy outweigh the risks. If so, the FDA will authorize clinical trials and monitor the results to decide whether the trials should continue or not.



Adjunctive vs. Non-adjunctive Dental Care: What's the Difference?

The TRICARE health care benefit covers **only** adjunctive dental care. Adjunctive dental care is that dental care which is medically necessary in the treatment of an otherwise covered medical (not dental) condition; is an integral part of the treatment of such medical condition; or is required in preparation for, or as the result of, dental trauma that may be or is caused by medically necessary treatment of an injury or disease.

The TRICARE health care benefit **does not** cover non-adjunctive dental care, which refers to any routine, preventive, restorative, prosthodontic, periodontic or emergency dental care that is not related to a medical condition. TRICARE beneficiaries receive these dental services through military dental treatment facilities and through one of two TRICARE dental programs.

All adjunctive dental care requires prior authorization. Prior authorization will determine if a beneficiary's condition is adjunctive or non-adjunctive dental care. The prior authorization requirement is waived only when essential adjunctive dental care involves a medical emergency, such as facial injuries resulting from a car accident.

Hospital services and supplies will be covered for a patient who requires a hospital setting for non-covered, non-adjunctive dental care when medically necessary to safeguard the life of the patient from the effects of dentistry on an underlying non-dental organic condition. Professional services related to the non-covered dental care are not covered; professional services related to the medical condition (excluding the dentist and anesthesiologist) are covered.

The following are some examples of adjunctive dental procedures that TRICARE covers:

- Removal of teeth and tooth fragments to treat and repair facial trauma resulting from an accidental injury.
- Total or complete ankyloglossia (tongue-tie) to alleviate difficulty swallowing or speaking. (Partial ankyloglossia is not covered.)
- Dental or orthodontic care that is directly related to the medical and surgical correction of a severe congenital anomaly.
- Dental care in preparation for, or as a result of, in-line radiation therapy for oral or facial cancer.

For a more detailed list of adjunctive dental procedures that TRICARE covers, access Chapter 8, section 13.1 of the *TRICARE Policy Manual* at www.tricare.osd.mil/tricaremanuals. ■

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- **FDA studies data from clinical trials and determines whether or not the drug, device, treatment or procedure should be made available to the public.**
Once the FDA has decided that a submission is safe and effective, it will place restrictions on how it is marketed and prescribed. The FDA also will ensure that labeling includes possible risks and side effects.
- **The new medical therapy is proven.**
Once the FDA gives approval, the drug, device, treatment or procedure is considered proven and will become available to the public. If the FDA feels that the risks outweigh the benefits, it will be rejected and the company/sponsor will receive a complete list of issues that need to be addressed.

Studying and testing a new drug or treatment before it can be approved for the general public takes 8.5 years on

average. The FDA gives “priority” classification, however, to those treatments that offer significant medical advances over existing therapies and tries to limit the process to 10 months from the time the application is submitted.

For the safety of its beneficiaries, TRICARE does not cover drugs, devices, medical treatments or procedures that have not been approved by the FDA or that have been categorized as “experimental/investigational.”

If you are unsure whether or not a drug or treatment is covered by TRICARE, view the TRICARE policy manual online at www.tricare.osd.mil or call Humana Military at 1-800-444-5445.

For more information about the FDA approval process, visit www.fda.gov. ■

Top Questions South Region Providers Are Asking

The consolidation of the new TRICARE South Region—which now includes Tennessee, except for the Ft. Campbell area; South Carolina; Georgia; Florida; Alabama; Mississippi; Arkansas; Oklahoma; and Texas, except the far western El Paso area—has been completed for four months. Former TRICARE Regions 3 and 4 transitioned on Aug. 1, 2004, while former Region 6 completed the transition on Nov. 1.

Here are the top 10 questions TRICARE providers have been asking since joining the South Region.

When is a referral needed?

To receive full TRICARE Prime benefits, beneficiaries must contact their primary care manager (PCM) for a referral before receiving any type of nonemergency treatment outside of the PCM's office. If you are a PCM, you will initiate all referrals except for behavioral health care. Referrals must be authorized by calling a Humana Military Health Care Finder (HCF) at 1-800-444-5445. Referrals also can be processed online by going to the Provider Resources section of www.humana-military.com.

When is a prior authorization required?

All inpatient hospital admissions and certain procedures require prior authorization. Refer to the chart in Section 7 of your *TRICARE Provider Handbook* for a listing of these procedures along with corresponding CPT codes.

How do I request a prior authorization?

Prior authorization requests may be made online, by phone or via fax. See the "Tips for Submitting Authorizations" section on page 68 of the *TRICARE Provider Handbook*.

Does TRICARE provide case management?

Yes, Humana Military nurses provide case management services for beneficiaries with complex health needs. Contact your local TRICARE Service Center if you have a TRICARE patient who may need case management. Refer to Page 72 of the *TRICARE Provider Handbook* for a list of conditions that call for referral to case management for evaluation.

Does TRICARE have contracted laboratories?

Yes, the TRICARE network of contracted laboratory service providers includes Quest Diagnostics® and LabCorp® of America.

How does TRICARE define an emergency?

TRICARE defines a true emergency as the sudden onset or worsening of a condition that is threatening to life, limb or sight. An emergency condition requires immediate medical attention either to treat the condition or relieve suffering

from painful symptoms. Any delay in treatment would mean risk of permanent damage to the patient's health. If a prudent layperson would reasonably believe that a true emergency as described is present, TRICARE will cover the emergency department care.

Does an inpatient admission after emergency care require an authorization?

Yes, hospitals must obtain authorization by calling a Humana Military HCF at 1-800-444-5445 within 24 hours of an emergency hospital admission. TRICARE Prime members must also contact their PCM for approval in the same time frame or the admission may be covered under the point-of-service option, which includes a deductible and cost-shares.

Does TRICARE allow for outpatient observation?

Physicians may evaluate, stabilize and treat patients for whom a full admission is not clear by using the 23-hour outpatient observation status. While outpatient observation stays generally should not exceed 23 hours, up to 48 hours of outpatient observation services may be authorized by Humana Military when medical necessity is clearly demonstrated. Observation stays of more than 48 hours will be processed as inpatient stays and require prior authorization.

Where do I file my claims?

The claims processor for the TRICARE South Region is PGBA, LLC (PGBA). PGBA can be contacted at 1-800-403-3950 or questions can be mailed to: PGBA South Region Claims Department, P.O. Box 7031, Camden, SC 29020-7031. Network providers must submit claims electronically. For more information on electronic claims submission, visit www.humana-military.com or call your TRICARE provider relations representative.

How can I check on the status of my claims?

Providers can check the status of their claims online if they register for Online Provider Services on the Humana Military site (www.humana-military.com). Providers may also call the PGBA automated voice response system at 1-800-403-3950. ■



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CONTACTS

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

PGBA (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 Sites
www.tricare.osd.mil
www.tricareonline.com

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



Medication Evaluation Recommended for Major Depression

ValueOptions is currently conducting a quality improvement activity to identify whether TRICARE beneficiaries are being seen for a psychiatric medication evaluation within 30 days of being diagnosed with major depression by a therapist. ValueOptions is Humana Military's subcontractor for behavioral health care services.

The Quality Management Committee is providing oversight for this initiative and has recommended that when a beneficiary meets the DSM-IV criteria for major depression, a referral to a psychiatrist or other physician be considered to assess the need for adjunctive medication management. Without adequate treatment, the risk of suicide for a patient with major

depression can be about 10–15 percent. An untreated depression can last 6 months or longer.

According to the American Psychiatric Association's Treatment Recommendations for Patients with Major Depressive Disorder, an evaluation should include the assessment of the most appropriate treatment modality, which could include pharmacotherapy, psychotherapy or the combination of medication plus psychotherapy or Electro-Convulsive Therapy. Additionally, a medical evaluation by a physician can help determine whether there may be medical causes, medication side effects or other factors contributing to the depressive symptoms.

If you are in need of assistance with referring a patient for behavioral health care services and are unaware of physicians in your area, please contact ValueOptions at 1-800-700-8646 for names of providers. ■

