

Behavioral Health Reports Let the PCM “Quarterback” See the Big Picture

Humana Military requires South Region behavioral health care providers to submit Behavioral Health Consult Return reports to primary care managers (PCMs) within 10 working days following the patient’s date of service. (For emergency treatment, you must submit a report within 24 hours.)

Why Are These Reports Important?

“Primary care managers are the quarterback of the medical team,” explains Dr. Gary Proctor, M.D., Federal Division Chief Medical Officer for ValueOptions. “They need an overview of every aspect of the patient’s treatment to provide the best overall care.”

Proctor concedes that sometimes confidentiality concerns make behavioral health providers hesitant to share information with other physicians. But he emphasizes the many situations in which patients are

being medicated by more than one provider. “Full disclosure to a central physician becomes critical to avoid dangerous drug interactions.”

Proctor advises informing patients about the reporting requirement and explaining that the “quarterback” needs to know what’s going on with every provider on the team.

“The PCM—who, of course, is also bound by confidentiality—is not interested in the specific details that might surface in psychotherapy,” he adds. “He or she just needs an overall diagnosis and description of treatment from each player.”

If a patient still balks at disclosure, documentation of the patient’s refusal must be faxed to Humana Military.

What Kind of Documentation Is Required?

Behavioral health consult reports should contain information ranging

from the beneficiary’s name and identification number to allergies, chief complaint, history of problem, clinical assessment, diagnosis, discharge planning, treatment plan goals and legible provider names and signatures.

A Consult Report Form is available on the Humana Military Web site (click on Provider Resources, then Behavioral Health, then ValueOptions Forms), or the required information can be submitted in a format convenient to the provider.

For more information about consult reporting requirements, along with updated fax numbers, visit www.humana-military.com. (Roll the cursor over the “Provider Resources” link on the home page and select “Behavioral Health” near the bottom of the drop-down menu.) ■

Filing Claims with Humana-Military.com—a Testimonial

Juliet Oni says filing TRICARE claims electronically using eZ TRICARE Claims on the Humana Military Web site, www.humana-military.com, since May 2004 has been easy and hassle-free. Best of all, she says, the majority of the medical practice’s claims are now paid in just over one week.

TRICARE network providers are required to choose an electronic claims filing method to submit TRICARE claims.

Ms. Oni is the office manager for Genesis Gastroenterology, a one-physician practice in Warner Robins, Ga. She manages the practice for her husband, Frederick Oni, M.D., a gastroenterologist. About 40 percent of their patients are TRICARE beneficiaries. First opening in August 2003, the office serves beneficiaries affiliated with nearby Robins Air Force Base.

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TRICARE Reference Room

How to Handle Non-Covered Services

No beneficiary wants to hear that a service or procedure is not covered, but sometimes it is necessary for providers to say so.

When that situation arises, you need to explain to the TRICARE beneficiary, both orally and in writing, that the service is not covered.

Getting a Waiver

Beneficiaries may agree to pay for non-covered services or procedures themselves, but you must request that they sign the Non-covered Services Waiver Form, located under “TRICARE Resources” in the “Provider Resources” section of the Humana Military Web site (www.humana-military.com).

If you do not obtain this waiver from the beneficiary and TRICARE does not authorize the service, you will be liable for the full cost of the service or procedure. General agreements to pay, such as those that a beneficiary may sign when being admitted to a hospital, are not considered to be evidence that the beneficiary knew the specific service or procedure in question was not allowable.

TRICARE policy considers a beneficiary to be fully informed about his or her responsibility to pay for a non-covered service only if you have obtained a signed waiver form before the service is rendered. The form should document the specific treatment, dates of service and billed amounts.

Keep copies of all signed waiver forms in your files.

Requesting Authorization

If you aren't sure whether TRICARE will cover a particular procedure or service, you can file an authorization request. Beneficiaries can file this request, as well. If the procedure or service is denied, TRICARE will send a letter to the beneficiary explaining the denial and outlining the appeal procedures.

More information, including a list of non-covered services and benefits, is available in the “Medical Coverage” chapter of the *TRICARE Provider Handbook*. ■

Filing Claims with Humana-Military.com—a Testimonial

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Available only to TRICARE network providers, eZ TRICARE Claims is a free service with no additional hardware or software to buy. The system uploads batches of CMS-1500 claims files directly from providers' practice management systems, which eliminates the need to rekey claims data. Encryption technology ensures that claims files are transmitted securely and in compliance with the rules of the Health Insurance Portability and Accountability Act (HIPAA).

The system is user-friendly, but when problems arise, Availability, the vendor Humana Military partnered with to create eZ TRICARE Claims, is available to offer customer support. Ms. Oni experienced some difficulties getting started, for example.

“I was very impressed. They worked with me over the phone and explained everything. Once the setup problems were rectified, it worked great.”

Ms. Oni now goes online every two or three days to file claims. When information is missing or incorrect, the system alerts her immediately to supply the missing data or revise as needed.

Previously, Genesis Gastroenterology had been filing claims through a vendor and if corrections were needed, claims would be returned to her by mail. She would need to correct the mistakes and send the revised claims back, a process that took several weeks. She's pleased that eZ TRICARE Claims eliminates such delays.

“You can correct the claim right there online,” Ms. Oni explains. “If it's not right, the system will let you know and you won't be able to move on without making the correction.”

With fewer claim submission errors, she can rely on the practice being paid faster. If posting claims on a Thursday, for example, she now expects to receive a check by the end of the following week.

“It's a lot faster than the way we did it before.”

Network providers must be registered users of the Humana Military Web site to use the system. To become a registered user and sign up for eZ TRICARE Claims, visit www.humana-military.com and select Online Provider Services. ■

Tips for Working with Dual-Eligible Beneficiaries

Transition to Nationwide Claims Processor Complete

After an eight-month transition period, all three TRICARE regions are now working with a single, nationwide claims processing contractor—Wisconsin Physicians Service TRICARE For Life (WPS-TFL)—for all dual-eligible beneficiary claims. Dual-eligible beneficiaries are TRICARE beneficiaries who are also entitled to Medicare Part A and Part B.

Now that the transition to WPS-TFL is complete, here is some good information to know about dual-eligible claims processing.

Dual-Eligible Beneficiaries Can Be Either Under Age 65 or Age 65 and Over

While most dual-eligible beneficiaries are age 65 and over, it is important to remember that some may be younger. Beneficiaries under the age of 65 may be dual-eligible based on disability or end-stage renal disease.



How to Identify Your Dual-Eligible Patients

Each dual-eligible patient must present a valid uniformed services or military identification card, as well as a Medicare card prior to receiving services. You should copy both sides of the cards and retain them for your files. If you have a question about a patient's eligibility, you can call the Defense Enrollment Eligibility Reporting System (DEERS) at 1-800-538-9552 to confirm TRICARE status and 1-800-772-1213 to confirm a patient's Medicare status.



How to Process Claims

Since Medicare is the primary payer, you should continue to follow Medicare rules for claims processing and submit your dual-eligible claims to Medicare. Medicare will electronically transfer claims for dual-eligible (Medicare/TRICARE) beneficiaries, regardless of their age, directly to WPS-TFL. If a beneficiary has other health insurance (OHI), he or she will need to file a paper claim (DD Form 2642) with WPS-TFL, which includes the Medicare Summary of Benefits and an explanation of benefits from their OHI.

If you have questions, WPS-TFL can be reached toll free at 1-866-773-0404. You can also visit WPS online at www.tricare4u.com. ■

Return Consult Reports in 10 Working Days

Consult reports are required to be returned to the primary care manager (PCM) or initiating provider within 10 working days of a patient encounter. Please be responsive to the request when asked to return a consult report for TRICARE beneficiaries. ■

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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



Meeting Access Standards Obligations for TRICARE Network Providers

Under normal circumstances, TRICARE Prime beneficiaries should have access to providers within specific time frames and certain distances from their homes.

Access Standards

TRICARE network providers servicing TRICARE Prime beneficiaries are obligated to meet the following access standards for appointments:

- **For urgent care or acute illness**, patients should receive an appointment within 24 hours.
- **For routine visits**, patients should receive an appointment within one week.
- **For specialty care or wellness visits**, patients should receive an appointment within four weeks (28 days).
- **Once in the office**, patients should be seen within 30 minutes for nonemergencies, except when you are providing emergency care to other patients and the normal schedule is interrupted. You should notify patients of the

cause for the delay and the length of delay anticipated, and then offer to reschedule the appointment.

Drive Time

Primary care managers (PCMs) should understand that beneficiaries are entitled to receive primary care within a 30-minute drive from their home under normal circumstances.

When helping patients with referrals to specialists, PCMs should also be aware that TRICARE Prime beneficiaries are to receive specialty care within an hour's drive from their home.

Verifying the Standards

Meeting the TRICARE Prime access standards is an essential condition for network providers. Network providers must notify Humana Military within 10 days of any change to demographic information, panel status or ability to meet the appointment standards. ■