

Some Prescriptions Have Special Requirements What to Know about Prior Authorizations and Quantity Limits

As you write prescriptions for your patients, it's important to be aware that some medications have special requirements that must be met before the prescription can be filled. Here's what you should know.

Prior Authorization

Certain medications, such as Enbrel, Lamisil, Sporanox and Viagra, require prior authorization from Express Scripts before they can be filled at the TRICARE Mail Order Pharmacy (TMOP) or network retail pharmacies under the TRICARE Retail Pharmacy (TRRx)

Program. Prior authorization is necessary to ensure that clinically appropriate treatment regimens are followed. Drugs that require prior authorization are usually medications that are not the first step in a treatment regimen.

The Department of Defense (DoD) Pharmacy and Therapeutics Committee determines the criteria for prior authorizations and which drugs are subject to those criteria.

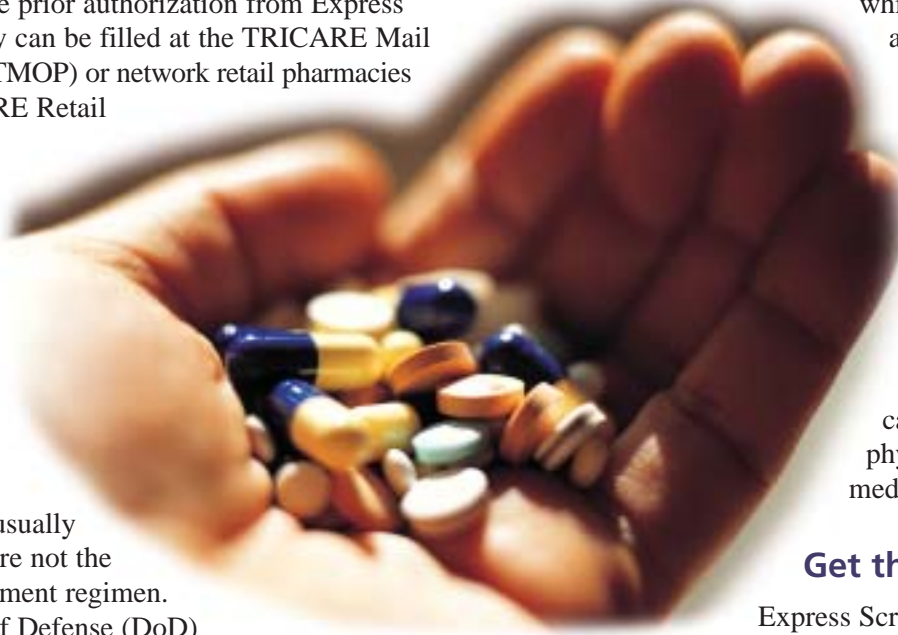
Except for antifungal medications, prior authorizations are good for a year, even if several new prescriptions for the medication are submitted during that year. Prior authorizations for the antifungal medications used for fungal infections

of the fingernails or toenails (itraconazole, terbinafine and ciclopirox) must be approved for each new course of therapy.

Quantity Limits

Quantity limits are a common practice in commercial health plans to help ensure beneficiaries receive the proper dose and recommended duration of therapy to optimize outcomes

while minimizing potential for adverse events, inappropriate therapy and waste. The DoD Pharmacy and Therapeutics Committee has established quantity limits on certain medications, which means the DoD will pay only for up to a specified quantity per 30-, 60- or 90-day supply. Exceptions to established quantity limits can be made if the prescribing physician is able to justify medical necessity.



Get the Details

Express Scripts Pharmacy Prior Authorization Forms and complete lists of medications that require prior authorization or are subject to quantity limits are available through the Express Scripts Web site at <http://member.express-scripts.com/dodCustom/home.do> (choose the link "Drugs that Require Prior Authorization" or "Drugs that Have Quantity Limits"). Or, you can call 1-866-DoD-TRRx. ■



How to Become a Network Provider

Humana Military uses network providers and non-network providers to deliver care to TRICARE beneficiaries in the South Region. Humana Military always refers beneficiaries to network providers first. Only when a network provider is unavailable will a beneficiary be referred to a non-network provider.

Network providers are “preferred providers.” They will get the most business from TRICARE beneficiaries. The following overview will help you better understand the differences between network and non-network providers and tell you how to go about becoming a network or “preferred” provider.

All Providers Must Be Authorized

All providers, regardless of whether they are network or non-network providers, must be authorized to provide care to TRICARE beneficiaries, meaning they must meet certain minimum eligibility requirements and participate in a verification process by PBGA, LLC, (PGBA) the company that pays TRICARE claims.

Network Providers

Network providers have a contractual agreement with Humana Military to

provide care to TRICARE beneficiaries. In exchange for being a “preferred provider,” network providers agree to accept the negotiated rate as payment in full for services rendered, agree to adhere to appointment access standards and always file claims for TRICARE beneficiaries.

Non-Network Providers

Non-network providers have no contractual relationship with Humana Military to provide care to TRICARE beneficiaries but are certified to do so.

There are two types of non-network providers: **participating** and **nonparticipating**.

Participating providers are those who have agreed to treat TRICARE beneficiaries on a case-by-case basis, have agreed to accept the TRICARE maximum allowable amount as payment in full and file claims for TRICARE beneficiaries.

Nonparticipating providers have no agreement to treat TRICARE beneficiaries although they are certified to do so. They may file claims for beneficiaries but are not required to file them. They are the last option for care for TRICARE beneficiaries.

To Become a Network Provider

If you wish to become a network provider, you may call PGBA at 1-800-403-3950 or visit www.humana-military.com and fill out an “online inquiry” located under “Becoming a TRICARE Provider” in the “Provider Resources” section. ■



Electronic Claims Filing Assistance

TRICARE requires all network providers to file claims electronically.

For assistance with any issues related to electronic media claims (EMC) submission for the TRICARE South Region, you can contact the PGBA EMC Help Desk at 1-800-325-5920, option 2.

You may also visit the Humana Military Web site at www.humana-military.com or the PGBA Web site at www.mytricare.com for more information regarding electronic claims submission. ■

Consult Reports Are Required within 10 Working Days

Consult reports are required to be returned to the primary care manager (PCM) or initiating provider within 10 working days of the patient encounter. For specialty referrals, all outpatient services and inpatient services, you must provide complete and legible documentation for these reports to be accurate and useful.

Consult reports, op reports and discharge summaries are important to the initiating provider for timely follow up and continuity of care. Please be responsive to the request when asked to return a consult report for TRICARE beneficiaries.

Providers who treat TRICARE beneficiaries coming from the local military treatment facility (MTF) may receive a faxed reminder to return a consult report for a recent visit/service. Your office should return the consult report, op report or discharge summary requested and use the designated fax reminder as the cover sheet. Please use the fax number listed in the upper right corner of the reminder page. This fax number is shown only on the reminder fax to providers for each beneficiary consult return request. This is to avoid having providers send documentation on all other TRICARE beneficiaries. ■



AutoFax System Simplifies Referral and Authorization Process

When working with referrals and authorizations, primary care managers (PCMs), facilities and specialists should be aware of the AutoFax system for coordinating the referral and authorization process. This Humana Military system automatically generates a faxed copy of the approved referral and sends it to any provider involved in delivering the service, such as the PCM, the referred-to provider and the facility involved. The beneficiary gets a similar confirmation delivered to them both by U.S. mail and via an automated outbound telephone call.

Oftentimes, the AutoFax referral or authorization will be the only notification a provider will get that he or she is getting a referral. If the patient has not called to make an appointment, the provider should keep the confirmation on file. Remember, patients do not activate about 50 percent of requested referrals, meaning a provider could get a number of referral confirmations by AutoFax and never be involved in providing the requested service. But for those services in which patients do activate the referral, it will be necessary to have the AutoFax confirmation.

The AutoFax confirmation will include the patient's demographic data and other information about the referral, such as the services authorized, the referring PCM and the Humana Military phone and fax numbers.

Providers are asked to: leave fax machines on after hours, including weekends, report any fax number changes to a

provider relations representative and program your fax machine so that your fax number appears on any requests sent by fax. ■

Fax Confirmations for Obstetrics and Maternity

For obstetricians and facilities involved with labor and delivery, the AutoFax system provides a confirmation for all approved services. The obstetrician will need an authorization to provide prenatal, delivery and postpartum care, and the facility will need authorization for the patient's labor and delivery. Failure to have such a confirmation could result in the provider and the facility having to pay for the service.

Authorization is required for all maternity inpatient stays as well. The benefit for length of stay for the mother and child in the hospital will be for not less than 48 hours following a normal vaginal delivery and not less than 96 hours following a cesarean section without complications. Maternity care involves the medical services related to conception and delivery, such as prenatal and postpartum care and treatment of complications of pregnancy. Postpartum care generally is covered through the sixth week post-delivery. ■

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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



Online Provider Services Offers Tutorial

Seeking new ways to increase office efficiency? The “Online Provider Services” section of the Humana Military Web site offers an online tutorial that shows, step by step, how providers and staff members can save time by processing referrals and authorizations online.

Access Provider Tutorial

To access the demonstration, go to www.humana-military.com and click on “Provider Resources” or “PCM Central.” These pages provide a link to the tutorial.

Providers who have not already registered on the site will be asked to do so before they can access the tutorial. At “Online Provider Services,” click on “Sign Up” on the right side of the page. Registration takes only a few minutes, and most user accounts are

activated within five business days. Official confirmation is sent via e-mail.

Save Time

“Online Provider Services” offers a number of advantages. In addition to initiating online referral and authorization requests, providers can check the status of an existing referral or authorization, check eligibility of a patient and look up diagnosis and procedure codes.

And providers save time. Most online referrals and authorizations are approved while the patient is still in the office. It takes only a few minutes to supply all the necessary information, in part because the system fills in much of the needed data automatically. Other methods of requesting referrals and authorizations, such as using the telephone or the fax, can take as long as 20 minutes.

Improve Efficiency and Accuracy

The online referral system helps increase efficiency by verifying patient eligibility while providers are making a referral request. The system also helps providers locate an appropriate specialist. After entering the patient’s demographic information, Social Security number and diagnosis, providers can search for a specialist according to specialty and ZIP code. For providers who are unsure of a diagnosis, the system offers a code lookup feature. Providers simply enter words that fit the diagnosis, and the system will match the wording to the proper code.

The Humana Military Web site is available 24 hours a day, seven days a week, making it convenient for providers and staff to gather information and make transactions. ■