TRICARE Provider News
A PUBLICATION FOR TRICARE PROVIDERS ISSUE 12: 2006

Medical Necessity for Non-Formulary Medications

The Department of Defense has established a "uniform formulary" consisting of generic and brand-named drugs, as well as a third tier of medications that are designated as "non-formulary."

If you prescribe a medication that is on the non-formulary list (www.tricare.mil/pharmacy) and medical necessity is not established, the non-formulary medication will be dispensed at the non-formulary cost-share ($22). However, if you provide an explanation of the prescription's medical necessity, you will help your patients save money.

Your patient can fill the prescription at formulary cost—a substantial savings—if you can supply information to Express Scripts, Inc. (ESI) showing there is a medical necessity for a non-formulary medication instead of any of the other therapeutic alternatives that are on the uniform formulary.

Active Duty Service Members (ADSMs)

If medical necessity is approved, ADSMs may receive non-formulary medication at retail network pharmacies and through the TRICARE mail-order pharmacy at no cost. ADSMs may not fill prescriptions for a non-formulary medication, unless it's determined to be medically necessary.

All Other TRICARE Eligible Beneficiaries

If medical necessity is approved, the beneficiary may receive the non-formulary medication at the formulary cost at retail network pharmacies and through the mail-order pharmacy.

Each non-formulary medication has its own medical necessity criteria and form. Visit the TRICARE Pharmacy Web site at www.tricare.mil/pharmacy/medical-nonformulary.cfm for medical necessity criteria and appropriate forms for each non-formulary medication.

You may also call ESI's TRICARE Retail Pharmacy Prior Authorization Line at 1-866-684-4488 for a medical necessity waiver form. You will be asked to complete and submit a Prior Authorization Request Form to ESI. Once your request is approved, you will receive a "letter of medical necessity" that your patient must present with the prescription at the pharmacy. ■

Consult Report Returns and MTFs

Partnering for Effective/Efficient Beneficiary Care

Military treatment facilities (MTFs) across the South region rely on Humana Military network specialists and facilities for the timely return of consult reports. Consult reports are requested on all MTF referred beneficiaries.

Consult reports include office visit consultations, evaluation and treatment notes, procedure notes, results and discharge summaries where applicable. Reminder faxes and phone calls go out to Humana Military network providers on a daily basis based upon the known appointment date for the beneficiaries in question.

Every effort is made to retrieve the consult report within 10 days of the patient encounter. This is to ensure speedy follow-up by the MTF provider to facilitate effective continuity of care.

Humana Military offers a single fax line that is dedicated to consult reports. This fax line is secured and managed by staff members who are responsible for logging all reports and forwarding the information on to the appropriate MTF. This fax method has proven to be efficient for timely processing, effective for provider offices and reliable for tracking patient information. Please be sure to look for the Humana Military-dedicated fax number on all referral confirmations sent to your office location for MTF beneficiaries.

We appreciate your attention to the consult report returns procedures and your swift responses on behalf of our TRICARE beneficiaries. ■

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Providing Emergency and Urgent Care to TRICARE Prime Beneficiaries

Emergency Care

Emergency care is covered for medical, maternity or psychiatric emergencies that would lead a "prudent layperson" to believe that a serious medical condition existed, or the absence of medical attention would result in a threat to his or her life, limb or sight and requires immediate medical treatment. This includes conditions that manifest painful symptoms requiring an immediate effort to relieve suffering, or a situation where the person is at immediate risk of serious harm to self or others. A maternity emergency is a sudden and unexpected medical complication which puts the mother or fetus at risk.

In the event of a life-, limb- or eyesight-threatening emergency, beneficiaries are advised to go, or be taken to, the nearest appropriate medical facility for care or they should call 911. In addition, the TRICARE Prime beneficiary's primary care manager (PCM) and Humana Military must be notified within 24 hours or the next business day of an inpatient emergency admission.

Urgent Care

Urgent care services are medically necessary services required for an illness or injury that will not result in further disability or death if not treated immediately, but has the potential to develop into such a threat if treatment is delayed longer than 24 hours. An urgent care condition could be a rising temperature, sore throat or sprain.

Urgent care must be coordinated in advance with the TRICARE Prime beneficiary's PCM or Humana Military, and a referral needs to be obtained. If urgent care is not coordinated, costs for care may be covered under the point-of-service option, and the beneficiary may pay higher out-of-pocket costs. If the beneficiary is enrolled at a military treatment facility (MTF) and is near home, he or she should contact his or her MTF PCM to coordinate a referral for urgent care. If the beneficiary is enrolled at an MTF and is traveling out of the area, he or she should contact Humana Military for help with locating a provider and obtaining a referral. Beneficiaries enrolled to civilian PCMs should coordinate referrals with their PCMs or Humana Military, regardless of where they are traveling. ■

TRICARE Well-Child Coverage

The preventive care and check-ups you as a health care professional provide from birth to age 6 can influence a child's health for the rest of his or her life. TRICARE covers well-child care in accordance with American Academy of Pediatrics (AAP) and Centers for Disease Control and Prevention (CDC) guidelines.

Well-child care is covered as clinical preventive care. The following is an overview.

In-hospital Newborn Care

- Circumcision (if performed after discharge, service is cost-shared as outpatient service)
- AAP-recommended newborn screenings, including, but not limited to: Hypothyroidism, Phenylketonuria, Hemoglobinopathies (for those in high-risk ethnic groups) and Galactosemia

The Department of Defense closely monitors AAP recommendations in regards to newborn metabolic screening. Recently, the AAP has endorsed a report recommending expanded metabolic screening for newborns. Additional information about the report can be found at http://mchb.hrsa.gov/screening/summary.htm and http://genes-r-us.uthscsa.edu.

Well-child Office Visits

It's recommended that you provide preventive care well-child visits as frequently as the AAP recommends, but no more than nine visits in two years. Visits for diagnosis or treatment of an illness or injury are covered separately under outpatient care.

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National Provider Identifier FAQs

What is the National Provider Identifier (NPI)?

The NPI is a 10-digit number that will be used to identify you to your health care partners, including all payers, in all Health Insurance Portability and Accountability Act of 1996 (HIPAA) standard transactions. The NPI will replace the identifiers you currently use in HIPAA standard transactions that you conduct with Medicare and other health plans—like TRICARE. HIPAA requires that all covered entities use NPIs in standard transactions by the following compliance dates: May 23, 2007 for all covered entities except small health plans and May 23, 2008 for small health plans.

How does a provider get an NPI?

A health care provider will be able to apply for an NPI in one of three ways:

- Apply through the Web-based application process at: https://nppes.cms.hhs.gov.
- Prepare and send a paper application form to the Enumerator (Fox Systems). A copy of the application form, including the mailing address, can be found at https://nppes.cms.hhs.gov. A health care provider may also call the Enumerator at 1-800-465-3203 (TTY 1-800-692-2326) to request a blank application.
- With the permission of the health care provider, an organization may submit a health care provider's application in an electronic file.

How many NPIs are needed per provider?

There are two types of health care providers in terms of NPIs:

- Type 1—Health care providers who are individuals. An individual is eligible for only one NPI.
- Type 2—Health care providers who are organizations, including physician groups, hospitals, nursing homes and the corporation formed when an individual incorporates him/herself.

Organizations must determine if they have "subparts" that need to be uniquely identified in HIPAA standard transactions with their own NPIs where a subpart is a component that furnishes health care, but is not itself a separate legal entity.

If you are a health care provider who is incorporated, you may need to obtain an NPI for your self (Type 1), and an NPI for your corporation or LLC (Type 2).

When should a provider begin sending their NPIs to TRICARE?

We encourage all providers to obtain their NPIs and begin using them as soon as possible. TRICARE is currently supporting a "dual use" period during which NPIs may be submitted on standard electronic claims along with the current legacy TRICARE identifiers (this will be required until further notice). At some point—no later than May 23, 2007—only NPIs will be accepted.

Additional information on NPIs can be found at www.cms.hhs.gov, including the document *The Who, What, When, Why and How of NPI: Information for Health Care Providers*, that can be downloaded as a pdf file. ■

TRICARE Well-Child Coverage

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The following chart shows TRICARE-covered tests and their AAP-recommended frequency.

Test	Frequency
History/physical examination/mental health assessment	Each well-child visit
Height and Weight	Each well-child visit
Head Circumference	Each well-child visit through age 2
Vision Screening (by PCM)	At birth and at well-child visit at age 6 months
Comprehensive Eye Exam (by Optometrist or Ophthalmologist)	Every 2 years for age 3 and older
Dental Screening	Each well-child visit
Tuberculin Test	Once at age 1; once at age 2
Hemoglobin or Hematocrit Testing	Once during first year; once during second year
Urinalysis	Once during first year; once during second year
Blood Pressure Screening	Annually between ages 3 and 6

Immunizations

TRICARE covers age-appropriate doses of vaccines recommended by the CDC's Advisory Committee on Immunization Practices. For a current schedule, refer to www.cdc.gov. ■

TRICARE ProviderNews

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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 Sites
www.tricare.mil
www.tricareonline.com

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

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Verifying TRICARE Eligibility

The first thing you probably do when a patient comes into your office is give them a clip board with forms to fill out and ask them for their insurance card. Getting this information is essential to verify your patient has health care coverage.

If your patient indicates they have TRICARE, please check to make sure the patient has a valid uniformed services ID card (military) or Common Access Card. It's important to be familiar with these ID cards so you can verify patient eligibility. Remember to make a copy of both sides of the card for your records. Although some beneficiaries may believe it is illegal to copy ID cards, it is in fact legal to copy them for authorized purposes (facilitating medical care, eligibility documentation and administration of other military-related benefits).

An ID card alone is not sufficient to prove eligibility, but it does provide necessary information that you should have in hand when calling Humana Military or verifying benefits online. Look for the following information:

- **Social Security number (SSN) or Sponsor SSN**
  Use the SSN found on the ID card when verifying the card holder's eligibility.
- **Expiration Date**
  Check the expiration date on the ID card in the box titled, "EXP DATE" (it will read "INDEF" for retirees). If expired, the beneficiary is ineligible for care and will need to update their information in the Defense Enrollment Eligibility Reporting System to get a new card and receive care.
- **Civilian Care**
  Check the back of the ID card to verify eligibility for TRICARE civilian care. The center section should read "YES" under the box titled, "CIVILIAN." If a beneficiary using TRICARE For Life (TFL) has an ID card that reads "NO" in this block, they are still eligible to use TFL if they have Medicare Part A and B.

Once you have obtained the pertinent identifying information from your patient, you can verify the eligibility by contacting Humana Military at 1-800-444-5445. You can also register and check eligibility online at www.humana-military.com. Be sure to retain a print-out of the eligibility screen for the patient's record. ■