

Fit for Life: Healthy Forces, Healthy Families Campaign Promotes Wellness Choices for 9.1 Million Beneficiaries

This year, the Military Health System (MHS) and TRICARE are taking steps to promote healthy lifestyles among its 9.1 million beneficiaries. The *Healthy Choices for Life* campaign is focused on weight management, smoking cessation and the responsible use of alcohol. Here's a quick look at why these health issues are so important.

Weight Management

In 2001, the Surgeon General declared overweight and obesity to be a U.S.

public health concern. This nationwide problem has only intensified since then. Today, two-thirds of Americans are considered to be overweight, one-third of whom are considered to be obese.

Upward weight trends are also seen in the MHS beneficiary population—active duty service members and families, retired service members and their families, and survivors—with the alarming report that military children are classified as overweight at a higher rate than children in the general American population. More than 3,000

active duty service members are discharged each year for failure to comply with Service's weight and fitness standards.

Being overweight or obese can lead to other serious health concerns, such as diabetes, hypertension, stroke, coronary artery disease, gallstones, respiratory disease, arthritis and cancer. Losing just 5 to 10 percent in body weight can reduce or even eliminate the risk of these health concerns.

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From the Desk of the Medical Director

*Florence Shafiq
Southeast Market
Medical Director*

There are numerous stories that convey the compassion and excellence of care provided through the partnering of our network physicians and Humana Military Healthcare Services associates. I'd like to share this one with you.

The individuals involved are a beneficiary, her husband who is a military chaplain, and a Humana Military case manager. The beneficiary was diagnosed with a recurrent glioblastoma.

For well over a year, the case manager and the chaplain shared at least one telephone conversation a month. The

conversations included responses to therapy with assessment of progress or lack thereof, family involvement, complications of therapy, feelings of despair, of hope, of anger, and finally of resolve and acceptance of the ultimate outcome.

After his wife's long battle had ended, the chaplain sent the following letter of thanks:

"Almost four months ago, my sweet wife lost a valiant battle to cancer. The whole ordeal lasted almost 20 months. During that time, your case manager served as our health care manager. I am writing to commend her for her unbelievable care and concern for us.

"I have been in the military for almost 25 years and I have never before experienced the kind of personal care and compassion that we received from

your case manager. She was there at regular intervals to seek out our needs and concerns, as well as to advise and make sure that my wife's treatment went smoothly. We never worried about health care because of the case manager's great care for us. Even after my wife's death, she continued to call with encouraging words."

This story demonstrates Humana Military's credo, "I Put the 'I CARE' in TRICARE." More importantly, it shows the level of collaboration and coordination of care between our TRICARE providers and Humana Military.

It is not often that one receives a note of thanks for one's daily initiatives. So today, I want to pass on that "thank you" to our providers who continue to deliver such excellent care to our TRICARE beneficiaries. ■



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Smoking Cessation

Historically, the military has had a reputation as an environment in which tobacco use is accepted and common. Two decades ago, just over half of military personnel on active duty were smokers. In recent years, the Department of Defense (DoD) has increased efforts to reduce tobacco use, and the rate has declined sharply. Despite this improvement, a 2002 survey of active duty service members found the first significant increase in smoking after many years of declining smoking rates.¹

Responsible Use of Alcohol

DoD survey findings indicate an increase in average alcohol consumption and the prevalence of heavy alcohol use. The rate of heavy alcohol use is nearly one in five active duty personnel, and binge drinking—consuming five or more drinks on the same occasion at least once during the past 30 days—rates are highest among young military personnel in some social situations.² Heavy alcohol use and binge drinking are higher among some active duty members than rates of similar civilian age groups.

Healthy Choices for Life Campaign

The goal of the *Healthy Choices for Life* campaign is to help TRICARE beneficiaries make decisions based on healthy choices for themselves and for their families.

In addition to other initiatives, TRICARE will feature a regular department, called “Healthy Choices



for Life,” in each edition of the *TRICARE Provider News* newsletter.

Look for future articles that offer providers the latest clinical information about weight management, smoking cessation and the responsible use of alcohol. We hope that this information will be beneficial to you in your role of encouraging TRICARE beneficiaries to make healthy choices for life!

You can also go online to www.tricare.osd.mil/healthylifestyles for information about initiatives and programs that are available to TRICARE beneficiaries. ■

^{1,2} Source: *DoD Surveys of Health Related Behaviors Among Military Personnel, 1980 to 2002 (2002 Questions: Any Smoking, Q45 and Q47; Heavy Smoking, Q46 Heavy Alcohol Use, Past 30 Days, Q15-Q18 and Q20-Q23 Binge Drank, Q24, and With Whom Drank, Q25)*

**Healthy People 2010:
 Taking Action to Improve
 the Nation’s Health**

In conjunction with the *Healthy Choices for Life* campaign, TRICARE encourages its civilian provider network to embrace the Federal government’s Healthy People 2010 initiative and offer programs and information that promote wellness.

Like the preceding Healthy People 2000 initiative—which was driven by an ambitious, yet achievable, 10-year strategy for improving the Nation’s health by the end of the 20th century—Healthy People 2010 is committed to promoting health and preventing illness, disability and premature death. Two overarching goals are to increase the quality and years of healthy life and to eliminate health disparities.

The Healthy People 2010 initiative aims to achieve its goals by identifying the most significant preventable health threats and establishing goals to reduce those threats by the year 2010. One way this is being accomplished is through the incorporation of Leading Health Indicators. As a group, the Leading Health Indicators reflect the major health concerns in the United States at the beginning of the 21st century:

- Physical activity
- Overweight and obesity
- Tobacco use
- Substance abuse
- Responsible sexual behavior
- Mental health
- Injury and violence
- Environmental quality
- Immunization
- Access to health care

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Cancer Trials Available to TRICARE Beneficiaries

Nearly 12,000 Military Health System (MHS) beneficiaries are diagnosed with cancer each year.

The Department of Defense (DoD), in partnership with the National Cancer Institute (NCI) through an interagency agreement, conducts the DoD Cancer Prevention and Treatment Clinical Trials Demonstration.

Family members of active duty personnel, as well as TRICARE-eligible retired service members and their families, may participate in NCI-sponsored clinical trials within military treatment facilities (MTFs) or at civilian cancer centers.

Three Phases of Trials

There are three phases of NCI clinical trials:

- Phase I trials: These are not covered currently by TRICARE due to their highly experimental nature.
- Phase II trials: TRICARE beneficiaries may participate in phase II trials, which study the safety and effectiveness of an agent or intervention, and evaluate how it affects the human body. These studies usually focus on a particular type of cancer.
- Phase III trials: TRICARE beneficiaries may also participate in phase III trials, which compare a promising new treatment against the standard approach.

Those appropriate for phase II trials include beneficiaries who have been diagnosed with cancer, as well as those who are at high risk for developing cancer and who want to decrease that risk.

Those appropriate for phase III trials include beneficiaries who have been diagnosed with cancer and want to participate in the most promising advances in cancer research.

Cost of Participation

Costs for screening tests to determine clinical trial eligibility, as well as associated costs of participation in the clinical trials, are covered by the DoD and NCI interagency agreement.

If the beneficiary enrolls in a clinical trial at an MTF, all outpatient care is provided free of charge. Services received in the civilian sector are subject to copayments/cost-shares and deductibles.

How to Participate

Contact the DoD Cancer Prevention and Treatment Clinical Trials Demonstration case manager before beginning the evaluation or any treatment under the clinical trial. The toll-free number is 1-800-779-3060.

Prior authorization is also required to participate in an NCI clinical trial. Humana Military case managers facilitate referrals to the DoD/NCI demonstration when beneficiaries are identified as possible clinical trial participants. The PCM may refer beneficiaries by contacting the demonstration case manager.

The NCI Web site (www.cancer.gov) lists some of the phase II and III NCI-sponsored clinical trials, but not all of them. To determine if there are clinical trials available, contact the demonstration case manager. ■

Healthy People 2010: Taking Action to Improve the Nation's Health

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These Indicators were chosen based on their ability to motivate action, the availability of data to measure progress and their importance as public health issues.

Consider the impact you can have on TRICARE beneficiaries' overall health and wellness by implementing health promotion programs and prevention education around these Leading Health Indicators. Coupled with your continued focus on high-quality medical intervention for disease and injury, such programming can really make a difference.

Publications are available at www.healthypeople.gov that provide extensive resources for implementing Healthy People

2010 initiatives. Additionally, as several Leading Health Indicators have the same focus as the *Healthy Choices for Life* campaign, look to the "Healthy Choices for Life" department in this newsletter to bring you information and ideas that will assist you in your health promotion endeavors.

The end results will be improved military readiness, a healthier population, lower health care costs and more satisfied patients—all of which will help TRICARE remain a U.S. health care leader.

For more information on Healthy People 2010 objectives or if you would like to become a Healthy People 2010 partner, visit www.healthypeople.gov or call 1-800-367-4725. ■

FAQs: TRICARE Vision Coverage

When it comes to maintaining eye health and protecting one's vision—as with virtually any other aspect of health care—an ounce of prevention can be worth a pound of cure. TRICARE vision care can be confusing because it varies according to beneficiary status and TRICARE program option. The following frequently asked questions will help you understand which vision benefits each of your TRICARE patients may receive.

1. Can an active duty service member visit an optometrist or ophthalmologist in the network for eye examinations?

TRICARE Prime active duty service members (ADSMs) must receive all vision care at a military treatment facility (MTF) unless specifically referred to a network provider, or non-network provider if a network provider is not available. TRICARE Prime Remote (TPR) ADSMs may obtain a comprehensive eye examination from a network provider as needed to maintain fitness-for-duty status without an authorization.

2. What is the vision coverage of a TRICARE Prime enrollee whose spouse is on active duty?

As an active duty family member, the spouse is covered for one routine eye examination every year without a copayment. Additionally, this person may receive a comprehensive eye examination every two years under TRICARE Prime's enhanced clinical preventive services benefit without a copayment. These services may be obtained from any MTF or TRICARE network optometrist/ophthalmologist. Preventive eye examinations from a network provider do not need a referral from the primary care manager (PCM) or authorization from Humana Military. If a network provider is not available, the beneficiary can access the services from a non-network provider with a PCM referral or referral from Humana Military.

What about their children?

In addition to a routine eye examination every year for TRICARE Prime children of all ages, vision screening is available under the well-child benefit. The well-child benefit is available from birth to age six and includes eye and vision

screening by a PCM during a routine examination at birth and at approximately six months of age. Comprehensive eye examinations are authorized once every two years between ages three and six. Children over age six assume the same coverage as any active duty family member enrolled in TRICARE Prime. There are no copayments for these services.

3. What is the vision coverage of a person whose spouse is on active duty but who uses TRICARE Extra or TRICARE Standard?

The active duty family member is covered for one routine eye examination every year. However, TRICARE Extra or TRICARE Standard cost-shares apply after the annual deductible has been met.

What about their children?

Children of ADSMs who are using TRICARE Extra or TRICARE Standard are covered for one routine eye examination every year. TRICARE Extra or TRICARE Standard cost-shares apply after the annual deductible has been met.

Vision screening is also available under the well-child benefit for children from birth to age six. The benefit includes eye and vision screening by a PCM during a routine examination at birth and at approximately six months of age. Comprehensive eye examinations are authorized once every two years between ages three and six. Children over age six assume the same coverage as any active duty family member using TRICARE Standard or TRICARE Extra.

4. What is the vision coverage of a retired service member who enrolls in TRICARE Prime?

The enrollee is covered for one comprehensive eye examination every two years. This benefit begins two years after the enrollee's last eye examination prior to retirement. He or she may receive care from any TRICARE network optometrist or ophthalmologist and MTFs when available. If visiting a network provider, beneficiaries must show their TRICARE Prime enrollment card.

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FAQs: TRICARE Vision Coverage

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Because vision services are covered under TRICARE Prime's enhanced clinical preventive services benefit, enrollees are not responsible for any copayments for vision care received from TRICARE network providers.

What if the retired service member decides to use TRICARE Extra or TRICARE Standard rather than enrolling in TRICARE Prime?

The beneficiary is not covered for routine vision care under TRICARE Extra or TRICARE Standard.

5. What is the vision coverage of a person enrolled in TRICARE Prime whose spouse is a retired service member?

Please see answer to Question 4.

What about their children?

Vision screening is covered under the well-child benefit. The well-child benefit is available from birth to age six and includes eye and vision screening by a PCM during a routine examination at birth and at approximately six months of age. Comprehensive eye examinations are authorized once every two years between ages three and six. Children over age six assume the same coverage as any retiree family member enrolled in TRICARE Prime.

6. What is the vision coverage of a wife using TRICARE Extra or TRICARE Standard whose husband is retired?

She is not covered for routine vision care under TRICARE Extra or TRICARE Standard.

What about their children?

Vision screening is available under the well-child benefit. The well-child benefit is available from birth to age six and includes eye and vision screening by a PCM during a routine examination at birth and at approximately six months of age. Comprehensive eye examinations are authorized once every two years between ages three and six. TRICARE Extra and TRICARE Standard cost-shares will apply after the annual deductible has been met. After age six, retirees' children who are using TRICARE Extra or TRICARE Standard are not covered for vision care.

7. Are eyeglasses or contact lenses cost-shared under TRICARE?

Active duty service members are covered for eyeglasses at MTFs at no cost.

For all other TRICARE beneficiaries, contact lenses or eyeglasses are only cost-shared with prior authorization for treatment of infantile glaucoma, keratoconus, dry eyes



when normal tearing is inadequate or absent, corneal irregularities other than astigmatism, or loss of human lens function resulting from eye surgery or congenital absence.

Benefits are limited to only one set of implantable lenses required to restore vision. A set may include a combination of both implantable lenses and eyeglasses when the combination is necessary to restore vision. If there is a prescription change related to the qualifying eye condition, a new set may be cost-shared.

Replacement lenses for those that are lost, have deteriorated or have become unusable due to physical growth are not covered. Adjustments, cleaning and repairs of eyeglasses are also not covered.

Additional Information

In addition to preventive exams, medically necessary eye exams are covered for all categories of TRICARE beneficiaries. TRICARE Prime beneficiaries need referrals for medically necessary visits if they are not performed at an MTF.

Beneficiaries who are diabetic are covered for an eye exam each year, no matter what their sponsor's military status, so long as they are enrolled in TRICARE Prime. There is no copayment for these exams.

If you need additional information about TRICARE's vision coverage, visit the TRICARE Web site at www.tricare.osd.mil or contact Humana Military at 1-800-444-5445. ■

Humana Military, PGBA Offer Claims Processing Resources

Humana Military and PGBA want to help all TRICARE providers have a better understanding of claims processing procedures. To reach that goal, we've developed the following resources:

Live Provider Seminars

Humana Military and PGBA plan to offer claims processing seminars this spring. The seminars will explain how claims processing works and how providers can facilitate the process. Your provider representative will invite you to a seminar or you can check the schedule in the Online Provider Services section of www.humana-military.com.

Web Sites

You can obtain the latest information about claims processing, check the status of claims and more, also in the Online Provider Services section. Registered users of either the Humana site or the PGBA Web site (www.myTRICARE.com) can also submit claims electronically.

IVR System

When calling is more convenient, you can use Humana Military's interactive voice response (IVR) system by calling

1-800-444-5445, or you can call PGBA at 1-800-403-3950 and speak to a provider representative to check on the status of claims, confirm the eligibility of a beneficiary, get an explanation of benefits and obtain pricing.

Remit Forms

Another way to ensure a smooth claims processing experience is to review all provider remits closely. The remit form is now easier to read, and it explains how to get a claim reconsidered satisfactorily.

ClaimCheck

During claims processing, PGBA uses the ClaimCheck[®] system to review claims and ClaimReview[®], an automated module in ClaimCheck, to check for inconsistencies with TRICARE-covered services. For example, the system will compare the procedure code with the diagnosis code. If the codes are inappropriate for each other, the claim will be denied and the remit will say, "Diagnosis Code and Procedure Code combination non-specific or unrelated."

To avoid such denials, and improve claims submission accuracy, your staff should review the Claims Processing and Billing chapter of the *TRICARE Provider Handbook*. ■

TRICARE Benefits Improve for Reservists and Their Families

The National Defense Authorization Act for 2005 improves the overall health benefits available to guardsmen, reservists and their families, and it makes permanent several of the TRICARE benefits authorized "temporarily" under 2004 defense legislation.

Here is a look at what TRICARE providers need to know:

- For Reserve Component members with delayed effective date orders to serve on active duty in support of a contingency operation for more than 30 days, the new legislation permanently authorizes TRICARE eligibility for up to 90 days prior to member's activation date for eligible members and their families.
- The legislation makes permanent the 180-day transitional period after deactivation in which certain Reserve Component members and their families receive TRICARE health benefits

under the Transitional Assistance Management Program (TAMP). Members must now have a comprehensive physical examination within 12 months before the scheduled date of separation from active duty service.

- The legislation authorizes a waiver of the TRICARE Standard and TRICARE Extra deductibles for Reserve Component family members whose sponsors are ordered to active duty for more than 30 days. Plus, it authorizes TRICARE to pay nonparticipating providers up to 115 percent of the TRICARE maximum allowable charge, enhancing continuity of care for these family members with their civilian providers.

Another provision will enable members of the Reserve Component (those called after Sept. 11, 2001, to serve for more than 30 days in support of a contingency operation, who served or will continuously

serve for 90 or more days) to purchase TRICARE Standard health care coverage for themselves and their family members after they demobilize and after their TAMP benefit ends.

The member must sign an agreement to continue serving for a period of one year or more in the selected reserve after their active duty ends. For every 90 days of consecutive active duty service, the member and family members may purchase one year of TRICARE Standard coverage for the same period they commit to serve in the selected reserves.

The option to purchase TRICARE Standard coverage will not be implemented until April 26, 2005.

More information about these changes will be available at www.tricare.osd.mil and www.defenselink.mil/ra. ■

Your Primer on TRICARE Prime in the South Region

As a TRICARE provider, it's important that you understand TRICARE Prime so that you can deliver care optimally and even assist beneficiaries in making the right health care decisions. Humana Military offers the following five-point primer as a quick reference to this managed care option.

1. TRICARE Prime Eligibility.

TRICARE Prime is available to:

- Active duty service members, family members, survivors and eligible former spouses of active duty personnel
- Retirees, their family members and survivors under age 65
- Reserve Component members and their families if the sponsor is activated for more than 30 consecutive days

All eligible beneficiaries must be enrolled in the Defense Enrollment Eligibility Reporting System. Providers can verify eligibility by calling Humana Military at 1-800-444-5445. You can also verify eligibility at time of service when beneficiaries present their TRICARE Prime enrollment and military ID cards.

2. Beneficiary Responsibilities.

To access TRICARE Prime care, eligible beneficiaries must enroll. Active duty service members are automatically covered under the TRICARE Prime benefit, but still must enroll. There is no enrollment fee for active duty family members. Retirees and their family members must pay an annual enrollment fee of \$230 for an individual or \$460 for a family.

Active duty service members and their families are not responsible for any copayments. There are exceptions: when using the TRICARE Prime point-of-service (POS) option or when filling prescriptions anywhere other than a military treatment facility (MTF) pharmacy.

Enrolled retirees and their families are responsible for copayments when seeking care from a network provider. The POS option also applies to retirees and their family members whenever they self-refer to a non-network provider for covered medical services (except for their first eight outpatient behavioral health visits).

Annual deductibles are not required of any TRICARE Prime beneficiaries, unless they use the POS option.

3. The Primary Care Manager.

TRICARE Prime beneficiaries select or are assigned a primary care manager (PCM) when they enroll. A PCM can be either an MTF provider or a provider within the TRICARE network of civilian providers.

TRICARE Prime beneficiaries enrolled with an MTF PCM receive most of their care from an MTF, augmented by the civilian network. Specialty care must be arranged and approved by Humana Military to be covered under TRICARE Prime.

TRICARE Prime beneficiaries with a civilian PCM receive most of their care from the civilian PCM. This could include:

- Internal medicine physicians
- Family practitioners
- Pediatricians
- General practitioners

Civilian PCMs provide and coordinate care, maintain patient health records and refer patients to specialists.

4. Specialty Care Referrals.

TRICARE Prime beneficiaries rely on PCMs for referrals to specialty care providers and services either at an MTF or within the civilian network. For these services to be covered by TRICARE, the network PCM must submit a referral request. Referrals or authorizations are not required for emergency care.

Local health care finders (HCFs) at TRICARE Service Centers (TSCs) can help you find specialty care after a referral is requested. When a network provider is unavailable, you may obtain a referral to a non-network provider on a case-by-case basis.

Humana Military network specialty providers must provide clearly legible, specialty care consultation and operative reports to referring providers within 10 working days of the patient's date of service. Hospitals and other facilities must also send all discharge summaries or operative reports to referring providers within 10 working days of the patient's date of service or discharge.

5. Point-of-Service Option.

Under the POS option, TRICARE Prime beneficiaries may self-refer to any TRICARE certified (network or non-network) provider for medical or surgical services without a PCM referral.

For behavioral health services, the POS option applies when the TRICARE Prime beneficiary receives nonemergency services from a non-network provider.

Although a referral is not required when using the POS option, certain prior authorization requirements still apply. The beneficiary will pay a deductible (\$300 individual and \$600 family) and 50 percent of the TRICARE allowable charge. There is no catastrophic cap protection when using the POS option. ■



Thinking Collection Agency for a Beneficiary Claim?

Avoid Debt Collection and Understand the Role of the DCAO

TRICARE strives to process and complete provider claims as quickly and accurately as possible. The Military Health System can be complex, however, which can occasionally lead to claims submission mistakes or oversights that result in unpaid claims and ultimately patient billing. It is important for providers and their staffs to learn claim submission pitfalls and avoid sending unpaid beneficiary claims to a costly collection agency.

“In a majority of cases involving unpaid claims, there has been an error in processing or incorrect information has been given about the beneficiary,” says Marcia Bonifas, deputy director, TRICARE Communications and Customer Service. “It is important to work with the claims processor and the beneficiary first to find out what is wrong and why the claim wasn’t processed. Most of the issues can be resolved in this first step.”

Quality, hassle-free medical care for themselves and their families is important to service members’ peace of mind, as well as the uniformed services’ broader goals of recruiting and retaining qualified personnel. Far too often service members must shoulder the burden of incorrectly processed claims, which causes them great concern and distracts them from their tasks at hand.

To ease beneficiaries’ burden and assist them in understanding and resolving claims issues, TRICARE staffs Debt Collection Assistance Officers (DCAOs) at each TRICARE Regional Office (TRO) and military treatment facility (MTF). The DCAO helps in determining the validity of collection agent claims or negative credit reports received for debts incurred as a result of health care under TRICARE.



After researching the beneficiary’s claim with the appropriate claims processor or other agency points of contact, the DCAO provides the beneficiary with a written resolution to the collection problem and notifies the collection agency that action is being taken to resolve the issue.

Follow These Error-Checking Steps

The most important action you can take for your practice and for TRICARE beneficiaries is to avoid the debt collection process altogether. By following these simple error-checking steps, you can help prevent the need to pursue debt collection.

1. Review the TRICARE explanation of benefits (EOB) statement when it arrives; if a claim is rejected, it will state the reason why.
2. If the EOB states that inaccurate beneficiary information is the reason for the denial, it is important to make every attempt to contact the beneficiary to obtain the correct information.
3. If an EOB does not arrive within 45 days, this may mean that there has been a problem in submission of the claim. Contact your TRICARE regional contractor, Humana Military, or if the patient has Medicare, contact the TRICARE dual-eligible fiscal intermediary, Wisconsin Physicians Service (WPS), at 1-866-773-0404.
4. Contact Humana Military if you have additional or corrected information regarding a rejected claim.

“It’s important for providers to read and understand the explanation of benefits. It’s critical to resolving claims issues before they become debt collection issues,” Bonifas says. “An overwhelming majority of claims issues could be solved with the explanation of benefits.”

Eliminate Mistakes that Lead to Rejected Claims

Many times claims are rejected because of mistakes made in entering the following common information. Awareness of these common mistakes can decrease the likelihood that they will occur and increase the likelihood that your claims are more accurately processed in a timely manner.

Incorrect Beneficiary Address

Service members move often or are in transit. It’s common for providers to have an old or temporary address on file. Ask beneficiaries to update their information during each visit.

Incorrect Social Security Number (SSN)

Typing errors and other factors can cause a wrong SSN. Always double-check the SSN with the beneficiary. Make sure to use the sponsor’s SSN, even if the beneficiary being treated is not the sponsor. (Exception: TRICARE-eligible

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FAQs about Behavioral Health Care

The following are answers to the top questions behavioral health care providers have about caring for TRICARE patients.

Do TRICARE Prime patients require a referral for outpatient services?

No. TRICARE Prime beneficiaries can self-refer for eight unmanaged outpatient psychotherapy visits per fiscal year (Oct. 1–Sept. 30). Please note that Psychological Testing (CPT 96100–96117) is excluded and continues to require authorization.

How do I obtain a behavioral health authorization for a patient?

Network providers may call ValueOptions to obtain authorization for claims payment purposes. Additional visits beyond the initial eight can be requested via fax or mail using the Outpatient Treatment Report.

How can I obtain forms?

ValueOptions forms are located on the Humana Military Web site at www.humana-military.com. Click on: TRICARE South Region, Provider Resources, Behavioral Health and ValueOptions forms.

Will I receive anything in writing stating the authorization parameters?

Yes. A letter will be faxed to your office stating the authorization number, begin and end dates, CPT codes and number of visits authorized. Please contact ValueOptions to ensure your correct fax number is on file.

Do psychiatric evaluations (90801) require a prior authorization?

Each provider is allowed one outpatient psychiatric interview session per beneficiary per year without authorization. If another is required, you must obtain prior authorization.

Is a physician referral required for Licensed Mental Health Counselors to provide TRICARE patient services?

Yes. TRICARE policy requires services rendered by LMHCs, Licensed Professional Counselors and Pastoral Counselors have a physician referral prior to the initial evaluation, as well as continued oversight throughout the course of therapy in order to be reimbursed by TRICARE. A Letter of Referral should be submitted with the claim to PGBA, LLC.

My request for behavioral health services was denied. Can I appeal?

Yes. A written request for reconsideration, along with a copy of the denial letter, the necessary components of the medical record and any supporting documentation should be mailed to ValueOptions. You will be notified of a decision within 30 days.

Have copayments changed for behavioral health services?

Yes. Copayments for Medication Management (CPT 90862), Psychiatric Evaluation (CPT 90801) and Psychological Testing (CPT 96100–96117) have a \$12 copayment for TRICARE Prime retirees and their family members. Copayments for all other services remain unchanged.

Where do I send the consultation report?

Fax consultation reports to 1-877-850-9599. Receipt of the report is logged and matched with the appropriate authorization and then forwarded to the appropriate military treatment facility (MTF) PCM. ■

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Avoid Debt Collection and Understand the Role of the DCAO

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unremarried former spouses provide their own SSN rather than their sponsor's.)

Incorrect Procedure and Diagnosis Codes

Providers should enter the most current procedure and diagnosis codes on claims and confirm coverage before performing a procedure if there are any questions whether a service is a TRICARE-covered benefit.

Unpaid Beneficiary Copayment

Many times beneficiaries are not aware of or simply forget the copayment. Care should be taken to make the beneficiary aware of the copayment at the time of treatment to avoid problems. Active duty service members and TRICARE Prime active duty families have no copayment. Network

and non-network providers who accept assignment cannot charge the beneficiary more than the patient responsibility.

Claims Resolution Assistance

Humana Military assists providers with claims questions and problems through a claims priority unit. Contact the unit before initiating any collection action against a TRICARE beneficiary. Call 1-800-444-5445 for information about reaching the claims priority unit.

More information on claims submission requirements can be found in your *TRICARE Provider Handbook* or online at www.humana-military.com. Humana Military also offers provider training, workshops and briefings throughout the South Region. You can find more information about these educational opportunities online. ■

Understanding Hospice Care

Providers Can Ease Difficult End-of-Life Decisions by Helping Patients Make Informed Choices

Hospice care is a choice for TRICARE patients with a terminal illness who are expected to live less than six months. It is a global treatment approach that offers a broad variety of supportive, palliative care and services to meet patients' end-of-life needs. In keeping with the principles of family-centered care, the patient's wishes and those of family members and friends figure prominently in care decisions.

Here's what you should know when you counsel your patients about hospice care.

What Does Hospice Care Cover?

Hospice covers four levels of care: routine home care, continuous home care, inpatient respite care and general hospice inpatient care. One of these levels will be in use at all times, and patients often shift among all four, depending on their needs and the needs of family members who are supporting them.

Care within these levels may include physician services, nursing care, counseling, medical equipment and supplies, medications, medical social services, physical and occupational services, speech and language pathology, and hospice short-term acute patient care related to the terminal illness. Hospice care does not contain the limits on custodial care and personal comfort items currently in force under the basic TRICARE coverage rules. However, services for an unrelated condition or injury, like a broken bone or unrelated diabetes, are still covered as a regular TRICARE benefit.

What Doesn't Hospice Care Cover?

Room and board are not covered under hospice care unless the patient is receiving inpatient level of care.

Patients also cannot receive other services/benefits (e.g., curative treatment related to the terminal illness) outside the hospice coverage unless the hospice care is formally revoked. In other words, no care is covered by TRICARE unless the hospice provides it or arranges for it.

Beneficiaries must submit a signed, dated statement through the hospice provider to formally revoke the hospice election. This does not alter the beneficiary's ability to reenter hospice care at a later time.

What Is the Patient's Responsibility?

The patient has no deductible under the hospice benefit. The hospice provider may bill the patient for 5 percent of the cost of outpatient drugs, or \$5 toward each prescription, whichever is less.

The provider may bill the patient for a cost-share for each respite care day equal to 5 percent of the amount TRICARE has estimated to be the cost of respite care, after adjusting the national rate for local wage differences.

Where Is Hospice Care Provided?

Hospice care can be provided in a number of settings: at home, in a hospice facility or in a military treatment facility (MTF). Care can shift between these facilities without affecting the hospice benefit. For

example, suppose a hospice patient is receiving care at home, but his or her support system breaks down or the family member providing care needs a break. The patient can receive inpatient hospice care, or respite care, at an MTF or hospice facility as part of the hospice benefit.

How Should Hospice Care Be Initiated?

You should discuss hospice care with terminally ill patients who are considered to have six months or less to live as an option for them and their family members in handling their care. As part of their decision-making process, patients may also request a consultation with a hospice facility to ask questions and learn more about how they will be cared for. Referring providers may wish to participate in this consultation.

Either the patient, his or her PCM, or a family member acting on the patient's behalf can initiate hospice care, but the hospice will not take action without a doctor's order.

Patients must complete an "election statement" that indicates their understanding of what hospice care involves. This statement, available through the hospice facility, must be filed with the regional contractor. The patient must be enrolled in the Defense Enrollment Eligibility Reporting System (DEERS) to be eligible for and to initiate hospice care.

Hospice care is provided in three benefit periods, each of which requires prior authorization. The patient's PCM should initiate and obtain the prior authorization from Humana Military on the patient's behalf.

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Understanding Hospice Care

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The first two benefit periods are each 90 days long and begin on the day that a hospice election statement is signed by the beneficiary and a physician's certificate of terminal illness is signed by both the attending physician and the hospice medical director. The final benefit period comprises an unlimited number of 60-day periods, each of which requires recertification of the terminal illness.

How Can Beneficiaries Find a Hospice?

The best way for beneficiaries to find a TRICARE-authorized hospice is to use the regional contractor's provider directory. Humana Military's provider directory is accessible online at www.humana-military.com or by calling 1-800-444-5445.

How Are Hospice Care Decisions Made?

Once patients elect hospice care, their care is managed by the medical director of the hospice as part of the interdisciplinary clinical team managing the case, always in consultation with patients and their families. PCMs may stay involved and participate in the clinical team, as well as manage any acute needs outside hospice coverage.

Where Can I Find Additional Information?

Review Chapter 11 of the *TRICARE Reimbursement Manual* for detailed information. You can view it online at www.tricare.osd.mil/tricaremanuals. ■

Alternatives to Hospice Care

Patients who do not elect hospice care have other options. These options, outlined below, must be sought outside of a military treatment facility (MTF) and require prior authorization.

Home Health Care

**Covered,
Prior Authorization Required**

The services covered under TRICARE home health care are the same benefits as those covered under Medicare home health care benefits. They provide a maximum of 28 hours per week part time, or 35 hours per week intermittent, skilled nursing care and physical, speech and occupational therapy. All care must be provided by a participating home health care agency.

Skilled Nursing Care

**Covered,
Prior Authorization Required**

Skilled nursing care typically is not provided in a nursing home or a patient's home, but rather in a Skilled Nursing Facility (SNF). Under the SNF benefit, TRICARE covers skilled nursing care and rehabilitative (physical, occupational and speech) therapies, room and board, prescribed drugs, laboratory work, supplies, appliances and medical equipment.

For TRICARE to cover a patient's admission to an SNF, the patient must have had a qualifying medical condition that was treated in a hospital for at least three consecutive days. Admission to the SNF is covered as long as the patient is admitted within 30 days of his or her discharge from the hospital (with some exceptions for medical

reasons). You will need to demonstrate the patient's need for skilled nursing services for TRICARE to pay for the SNF care.

Long-Term Care

Not Covered

Long-term care (LTC), also known as "custodial care," involves primarily providing an individual assistance with activities of daily living or supervision of someone who is cognitively impaired. Long-term care can be provided in many settings, including nursing homes, assisted living facilities, adult day care or at a patient's home. Long-term care is not a TRICARE covered benefit.

Room, board and the services mentioned above that are a covered benefit for SNF care are not covered under Medicare or TRICARE if determined to be part of long-term care. Long-term care costs are the patient's responsibility.

Patients can purchase LTC insurance through commercial insurance programs or the Federal Long Term Care Insurance Program (FLTCIP). ■



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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



Web Bytes

PCM Central Offers Unique Tools for Primary Care Managers

Wouldn't it be nice if there were one online repository of information and resources that you could reference as you perform your duties as a TRICARE primary care manager (PCM)?

Now there is. Humana Military has created "PCM Central" to provide you and your staff members with the tools you need to manage TRICARE Prime beneficiaries' care effectively.

PCM Central is easy to access. Simply go to the home page of www.humana-military.com, click on "Provider Resources," then on "PCM Central."

Once there, you will find PCM tools that are not available anywhere else on the Humana Military site.

To access most of these tools, however, you need to establish an online services account. If you haven't already done so, you can register for an account by clicking the "Sign Up" link on the right-hand side of the page.

Once registered, you or your staff members can do the following through PCM Central:

- Check on the status of a referral, authorization or claim.
- Enter a new referral or authorization.
- Check a patient's eligibility.
- Check fee schedules.
- Look up diagnosis or procedure codes.

Two other important PCM Central features include "My TRICARE Patient List" and "Patterns of Medical Management Reports."

By clicking the My TRICARE Patient List link, you can view a list of your patients and even see all current patient claims.

The Patterns of Medical Management Reports feature allows you to review your patterns of care and compare those patterns with those of other providers of similar size. You can determine if your patients have a higher propensity of hospitalization, for example, or you can see whether your patients are being referred to specialists at a greater or lesser rate.

You'll also find the latest headlines, a link to the *TRICARE Provider Handbook* and more. For a guide on what else PCM Central offers, click the Site Demo link on the right-hand side of the page. ■