

New TRICARE Reserve Select Health Plan Launched April 26

Understanding Your Role

The new TRICARE Reserve Select program that started on April 26, 2005, provides some Reserve Component members¹ and their families continued access to TRICARE.

Reserve Component members called or ordered to active duty for more than 30 days in support of a contingency operation now have 180 days of health care coverage under the Transitional Assistance Management Program (TAMP) upon separation from duty and may also purchase further coverage under the new TRICARE Reserve Select health plan.

What Is the Coverage?

Individuals who purchase TRICARE Reserve Select receive comprehensive coverage similar to the coverage

available through TRICARE Standard and TRICARE Extra for active duty family member, including such TRICARE-covered services as:

- Urgent and emergency care, including ambulance services
- Family health care
- Obstetrics, gynecology and maternity services
- Clinical preventive services, including health screening and immunizations
- Behavioral health care, including partial hospitalization and residential treatment
- Annual eye examinations
- Durable medical equipment (DME) and supplies
- Ancillary services, such as laboratory and radiology
- Prescription drug coverage

They may receive care from any civilian TRICARE certified/authorized providers, TRICARE network or non-network. Care may also be accessed from an MTF on a space-available basis only. They also can fill prescription medications through MTF pharmacies, the TRICARE Mail Order Pharmacy (TMOP) program or at TRICARE retail network and non-network pharmacies.

For more information about covered services, refer to the *TRICARE Reserve Select Handbook* on the TRICARE Web site at www.tricare.osd.mil/reserve/reserveselect.

The TRICARE Reserve Select card looks very similar to a TRICARE Prime card. Look for “TRICARE Reserve Select” at the top of the card.

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From the Desk of the Medical Director

*John A. Polston, DO
GulfSouth Market Office
Medical Director*

After having been employed as the Humana Military GulfSouth Market Office Medical Director for only a month, I received a call from a health care finder (HCF) with profound concern in her voice. She explained that she had interviewed an active

duty service member and his 22-year-old spouse who had just given birth to their first-born child, a boy, who was afflicted with port wine stain deformities. These deformities are large vascular malformations that are exhibited by large, dark, wine-colored discolorations about the facial and neck areas.

The HCF went on to explain that the rather apprehensive father had researched the Internet and learned of a physician in New York willing to

schedule an immediate appointment to perform a new radical treatment on the infant. I reflected on my past encounters with families with children affected by port wine stain deformities and how these dreadful defects have devastated parents and children. I imagined the panic this young couple must be experiencing.

The HCF and the beneficiary services representative (BSR) at this TRICARE Service Center had the insight to

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Make a copy of the card for the patient's file as proof of enrollment. TRICARE Reserve Select requires that you collect the appropriate cost-share from the beneficiary at the time of the visit.

What Services under TRICARE Reserve Select Require Prior Authorization?

TRICARE Reserve Select beneficiaries require prior authorization from Humana Military for the following services:

- Adjunctive dental services
- Admission or transfer to skilled nursing facilities (SNFs), rehab hospitals, and long term acute care (LTAC) facilities
- Blepharoplasty
- Durable medical equipment (DME)—electronic hospital bed, continuous positive airway pressure (CPAP) machine, apnea monitor, patient lifts, pneumatic compressor, bone stimulator, continuous passive motion (CPM) machine, power vehicle or wheelchair, certain orthotics, certain prosthetics, any miscellaneous code if line item rental or purchase price is greater than \$500
- Home health services
- Hospice care
- Hysterectomy
- Inpatient nonemergency mental health admissions
- Outpatient mental health visits beyond the 8th visit or more frequently than one per week
- Reduction mammoplasty
- Septoplasty
- Speech therapy

- Transplants for solid organ and stem cell
- Termination of pregnancy
- Uvulopalatopharyngoplasty (UPPP)

Where Do I Submit TRICARE Reserve Select Claims?

TRICARE Reserve Select beneficiary claims should be submitted to PGBA in the same manner as TRICARE Standard/Extra beneficiary claims.

The claims address for submitting TRICARE Reserve Select claims is:

PGBA South Region
Claims Department
P.O. Box 7031
Camden, SC 29020-7031

TRICARE network providers should submit claims to Humana Military/PGBA using their current methodologies.

Where Should I Direct Questions?

Humana Military administers TRICARE Reserve Select in the TRICARE South Region and provides customer service, including plan enrollment and claims payment.

You may contact Humana Military at 1-800-444-5445 or visit www.humana-military.com if you have questions or need additional information about TRICARE Reserve Select.

You may also visit www.tricare.osd.mil/reserve/reserveselect for more information on coverage offered by TRICARE Reserve Select. ■

¹ *The Reserve Component (RC) includes the Army National Guard, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard, the Air Force Reserve, and the U.S. Coast Guard Reserve.*

Who Is Eligible for TRICARE Reserve Select?

Reserve Component members who meet the following qualifications may be eligible for the TRICARE Reserve Select program:

1. The member is called or ordered in support of a contingency operation under Title 10 for a period of greater than 30 days. (This is retroactive to Reserve Component members who were called to active duty in support of a contingency operation on or after Sept. 11, 2001.)

2. The member must have served continuously on active duty for 90 days or more under such call or order*—the length of time served determines the maximum period of coverage you may purchase under TRICARE Reserve Select.

** If the Reserve Component member is otherwise eligible, but did not serve continuously on active duty for 90 days under that call-up due to an injury, illness or disease incurred or aggravated while they were activated, they may be eligible for one year of coverage.*

3. The member agrees to serve in the Selected Reserve for a length of time (in whole years) equal to or less than the period of eligibility for TRICARE Reserve Select.

a. If the member separated from qualifying active duty service after April 26, 2005, the member must (1) enter into a Service Agreement by the last day of active duty, (2) execute the Service Agreement with the Service/Reserve Component and (3) submit a completed enrollment form and initial premium payment to Humana Military so they receive it 30 days before the end of TAMP.

b. If the member separated from qualifying active duty service on or before April 26, 2005, the member and the Service/Reserve Component must execute a Service Agreement no later than October 28, 2005. ■

Sign up Online for Upcoming TRICARE Seminars

The Online Provider Services section of the Humana Military Web site now offers the ability to view and sign up for upcoming TRICARE seminars.

The seminars, which cover a range of topics for understanding TRICARE and working with Humana Military, are ideal for TRICARE network and non-network providers and their staff members.

To use the new seminar sign-up tool, go to www.humana-military.com, click on "Provider Resources," then click on "Online Provider Services." Scroll down the page to the "Headlines" section and click on the link that says, "View the Local Provider Seminar Schedule."

For each seminar, under "Details," the tool lists:

- Seminar title
- The audience the seminar is designed to serve
- Location, date and time
- Number of seats that are available
- A brief description of the seminar and agenda
- A telephone number and/or directions

To find the seminar that fits your schedule more quickly, you can sort the list by location or date.

If you don't want to scroll through the entire list, you also use the "create custom list" feature that searches for

seminars according to city, ZIP code, date and/or audience (network or non-network providers) criteria.

Once you have chosen a seminar to attend, you can click that seminar's "Register" link and a new page will open to begin online registration. You will need to enter your 9-digit Provider ID and click the "New Reservation" button. The system then reserves your seat at the seminar, along with the number of seats for any additional personnel from your office who wish to attend. ■



From the Desk of the Medical Director

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conclude that there was certainly treatment available closer to their duty station. They requested that the parents allow them time to research the local area, and the family readily agreed.

After much research, they identified the Chairman of Dermatology at a major university who was able to treat the child, but unable to schedule an appointment within a month. Literature reveals that it is imperative that port wine stains be evaluated as soon as possible as the malformation may be associated with Sturge Weber Syndrome.

The BSR explained the sense of urgency to the physician, who in turn took the initiative to contact the family personally and schedule an evaluation.

Treatment for port wine stains can often be considered experimental; therefore, I requested that clinical findings be forwarded to me, as well as Humana Military Second Level Review (SLR). The BSR contacted the SLR associates and explained the urgency of the referral and recommendations by the dermatologist.

Following review of the clinical information submitted, it was

determined that the child would be scheduled for Pulse Dye Laser treatment within the recommended time frame.

There is no question that our associates strive to put the "I Care" in TRICARE. And we repeatedly experience our provider partners teaming with us and making every effort to lessen the worry, anxiety and apprehension that many of our military beneficiaries endure when having to cope with family separation coupled with unforeseen illness and disease. My hat's off to you! ■

HIPAA National Provider Identifier Simplifies Communication

One Unique Identifier for Providers Nationwide Will Make Coordinating Benefits Faster, Easier

One of the benefits of the “electronic age” is the speed at which data can be exchanged and transactions completed. But in the health care industry, progress has been hampered by the lack of industry-wide standards and the lack of a single, unique identifier for each health care provider.

“Until now, any health plan that providers work with could assign them an ID number to use with that health plan,” explains Sherry McKenzie, chief of operational architecture and HIPAA electronic standards for TRICARE’s Information Management Division. “Not only did that mean providers had to keep track of multiple ID numbers, but it also made coordinating benefits and exchanging information across health plans more difficult and expensive.”

The new National Provider Identifier (NPI) program, called for in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), will ease that complexity. Slated to begin May 23, 2005, the program gives providers a two-year window to apply for their unique NPI.

About NPI

The NPI is a 10-digit number that identifies a provider and will be required in all HIPAA-standard transactions. Each NPI will be assigned and managed by the National Plan and Provider Enumeration System (NPPES), a newly created federal registry, and will stay with the provider for life.

Providers who must participate include individuals (physicians, dentists, nurses, pharmacists, physical therapists, etc.), as well as organizations (hospitals, clinics, HMOs, laboratories, pharmacies, etc.) that provide health care.

McKenzie notes that the NPI is an important step toward making the health care industry more efficient.

“We are behind some other industries in being able to use electronic transactions for various administrative purposes. For example, the financial industry does almost everything electronically. Now, having this standard national identifier will help us to implement transactions and move the health care industry further into the electronic world.”

A Practical Approach

The NPI number itself does not contain built-in “intelligence,” such as the type of provider or the state where the provider is located. The information required to apply for an NPI is similar to what state licensing boards require.



The NPI will make that basic information about providers more accessible and easily exchanged among health plans, however.

LCDR Stephanie Bardack of the DoD Patient Safety Office notes the practical nature of the NPI in today’s world.

“In the past, when providers would spend their entire career practicing in one state, their information would be provided to the state,” Bardack says. “Today, many providers move about the country, and billing systems are much more complicated than they once were. Having a single number to identify a provider across the country just makes sense.”

What You Need to Do

Providers have between May 23, 2005, and May 23, 2007, to apply for their NPI, either online or by completing a paper application. You are urged to apply as soon as possible.

Once you receive your NPI, it will be yours for life and will not need to be renewed. You will be required to inform the NPPES of any changes to your information (such as a change of address) within 30 days.

Under NPI guidelines, health plans may also choose to use the NPI in non-HIPAA transactions to replace previously assigned ID numbers.

To Learn More

If you want to learn more about the NPI, visit TRICARE’s Web site at www.tricare.osd.mil/hipaa/identifiers.html. If you have specific questions, e-mail TRICARE at hipaamail@tma.osd.mil. ■

Certain Behavioral Health Providers Need 'Letter of Referral'

According to TRICARE policy, licensed mental health counselors (LMHC), licensed professional counselors (LPC) and pastoral counselors may provide covered mental services upon the referral and under the supervision of a physician.

Before treatment can begin, a physician must conduct an initial evaluation, make a diagnosis and agree with the counselor about a course of treatment. During the course of treatment, the physician must provide ongoing oversight with the LMHC, LPC or PC.

An M.D. or D.O. can provide the letter of referral. The letter of referral must be submitted with the first claim. If the provider is filing claims electronically, he or she can send the letter of referral by fax to 1-803-462-3990.

Psychiatrists, psychologists, licensed clinical social workers (LCSW) and licensed marriage and family therapists (LMFT) are not required to follow the letter of referral process. ■



Referral, Authorization Requirements Vary for Behavioral Health Services

TRICARE beneficiaries are covered for a range of outpatient and inpatient behavioral health care services. These include:

- Individual psychotherapy
- Group or conjoint therapy
- Crisis intervention
- Collateral visits
- Family therapy
- Psychoanalysis
- Medication management
- Substance use rehabilitation stays
- Inpatient hospital care
- Acute inpatient care
- Inpatient psychotherapy

Beneficiaries may seek eight unmanaged outpatient visits in each fiscal year (Oct. 1–Sept. 30) without a referral or authorization. Certain outpatient services, however, such as psychoanalysis, crisis intervention, psychological testing and substance use treatment, require prior authorization.

Since there is no way for a provider to ensure that the beneficiary has not exceeded his or her limit of eight unmanaged outpatient visits per fiscal year, behavioral health providers are encouraged to call for prior authorization for all outpatient behavioral health services.

All inpatient behavioral health admissions require authorization.

When a beneficiary has been referred for behavioral health care, TRICARE requires the rendering provider to fax a consult report to the PCM or referring provider within 10 working days of the initial visit. Emergency consult feedback is requested within 24 hours. Behavioral health care that has been self-referred does not require a consultation report.

For more information about behavioral health or substance use care, contact Humana Military's behavioral health contractor, ValueOptions, at 1-800-700-8646. ■

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 routine specialty referrals for initial office visits, 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 returned to the initiating provider are important 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. ■



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:

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*. ■

Requirements When Dual-Eligible Patients Seek Behavioral Health Care

Behavioral health care providers should be aware of the requirements for dual-eligible beneficiaries, those eligible for both Medicare and TRICARE, seeking behavioral health care.

Submitting Claims

For dual-eligible beneficiaries, TRICARE pays secondary to Medicare. (Exception: For active duty family members (ADFM)s who are dual eligible and only have Medicare Part A, TRICARE is the primary payer for outpatient services.)

All TRICARE dual-eligible claims are processed by a single, nationwide claims processing contractor—Wisconsin Physicians Service TRICARE For Life (WPS-TFL).

Since Medicare is the primary payer to TRICARE, behavioral health providers who care for these beneficiaries should continue to follow Medicare rules for claims processing and submit your dual-eligible claims to Medicare first. Medicare then pays its portion and electronically transfers these claims directly to WPS-TFL.

Certain licensed providers are not recognized by Medicare, including licensed mental health counselors (LMHCs), licensed professional counselors (LPCs) and pastoral counselors (PCs). These providers should submit electronic claims for beneficiaries eligible for TRICARE and Medicare to WPS-TFL at www.tricare4u.com or paper claims at the following address:

Claims Submission
Wisconsin Physicians Services
PO Box 7890
Madison, WI 53708-7890



Obtaining Prior Authorizations

Prior authorization is not required for outpatient behavioral health services for beneficiaries eligible for TRICARE and Medicare.

Authorization is also not required for inpatient behavioral health care, but providers should be aware that

the Medicare lifetime inpatient benefit is different for each level of care. Therefore, if a beneficiary has exhausted his or her Medicare lifetime benefit or his or her fiscal TRICARE benefit, then authorization is required. Authorization can be obtained from Humana Military's behavioral health care subcontractor, ValueOptions, by calling 1-800-700-8646.

Please note that ValueOptions does not authorize care for any dual-eligible beneficiary until he or she has exhausted the Medicare benefit. At that point, TRICARE would become primary payer, and ValueOptions would authorize inpatient care under the same process used to authorize inpatient care for TRICARE Standard beneficiaries. This procedure applies to inpatient services only because outpatient services for mental health do not have a benefit limit.

Also note that ValueOptions does not issue authorizations for LMHCs, LPCs or PCs to provide services to dual-eligible beneficiaries.

For more information, providers can call WPS toll-free at 1-866-773-0404, visit www.tricare4u.com, or mail inquiries to the following address:

Customer Service
Wisconsin Physicians Service
P.O. Box 7889
Madison, WI 53707-7889 ■

Web Speeds Up Referral and Authorization Requests

Wouldn't it be nice to obtain a referral or authorization for your TRICARE patients in as little as five minutes? You can.

Once you've become a registered user of the Humana Military Web site (www.humana-military.com), you and your staff members can enter a new referral or authorization request online.

An online referral or authorization can be accomplished in as little as five minutes, compared with potential telephone and fax referral wait times. One reason the online system is so efficient is that it automatically completes much of the information needed for you. The majority of online referrals and authorizations are approved on the spot and can be done while the patient is still in the office.

Providers can access the online referral and authorization section of the site by going to www.humana-military.com, clicking on "Provider Resources," "Online Provider Services" and then on the "Online Referrals and Authorizations" links.

If you are used to doing referrals and authorizations by fax or telephone, you may want to view the online tutorial available in the "Online Provider Resources" section.

In addition to shortening the initial referral and authorization process, the online system offers several other advantages. It lets you check the status of an existing referral or authorization, get a list of provider services, search for specialists and look up diagnosis and procedure codes.

The specialist search feature lets you search by ZIP code and specialty to find the closest provider for a given service. Or you can let the system find the most appropriate provider for you by inputting the patient's demographic information, Social Security number and diagnosis.

File Your Claim on the Web

For secure, fast, error-free electronic claims processing, go to Online Provider Services at www.humana-military.com to register for and use eZ TRICARE Claims. Your staff will be happier and your cash flow will improve. A winning combination. ■

Can't Find It on the Web

The Humana Military Web site (www.humana-military.com) now features a new search engine that finds answers to your TRICARE questions with greater speed and accuracy than ever before. It uses cutting-edge technology to understand questions and match them with relevant answers found within the TRICARE information on the Web site. ■

If you are unsure of a diagnosis code when building the referral or authorization request, you can use the system's diagnosis code look-up feature. Just enter a description that fits the diagnosis and the system will match the description to the proper code.

If you haven't already done so, you can become a registered user of the Humana Military Web site by clicking the "Sign Up" link on the right-hand side of the Online Provider Services page and following the prompts given by the "User Sign up Wizard." Keep in mind that only network providers have access to the referral/authorization screens. ■



Claims Corner

How Claims Are Checked and Reviewed

All claims sent to Humana Military and its claims contractor, PGBA, LLC (PGBA), are reviewed by two automated systems: ClaimCheck®, which looks for inconsistencies with the claim, as well as ClaimReview®, which reviews the consistency of diagnosis and procedure codes provided on the claim.

Unnecessary claim denials can be avoided if your office has a clear understanding of these systems and what they will reject.

ClaimCheck

ClaimCheck is a tool that evaluates professional billing for CPT code combination appropriateness.

Strictly following CPT coding guidelines will help eliminate claim rejects. You can avoid claim line rejects by assigning primary and supporting codes that denote the reason for the procedure, as well as any diagnosis that affects treatment.

Some of the ClaimCheck edits are:

- Procedure unbundling
- Incidental procedure
- Mutually exclusive procedure
- Assistant surgeon requirements
- Age conflicts
- Gender conflicts
- Unlisted procedures
- Duplicate and bilateral procedures
- Preoperative (preop) and postoperative (postop) surgical allowances

Any edits that ClaimCheck makes will be explained in a message code on the remittance. Humana Military updates ClaimCheck annually with new coding based on current industry standards.

Be aware that the government contract does not allow providers to bill

TRICARE beneficiaries for amounts considered by ClaimCheck to be unbundled or incidental.

TRICARE does not use ClaimCheck to review claims for pharmacy, physical therapy or inpatient institutional stays.

ClaimReview

ClaimReview is an automated module in ClaimCheck that considers the relationship between the submitted diagnosis and the procedures.

To avoid unnecessary claim line rejects, be careful to assign a diagnosis code that represents the reason the procedure is performed and provide information on any diagnosis that would affect the treatment.

ClaimCheck/ClaimReview Rejections

If you receive a ClaimCheck or ClaimReview rejection, you should review your medical documentation

for any additional appropriate diagnosis and submit it on a “corrected claim.”

After such review, if other diagnoses cannot be found, a reconsideration can be requested by sending supporting medical record information to the TRICARE South Correspondence address (below). When submitting a ClaimCheck/ClaimReview rejected claim for reconsideration, follow the process outlined on the back of the remittance.

If you have questions about claims edits, contact PGBA at 1-800-403-3950.

TRICARE South Correspondence
P.O. Box 7032
Camden, SC 29020-7032 ■

HA9—INVALID REND PHYSICIAN SSN

A common reason for rejected claims, this error message is returned when PGBA, LLC, the claims processor for the South Region, does not recognize the number submitted for Rendering Physician ID. The Rendering Physician ID is typically the SSN of the physician who rendered the service.

If you are located in Texas, Oklahoma, Arkansas, or the western half of Louisiana, you may have previously been sending a 4-digit alphanumeric “sub-ID” to the processor that had the contract prior to Nov. 1, 2004. Now that you are sending your TRICARE claims to PGBA, you need to send the rendering physician’s SSN in the Rendering Physician ID field.

For assistance with this error, or any other 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 either www.humana-military.com or www.mytricare.com for more information regarding electronic claims submission.

Remember, TRICARE requires all network providers to file claims electronically. ■

DoD Generics Policy

What You Need to Know

One year ago this June, Express Scripts, Inc. began administering the new, nationwide TRICARE Retail Pharmacy (TRRx) program. Thanks to this program, TRICARE beneficiaries can travel anywhere across the U.S. or its territories and have their prescriptions filled easily at any of 53,000 network retail pharmacy locations.

The TRRx program has also meant that the Department of Defense's (DoD) 10-year-old, mandatory generic drug program is now being enforced more consistently across the nation. This program requires that prescriptions be filled with the generic product, if one is available, at the generic copayment. If a generic equivalent does not exist, the brand-name drug is dispensed at the brand-name copayment.

Saving Millions

"DoD's long standing mandatory generic policy has saved our beneficiaries and taxpayers countless millions of dollars while providing quality pharmaceutical products," explains Col. James Young, director of DoD Pharmacy Programs for the Office of the Assistant Secretary of Defense.

"We encourage you to prescribe generic products whenever possible. In doing so, you help us conserve valuable resources that enable us to continue our commitment to provide the best pharmaceutical care to all our beneficiaries," continues Col. Young. "It is estimated that the use of generics saves DoD almost \$50 million per year, and it is a tribute to you that this process is working so well."

Generic medications work the same as their brand-name counterparts in dosage, strength, performance and use. They must meet the same Food and Drug Administration (FDA) quality and safety standards.



Prescribing Brand Name Instead

If you feel that a brand-name drug (for which a generic equivalent is available) is medically necessary for a beneficiary, it is recommended that you receive authorization from Express Scripts prior to writing the prescription. Otherwise, the beneficiary may be responsible for the entire cost of the medication.

Medical necessity waivers are approved if one or more of the following situations exist:

- The patient must experience, or would be likely to experience, significant adverse effects from the generic medication.
- The generic medication has resulted in, or is likely to result in, therapeutic failure.
- The patient has previously responded to the brand-name medication, and changing to the generic medication would incur an unacceptable clinical risk.

To obtain a medical necessity waiver, call the TRRx Prior Authorization Line at 1-866-684-4488. You will be asked to complete and submit a Prior Authorization Request Form (also available in the frequently asked questions (FAQs) portion of the Express Scripts Web site www.express-scripts.com/TRICARE).

Once Express Scripts has approved the request, you will receive a "letter of medical necessity," which the beneficiary must present with the prescription at the pharmacy. At that time, the pharmacist will provide the beneficiary with the brand-name medication at the brand-name copayment.

Getting More Information

For more information about the safety and reliability of generic medications, visit the FDA Web site at www.fda.gov.

To learn more about medical necessity waivers or the TRRx program, visit www.express-scripts.com/TRICARE or call 1-866-DoD-TRRx. ■

Healthy Choices for Life

Motivating Patients to Adopt Healthy Living Habits

Doctors aren't the only ones who understand the critical importance of healthy living. But often they are the ones who hold the keys to change.

Whether patients need to lose weight, adopt a healthy eating plan or quit smoking, you can play a critical role—particularly when patients are undergoing periods of relapse.

Dr. Bruce Berger, professor at Auburn University, Ala., suggests an approach called “motivational interviewing,” a method of communication used to encourage individuals to change.

When it comes to behavioral change, ambivalence is a common reaction, Dr. Berger said at a recent TRICARE conference. In fact, 70 percent of people who are faced with change do not feel ready to comply.

Dr. Berger suggests taking three to five minutes during patient visits to apply motivational interviewing techniques that can help individuals move past feelings of resistance and through several “stages of change” (see chart). The object is to move patients from one stage to the next rather than directly to action. Once each stage is achieved, action can occur and maintenance of the new behavior can be sustained.

Such motivational interviewing techniques include the following:

1. Assess the patient's readiness to adhere to a prescribed regimen.

This can be achieved by discussing “the good things and the less good things.” Discover what the patient likes and dislikes about the proposed changes. Discuss if the patient

believes he or she can do what is asked, what will help, and what might be potential barriers.

2. Help the patient move forward in the stage continuum by using stage-specific, tailored questioning.

Gauge the patient's lifestyle and how he or she views it. Asking the patient to describe a typical day's routine will help you to identify dietary needs/problems and exercise habits.

Posing questions such as “What is making it difficult to [insert behavioral change]?” or “What would have to happen in order to implement the change?” enable patients to create their own resolutions.

It is essential that patients recognize the benefits that will come from engaging in the changed behavior. Ask open-ended questions to determine how they believe they will benefit. If they don't know, or if they don't list all of the results, it is appropriate to share information to help them see the rewards that will likely come.

Dr. Berger suggests the following during motivational interviews:

When gathering information and assessing patients' needs: listen carefully, express empathy, help patients make their own decisions, roll resistance, avoid argumentation, develop discrepancy and support self-efficacy.

When eliciting change talk: ask evocative questions, explore readiness, explore the decisional balance,

elaborate, query extremes, look back/look forward and explore goals and values.

He also offers an acronym, GAWPOW, as a guide to help health care providers communicate and motivate change:

Goals—Discuss what the new regimen will do for the patient.

Action—Learn what actions are required to achieve results.

When—Establish a start date.

People—Discuss whether individuals or things can offer motivation.

Obstacles—Encourage the patient to be honest and realistic in removing barriers.

What—Establish what the patient will use to measure his or her success.

For more information about motivational interviewing and the stages of change, you can view the presentation Dr. Berger gave to Military Health System providers at the 2005 TRICARE Conference online at the link below.

Additional information can also be found in the June 2004 ACP Observer article, “Strategies to help patients change their behavior,” at the link listed below. ■

Healthy Choices FOR LIFE

Stages of Change

Pre-contemplation

Contemplation

Preparation

Action

Maintenance

Dr. Berger's presentation:

www.tricare.osd.mil/conferences/2005/ppt/086BBerger.ppt

ACP Observer article:

www.acponline.org/journals/news/jun04/behavior.htm

Humana Military Healthcare Services, Inc.
P.O. Box 740044
Louisville, KY 40201-7444

CONTACTS

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

PGBA (claims)
1-800-403-3950

**Wisconsin Physicians Service (WPS)
(TRICARE For Life claims)**
1-866-733-0404
www.tricare4u.com

ValueOptions (behavioral health)
1-800-700-8646

Pharmacy Customer Service
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CMAC Payments Now Based on 'Site of Services'

TRICARE CHAMPUS Maximum Allowable Charge (CMAC) changes for 2005 are effective for services rendered on or after April 1, 2005. The most significant changes to the CMAC include payments based on "site of services" as TRICARE will now implement similar payment methodologies utilized by Medicare.

Although payment based on site of service is a new concept to TRICARE, it is already used by Medicare to distinguish between services rendered in a facility setting as opposed to a non-facility setting.

Previous CMAC pricing by provider class will be superseded by the following four categories:

Category 1—Services of M.D.s, D.O.s, optometrists, podiatrists, psychologists, oral surgeons, occupational therapists, speech

therapists, physical therapists, and audiologists provided in a facility, including hospitals (both inpatient and outpatient where the hospital is generating a revenue bill, e.g., revenue code 510), residential treatment centers, ambulances, hospices, military treatment facilities, psychiatric facilities, community mental health centers, skilled nursing facilities, ambulatory surgical centers, etc.

Category 2—Services of M.D.s, D.O.s, optometrists, podiatrists, psychologists, oral surgeons, occupational therapists, speech therapists, physical therapists, and audiologists provided in a non-facility, including provider offices, home settings, and all other non-facility settings.

Category 3—Services, of all other providers not found in category 1, provided in a facility, including hospitals (both inpatient and outpatient

where the hospital is generating a revenue bill, e.g., revenue code 510), residential treatment centers, ambulances, hospices, military treatment facilities, psychiatric facilities, community mental health centers, skilled nursing facilities, ambulatory surgical centers, etc.

Category 4—Services of all other providers, not found in category 2, provided in a non-facility, including provider offices, home settings, and all other non-facility settings.

Note: Services and procedure codes not affected by payment based on site of service include anesthesia services, laboratory services, component pricing services, such as radiology and "J" codes.

Access the CMAC rates portion of the TRICARE Web site at www.tricare.osd.mil/cmhc/ to determine the new CMAC rates based on site of service. ■