

Three Medications Move to Non-Formulary Status

TRICARE has selected three medications to be designated as non-formulary: Nexium® (esomeprazole), a medication for ulcers and other stomach problems, and Teveten® (eprosartan) and Teveten® HCT (eprosartan with hydrochlorothiazide), both used to treat high blood pressure.

“With the selection of the first three non-formulary drugs, we have taken an important step in standardizing formulary management within the Department of Defense,” said Dr. William Winkenwerder Jr., Assistant Secretary of Defense for Health Affairs and director of TRICARE.

Patients currently using Nexium, Teveten or Teveten HCT may consult you about prescribing formulary alternatives. A summary of formulary alternatives to the non-formulary medications and their corresponding copayment is listed in the chart to the right.

Nexium, Teveten or Teveten HCT will not be routinely available on local military treatment facility (MTF) formularies. MTFs will be able to fill non-formulary

Non-Formulary	Formulary Alternative	Copayment
Nexium®	Omeprazole	\$3
	AcipHex®	\$9
	Protonix®	\$9
	Prevacid®	\$9
	Zegerid®	\$9
Teveten®/ Teveten HCT®	Avapro®/Avalide®	\$9
	Cozaar®/Hyzaar®	\$9
	Diovan®/Diovan HCT®	\$9
	Micardis®/Micardis HCT®	\$9
	Atacand®/Atacand HCT®	\$9
	Benicar®/Benicar HCT®	\$9

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From the Desk of the CMO

*Dr. Winston Blake
Medical Director, Southwest Market
Humana Military Healthcare Services, Inc.*

Shortly after the initiation of the new TRICARE contract, which covers the medical management of active duty members, we received an urgent call from an MTF for assistance with an active duty service member.

The member initially presented to the MTF with bone pain and was admitted to a local civilian facility where cancer

was diagnosed. The initial treatment plan was possible disarticulation of the involved limb due to rapid disease progression. A second opinion was sought at a civilian center of excellence.

A case manager was assigned and the member was transferred to a medical facility some 2,000 miles from his primary support structure, his spouse and young children. The case manager quickly became the vital link between the MTF, the civilian facility, the family and the member, thus alleviating much of the anxiety and hardship caused by his illness.

After confirmation of the initial diagnosis, the patient was treated with chemotherapy and an autologous stem cell transplant. Thanks to the sensitivity, compassion and professionalism of the case manager and the rest of the medical team, the member is doing well without the loss of any limbs. In this case, military and civilian providers, facilitated by Humana Military case managers proved to be an awesome team. Our thanks to each of you who help us write terrific stories of caring and healing like this each day. ■



Capital and Direct Medical Education Expenses

Here's How to Get Reimbursed

TRICARE will reimburse hospitals annually for their portion of capital costs which is derived from the allowable capital cost shown on Medicare reports. The capital costs will be reduced in accordance with the statutory reductions for Medicare.

In addition, for approved teaching programs, TRICARE will reimburse hospitals annually for direct medical education (DME) costs, which is derived from the allowable DME cost shown on the Medicare cost reports.

To fully understand the calculation of capital and DME costs, please refer to the TRICARE Reimbursement Manual, Chapter 6, Section 8.

TRICARE will provide reimbursement for capital and direct medical education expenses on an annual basis as long as the provider submits a timely request for such reimbursement and follows the necessary instructions. Such reimbursement is subject to a number of regulations, which are outlined for

you in the instructions for the TRICARE Request for Reimbursement of Capital and Direct Medical Education Costs Form.

You can download and print the form and the instructions from www.mytricare.com. Here's how:

- Start at the home page for My TRICARE (www.mytricare.com) and click on the "Forms" link on the left side of the page. Clicking the link will take you to a map. When you click on the South Region, you will see lists of forms for beneficiaries and sponsors and for providers.
- Under the list of forms for providers, click on the link to "Reimbursement of Capital and Direct Medical Education Costs."

When completing the form, you must give the total number of inpatient days, which is the number of days provided to all patients in units subject to diagnosis-related group (DRG) based payments. The request must be submitted

on or before the last day of the twelfth month following the close of the cost-reporting period, and the request must correspond to the Medicare cost-reporting period. Properly completed requests will be processed in 30 to 45 days. All providers must submit the applicable pages from their Medicare Cost Report. When requesting reimbursement, be sure to use an original signature because copied signatures will not be accepted.

The form requests information on the hospital name and address, the TRICARE provider number, the Medicare provider number, the period covered and total inpatient days. The form also requires the number of inpatient days that were "allowed" for payment, the total allowable capital costs, the number of full-time equivalent residents and interns, and the total number of inpatient beds.

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requests for these medications only if both of the following conditions are met:

- 1) An MTF provider writes the prescription, and
- 2) Medical necessity is established for these products.

MTFs may (but are not required to) fill a Nexium, Teveten or Teveten HCT prescription written by a non-MTF provider to whom the patient was referred by the MTF, as long as medical necessity has been established.

Establishing Medical Necessity

Proof of medical necessity is not needed in order for your patient to fill a non-formulary medication through the TRICARE Retail Pharmacy program or the TRICARE Mail Order Pharmacy program, unless your patient is an active duty service member. If you feel that it is medically necessary for your patients to receive a non-formulary medication instead of any of the formulary alternatives that

are on the Uniform Formulary, the medication can be provided at the formulary copayment if you can substantiate medical necessity.

Medical Necessity Forms are available on the TRICARE Pharmacy Web site www.tricare.osd.mil/pharmacy/medical-nonformulary.cfm. Procedures for how to complete and submit medical necessity information can be found on the form.

IMPORTANT NOTE ABOUT NEXIUM: Beneficiaries who already have a medical necessity determination for Nexium on file at the TMOP are required to reestablish medical necessity for the drug under the new medical necessity criteria approved by the Director, TMA in order to receive Nexium at the \$9.00 formulary copayment. Existing TMOP medical necessity determinations under the previous criteria for Nexium became invalid on July 17, 2005. ■

Clinical Peer Review Supports Best Practices in Behavioral Health Care

Many TRICARE providers have participated in peer review processes. Peer review provides the opportunity to have others look at your work and provide constructive feedback. It also helps ensure that patients are progressing and that treatment is appropriate.

Although most providers “start where the client is,” it is imperative in this cost-driven economy to remember that you as the provider are also “guiding treatment.” That means looking at individual needs and addressing issues so that behavioral health care patients can draw on the skills they learn and carry them over into their everyday lives. It does not mean that treatment is indefinite. Even chronic patients need to have the opportunity to put newly learned coping skills into practice and to manage in their communities with a variety of support systems that you can help facilitate.

Since the transition to the new TRICARE South Region, ValueOptions’ Utilization Management Department has implemented a peer review process for behavioral health care providers. The process gives you the opportunity for clinical peer review when requested care may potentially be denied. *It is important to understand that peer review affects only a small percentage of authorization requests.*

How Peer Review Works

Peer review is handled by the Utilization Management Department, which is made up of licensed professional social workers, marriage and family therapists, nurses and psychologists. Peer reviews are done by “like licensure” staff whose goal is to ensure that beneficiaries receive

care that is individualized and goal-oriented. This allows both providers and beneficiaries to determine how they are progressing and where they need to focus additional attention.

The ValueOptions peer reviewer will review requests for ongoing treatment and make decisions based on “best clinical practices” for the diagnosis, as well as individual clinical necessity. If adequate information is not available to make this determination, the reviewer will contact the provider by phone. The reviewer will ask for a written summary detailing why the beneficiary needs continued treatment, the goals of this treatment and an anticipated discharge date.

If the reviewer determines, after reviewing all clinical information, that the treatment meets clinical necessity, ValueOptions will fax an authorization in the usual manner. If requested services are denied, a letter will be mailed to you and the beneficiary that explains the appeals process.

Of course, if a beneficiary’s condition should change and you deem treatment to be indicated (even though a previous authorization request was denied), you should resubmit the request, noting the new circumstances. ValueOptions will consider these new developments in any subsequent treatment reviews.

If you have questions about peer reviews or utilization management, you can e-mail ValueOptions at provhelptricare@valueoptions.com or call your provider representative 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 these reports to be accurate and useful, you must provide complete and legible documentation.

Consult reports, “op” reports and discharge summaries returned to the

initiating provider are important for timely follow-up and continuity of care, so please be responsive when asked to return a consult report for TRICARE beneficiaries.

Providers who treat TRICARE beneficiaries referred from a local military treatment facility (MTF) may receive a faxed reminder to

return a consult report for a recent visit or service. Your office should return the consult report, “op” report or discharge summary requested and use the designated fax reminder page as the cover sheet. Please use only the fax number listed in the upper right corner of the reminder page. ■

Physicians in Shortage Areas Eligible for Bonus Payments

Since June 2003, network and non-network physicians (M.D.'s and D.O.'s) who qualify for Medicare Bonus Payments in Health Professional Shortage Areas (HPSAs) may be eligible for a 10 percent bonus payment for claims submitted to TRICARE. Moreover, since September 2003, podiatrists, oral surgeons and optometrists also have been able to qualify for bonus payments.

Recently, TRICARE determined that network and non-network primary care physicians who qualify for Medicare Bonus Payments in Physician Scarcity Areas (PSAs) may be eligible for a five percent bonus payment for claims submitted on or after Jan. 1, 2005. The five percent bonus payment does not apply to podiatrists, oral surgeons and optometrists.

Providers can determine if they are in an HPSA by accessing the U.S. Department of Health and Human Services, Bureau of Primary Health Care Web site at www.bphc.hrsa.gov, locating the Data Sources section and clicking on the HPSA Database link. There is also bonus payment information, including HPSA and Physician Scarcity Area designations, on the CMS Web site at www.cms.hhs.gov/providers/bonuspayment/.

How Bonus Payments Are Calculated

For those providers who are eligible and located in an HPSA, Humana Military's claims administrator, PGBA, LLC (PGBA), will calculate a quarterly 10 percent bonus payment from the total paid amount for TRICARE claims that contain modifiers QB (rural area) or QU (urban area) in Box 24d of the CMS-1500 claim form.

For those providers in a Physician Scarcity Area, PGBA will calculate a quarterly five percent bonus payment from

the total paid amount for TRICARE claims that contains the modifier AR (Physician Scarcity Area) in Box 24d of the CMS-1500 claim form.

Bonus payments will be calculated on TRICARE Prime, TRICARE Prime Remote, TRICARE Prime Remote for Active Duty Family Members, TRICARE Extra, TRICARE Standard and TRICARE Reserve Select claims and the amount paid by the government on other health insurance (OHI) claims. There can be only one HPSA and one PSA bonus paid for one service. The provider may receive both bonuses for a total of 15 percent on the same service.

When submitting a claim for the bonus payment, providers must include the QB, QU or AR CPT modifier in Box 24d of the CMS-1500 claim form. For CPT codes with multiple modifiers, place the QB, QU or AR modifier last. Only the professional component will be used in the calculation of the bonus payment for services that contain both a professional and technical component. Those providers who are eligible and do not submit claims with the appropriate modifier will not receive the bonus payment from TRICARE. There are no retroactive payments, adjustments or appeals for obtaining a bonus payment, so be sure to include the bonus payment modifier with your initial claims submission if you are eligible.

If you have questions about the bonus payments, contact Humana Military at 1-800-444-5445. ■

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If you have questions about how to complete the form, you can get more information on the www.mytricare.com Web site. You also may contact a Humana Military capital and direct medical education expenses specialist by calling 502-580-3420, faxing to 502-580-9708 or e-mailing to HMHSCapitalDirectMedEd@humana.com. To submit requests or to write to the capital and medical education expenses specialist, please use the following address:

Humana Military Healthcare Services
Attn: Claims Oversight Department—Polly Hall
500 West Main Street
Louisville, KY 40202

Any questions concerning these revisions should be directed to Suzanne Corum at Humana Military at 502-580-2603. ■

Diagnosing and Treating Service Members Returning from Southwest and Central Asia Deployments

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Physicians treating patients who have returned from deployments to Iraq, Afghanistan and Kuwait should be aware of some unique, possible exposures of this population. For example, service members could return home with diseases that are rarely seen in the United States, including infectious diseases that may not be apparent for some time after they first return.

While documenting medical history, it is critical that veterans be queried about where they have been, any symptoms or acute diseases they experienced during or after deployment, compliance with prophylactic medications and immunizations, any unusual environmental conditions they recall, and other items that you might normally consider when questioning about international travel and high-risk occupations.

Diseases that civilian physicians like you may encounter in this patient population can be considered in three broad categories:

- Common conditions that may or may not occur at a higher incidence in recently returned veterans, and for which the deployment may be either unrelated or an aggravating factor (e.g., chronic skin or respiratory problems)
- Diseases rarely seen in U.S. clinics or hospitals, but which occur fairly frequently in those who have served in Southwest or Central Asia (e.g., cutaneous leishmaniasis)

- Diseases that are relatively uncommon even among veterans of Iraq and Afghanistan but which, if missed or not appropriately treated, could have serious consequences (e.g., visceral leishmaniasis, falciparum malaria, Q fever and acute eosinophilic pneumonia)

This overview is by no means comprehensive, but it is meant to highlight three conditions that most U.S. providers are unlikely to have experience diagnosing or managing. This is not intended to be a definitive guide for these conditions, so you should pursue other sources for more clinical information (e.g., specific diagnostic tests, drugs of choice and dosages, etc.), as you would for any disease you do not normally encounter. A bit more space is devoted here to acute eosinophilic pneumonia simply because there is less literature generally available on this syndrome.

Leishmaniasis, Cutaneous

Cutaneous leishmaniasis (CL), an infection by protozoan parasites of the genus *Leishmania*, is being seen in increasing numbers of military and civilian personnel who have been deployed to Iraq, Kuwait and Afghanistan.

The parasite is inoculated into the skin by the bite of an infected sand fly. The incubation period is usually two to eight weeks, but may be years, depending on initial inoculum size.

Symptoms and signs are an inflammatory papule or nodule that slowly increases in size and ulcerates. Lesions may be hyperkeratotic and do not always ulcerate. There may be involvement of proximal lymph nodes. Psoriasiform, vesicular and eczematous lesions are not likely to be cutaneous leishmaniasis. The base will crust over, but the ulcer spreads under the edge of a firm and raised border. Lesions are usually on exposed skin (where sand flies might bite) and are rarely seen in the scalp or on the palms and soles.

Laboratory confirmation requires demonstration of the parasite (or PCR in a specialized laboratory). To obtain a specimen, first clean the ulcer base, then scrape the base and place scrapings onto a glass slide, and stain with Giemsa or Diff-Quick. Prepare Giemsa stained touch preps using a small full thickness skin biopsy from the lesion's edge. Divide the biopsy specimen longitudinally into halves for culture and histology. The diagnosis must be confirmed before treatment is offered.

Currently, antimony-based compounds are the drugs of choice for treatment of complicated CL. Treatment is generally with pentavalent antimonials, such as Pentostam® (sodium stibogluconate).

For detailed information on leishmaniasis diagnosis and treatment, refer to the following Web site information:

1. Army Policy for Management of Suspected Cutaneous Leishmaniasis,

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Office of The Surgeon General, 10 Sept 2004, which can be found at: www.pdhealth.mil/downloads/Guidance_for_Mgmt_of_Leish_Cases.pdf

Appendix 1, Clinical Policy Guidance for the Management of Suspected Cases of Cutaneous Leishmaniasis in Operation Iraqi Freedom and Operation Enduring Freedom

Appendix 2, Leishmania Scraping and Biopsy Procedures

2. Updated information paper, Emerging Health Issues: Leishmaniasis among Soldiers in OIF/OEF, 10 March 2005 at: www.pdhealth.mil/downloads/OTSG_Leishmaniasis_information_paper_10_MAR05.pdf

Malaria

Military and civilian health care providers may encounter malaria in service members and civilians returning from deployments in Afghanistan and Iraq. Malaria is transmitted by bites of infected anopheline mosquitoes and varies seasonally and geographically in these deployment areas. In the indigenous population in Afghanistan and Iraq, *Plasmodium vivax* accounts for 80 and 95 percent of diseases, respectively. *Plasmodium falciparum* is the cause of remaining cases. (These numbers may not be up-to-date due to relatively unreliable reporting in recent years because of conflicts and war in the countries.)

Malaria can present as soon as five days after arrival in an endemic area, and anytime thereafter, under conditions of continuous exposure. The usual incubation period for *P. vivax* is 14 days, but it can range from 12 days to 10 months even if a patient had been thoroughly compliant with prophylactic medication during

deployment (to suppress blood-stage malaria) and a two-week course of primaquine after departing the theater (to eradicate persistent hepatic parasites). Primaquine should be included in the treatment regimen for individuals with documented *P. vivax* malaria. Primaquine should not be given to pregnant or G6PD-deficient individuals. For more on treatment, see the CDC's treatment guidelines at www.cdc.gov click on "Diseases and Conditions" on the left side navigation bar, click on letter "M" and then click on "Malaria." Scroll down and click on "Clinicians/Healthcare Settings" then click on "Treatment of Malaria."

Acute Eosinophilic Pneumonia (AEP)

Acute eosinophilic pneumonia (AEP) is one of a heterogeneous group of disorders collectively termed the eosinophilic pneumonias or eosinophilic lung diseases. These disorders are characterized by eosinophilic infiltration of the lung, which may or may not be accompanied by peripheral blood eosinophilia. Eosinophilic pneumonia may be seen in association with a diverse group of known clinical disorders, including parasitic and fungal infections, immunologic and systemic diseases, and drug toxicity. These secondary forms can present as simple, acute or chronic eosinophilic pneumonia. In the absence of an identifiable cause, simple, acute and chronic eosinophilic pneumonia may also be idiopathic.

Eosinophilic lung disease can be diagnosed by several means. Infiltrates on chest radiographs combined with peripheral blood eosinophilia can be used to define eosinophilic pneumonia; however, this indirect approach has two limitations. First, peripheral blood

eosinophilia does not prove that infiltrates on chest radiographs are eosinophilic in origin, and second, eosinophilic infiltration of the lung is not always accompanied by peripheral blood eosinophilia. More directly, pulmonary eosinophilia can be assessed using bronchoalveolar lavage (BAL) or lung biopsy (open or transbronchial).

Patients with AEP typically present with an acute respiratory illness of one- to seven-days duration, manifested by fever, dyspnea, cough, pleuritic chest pain, myalgias, crackles on chest auscultation, hypoxemic respiratory insufficiency, bilateral diffuse infiltrates on chest radiographs, and increased eosinophils in BAL fluid or lung biopsy. Respiratory insufficiency progresses to respiratory failure requiring mechanical ventilation in a high percentage of cases.

AEP may be mistaken for other diseases, particularly community-acquired pneumonia, resulting in delayed or missed diagnosis. As defined by the North American-European Consensus Committee, many patients with AEP meet the criteria for acute lung injury (ALI), including its most severe subset—acute respiratory distress syndrome (ARDS). Distinguishing AEP from other conditions underlying ARDS, and from infectious pneumonia, is critical because of differences in response to corticosteroids and outcome. Patients with AEP characteristically show a rapid response to corticosteroids and have an excellent prognosis resulting in a favorable outcome in most patients, whereas non-AEP patients with ARDS do not benefit from corticosteroid therapy and have a poor prognosis with mortality rates reported to range from 10 percent to 90 percent.

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Peripheral blood eosinophil counts may be normal; however, 19 of 27 (70 percent) patients described in separate studies by Umeki and Philit had peripheral blood eosinophilia greater than 0.5×10^9 per Liter (500 per mm^3) at some point during the course of illness. Thus, the presence or absence of peripheral blood eosinophilia is of questionable value in diagnosing AEP, but it may serve as an important clue to guide additional, clinical steps particularly if the patient is already receiving antimicrobial therapy for a presumed infectious process, but not improving. BAL fluid provides an even more important clue to the diagnosis of AEP. BAL fluid eosinophilic percentages and total numbers are markedly increased in AEP, whereas ARDS is usually associated with increased neutrophils, and most viral and bacterial pneumonias typically are not characterized by BAL eosinophilia. In the appropriate clinical setting, BAL eosinophilia is itself adequate justification for a trial of corticosteroids without tissue biopsy. When BAL eosinophilia is present, the patient should be evaluated for known causes of pulmonary eosinophilia. BAL fluid should be cultured and

stained for infectious agents, as the most important point in the differential diagnosis is the exclusion of an infectious process.

The radiologic findings in AEP are similar to those of pulmonary edema, but other considerations in the radiologic differential diagnosis include pulmonary hemorrhage and either viral or atypical bacterial pneumonia.

AEP is associated with a variety of clinical disorders, including fungal and parasitic infections, immunologic and systemic diseases and drug toxicity. AEP has been strongly associated with initiation of cigarette smoking (or re-initiation after prior cessation). It has also been associated with inhalation of various agents, including dust, Scotchguard, heroin and smoke from fireworks. Although many associations are known, the exact cause or causes and the mechanism by which eosinophils are recruited into the lungs in AEP are unclear.

At least 20 troops serving in Operation Iraqi Freedom or Operation Enduring Freedom have developed AEP. These were typically new-onset smokers, but without another, consistent exposure

that set them apart from non-cases in a statistically significant manner. Still, ubiquitous conditions—such as high environmental particulate levels, or dusts or volatile organics associated with new construction—may have selectively induced AEP in genetically susceptible individuals whose lungs were “set up” by the immunological or physiological response to tobacco smoke. The deployment of such a large number of troops, combined with the significant increases in tobacco use that can be associated with deployments, may have further contributed to the clustering of otherwise rare cases.

AEP patients respond rapidly to corticosteroids and do not relapse once corticosteroids are discontinued. Spontaneous recovery also occurs. ■

References:

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Kotwal RS, Wenzel RB, Sterling RA, Porter WD, Jordan NN, Petruccioli BP. An outbreak of malaria in US Army Rangers returning from Afghanistan. *JAMA* 2005;293:212-216

Shorr AF, Scoville SL, Cersovsky SB, Shanks GD, Ockenhouse CF, Smoak BL, Carr WW, Petruccioli BP. Acute eosinophilic pneumonia among US military personnel deployed in or near Iraq. *JAMA* 2004;292:2997-3005. ■

Submitting Referral and Authorization Requests Online

Submitting your requests for referrals or authorizations online at www.humana-military.com is an effective and speedy method for processing your TRICARE referral and authorization requests. Web entry of referrals and authorizations includes some pre-populated information saving you time and eliminating paperwork. Follow these tips to ease the process:

Complete the request accurately.

You and your office staff can prevent problems and delays when entering a request by paying special attention to the required fields necessary to complete the referral or authorization for submission including the patient's gender and diagnosis. It is important that any referral or authorization request include complete and accurate information to prevent delays in processing and generating a confirmation.

Access the "Code Look-Up" feature.

Our "code look-up" feature provides you with immediate explanation on whether or not a referral or authorization is needed, as well as determination on covered versus non-covered services. Procedure requests will also inform you if the service is expected to be performed at an Ambulatory Service Center (ASC) according to ASC grouper crosswalk.

The code look-up feature helps to decrease the number of unnecessary requests your office may submit. Humana Military will not generate an approval for non-covered services or for those that do not require a referral.

Find a specific provider from the online provider listing.

If you have a preferred network provider you wish to select for the referral or authorization, our online services offer a listing of area network providers for you to choose. We are happy to make the selection for you.

By following these simple tips when using the online referral and authorization process, you will get the referrals you really need, faster!!! ■

Fax confirmations are generated for **approved** referrals and authorizations and will ensure the primary care manager and/or specialty provider are notified.

Beneficiaries will receive a letter with the approved referral or authorization, provider information and direction to call for an appointment. ■

Correction to TRICARE Provider News, Special Bulletin Edition, 2005: Issue 1

In the article entitled, "Navigating HIPAA and PHI," please see the revised answer below relating to the disclosure of health information to minors.

If a patient is a minor or is not competent to make health care decisions, may I release information to the parent or guardian?

Providers may release PHI to the parent or guardian without consent in most cases. Individual state law may prohibit the release of a minor's information for health

issues such as alcoholism, abortion, drug abuse, behavioral health, venereal disease or HIV. Please consult with your state law and see the FAQs available on the Health and Human Services Web site at www.os.dhhs.gov/ocr/hipaa for more information.

For questions regarding health information privacy or the Privacy Rule please contact HHS at OCRPrivacy@hhs.gov. ■

Join the Team! Show Your Support for Our Military at www.americasupportsyou.mil

As a TRICARE provider, you are already supporting our Armed Forces. But are you aware of the “AMERICA SUPPORTS YOU” campaign, and are your contributions being officially recognized?

The AMERICA SUPPORTS YOU campaign is a Web-based initiative at www.americasupportsyou.mil that is sponsored by the Department of Defense (DoD). The goal of this program is to provide an electronic forum for communicating public support directly to the dedicated men and women of our Armed Forces worldwide.

Since the campaign was launched in November 2004, the amount of community and corporate support has increased dramatically. The DoD’s Community Relations and Public Liaison representative says that approximately 700 people visit the site and register their support daily.

Secretary of Defense Donald H. Rumsfeld recently remarked on the overwhelming support for the program. “America’s support for the Armed Forces has been sustained and deep, spanning every segment of society—from families, schools and local communities, to multinational corporations,” he said. “All are doing their part to demonstrate a profound appreciation for the dedication and sacrifice of these brave men and women—and without a doubt, they deserve it.”

As a TRICARE provider, you make an enormous contribution to the lives of service members and their families. Your role is very important to the health and well-being of our nation’s military family. It is reassuring for active duty service members to know that the health care needs of their families back home, as well as their own upon returning home, will be met.

Visit the AMERICA SUPPORTS YOU Web site at www.americasupportsyou.mil today to register and join others in this important military support mission. Upon registration, you will receive a “dog tag,” bearing the official campaign logo, that you can wear to help publicize the program.

The Web site also features valuable information and resources about organizations with which you can become involved. You can read stories about what others are doing to encourage our men and women of the Armed Forces, discover ways to lend your support and read messages of appreciation from the troops.

You can also encourage your colleagues and others to support the troops, too. Visit the AMERICA SUPPORTS YOU Web site for downloads of official promotional materials that you can print out to help spread the word about this program. There are many ways you can take part in the AMERICA SUPPORTS YOU effort:

- Display and distribute promotional posters, brochures and other logo items in your office.
- Distribute AMERICA SUPPORTS YOU dog tags within your organization.
- Include AMERICA SUPPORTS YOU themes in your materials, publications, special events, activities, conferences and speeches.

Let our brave and dedicated servicemen and servicewomen know that you support them by actively participating in the AMERICA SUPPORTS YOU campaign. Visit www.americasupportsyou.mil today! ■

TRICARE Conducts Random Physician Surveys

Congress and the Department of Defense (DoD) want to know if the TRICARE program provides sufficient access to the health care services to military members and their families. While much of the care received by the active duty service members, retired service members, eligible family members and other beneficiaries is delivered within military treatment facilities (MTF) or by contracted networks of civilian providers, a substantial amount of health care is also delivered by civilian physicians who are not affiliated with military medicine, especially in those areas of the United States not near a military base.

As such, DoD’s TRICARE Management Activity (TMA) is asking civilian providers across the United States if they are accepting new TRICARE Standard patients and, if not, why

not. TMA will randomly survey full-time practicing civilian providers (MDs and DOs) from all 50 United States and the District of Columbia using a combination of mailed and telephonic questionnaires. If selected, the physician’s billing manager will be asked to answer the short survey on behalf of the physician. The survey will take about five minutes to complete. By surveying physicians over a three-year period, TMA hopes to gain a better understanding of the level of TRICARE Standard acceptance among civilian physicians throughout the United States.

The surveys meet the requirement of the National Defense Authorization Act for FY 2004. ■

Understanding TRICARE's Maternity Coverage

Maternity care involves the medical services related to prenatal care, labor and delivery, as well as postpartum care. Any woman eligible for TRICARE benefits can receive maternity care from the first obstetric (OB) visit through up to six weeks after the birth of the child. This includes spouses, eligible former spouses, spouses of retirees and TRICARE-eligible unmarried children of active duty service members (ADSMs).

Referrals and Authorizations

If you are the primary care manager (PCM) for a beneficiary who becomes pregnant, you'll need to either refer her to an obstetrics (OB) specialist or, if you are going to manage the pregnancy, handle the prior authorizations necessary throughout her pregnancy. Obstetric services require a prior authorization from Humana Military, which should be obtained at the mother's first appointment with you (the PCM) about the pregnancy. The prior authorization will begin with the first prenatal visit and remain valid until 42 days after birth. Prior authorization must be obtained for both inpatient and outpatient services.

If your patient is enrolled in TRICARE Prime and intends to deliver in a civilian (non-MTF) facility or birthing center, a separate prior authorization for the delivery portion of her maternity care must be obtained. The separate prior authorization should be obtained as soon as her pregnancy is confirmed.

What's Covered/Not Covered

TRICARE covers maternity-related treatment based on medical necessity.

TRICARE covers:

- Services and supplies associated with prenatal, childbirth, postpartum care and complications
- Epidural anesthesia for pain management during delivery
- An ultrasound, if medically necessary, (within the maternity care global fee). Determining gender is not considered medically necessary. Maternity ultrasound is covered (outside the global fee) only with diagnosis and management of conditions that constitute a high-risk pregnancy.
- TRICARE-certified/authorized birthing centers
- Emergency Cesarean section
- Circumcision

Prior authorization is also required for the following maternity-related services:

- Maternity inpatient stays (length of stay benefit cannot be restricted to less than 48 hours following a normal vaginal delivery or 96 hours following a Cesarean section)
- Planned Cesarean section and tubal ligation

TRICARE does not cover:

- Services and supplies related to noncoital reproductive procedures (artificial insemination, etc.)
- "Routine" ultrasounds are not covered. If a provider or beneficiary wishes to perform a "routine" ultrasound, it will not be covered in addition to or separately from the global maternity benefit. Beneficiaries can choose to pay for a routine ultrasound separately from their TRICARE benefits if they complete a "Request For Non-Covered Services Form" prior to the service being rendered.
- Off-label use of FDA-approved drugs to induce or maintain tocolysis
- Home Uterine Activity Monitoring (HUAM), telephonic transmission of HUAM data or HUAM-related telephonic nurse or physician consultation
- Lymphocyte or paternal leukocyte immunotherapy for the treatment of recurrent spontaneous fetal loss
- Salivary estriol test for preterm labor
- Personal comfort items such as private rooms and televisions after delivery

For more information about maternity care, contact Humana Military at 1-800-444-5445 or visit www.humanamilitary.com. ■

Electronic Claims Filing Assistance

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

You may also visit www.humana-military.com or www.mytricare.com for more information regarding electronic claims submission. ■

TRICARE Requires Use of National Provider Identifier

The Department of Health and Human Services (DHHS) adopted the Health Insurance Portability and Accountability Act (HIPAA) National Provider Identifier (NPI) final rule as the standard unique identifier for health care providers on Jan. 23, 2004. This rule became effective May 23, 2005, and affects both individual providers (e.g., physicians, nurse practitioners and pharmacists) and organizational providers (e.g., hospitals and pharmacies) who conduct HIPAA standard electronic transactions. Beginning May 23, 2007, providers must use the NPI when conducting HIPAA standard electronic transactions. The goal of the NPI is to simplify the administration of the health care system and enable efficient electronic transmission of health information.

Each individual health care provider will be assigned only one NPI that will be used for medical services provided under every medical plan or program (e.g., a civilian health plan like Kaiser or a military health plan like TRICARE).

Health care organizations may have multiple NPIs if they choose; for example, a hospital would be assigned an NPI and their outpatient departments, surgical centers and laboratories also may be assigned separate NPIs.

The NPI is meant to be a lasting identifier and would not usually change as a result of changes in a health care provider's name, address, ownership, membership in health plans or Healthcare Provider Taxonomy classification.

You may submit an electronic application for your NPI, via the Centers for Medicare and Medicaid Services (CMS) Web site at <https://nppes.cms.hhs.gov>. CMS will accept paper NPI applications from those organizations that have participated in their "pilot" test. CMS anticipates acceptance of paper applications for NPIs from all providers beginning July 1, 2005. More detailed information on the application process and where to submit applications can

be found on the CMS Web site at www.cms.hhs.gov.

The TRICARE Management Activity (TMA) will be implementing new requirements to ensure compliance by both contractors and providers. Once you obtain your NPIs, you will need to submit your NPIs to TRICARE in order to conduct HIPAA standard electronic transactions, such as electronic claims or electronic eligibility queries. More details regarding where to submit your NPI will be communicated as they are developed.

Where Can You Find More Information?

The TRICARE HIPAA Office of Electronic Standards has made several documents available online to provide additional information to providers. All materials can be found at www.tricare.osd.mil/hipaa/identifiers.html. Questions may be sent to the TMA HIPAA Office of Electronic Standards via e-mail at hipaamail@tma.osd.mil. ■

TRICARE Unveils New Extended Care Health Option (ECHO)

On Sept. 1, 2005, TRICARE's Extended Care Health Option (ECHO) will replace the existing TRICARE Program for Persons with Disabilities (PFPWD). This new program will continue to deliver financial assistance to active duty family member beneficiaries who have a qualifying condition as defined by the law. It will also continue to offer an integrated set of services and supplies that supplement the basic TRICARE program options—TRICARE Prime, TRICARE Standard and TRICARE Extra.

There are many similarities between PFPWD and ECHO, as well as differences. For example, the government's cost-share has increased

from \$1,000 to \$2,500 per month, and home health and respite care benefits have expanded.

TRICARE ECHO Eligibility

TRICARE ECHO is only available to active duty family members who have a qualifying condition. The following are qualifying conditions under both PFPWD and ECHO:

- Moderate or severe mental retardation
- A serious physical disability

The law adds an additional basis for a qualifying condition under ECHO:

- An extraordinary physical or psychological condition of such complexity that the beneficiary is homebound

Additionally participants will need to register in the members Exceptional Family Member Program to be eligible for ECHO.

Details to Come

Look for additional information about the new TRICARE ECHO program soon on the TRICARE Web site at www.tricare.osd.mil. Current PFPWD participants will be receiving letters explaining the change from PFPWD to ECHO.

If you believe that one of your patients has a condition that may qualify for services under TRICARE ECHO, contact Humana Military at 1-800-444-5445. ■

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
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

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Provider News is published by TRICARE Management Activity. Please provide feedback at www.tricare.osd.mil/evaluations/newsletters.



Speech Therapy and Requirements for TRICARE Beneficiaries Ages 3 to 21 Who Are Receiving Special Education Services

Sometimes speech, language and voice dysfunctions result from congenital anomalies, disease, injury, hearing loss, communication or pervasive developmental disorders or a therapeutic process. Speech therapy is a medical process to evaluate, treat, habilitate and rehabilitate those dysfunctions. Under TRICARE, these services may be cost-shared when medically necessary and provided or prescribed and supervised by a physician.

There are some speech services that are not covered by TRICARE. For example, services provided to address speech, language or communication disorders resulting from occupational or educational deficits are not covered. Myofunctional, or tongue thrust therapy, and videofluoroscopy evaluation in speech pathology are considered unproven and, therefore, are not covered.

For beneficiaries ages 3 to 21 who are receiving special education services from a public educational agency, such as the local school system, outpatient speech services

may be covered by TRICARE **only** when timeliness and intensity of the services needed cannot be provided by the public educational agency.

For beneficiaries age 3 to 21, who are receiving special education services from a public educational agency, Humana Military must first confirm that services cannot be received from the local school system.

The local educational agency will need to complete an Individual Educational Program (IEP) Form. (A Public Facility Use Certification Form is also acceptable and can be downloaded from the Humana Military Web site at www.humana-military.com under "Forms" in the Beneficiary Resources section.)

The completed IEP Form (or Public Facility Use Certification Form) should be faxed to Humana Military at 1-877-548-1547 to receive authorization. ■