

Skilled Nursing Facilities: Prior Authorization for TRICARE Dual-Eligibles

Skilled nursing facilities (SNFs) are now required to get prior authorization for care provided to Medicare-eligible TRICARE beneficiaries once Medicare benefits are exhausted and TRICARE becomes the primary health care coverage, or day 101 of the beneficiary's stay.

Medicare and TRICARE cover medically necessary skilled nursing care and rehabilitative therapies, including room and board, prescription medication and laboratory services, provided in the SNF. However, Medicare covers only the first 100 days of SNF care, while TRICARE covers treatment as long as it is medically necessary, at the appropriate level, and is a TRICARE-covered service. For TRICARE to reimburse the care, the beneficiary must receive care from a Medicare-certified and TRICARE-certified SNF and a participation agreement must be on file with TRICARE.

SNF Admission Criteria

TRICARE defines a SNF as a facility with the staff and equipment to provide skilled nursing, skilled rehabilitation or other medically necessary health care services including prescription medications. Skilled nursing care is not typically provided in a nursing home or a patient's home.

For TRICARE to cover your patient's SNF admission, he or she must meet the following criteria:

- The patient must be treated in a hospital for at least three consecutive days, not including the day of discharge
- The patient must be admitted within 30 days of hospital discharge (with some exceptions) to a SNF

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From the Desk of the CMO

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Humana Military Healthcare Services, Inc.'s (Humana Military's) improved provider data and referral systems now offer better matching of the proper specialist with the patient's needs, improving both specialists' and referring providers' experiences, and helping beneficiaries get the care they need quickly and efficiently.

Benefits for Specialists

The improved system is able to consider practice restrictions as well as exceptions to the services usually provided by similar specialists. This detailed practice information helps better match referred patients to

available specialists, reducing phone calls, unproductive visits and rescheduling.

Examples of restrictions are:

- Patient age limitations
- Preference for referral to group versus individual providers
- Not accepting new referrals

Examples of exceptions are:

- Electrophysiology studies in cardiology
- Hand surgery in orthopedics
- Not treating back patients in orthopedics

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- The patient’s treatment plan must demonstrate a need for medically necessary rehabilitation and skilled services
- The facility must be a Medicare-participating provider

The patient must be assessed using the Minimum Data Set (MDS) assessment form, even once TRICARE is the primary payer.

Dual-Eligible Beneficiaries

For TRICARE dual-eligible beneficiaries, during the first 100 days of an inpatient SNF stay, TRICARE will function as a secondary payer to Medicare. When TRICARE is the primary payer, the MDS assessment data may be collected for claim adjudication or audit and tracking purposes at any time.

For dual-eligible beneficiaries:

- For days 1–20, Medicare pays 100 percent
- For days 21–100, Medicare covers all costs, except for the required Medicare copayment; TRICARE covers the copayment
- After day 100, TRICARE is the primary payer and beneficiaries pay TRICARE beneficiary cost-shares

In order to avoid continued coverage issues or payment penalties, submit your prior authorization request with supporting documentation to Wisconsin Physicians Service on day 90 of the SNF stay. The form and additional information can be found at www.TRICARE4U.com. ■

Are You Ready for HIPAA 5010?

TRICARE Management Activity and Humana Military Healthcare Services, Inc. (Humana Military) are taking action to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Version 5010 transaction standards. HIPAA requires all covered entities in the health care industry to adhere to standards in the electronic transmission of health care transactions including claims, remittance, eligibility, claims status requests, their related responses and privacy and security standards.

The Version 5010/D.0 upgrade will replace Version 4010/5.1 transaction standards in order to improve and enhance administrative data exchanges.

According to the Centers for Medicare & Medicaid Services, Level II compliance with Version 5010 standards must be achieved by Dec. 31, 2011. Level II compliance means that “a covered entity has completed end-to-end testing with each of its trading partners, and is able to operate in production mode with the new versions of the standards.” All covered entities must be fully compliant by Jan. 1, 2012.

As you prepare for the HIPAA 5010 implementation, it is important to contact your vendor, clearinghouse, billing service or payer if they supply your software. They will provide detailed information on what steps your office or facility needs to take toward a smooth transition.

Here are some readiness questions you should ask:

- Will HIPAA 5010 and ICD-10 software upgrades or changes be provided in one or multiple releases?
- What will the cost of upgrades or changes be to my practice?
- When will upgrades or changes be available for testing?
- When can I begin testing each transaction (e.g., 837 Claims, 835 Remittance Advice)?
- Will I be required to test with each trading partner or payer?
- What are the steps and time frame for completing a testing cycle?
- Can 4010 and 5010 transactions be processed concurrently?
- How will I know my implementation has been successfully completed?
- What is my contingency plan if my systems are not compliant on Jan. 1, 2012? (**Note:** If your systems are not compliant, you may not submit claims electronically using 4010 transactions on or after Jan. 1, 2012.)

For additional information on Version 5010/D.0 standards, visit www.cms.gov/Versions5010andD0. ■

From the Desk of the CMO

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To inform Humana Military about restrictions and exceptions in your practice, go to www.humana-military.com, log in to MyHMHS for Providers, and select Office Administration Information. A provider relations representative will review your request and update your record.

Information for Referring Providers

For referring providers, Humana Military recommends submitting requests online through the MyHMHS for

Providers. The Web referral system will recommend a specialist and four alternatives, taking into account practice restrictions and exceptions, network participation, distance, quality and affordability.¹ Accepting one of these providers usually generates an immediate online approval. Directing the referral to a different provider may result in manual review, a request for additional information and a brief approval delay. Using the Web system to match beneficiaries to specialists can reduce calls and work for primary care offices. ■

1. Information about quality and affordability measures is available in MyHMHS for Providers at www.humana-military.com.

Humana Military's Web Secured Access

Humana Military Healthcare Services, Inc. (Humana Military) encourages TRICARE providers, their office staff and hospital and clinic personnel to register for MyHMHS for Providers, the secure Web portal. MyHMHS for Providers will allow you to verify patient eligibility, submit referrals and authorizations and offer optional electronic submission for your TRICARE claims.

You may register for MyHMHS for Providers by clicking the "Providers" link on www.humana-military.com. A Registration Wizard is available to guide you through the registration process. To begin, you must choose a unique user ID. The user ID allows you to change your password and personal information. After logging in with your user

ID, you will need to request access to one or more provider IDs to view secure data. Once Humana Military associates your user ID with your provider ID, you can add and modify secure information.

Note: If you have not accessed your provider ID within the last 180 days, your information will be removed.

For instant access to a provider ID, providers may opt for an express code. Express codes are created and maintained by site administrators in provider offices or by Humana Military provider representatives.

For more information about Web secured access, please visit the Humana Military website at www.humana-military.com. ■

TRICARE E-prescribing Initiative

Electronic prescribing (e-prescribing) allows you to safely and efficiently prescribe TRICARE-approved medication to your patients. TRICARE is encouraging all providers to begin using e-prescribing for TRICARE beneficiaries. By electronically submitting your patients' prescriptions directly to the pharmacy, you can reduce potential medication errors.

E-prescribing also offers you access to the TRICARE Uniform Formulary—a list of TRICARE-covered generic and brand-name drugs. The formulary tells doctors if a medication can be prescribed as a brand name or generic. Medications considered non-formulary are subject to higher cost-shares. Using the formulary while e-prescribing allows you to prescribe generic medications with the lowest out-of-pocket costs to beneficiaries and avoid medications not covered by TRICARE.

TRICARE beneficiaries who have maintenance prescriptions should consider using TRICARE Pharmacy Home Delivery. After military treatment facility (MTF) pharmacies, TRICARE Pharmacy Home Delivery is the least expensive option. The home delivery option delivers medications directly to your patients' homes, with up to a 90-day supply of medications for zero or minimal out-of-pocket costs depending on the medication's classification on the formulary (e.g., generic, brand name).

Note: Electronic prescriptions cannot be routed to MTF pharmacies at this time. ■

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www.myTRICARE.com

Behavioral Health
1-800-700-8646

Pharmacy Customer Service
1-877-363-1303
www.express-scripts.com/TRICARE

TRICARE Web Site
www.tricare.mil



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Provider Contracts: Credentialing Applications and Recredentialing

Humana Military Healthcare Services, Inc. (Humana Military) and its subcontractors ensure that physicians, licensed independent practitioners, facilities and other health care professionals within the TRICARE network meet credentialing and recredentialing criteria. Adherence to credentialing criteria that meets or exceeds Department of Defense (DoD) requirements ensures a quality health care system for TRICARE and quality health care experiences for TRICARE beneficiaries.

Once approved for participation, you are monitored for quality of care and adherence to DoD and Humana Military standards. Humana Military uses several methods to monitor quality, including:

- Recredentialing providers at least every three years
- Reviewing complaints and grievances
- Conducting focused clinical quality and preventive health studies

When you receive a recredentialing application from Humana Military, it is critical that you complete it and return

it to Humana Military as directed in the correspondence. This will ensure your network participation is maintained and there is no disruption to beneficiaries.

Note: If you do not return the completed recredentialing application within the specified time frame, Humana Military will start the process for removing you from the TRICARE network and reassigning beneficiaries, if you are a primary care manager.

Completing the recredentialing application is quick and easy. Simply review the prepopulated application, correct any discrepant data, answer the questionnaire and attach explanations, if necessary. Please pay special attention to your contact information (e.g., address, phone numbers, fax numbers). Next, sign and date the *Attestation Statement/Consent and Release Form*, attach a copy of your current Drug Enforcement Administration certificate and malpractice insurance declaration sheet showing you as the insured, as well as the amounts and dates of coverage, and fax or mail the form and attachments to Humana Military. ■