To better serve beneficiaries worldwide, the Department of Defense (DoD) is consolidating the TRICARE regions in the continental United States this year from 12 regions to three—West, North and South. The new regional contractors are TriWest Healthcare Alliance (West), Health Net Federal Services, Inc. (North) and Humana Military Healthcare Services, Inc. (South). This move is intended to simplify the administration of the TRICARE program and improve beneficiaries’ access to health care. It is also intended to make TRICARE more accountable to beneficiaries and providers alike, in particular by streamlining the various processes and steps that providers take to serve beneficiaries in a simpler and more efficient manner.

In addition to consolidating regions, the DoD “carved out” various other contracts (e.g., retail pharmacy, TRICARE For Life) for services that were previously administered separately by the regional health care contractors. Now these services are centralized under national contracts.

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**TRICARE’s Regional Consolidation**

To All Network Providers:

Health Net Federal Services Inc. (Health Net) has been selected by the government as the managed care support contractor (MCSC) for the TRICARE North Region. On behalf of Health Net, I welcome all our providers, former members of the Humana Military Health Services, Inc., (Humana Military) network and the Sierra Military Health Services (SMHS) network, as well as new providers joining our network, to the Health Net team.

It is our commitment as part of this outcomes-driven contract to provide TRICARE beneficiaries with high quality, “best value” health care, and with services that will result in a high level of beneficiary satisfaction. We know that our team, with your participation and professional support, will successfully deliver on our promise throughout the life of this contract.

I feel honored to be part of this effort and to be an associate of Health Net. As a retired United States Air Force Military Medical Officer, I am delighted to be back as a member of the TRICARE team, and I look forward to working with all of you.

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**Introducing Health Net Federal Services**

Health Net Federal Services, Inc. (Health Net) based in Rancho Cordova, Calif., with regional offices throughout the North Region welcomes providers to the TRICARE North Region. Having served as managed care support contractor for the West Coast and Southern areas of the United States for more than 15 years, Health Net has extensive experience administering the TRICARE program.

**Transition**

Now charged with managing the health care needs of the North Region, Health Net has completed the transition period and welcomes former Northeast Region providers familiar with Sierra Military Health Services and for former Heartland and Mid-Atlantic Region providers familiar with Humana Military Healthcare Services.

First and foremost, Health Net has selected PGBA, LLC (PGBA) for claims processing—the same subcontractor that you have been working with under your outgoing contractor. (See “Health Net Partners with PGBA for Claims Processing” on page 4 for more information.) Health Net is also working toward a smooth transition for beneficiaries, with no changes in continuity of care. Most providers under the outgoing contractors are being retained by Health Net.
TRICARE’s Regional Consolidation

continued from page 1

Known as “the next generation of contracts,” regional consolidation and carve-out programs are designed to improve health care portability for beneficiaries and simplify administrative processes for TRICARE and providers.

North Region Rollout Schedule

Each of the new TRICARE regions will be phased in according to a rollout schedule. In the north, former regions 1, 2 and 5 will become the TRICARE North Region and will begin working with Health Net.

Practices in the following states and locations become part of the North Region under TRICARE’s new consolidation plan, as of the following dates:

• Virginia*, West Virginia*, North Carolina, Kentucky, Ohio, Indiana, Illinois, Michigan, Wisconsin, and portions of Iowa (Rock Island Arsenal area), Missouri (St. Louis area), and Tennessee (Ft. Campbell area)—as of July 1, 2004

*Eastern West Virginia and Northern Virginia near Washington D.C. (former Region 1) will transition on Sept. 1, 2004

• Maine, New Hampshire, Vermont, New York, Pennsylvania, New Jersey, Connecticut, Rhode Island, Massachusetts, Delaware, Maryland, and the District of Columbia—as of Sept. 1, 2004

What’s New?

As a North Region provider, you will continue to deliver the same quality care you always have. There are minimal changes to the delivery of the TRICARE benefit. Most of what’s new will be administrative as you begin working with Health Net as part of the North Region.

Some referral requirements may be different from what you are accustomed to under the outgoing contractors, for example.

Regional Rollout Schedule

<table>
<thead>
<tr>
<th>Former Region</th>
<th>New Region</th>
<th>Date Effective</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Region 1 (Northeast)</td>
<td>North</td>
<td>Sept. 1, 2004</td>
<td>1-877-TRICARE (1-877-874-2273)</td>
</tr>
<tr>
<td>Region 2 (Mid-Atlantic)</td>
<td>North</td>
<td>July 1, 2004</td>
<td><a href="http://www.healthnetfederalservices.com">www.healthnetfederalservices.com</a></td>
</tr>
<tr>
<td>Region 3 (Southeast)</td>
<td>North</td>
<td>July 1, 2004</td>
<td></td>
</tr>
<tr>
<td>Region 4 (Gulf South)</td>
<td>South</td>
<td>Aug. 1, 2004</td>
<td>1-800-444-5445 <a href="http://www.humana-military.com">www.humana-military.com</a></td>
</tr>
<tr>
<td>Region 5 (Heartland)</td>
<td>South</td>
<td>Aug. 1, 2004</td>
<td></td>
</tr>
<tr>
<td>Region 6 (Southwest)</td>
<td>South</td>
<td>Nov. 1, 2004</td>
<td></td>
</tr>
<tr>
<td>Region 7/8 (Central)</td>
<td>West</td>
<td>Oct. 1, 2004</td>
<td>1-888-TRIWEST (1-888-874-9378)</td>
</tr>
<tr>
<td>Region 9 (Southern California)</td>
<td>West</td>
<td>July 1, 2004</td>
<td><a href="http://www.triwest.com">www.triwest.com</a></td>
</tr>
<tr>
<td>Region 10 (Golden Gate)</td>
<td>West</td>
<td>July 1, 2004</td>
<td></td>
</tr>
<tr>
<td>Region 11 (Northwest)</td>
<td>West</td>
<td>June 1, 2004</td>
<td></td>
</tr>
<tr>
<td>Alaska and Hawaii</td>
<td>West</td>
<td>July 1, 2004</td>
<td></td>
</tr>
</tbody>
</table>

If you are still unsure what region your practice is in, please see www.tricare.osd.mil.

How can I help TRICARE beneficiaries find answers to their questions about the transition to the North Region?

You can refer TRICARE beneficiaries to Health Net Federal Service’s enhanced, interactive customer service tools, including the Health Net Web site at www.healthnetfederalservices.com and the toll-free customer service line at 1-877-TRICARE (1-877-874-2273).

Click here to view referral requirements
Health Net Federal Services, Inc. (Health Net) makes every effort to provide you with a prompt response to TRICARE patient referral requests. So that the process runs smoothly, we have developed this information as a supplement to the TRICARE Provider Handbook to assist you with the referral system and improve our response time to you.

**When Do You Need a Referral from Health Net?**

You will find that many TRICARE patients do not need to have a specialty care referral coordinated with Health Net, as there are now fewer referral requirements. Coordinate your specialty care referrals with Health Net based on the following:

- **TRICARE Prime beneficiaries** who reside within an approximate 40-mile radius (defined by zip code) of a Military Treatment Facility (MTF) require a referral from Health Net.
- **TRICARE Prime and TRICARE Prime Remote For Active Duty Family Members** beneficiaries who do not reside in the approximate 40-mile radius of an MTF do not require a referral from Health Net.
- **TRICARE Prime and TRICARE Prime Remote For Active Duty Family Members** beneficiaries require referral from Health Net for non-network provider care, unless the beneficiaries choose to self-refer using their Point-of-Service (POS) option and pay higher out-of-pocket expenses.
- **Active duty service members** require a referral from Health Net for any civilian (network or non-network) provider specialty care including notification of emergency room services.
- **TRICARE Standard and TRICARE dual eligible** (i.e., those with Medicare Part B coverage) beneficiaries do not require a referral from Health Net.

TRICARE Prime and TRICARE Prime Remote For Active Duty Family Members beneficiaries must still coordinate their referrals through their PCM and network specialty care providers, except for preventive care services (refer to your TRICARE Handbook) and the eight initial outpatient behavioral health visits from network providers. TRICARE Standard beneficiaries may self-refer to TRICARE-authorized providers.

**Completing the TRICARE Service Request/Notification Referral Request Form**

- **To obtain a referral,** you will need to complete the TRICARE Service Request/Notification Form:
  - Access either the Microsoft Word or Adobe Acrobat version of the TRICARE Service Request/Notification Form online through the Health Net Web site (www.healthnetfederalservices.com) under the Provider - Authorizations section of the site. A sample completed form and detailed instructions are also on the site.
  - You can type in each form field and complete the form without having to hand write the information.
  - If you choose to fill out the form by hand, be sure to write legibly so that all letters and numbers are clear. A copy of the form has been included with this communication.
  - Print the form and fax it to Health Net at 888-299-4181
- **Fully complete every section** of the form so that we have all of the information we need to process your request and be sure to include clinical history/previous treatment and supporting test results.

**Fax your referral requests to Health Net at 888-299-4181**

- **Do not include a fax cover sheet. Please fax each patient referral request separately.**
- **Urgent requests:**
  - When service is needed within 72 hours, write “URGENT” in large capital letters at the top of the form to identify requests that need expedited processing.
  - When service is needed within 24 hours, call Health Net at: 877-TRICARE (877-874-2273)
- **For routine referrals,** submit requests a minimum of seven (7) days prior to the anticipated date of service.

**Note:** If you have an approved referral from Humana Military Healthcare Services (former Regions 2/5) or Sierra Military Health Service (former Region 1), Health Net will honor the services and dates as approved.

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1. The 40-mile radius (defined by zip code) around an MTF is also referred to as an MTF Prime Service Area (PSA).
2. During the referral process, Health Net will also confirm if the MTF offers the specialty service being requested and determine its ability to accept the patient, before care is referred to the civilian network.
Health Net Resources

Health Net has developed a variety of resources to aid you and your staff during the North Region transition period and well into the future. “You can expect Health Net to bring an enhanced level of service to you by making services available through the phone, Web and personal contacts, and by encouraging regular and ongoing communication regarding program activities and events,” explains Scott Kelly, Health Net senior vice president.

IVR System

Health Net’s Interactive Voice Response (IVR) system is available 24 hours a day, seven days a week through the toll-free service line, 1-877-TRICARE (1-877-874-2273).

The IVR system responds to your natural speech patterns or to touch tone responses. It is an easy way to get answers to routine questions, such as verifying beneficiary eligibility, learning a TRICARE allowable charge rate and checking the status of claims.

When you call, say “Provider” to access the menu of services.

If you prefer to speak to someone directly, service representatives are available from 8 a.m. to 7 p.m. Eastern Time and from 7 a.m. to 6 p.m. Central Time.

Internet Portal

Health Net has also developed an Internet portal for North Region providers that gives you everything you need at your fingertips. Go to www.healthnetfederalservices.com, go to your region, then click on the “Provider” tab at the top of the page and create your own account. Registration is fast and simple. Once you have an account, you can view and easily manage multiple tasks:

- Verify patient eligibility
- Submit claims online
- Check claims status
- View electronic summary payment vouchers (online remits)
- Reconcile claim payments
- Sign up for electronic funds transfer (EFT)
- View hospital comparison information
- Send secure e-mail
- Find network specialty providers
- View your patients’ benefits information (through “patient eligibility”)
- Conduct patient information searches (through “patient eligibility”)
- View the TRICARE Provider Handbook, newsletters and bulletins online as they are published and/or updated
- See an overview of Healthy People 2010 to learn how you can play an active role

You’ll find that managing these everyday tasks will be so much easier using the Health Net provider portal. TRICARE information is also available at www.tricare.osd.mil/provider.

Provider Handbook

In addition to using the above resources, you will want to read the new North Region TRICARE Provider Handbook closely. It offers extensive information about the TRICARE Program and working with Health Net.

If you have not received your handbook or if you have additional questions, call Health Net toll free at 1-877-TRICARE (1-877-874-2273) or visit the Health Net Web site at www.healthnetfederalservices.com.
Transition Edition 2004

Health Net Partners with PGBA for Claims Processing

Health Net Federal Services, Inc. (Health Net) has partnered with PGBA, LLC (PGBA) of South Carolina to serve as the claims processor for the North Region. PGBA is the same claims processing subcontractor that providers in the north have been working with under their outgoing managed care support contractors. This decision simplifies your transition to the North Region in a number of ways, including:

• All claims clearinghouses that you used previously will continue to function after the transition.
• If you are already registered to submit electronic claims on myTRICARE.com, you can continue to use your existing password and submit claims the way you always have.

Claims Submission Transition

Your claims processor might not be changing, but the mailing address is.

Network providers in the North Region are required to submit claims electronically (see “Health Net and PGBA Offer Three Electronic Claims Submission Options” on page 5). Paper claims from non-network providers should be addressed to:

Health Net Federal Services, Inc.
c/o PGBA, LLC/TRICARE
P.O. Box 870140
Surfside Beach, SC 29587-9740

For health care services you provided prior to your area’s transition date, you can continue submitting claims as you always have. Claims submission transition information is as follows:

• Providers in former Regions 2 and 5 should continue to submit claims to Humana Military Healthcare Services/PGBA for services provided before July 1, 2004. For services on or after July 1, 2004, you should submit claims to Health Net/PGBA.
• Providers in former Region 1 should continue to submit claims to Sierra Military Health Services/PGBA for services before Sept. 1, 2004. For services on or after Sept. 1, 2004, you should submit claims to Health Net/PGBA.

Claims Processing Timelines

To avoid delayed payments, make sure to include all required information on a claim, including your provider identification number, referring physician’s full name and medical degree, prior authorization number, and in the occasional instance of paper claims, a signature.

Most “clean” claims will be processed within 30 days. If a claim takes more than 30 days, you will generally receive interest in addition to the payment amount.

You can check the status of claims on Health Net’s Web site, call customer service (1-877-TRICARE) or write to Health Net Federal Services, Inc., c/o PGBA, LLC/TRICARE at the above address.

Appealing Denied Claims

If you should disagree with a Health Net decision, you have a number of recourses, depending on the situation.

Administrative Review

To appeal a medical claim with Health Net, network providers must go through an administrative review process. In requesting a review, you will have to state what you disagree with in Health Net’s handling of the claim.

You can request administrative reviews for the following reasons:

• If a payment was reduced because no authorization was on file and extenuating circumstances prevented you from obtaining an authorization
• If a claim was denied as not medically necessary
• If a request is sent from a beneficiary for a review of services

All requests should include the sponsor’s Social Security number, the patient’s name, the date of service and your contact information. Also include a statement of the facts involved in the request and documentation to support the claim. Medical necessity reviews will be sent to an independent peer reviewer.

You must send written requests for reviews within 90 days of a claim’s denial. Send administrative review requests to:

Health Net Federal Services, Inc.
c/o PGBA, LLC/TRICARE Administrative Reviews
P.O. Box 870148
Surfside Beach, SC 29587-9748.

Allowable Charge Review

If you disagree with the reimbursement allowed on a claim, you can request an allowable charge review.

continued on page 5
Health Net and PGBA Offer Three Electronic Claims Submission Options

Like many companies in the health-insurance industry, Health Net is dedicated to promoting electronic claims. In fact, all network providers are required to submit all claims electronically after the North Region transition.

Electronic claims will help network providers submit cleaner claims, receive payment faster and reduce paperwork.

With electronic claims tools, users are required to provide all the necessary information before submitting claims. If something is missing, the system automatically prompts the user to provide the additional information. Please note, there is no requirement for attachments when you submit claims electronically. If Health Net/PGBA need additional information from you, they will contact you directly. This will NOT delay the processing of your claim or any payment.

By submitting claims electronically, you can also receive direct payments through electronic funds transfer (EFT). The service is free, and with EFT, you don’t have to wait for the check to arrive in the mail. You can sign up for EFT at www.healthnetfederalservices.com or www.myTRICARE.com. Also, instead of waiting for remits in the mail, you can view them online or request electronic remit statements.

Health Net and PGBA offer three options for submitting claims electronically.

**XPressClaim**

For providers who submit less than 150 TRICARE claims per month, Health Net recommends the XPressClaim™ option, available on www.healthnetfederalservices.com and on www.myTRICARE.com.

Providers must register online, but the service is free. There is no additional hardware or software to buy so long as a provider has access to the Internet.

XPressClaim accepts CMS-1500 and UB-92 claims. The system will adjudicate most TRICARE claims upon submission and will provide a clear explanation of what TRICARE allows and what the patient owes. It also uses encryption technology to transmit claims securely and protects confidentiality in compliance with rules under the Health Insurance Portability and Accountability Act (HIPAA).

**Companion Direct**

For larger provider practices that may prefer to use a claims clearinghouse, Health Net recommends Companion Direct. Companion Direct has an existing relationship with PGBA.

For more information, visit www.companiondirect.com, or call 1-888-CTHELP1 (1-888-284-3571).

**Other Clearinghouses**

You are also welcome to use other clearinghouses. Established clearinghouses may allow you to submit claims to other payers besides TRICARE, and your office staff may already be familiar with other systems.

Clearinghouses that worked with TRICARE previously in the North Region should continue to work with the Health Net/PGBA following the transition.

For help in deciding which electronic claims option is best for you, call 1-877-EDI-CLAIM (1-877-334-2524).

**Appealing Denied Claims**

These requests must also be made within 90 days, but providers can make them by phone at 1-877-TRICARE (1-877-874-2273). Make sure you have a copy of the claim and the TRICARE EOB or Summary Payment Voucher, as well as supporting medical records and any new information that was not originally submitted with the claim. Send allowable charge review requests to:

Health Net Federal Services, Inc.
c/o PGBA, LLC/TRICARE
Allowable Charge Reviews
P.O. Box 870141
Surfside Beach, SC 29567-9741
As of June 1, 2004, Express Scripts, Inc. of Maryland Heights, Mo., became the sole benefit manager of the Department of Defense (DoD) TRICARE Retail Pharmacy (TRRx) program.

Previously administered by the TRICARE managed care support contractors in each region, the retail pharmacy benefit was not portable for beneficiaries traveling out of their regions. Under the new nationwide program, beneficiaries now have access to a network of about 53,000 retail pharmacies throughout the U.S., the District of Columbia, Guam, Puerto Rico and the U.S. Virgin Islands.

For providers, there is not much change under the new TRRx program.

- The same rules concerning TRICARE covered and non-covered medications apply.
- There are no changes to the current quantity limits, as listed on the DoD Quantity Limits for Prescription Drugs and Products page (www.pec.ha.osd.mil/qtylimit.htm).

Prior Authorization Determinations

Through the DoD Pharmacy and Therapeutics (P&T) Committee, the list of medications requiring prior authorization is being standardized across all TRRx points of service and the TRICARE Mail Order Pharmacy (TMOP) program. The list of medications requiring prior authorization under TRICARE will likely continue to be very small.

The DoD P&T committee will meet quarterly, and over time may make changes to the list of drugs requiring a prior authorization. TRICARE formulary information, to include drugs requiring prior authorization, may be found at: www.tricare.osd.mil/pharmacy.

Please review the following list of drugs requiring prior authorization as of June 2004 that may affect your practice. The generic equivalent for each drug is noted in parentheses.

- Viagra (Sildenafil)
- Levitra (Vardenafil)
- Cialis (Tadalafil)
- Enbrel (Etanercept)
- Humira (Adalimumab)
- Injectable gonadotropins [fertility agents], including: follitropin alfa, follitropin beta, menotropins, urofollitropin (Gonal-F, Follistim, Humegon, Pergonal, Repronex, Fertinex, Bravelle)
- Kineret (Anakinra)
- Lamisil (Terbinafine oral)
- Penlac (Ciclopirox)
- Raptiva (Efalizumab)
- Sporanox (Itraconazole)
- Human Growth Hormone

For most drugs, prior authorizations are valid for one year, so in most cases, you do not need to take additional action to continue prior authorizations determinations that the previous TRICARE pharmacy benefit manager authorized for your TRICARE patients prior to June 1, 2004.

New prior authorization forms for both the TRRx and TMOP programs are available on the Express Scripts Web site (www.express-scripts.com/TRICARE) or by calling 1-866-DoD-TRRx or 1-866-DoD-TMOP.

TRICARE has a long-standing mandatory generic drug policy and will not pay for branded products when generic alternatives exist, unless a medical necessity is justified.

Centralized Customer Service

Under the new TRRx contract, Express Scripts handles all provider and beneficiary customer service questions related to the TRICARE pharmacy benefit. A single retail pharmacy customer service line is now available at 1-866-DoD-TRRx (1-866-363-8779).

Providers are encouraged to inform patients that they should no longer contact TRICARE Service Centers (TSCs) for questions about the TRRx Program and instead use the new customer service line above.
DoD Uniform Formulary Creates New Three-Tiered Pharmacy Cost Structure

This year, TRICARE is establishing a single, national Uniform Formulary under the TRICARE Pharmacy Benefits Program, implemented through Title 32 Code of Federal Regulations, Part 199.21. Major provisions of the rule include the establishment of:

- A new Department of Defense (DoD) Pharmacy and Therapeutics (P&T) Committee
- A Beneficiary Advisory Panel (BAP)
- A three-tier cost-share structure for the pharmacy benefit.

When the final rule for the new formulary was published in April 2004, Dr. William Winkenwerder, Jr., assistant secretary of defense for health affairs, explained, “The formulary will bring consistency and standardized management to our $4 billion pharmacy benefit. The new tiered cost structure encourages a more cost-effective use of the benefit, while also providing beneficiaries with continued access to the medications they need.”

Charged with establishing and maintaining the DoD Uniform Formulary, the DoD P&T Committee is a representative group of uniformed services clinicians, primarily physicians and pharmacists. The physicians and pharmacists on the committee will evaluate prescription drugs based on their relative clinical and cost effectiveness when compared with other drugs in the same therapeutic class to recommend in which tier a drug should be categorized.

The committee will meet on a quarterly basis. Any committee recommendations regarding the DoD Uniform Formulary will be reviewed and commented on by the BAP. Committee minutes and BAP comments will then be forwarded to the Director of the TRICARE Management Activity for approval.

How does the DoD Uniform Formulary affect the TRICARE Pharmacy benefit?

Drug coverage under the TRICARE Pharmacy benefit has not changed; however, cost-shares for certain drugs may change should they be moved to the third-tier (non-formulary tier) under the DoD Uniform Formulary.

Changes to the formulary tier for specific medications will be communicated to providers via this newsletter or on the TRICARE Pharmacy Web site (www.tricare.osd.mil/pharmacy), in addition to other electronic and print media.

The Cost of Filling Prescriptions

Cost-shares for the TRICARE pharmacy benefit are detailed in the chart below. Note that the cost-shares for generic and formulary medications remain unchanged.

Drugs moved to the third tier (non-formulary status), however, may be prescribed and dispensed to the beneficiary at the third tier cost-share.

Non-formulary (third tier) drugs may also be cost-shared at the formulary (second tier) amount, if documentation is submitted to TRICARE to validate that the non-formulary drug is medically necessary compared to the formulary products. For example, the patient cannot use comparable formulary medications because of allergic reactions, etc.

Additionally, TRICARE has a long-standing mandatory generic drug policy and will not pay for brand name products when generic alternatives exist. TRICARE will cover brand name drugs when generic alternatives exist, only if you justify medical necessity for use of the brand name drug.

More information on the pharmacy benefit and formulary coverage may be found at www.tricare.osd.mil/pharmacy.

TRICARE Pharmacy Cost-Shares

<table>
<thead>
<tr>
<th>Place of Service</th>
<th>Generic</th>
<th>Formulary (brand name)</th>
<th>Non-formulary</th>
</tr>
</thead>
<tbody>
<tr>
<td>MTF Pharmacy</td>
<td>$0</td>
<td>$0</td>
<td>$0 (only available with validated medical necessity)</td>
</tr>
<tr>
<td>TMOP (up to a 90-day supply)</td>
<td>$3</td>
<td>$9</td>
<td>$22</td>
</tr>
<tr>
<td>Retail Network Pharmacy (up to a 30-day supply)</td>
<td>$3</td>
<td>$9</td>
<td>$22</td>
</tr>
<tr>
<td>Non-network Retail Pharmacy (up to a 30-day supply)</td>
<td>$9 or 20% of total cost (whichever is greater) after deductible has been met (E1-E4 $50 per person/$100 per family; All others $150 per person/$300 per family)</td>
<td>TRICARE Prime—50% cost-share after point-of-service (POS) deductible has been met ($300 per person/$600 per family)</td>
<td>$22 or 20% of total cost (whichever is greater) after deductible has been met (E1-E4 $50 per person/$100 per family; All others $150 per person/$300 per family)</td>
</tr>
</tbody>
</table>

TRICARE Prime—50% cost-share after POS deductible has been met ($300 per person/$600 per family)
As you may have already noticed, many TRICARE beneficiaries—especially active duty service members—are presenting new, dramatically different looking identification cards.

Although the card itself does not bear a title, it is called the Common Access Card (CAC). It will be replacing the Uniformed Services Identification (ID) card, which has been in existence since 1994.

The Department of Defense, in conjunction with the seven uniformed services, began issuing the CAC in 2003. The transition to the CAC is being phased in over several years. Until the transition is completed, both the CAC and ID card serve as evidence of TRICARE eligibility.

Card validity can be confirmed by matching the card with the patient and by checking the card’s expiration date. With the exception of children under the age of 10, beneficiaries should be in possession of their own card. Since children are not routinely issued their own card until age 10, use their parent’s card to verify eligibility.

Also new on the scene is a universal TRICARE Prime Enrollment Card, which is issued to beneficiaries enrolled in TRICARE Prime, TRICARE Prime Remote and TRICARE Prime Remote for Active Duty Family Members.

At check-in, some patients may present their enrollment card. While the enrollment card provides important contact information, it does not confirm eligibility and should not be used as a replacement for either the CAC or ID card.

Only the Uniformed Services ID card or the new CAC may be used to verify eligibility. For that reason, you should make a photocopy of each beneficiary’s card (both sides) and retain copies for future reference.

How do I determine a patient’s eligibility for TRICARE?

Providers can confirm that a patient has a valid uniformed services (military) identification (ID) card (or authorization letter of eligibility) by checking the expiration date and “civilian-yes” on the back of the card. Call 1-877-TRICARE or visit www.healthnetfederalservices.com to verify eligibility.

TRICARE Management Activity (TMA) provides TRICARE Prime beneficiaries with a uniform behavioral health care benefit worldwide.

The continuing policy allows beneficiaries to obtain the first eight outpatient visits per year without prior authorization. Additionally, TRICARE Prime enrollees do not need a referral from their PCM.

The ninth and subsequent visits will require authorization from Health Net Federal Services before the beneficiary will be covered under TRICARE.

Here are a few other reminders about delivering behavioral health care to TRICARE Prime beneficiaries:

1. You can provide behavioral health care services to beneficiaries if you are a:
   - Psychiatrist
   - Clinical psychologist
   - Certified psychiatric nurse specialist
   - Clinical social worker
   - Certified marriage and family therapist
   - Pastoral counselor
   - Mental health counselor

   Note: Pastoral counselors and mental health counselors must have a referral and be under physician supervision.

2. All nonemergency inpatient behavioral health care requires prior authorization from Health Net.

3. The TRICARE Provider Handbook provides detailed information about covered and non-covered services, medical record documentation and reimbursement for behavioral health care.

Contact Health Net at 1-877-TRICARE (1-877-874-2273) for eligibility verification and other questions.
With so many deployed troops and medical personnel, coordination of care between military treatment facilities (MTFs) and TRICARE’s network of civilian providers has never been more essential. “When we experience deployments and a loss of military medical personnel, that’s when network providers are even more important,” according to Col. Joyce Grissom, chief, clinical quality program, TRICARE Management Activity. “Short of joining the military, the most patriotic thing civilian providers can do is to be willing to treat TRICARE patients.”

Provider support of the local MTF is key. When a beneficiary who resides in a prime service area needs care that is available within the MTF, Health Net will refer TRICARE Prime beneficiaries to the MTF. Network providers can work directly with Health Net who will offer the MTF the right of first refusal when services are available at the MTF.

Jody Donehoo, Ph.D., senior health program analyst, explains, “In order to preserve the nation’s investment in our military medical systems, we must optimally manage the resources of the MTF.”

In some areas where many military medical personnel are deployed, more civilian TRICARE Network providers are assuming the role of PCM for deployed beneficiaries’ families and for non-deployed personnel enrolled in TRICARE Prime. Health Net will inquire with the MTF for both primary care assignment and specialty treatment before sending a beneficiary elsewhere within the network.

The MTF is required to provide acceptance or refusal of that patient care request quickly, before the patient is reassigned to a TRICARE network provider.

“The MTF ‘right of first refusal’ will help us reach our goal of making the MTFs the most preferred provider within the network,” Donehoo says.

Grissom adds, “The MTFs are saying ‘try us first’ before you turn to another provider.”

It’s important not to make assumptions about the type of care offered at the local MTF. For instance, the type and degree of care varies from one MTF to another. MTFs range in size, from small clinics providing active duty personnel with primary care to very large, multi-specialist teaching hospitals.

During combat situations, as more medical personnel are deployed, the capacity and capabilities of the MTF also shift significantly. Specialty services that become unavailable due to deployment of an MTF clinician can become available when the specialist returns or when the deployed specialist is replaced or back-filled in the MTF by another civilian or military clinician of the same specialty.

“Communication between the MTF and the network is crucial. The very purpose of the network providers is to complement the military resources as our capacity shifts up and down,” Grissom says.

“Our troops and their families should always be getting the right care, regardless of our deployment situation.”

Learn more about your local MTFs and right of first refusal guidelines by reviewing your TRICARE Provider Handbook or the TRICARE Web site at http://www.tricare.osd.mil/mtf/Main.cfm.
TRICARE Brings Health Care Home

What Home Health Agencies Need to Know

In the past, TRICARE’s home health care was a fee-for-service reimbursement benefit based solely on medical necessity. Only skilled nursing, occupational and physical therapy, and speech and language pathology services were covered under the policy. However, when the new TRICARE regions roll out, so do changes to the home health benefit.

Changes in Billing

TRICARE is implementing a prospective payment system patterned after Medicare’s existing plan. Under the new policy, billing will be managed in 60-day episodes of care. For every 60-day episode, home health agencies (HHAs) will receive two payments.

The first payment is a Request for Anticipated Payment (RAP)—60 percent of the total estimated care for the 60-day episode. In order to receive this initial payment, the patient’s primary care physician must establish a treatment plan. The HHA then completes the Outcome Assessment Information Set (OASIS) using the information in the treatment plan. Those documents must be received and processed by the regional contractor before the RAP will be remitted.

At the end of the 60-day episode of care, the HHA submits an outline of all provided services to the regional contractor. Once that statement is processed, the HHA then receives the final 40 percent of the claim. If the patient requires additional home health care after the 60 days, the HHA must complete another OASIS and go through the process again to receive payment.

Changes in Care

Payment processes aren’t all that’s changing with TRICARE’s home health care benefit. The extent of covered services is changing as well. The new home health care plan is designed to provide a more complete array of coverage, including:

- Physical or occupational therapy
- Physician-directed medical social services
- Routine and non-routine medical supplies
- Services at hospitals when the care involves equipment that cannot be brought into the home

It is important to note that assistance with activities of daily living (washing laundry, cleaning dishes, etc.) is not part of the home health benefit. While the home health care professional may provide some assistance with basic daily living care, these tasks are considered ancillary and are not his or her primary duties while in the patient’s home.

If you have questions about the new home health care benefit, contact your regional contractor.

Nationwide Claims Processing Established for Dual-Eligible Beneficiaries

As part of the next generation of TRICARE contracts, the TRICARE Management Activity (TMA) selected a single contractor, Wisconsin Physicians Service (WPS) to handle claims processing and provide related customer and administrative services for about 1.7 million dual-eligible beneficiaries—those eligible for both Medicare and TRICARE—in the United States, U.S. Virgin Islands, Puerto Rico, Guam, American Samoa and the Northern Mariana Islands.

WPS is implementing this program for dual-eligibles under the title “WPS TRICARE For Life (WPS TFL).”

WPS TFL Rollout Schedule

<table>
<thead>
<tr>
<th>Region</th>
<th>Rollout Date</th>
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<tbody>
<tr>
<td>Region 11</td>
<td>April 1, 2004</td>
</tr>
<tr>
<td>Regions 2/5</td>
<td>June 1, 2004</td>
</tr>
<tr>
<td>Regions 9/10</td>
<td>June 1, 2004</td>
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<tr>
<td>Alaska and Hawaii</td>
<td>July 1, 2004</td>
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<tr>
<td>Regions 3/4</td>
<td>Aug. 1, 2004</td>
</tr>
<tr>
<td>Region 1</td>
<td>Sept. 1, 2004</td>
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<tr>
<td>Region 7/8</td>
<td>Oct. 1, 2004</td>
</tr>
<tr>
<td>Region 6</td>
<td>Nov. 1, 2004</td>
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</tbody>
</table>

If you currently submit claims on a patient’s behalf to Medicare, then you no longer need to submit an additional claim to TRICARE (which acts as second payer after Medicare) for payment.

WPS signed agreements with each state’s Medicare carrier, which allows Medicare to pay its portion and then submit claims directly to WPS TFL for processing. WPS TFL then sends its payment for the remaining beneficiary liability directly to you.

continued on page 11
Clinicians and the TRICARE Fraud Squad

Partners in the Fight

By Barbara Jannotti, Senior Health Care Fraud Specialist

Through both troubled and peaceful times, one goal of the Department of Defense’s (DoD) Military Health System (MHS) that remains constant is the commitment to providing cost-effective quality health care to its 8.9 million beneficiaries. However, health care fraud and abuse constantly impede the ability to realize that goal.

It’s easy to see why when you consider that the National Health Care Anti-Fraud Association estimates that 3 percent, or $42 billion, of what Americans spend annually on health care is lost to fraud.

The TRICARE Management Activity (TMA) Program Integrity Office (PI) in Aurora, Colo., is the central coordinating agency for investigating cases of alleged fraud and abuse committed against the DoD MHS’ TRICARE Program.

More than 15 years of experience has taught TMA PI (known as the TRICARE Fraud Squad) that to adequately address the fraud and abuse problem requires teamwork and working relationships between TRICARE, its contractors, law enforcement, the Department of Justice (DOJ) and those in the public and private sectors. In cooperation with investigative agencies and DOJ between 1999 and 2003, TMA PI has helped return more than $25 million to DoD.

Operation TRICARE Fraud Watch, launched in 1999, has contributed to enhanced information sharing and in the creation of a fraud section of the TRICARE Web site (www.tricare.osd.mil/fraud). Operation TRICARE Fraud Watch also has enforced an aggressive regional contractor oversight plan that emphasizes a commitment to the detection and referral of fraud cases to TMA PI, as required by each contract.

Clinicians play a key role in the fight against fraud and abuse because they are on the front line and are more likely to detect aberrant or dangerous practices that would otherwise not be identified or detected.

Take the case of the pharmacist with pharmacies in Kansas and Missouri who was convicted of diluting cancer chemotherapeutic treatments sold to physicians’ offices. The scam went undetected for 10 years until an oncologist became suspicious.

Concerned about patient welfare, the oncologist personally paid for testing the IV chemotherapeutic solution ordered from the pharmacy. The test results revealed that the solution had been prepared at 30 percent of the strength ordered. Federal agents arrested the pharmacist after the oncologist notified them of the test results. The pharmacist pled guilty to 20 charges and was sentenced to 30 years in prison.

Such situations cannot always be readily identified by fraud units or the patients involved. The involvement of clinicians is vital because they are in the position and have the knowledge to detect and report problems.

The fraud and abuse section of the TRICARE Web site will soon offer a link for reporting suspicious practices directly to TMA PI. Allegations can also be reported in writing to the Program Integrity Office, TRICARE Management Activity, 16401 East Centretech Parkway, Aurora, CO 80011-9066 or faxed to (303) 676-3981.

Fighting the fraud and abuse that is infecting the health care industry takes a team effort. Join in and help the DoD MHS achieve its goal in providing quality health care to its beneficiaries. ■

Nationwide Claims Processing Established for Dual-Eligibles

continued from page 10

If a beneficiary has other health insurance (OHI), then Medicare pays first and forwards the claim to the OHI, which pays second. In these instances, the beneficiary must file a paper claim (DD Form 2642—available online at www.tricare.osd.mil/claims) with WPS TRICARE For Life (P.O. Box 7890, Madison, WI 53707-7890).

Paper claims also must be submitted to WPS TFL if you do not participate in Medicare, or if the services you’ve provided are not Medicare-covered benefits.

Because TFL claims processing is being transitioned over eight months, outgoing regional claims processors will continue to process claims for services that your dual-eligible beneficiaries receive until WPS TFL has been implemented in your state (see WPS TFL Rollout Schedule on page 10). ■
What’s New Online

... at www.healthnetfederalservices.com

Health Net Federal Services is offering new services online that will help you better manage your TRICARE patients’ health care. Important features available in the provider section of the Health Net Web site include:

XPressClaim Online Claim Submission—Submit TRICARE professional and institutional claims online using XPressClaim from PGBA.

Electronic Funds Transfer—Sign-up to receive payments directly to your bank account with EFT payments.

Check Claim Status—Determine the status of a claim, receive information about the payment of a previously processed claim, review other health insurance information, and/or receive electronic summary payment voucher statements (online remits) for processed claims.

Patient Eligibility Verification—Verify TRICARE beneficiary eligibility by registering on the Web site. You’ll also be able to verify whether the beneficiary’s deductible or catastrophic cap has been satisfied.

TRICARE Educational Materials—Reference the TRICARE Provider Handbook and other program materials for information on TRICARE benefits, referrals and authorizations, and claims processing.

Important Forms—Download printable versions of important forms for facilitating patient care.

Newsletters, Bulletins and Other Resources—Read timely articles, frequently asked questions, and other valuable information regarding TRICARE and wellness issues.

Contact Us—Obtain essential phone numbers, addresses and customer service information when you need assistance with the TRICARE program.

Healthy People 2010—Find out how you can help implement Healthy People 2010 initiatives.

... at www.tricare.osd.mil

The TRICARE Web site offers you the most up-to-date information regarding TRICARE programs, policies, benefits and reimbursement rates.

The provider section of the TRICARE Web site (www.tricare.osd.mil/provider) is updated regularly and features many resources, including “The Doctor Is In,” a column that offers helpful information about treating TRICARE beneficiaries.