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

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

Weight Management
In 2001, the Surgeon General declared overweight and obesity to be a U.S. public health concern. This nationwide problem has only intensified since then. Today, two-thirds of Americans are considered to be overweight, one-third of whom are considered to be obese.

Upward weight trends are also seen in the MHS beneficiary population—active duty service members and families, retired service members and their families, and survivors—with the alarming report that military children are classified as overweight at a higher rate than children in the general American population. More than 3,000 active duty service members are discharged each year for failure to comply with Service’s weight and fitness standards.

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

continued on page 2

From the Desk of the CMO
Pedro N. Rivera, MD
Chief Medical Officer
Health Net Federal Services

Health Net Federal Services, Inc. (Health Net) is now in full operation in the TRICARE North Region and remains highly motivated in supporting TRICARE and military medicine. I am happy to take this opportunity to share with you the realities of the “first 90 days” of operations.

Transition from the previous TRICARE contracts to the TRICARE North Region contract has been challenging and complicated by a number of unanticipated and disruptive factors. Staffing and resource requirements increased dramatically and our workload was considerably higher than anticipated.

For example, Health Net is processing between 3,800 and 4,000 referrals and authorizations per day as opposed to the anticipated amount of 2,200. We also receive 25,000 phone calls per day compared to the 9,800 originally forecasted.

In addition, we continue to receive many unnecessary referral and authorization requests. Please review the information on our Web site at www.healthnetfederalservices.com under the “Authorizations” tab to learn more about these requirements.

To meet this unanticipated workload, we intensified our hiring process and reallocated staffing resources by expanding our number of regional offices and recruiting 240 additional associates. We also redesigned our Medical Management Department and created a streamlined referral and authorization processing system to provide a more timely response.

I am glad to report that we are moving in the right direction to provide better customer service and our correspondence to you and your patients has improved significantly.

We are looking forward to better days, but we will not stop until we have refined our processes and are able to experience ongoing operational success.

Thank you for your patience and support.
Smoking Cessation

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

Responsible Use of Alcohol

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

Healthy Choices for Life Campaign

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

In addition to other initiatives, TRICARE will feature a regular department, called “Healthy Choices for Life,” in each edition of the TRICARE Provider News newsletter.

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

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

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

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

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

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

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

Source: DoD Surveys of Health Related Behaviors Among Military Personnel, 1980 to 2002 (2002 Questions: Any Smoking, Q45 and Q47; Heavy Smoking, Q46 Heavy Alcohol Use, Past 30 Days, Q15-Q18 and Q20-Q23 Binge Drank, Q24, and With Whom Drank, Q25)
Early 12,000 Military Health System (MHS) beneficiaries are diagnosed with cancer each year.

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

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

Three Phases of Trials

There are three phases of NCI clinical trials:

- Phase I trials: These are not covered currently by TRICARE due to their highly experimental nature.

- Phase II trials: TRICARE beneficiaries may participate in phase II trials, which study the safety and effectiveness of an agent or intervention, and evaluate how it affects the human body. These studies usually focus on a particular type of cancer.

- Phase III trials: TRICARE beneficiaries may also participate in phase III trials, which compare a promising new treatment against the standard approach.

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

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

Cost of Participation

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

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

How to Participate

The Cancer Clinical Trials Coordinator for the TRICARE North Region can assist you. Contact Kay Beck, RN, at 1-800-395-7821 from 8 a.m. to 5 p.m. Eastern Standard Time. Be sure to contact her before beginning the evaluation or any treatment under the clinical trial.

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

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

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

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

What about their children?
In addition to a routine eye examination every year for TRICARE Prime children of all ages, vision screening is available under the well-child benefit. The well-child benefit is available from birth to age six and includes eye and vision screening by a PCM during a routine examination at birth and at approximately six months of age. Comprehensive eye examinations are authorized once every two years between ages three and six. Children over age six assume the same coverage as any active duty family member enrolled in TRICARE Prime. There are no copayments for these services.

3. What is the vision coverage of a person whose spouse is on active duty but who uses TRICARE Extra or TRICARE Standard?
The active duty family member is covered for one routine eye examination every year. However, TRICARE Extra or TRICARE Standard cost-shares apply after the annual deductible has been met.

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

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

4. What is the vision coverage of a retired service member who enrolls in TRICARE Prime?
The enrollee is covered for one comprehensive eye examination every two years. This benefit begins two years after the enrollee’s last eye examination prior to retirement. He or she may receive care from any TRICARE network optometrist or ophthalmologist and MTFs when available. If visiting a network provider, beneficiaries must show their TRICARE Prime enrollment card.

continued on page 5
FAQs: TRICARE Vision Coverage

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

What if the retired service member decides to use TRICARE Extra or TRICARE Standard rather than enrolling in TRICARE Prime?
The beneficiary is not covered for routine vision care under TRICARE Extra or TRICARE Standard.

5. What is the vision coverage of a person enrolled in TRICARE Prime whose spouse is a retired service member?
Please see answer to Question 4.

What about their children?
Vision screening is covered under the well-child benefit. The well-child benefit is available from birth to age six and includes eye and vision screening by a PCM during a routine examination at birth and at approximately six months of age. Comprehensive eye examinations are authorized once every two years between ages three and six. Children over age six assume the same coverage as any retiree family member enrolled in TRICARE Prime. There is no copayment for these services.

6. What is the vision coverage of a wife using TRICARE Extra or TRICARE Standard whose husband is retired?
She is not covered for routine vision care under TRICARE Extra or TRICARE Standard.

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

7. Are eyeglasses or contact lenses covered under TRICARE?
Active duty service members are covered for eyeglasses at MTFs at no cost.

For all other TRICARE beneficiaries, contact lenses or eyeglasses are only cost-shared with prior authorization for treatment of infantile glaucoma, keratoconus, dry eyes when normal tearing is inadequate or absent, corneal irregularities other than astigmatism, or loss of human lens function resulting from eye surgery or congenital absence.

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

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

Additional Information

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

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

If you need additional information about TRICARE’s vision coverage, visit the TRICARE Web site at www.tricare.osd.mil or contact Health Net at 1-877-TRICARE.
Correct V Codes Mean Hassle-Free Reimbursement

Proper billing translates into hassle-free claims reimbursement. Health Net and PGBA remind you that it is especially important to use the proper V codes for claims reimbursement. A V code designates a primary diagnosis for an outpatient claim that explains the reason for a patient’s visit to your office.

Choose the Correct V Codes

Be sure to use the correct V code diagnosis to indicate the reason for the visit. The V code must match the CPT code, to indicate the procedure that you are performing as it correlates to the V code diagnosis.

How to Bill with V Codes

V codes correspond to either descriptive, generic, preventive, ancillary or required medical services, and should be billed accordingly.

Descriptive V Codes—For V codes that provide descriptive information as the reason for the patient visit, you may designate that description as the primary diagnosis. An example of a descriptive V code includes a routine infant or child health visit, which is designated as V20.2.

Generic V Codes—For generic non-payable services, such as lab, radiology or Pre-Op, a generic V code should not be used as a primary diagnosis. Rather, the underlying medical condition should be listed as the primary diagnosis for these ancillary services.

Preventive V Codes—For preventive services, a V code that describes a personal or family history of a medical condition is sufficient as a primary diagnosis without the need for additional diagnostic information. Examples are a mammography, a Pap smear or a Fecal Occult Blood screening.

For more information about V Codes, see the chart on page 7. The information in the chart is more accurate than what is contained on page 79 of the TRICARE Provider Handbook.

TRICARE Benefits Improve for Reservists and Their Families


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

- For Reserve Component members with delayed effective date orders to serve on active duty in support of a contingency operation for more than 30 days, the new legislation permanently authorizes TRICARE eligibility for up to 90 days prior to member’s activation date for eligible members and their families.
- The legislation makes permanent the 180-day transitional period after deactivation in which certain Reserve Component members and their families receive TRICARE health benefits under the Transitional Assistance Management Program (TAMP). Members must now have a comprehensive physical examination within 12 months before the scheduled date of separation from active duty service.
- The legislation authorizes a waiver of the TRICARE Standard and TRICARE Extra deductibles for Reserve Component family members whose sponsors are ordered to active duty for more than 30 days. Plus, it authorizes TRICARE to pay nonparticipating providers up to 115 percent of the TRICARE maximum allowable charge, enhancing continuity of care for these family members with their civilian providers.
- Another provision will enable members of the Reserve Component (those called after Sept. 11, 2001, to serve for more than 30 days in support of a contingency operation, who served or will continuously serve for 90 or more days) to purchase TRICARE Standard health care coverage for themselves and their family members after they demobilize and after their TAMP benefit period ends.

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

The option to purchase TRICARE Standard coverage will not be implemented until April 26, 2005. Policies and procedures for this new benefit have not yet been defined.

More information will be available in future TRICARE publications and on the TRICARE Web site at www.tricare.osd.mil, as well as the reserve affairs Web site at www.defenselink.mil/ra.
## A Guide to Preventive Care V Codes

<table>
<thead>
<tr>
<th>Preventive Care Services</th>
<th>Proper V Code</th>
<th>Related CPT Codes</th>
<th>Care Intervals and Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>School Physicals</strong></td>
<td>V70.0</td>
<td>99201–99205</td>
<td>Children ages 5 and under 12 are authorized to have a school physical. Children ages 12 and older are authorized only if a physical is required. TRICARE Prime beneficiaries do not have a copayment, but they must use a network provider. TRICARE Extra or TRICARE Standard beneficiaries will pay the applicable cost-share and deductibles.</td>
</tr>
<tr>
<td></td>
<td>V70.3</td>
<td>99211–99214</td>
<td></td>
</tr>
<tr>
<td></td>
<td>V70.5</td>
<td>99383–99393</td>
<td></td>
</tr>
<tr>
<td></td>
<td>V70.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Pap Smears</strong></td>
<td>V72.3</td>
<td>88141–88155</td>
<td>Annually for women over the age of 18 (younger if sexually active). No PCM or Health Net referral or copayment is required for TRICARE Prime beneficiaries, but they must use a network provider. For TRICARE Extra or TRICARE Standard beneficiaries, the applicable cost-share and deductibles apply.</td>
</tr>
<tr>
<td></td>
<td>V76.2</td>
<td>88164–88167</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>99201–99215</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>99301–99313</td>
<td></td>
</tr>
<tr>
<td><strong>Optometry</strong> (Eye Exams)</td>
<td>V72.0</td>
<td>92002</td>
<td>TRICARE Prime active duty family members receive one clinical preventive comprehensive eye exam every two years; TRICARE Prime retirees and their family members receive one comprehensive eye exam every two years; TRICARE Extra and TRICARE Standard retirees are excluded from clinical preventive and comprehensive eye exams and screening. A TRICARE Prime, TRICARE Extra or TRICARE Standard infant active duty family member may receive one eye and vision exam by the PCP during routine exam at birth and at approximately 6 months of age under the well-child benefit. Use V20.2 for eye exams under the well-child benefit. A child active duty family member may receive two pediatric comprehensive eye exams between the ages of 3–6 years under the well-child benefit (Use V20.2). For all benefits listed above, there is no copayment for Prime beneficiaries. Cost-shares and deductibles apply to TRICARE Extra or TRICARE Standard beneficiaries. TRICARE For Life beneficiaries are excluded from routine screening. Diabetic patients, at any age, are allowed annual comprehensive eye examinations. In addition to the preventive eye exam benefits listed above, active duty service members and their families are also covered for one comprehensive eye exam per year with no copayment. A PCM or Health Net referral is not needed, but TRICARE Prime beneficiaries must see an MTF or network optometrist or ophthalmologist. The V code can be used for the annual exam, however if a medical condition is identified, use medical diagnosis CPT codes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>92004</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>92012</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>92014</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>92015</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>99172</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>99173</td>
<td></td>
</tr>
<tr>
<td><strong>Well-Child Visits</strong></td>
<td>V20.2</td>
<td>Refer to relevant CPT codes based on service, also listed in the TRICARE Policy Manual Ch. 7, Section 2.5.</td>
<td>Includes routine newborn care, comprehensive health promotion (birth to 6 years) and disease prevention exams, vision and hearing screenings, height/weight/head circumference, routine immunizations (according to CDC guidelines), and developmental/behavioral appraisals (according to American Academy of Pediatrics). Copayments are not required of Prime beneficiaries. TRICARE Extra and TRICARE Standard beneficiaries will pay the applicable cost-share and deductibles. Immunizations should be administered at age appropriate doses as suggested by the current schedule of recommended vaccines by the Center for Disease Control on Immunization Practices at <a href="http://www.dcd.gov">www.dcd.gov</a>.</td>
</tr>
<tr>
<td><strong>Regular Immunizations</strong></td>
<td>V20.2</td>
<td>90471–90474</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>90476–90748</td>
<td></td>
</tr>
<tr>
<td><strong>Mammograms</strong></td>
<td>V70.0</td>
<td>76092</td>
<td>Performed annually for women over age 39. (Baseline at 35 for high risk, then annually.) There is no copayment for Prime beneficiaries, and applicable cost-shares and deductibles apply to TRICARE Extra and TRICARE Standard beneficiaries.</td>
</tr>
<tr>
<td></td>
<td>V70.5</td>
<td>HCPCS Code: G0202</td>
<td></td>
</tr>
<tr>
<td></td>
<td>V70.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Colonoscopy</strong></td>
<td>V70.0</td>
<td>45355–45385</td>
<td>Proctosigmoidoscopy/Sigmoidoscopy once every 3 to 5 years (beginning at age 50). Colonoscopy once every 2 years beginning at age 25 or 5 years younger than the earliest age of diagnosis for colon rectal cancer; then annually after age 40 for people with hereditary non-polyposis colon rectal cancer syndrome. Colonoscopy should be performed every three to 5 years beginning 10 years earlier than the youngest affected relative with sporadic colon rectal cancer. There is no copayment required for Prime beneficiaries. Applicable cost-share and deductibles apply to TRICARE Extra or TRICARE Standard beneficiaries.</td>
</tr>
</tbody>
</table>
TRICARE strives to process and complete provider claims as quickly and accurately as possible. The Military Health System can be complex, however, which can occasionally lead to claims submission mistakes or oversights that result in unpaid claims and ultimately patient billing. It is important for providers and their staffs to learn claim submission pitfalls and avoid sending unpaid beneficiary claims to a collection agency.

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

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

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

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

Follow These Error-Checking Steps

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

1. Review the TRICARE summary payment voucher, also known as a remit, when it arrives; if a claim is rejected, it will state the reason why.
2. If the remit states that inaccurate beneficiary information is the reason for the denial, it is important to make every attempt to contact the beneficiary to obtain the correct information.
3. Contact your TRICARE regional contractor, Health Net, or if the patient has Medicare, contact the TRICARE dual-eligible fiscal intermediary, Wisconsin Physicians Service (WPS), if you have additional or corrected information regarding a rejected claim.

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

Eliminate Mistakes that Lead to Rejected Claims

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

Incorrect Beneficiary Address

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

continued on page 9
Providers Rely on Helpful Online Claims Features

Health Net and its claims processor PGBA have teamed up to develop a host of online tools at www.healthnetfederalservices.com and at www.myTRICARE.com that will make your claims submission and management processes run more efficiently.

Thanks to these online tools, providers are finding it easier than ever to electronically submit and track patient claims, view remit statements and receive lightning fast claim payments.

**View Remits Online And Use Other Claims Tools**

Because TRICARE network providers must submit claims electronically, they get paid faster and have less paperwork to worry about. Whether submitting claims through a claims clearinghouse, Companion Direct or XPressClaim™, you can go to the provider section of www.healthnetfederalservices.com and view your remits online and reconcile claim payments, as well as check your remittance records for accuracy. Non-network providers are also encouraged to take advantage of these tools.

On either the Health Net or PGBA Web site, you can check patient claim status and claim payments, patient eligibility and other health insurance (OHI) information.

As a member of myTRICARE.com, you will receive a unique user name and password, along with a unique Security Key Code for each staff member who will use the system. Once you have registered, you can see patient information from processed claims over the past year, and you will only have to input new patient information by TRICARE sponsor Social Security number and patient date of birth.

**Get Your Claims Paid Faster With EFT**

Thanks to electronic funds transfer (EFT), TRICARE claims are paid more quickly and efficiently. If your office is set up to submit claims electronically, then you are ready to sign up for EFT.

You must first activate your signature authority, which lets you disburse funds, sign checks, and add, change or terminate bank account information. Sign in to www.myTRICARE.com and go to the EFT tab at the top of the Provider Welcome page.

For more information about these tools, visit www.healthnetfederalservices.com or www.myTRICARE.com.

---

**Thinking Collection Agency for a Beneficiary Claim?**

Avoid Debt Collection and Understand the Role of the DCAO

*continued from page 8*

**Incorrect Social Security Number (SSN)**

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

**Incorrect Procedure and Diagnosis Codes**

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

**Unpaid Beneficiary Copayment**

Many times beneficiaries are not aware of or simply forget the copayment. Care should be taken to make the beneficiary aware of the copayment at the time of treatment to avoid problems. Active duty service members and TRICARE Prime active duty families have no copayment. Network and non-network providers who accept assignment cannot charge the beneficiary more than the patient responsibility.

**Claims Resolution Assistance**

Health Net assists providers with claims questions and problems through the toll-free number, 1-877-TRICARE. Call that number before initiating any collection action against a TRICARE beneficiary.

More information on claims submission requirements can be found in your TRICARE Provider Handbook or online at www.healthnetfederalservices.com.
Understanding Hospice Care

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

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

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

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

What Doesn’t Hospice Care Cover?
Room and board are not covered under hospice care unless the patient is receiving an inpatient level of care.

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

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

What Is the Patient’s Responsibility?
The patient has no deductible under the hospice benefit. The hospice provider may bill the patient for 5 percent of the cost of outpatient drugs, or $5 toward each prescription, whichever is less.

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

Where Is Hospice Care Provided?
Hospice care can be provided in a number of settings: at home, in a hospice facility or in a military treatment facility (MTF). Care can shift between these facilities without affecting the hospice benefit. For example, suppose a hospice patient is receiving care at home, but his or her support system breaks down or the family member providing care needs a break. The patient can receive inpatient hospice care, or respite care, at an MTF or hospice facility as part of the hospice benefit.

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

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

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

Hospice care is provided in three benefit periods, each of which requires prior authorization. The patient’s PCM

continued on page 11
Understanding Hospice Care
continued from page 10

should initiate and obtain the prior authorization from Health Net on the patient’s behalf.

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

How Can Beneficiaries Find a Hospice?
The best way for beneficiaries to find a TRICARE-authorized hospice is to use Health Net’s provider directory, which is accessible online at www.healthnetfederalservices.com or by calling 1-877-TRICARE.

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

Where Can I Find Additional Information?
Review Chapter 11 of the TRICARE Reimbursement Manual for detailed information. You can view it online at www.tricare.osd.mil/tricaremanuals.

Alternatives to Hospice Care

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

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

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

For TRICARE to cover a patient’s admission to an SNF, the patient must have had a qualifying medical condition that was treated in a hospital for at least three consecutive days. Admission to the SNF is covered as long as the patient is admitted within 30 days of his or her discharge from the hospital (with some exceptions for medical reasons). You will need to demonstrate the patient’s need for skilled nursing services for TRICARE to pay for the SNF care.

Long-Term Care
Not Covered

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

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

Patients can purchase LTC insurance through commercial insurance programs or the Federal Long Term Care Insurance Program (FLTCIP).
Patients enrolled in TRICARE have rights and responsibilities pertaining to their health care.

Patients have the right to:
• Receive information.
• Choose health care providers and plans.
• Access emergency care.
• Participate in treatment.
• Be treated with respect and non-discrimination.
• Protect their health care information.
• File complaints and appeals.

Patients have the responsibility to:
• Maximize their health.
• Make smart health care decisions.
• Be knowledgeable about TRICARE.
• And more ...

Why is it important for your TRICARE patients to know and understand their rights and responsibilities? Because those who do can live a healthier life, make more informed health care decisions and effectively communicate with you, their provider. As a result, the time you spend with patients will be more productive.

Refer beneficiaries to Health Net’s Web site for more information (go to www.healthnetfederalservices.com, click on the “Healthy Living” tab at the top, then click on the “Bill of Rights” link on the left navigation bar).