Discuss Mammography Now

One in eight women will be diagnosed with breast cancer in her lifetime. Will it be a patient in your office? Regular mammograms increase the chances of detecting breast cancer early, when it's most treatable. October is National Breast Cancer Awareness Month. As a provider, your recommendation is one of the most important factors that influences whether a woman obtains a mammogram.

While benefits and risks of mammography – what age to start, false-positive findings – must be balanced, it is essential all women are informed about breast cancer screening.

- For TRICARE beneficiaries, one screening mammogram is covered annually for all women beginning at age 40 and women in certain risk categories beginning at age 30. Remind your patients that there's no cost or prior authorization required.

Working together we can help make a difference.

Stay Healthy with Health Net

The camouflage pink ribbon symbolizes our united front in the fight against breast cancer for military members and their families.

Healthy People 2020 Corner

For information on Healthy People 2020 objectives supporting the increase of breast cancer screenings and the reduction of cancer rates, visit www.healthypeople.gov. Printable breast cancer awareness resources are also available on our website at www.hnfs.com.

Behavioral Health Care and TRICARE

Behavioral health care is an important TRICARE benefit, and we want to make sure you have all of the information and resources you need as you care for your TRICARE patients. To find information about behavioral health care benefits and other available resources, we encourage you to visit www.hnfs.com > I’m a Provider > Behavioral Health/Behavioral Health Home Page.

Health Net Federal Services, LLC (Health Net) also offers the Online Behavioral Health Resource Center, provided by Health Net’s behavioral health subsidiary, MHN, which is designed to help beneficiaries balance work, family and life.

The Health Net Warrior Care Support Program provides complete health care planning and coordination services for Warriors who have been severely injured or have a combat-related behavioral health diagnosis and their families. Each Warrior is provided his or her own Health Net Health Care Coordinator who works together with the military treatment facility and the Department of Veterans Affairs to serve as a single point of contact for all civilian health care services. Find answers to frequently asked questions about the Warrior Care Support Program at www.hnfs.com > I’m a Provider > Behavioral Health/Warrior Care Support Program.

Meeting the Needs of Returning Military Services Members

A Symposium for Primary Care & Mental Health Professionals
Saturday, November 3, 2012
Hope Hotel and Conference Center
Wright-Patterson Air Force Base, Ohio

Participants can earn continuing education credit/contact hours. The fee for this conference is $65 per person. Visit www.hnfs.com or pennstatehershey.org/ce for registration information.
Understanding the Referral Process

For most specialty care, TRICARE network providers are required to have a valid referral for patients enrolled in a TRICARE Prime plan—TRICARE Prime, TRICARE Prime Remote and TRICARE Young Adult Prime. The primary care manager (PCM) submits the request to Health Net for review and, if approved, a Health Net referral is issued.

Time frames and specifics

All Health Net referrals specify a time frame and/or number of visits for the specialty care. The specifics of the approved referral are then documented in PGBA's claims processing system, allowing claims to be paid appropriately. Note: The codes listed on the referral are commonly used codes to bill specialty services; however, they are not a guarantee of payment. It is your responsibility to accurately bill the appropriate codes for the services rendered.

What if care is needed beyond the approved timeframe or number of visits?

Health Net referrals for evaluation and treatment are valid for the time frame specified, and only for the number of visits specified. However, certain services, such as allergy shots or behavioral health therapy, may require continuous care. In those circumstances, the PCM or the specialist must request an additional referral from Health Net to allow for continuity of care and proper claims processing. If the specialty care is received outside the scope of the original referral, and an additional referral has not been approved by Health Net, the claim may be denied or processed as Point of Service.

Right of first refusal

Military treatment facilities (MTFs) are the first choice to render requested specialty care for TRICARE Prime beneficiaries. This process is known as the right of first refusal.

When Health Net receives a referral request, it is reviewed to determine whether services can be provided at the MTF. The MTF is given the opportunity to accept or decline the care at its facility.

In order to minimize beneficiary dissatisfaction and to reduce any confusion as to who will render care, please advise your patients that care may be sent to the MTF before a civilian specialist. In addition, TRICARE Prime beneficiaries should not be treated prior to receiving approval. This ensures the MTF has exercised its right of first refusal.

Visit our website for further information on referral guidelines at www.hnfs.com > I’m a Provider > Authorizations > Referral Guidelines.

How do I know if a request should be marked urgent?

Nearly all referral requests are routine unless the patient needs care in less than 72 hours. An urgent request is for care needed within 24–72 hours and an emergent request is for care needed within 24 hours or less. Each request type has specific submission requirements. Learn more about prioritizing referral requests at www.hnfs.com > I’m a Provider > Authorizations/Submit a Request > How to Submit.

Benefit Corner

New Inpatient TRICARE Service Request/Notification form

In an effort to help us complete inpatient requests more efficiently, a new Inpatient TRICARE Service Request/Notification form has been developed. The new form specifically covers inpatient admission notification and elective admission authorization requests, and has specific fields for physical and behavioral health admissions. Find this and all forms at www.hnfs.com > I’m a Provider > Forms.

Inpatient behavioral health authorization requirement

This is a clarification of the prior authorization policy concerning inpatient behavioral health services and beneficiaries with other health insurance (OHI). Beneficiaries with OHI only require a prior authorization for inpatient behavioral health services. Review for all other services will be performed at the time the claim is submitted after payment by the OHI. Visit our behavioral health benefits page for more detailed behavioral health information on our Benefits A-Z at www.hnfs.com > I’m a Provider > Benefits & Copays > Benefits A-Z > Behavioral Health.
PATIENT SAFETY CORNER

Reducing avoidable hospital readmissions

According to a study funded by the Agency for Healthcare Research and Quality, patients discharged from the hospital who have a clear understanding of their after-hospital care instructions – for example, how to take their medications, when to make follow-up appointments – are 30 percent less likely to be readmitted or seek emergency room (ER) treatment. Reducing avoidable readmissions saves costs and resources; supports safer, higher quality of care; and increases patient satisfaction.

Medication discrepancies, poor communication, lack of patient education, low patient compliance, and lack of medical follow-up are factors that contribute to avoidable readmissions. Providers play an important role in improving quality of care and continuity of care across care settings. To create an ideal transition for patients from a hospital setting to an office practice, the Institute for Healthcare Improvement (IHI) recommends:

Following a hospitalization, provide timely access to care:

- Review information received from the hospital.
- Provide appropriate level and type of follow-up care for discharged patients (high-risk, moderate-risk, low-risk)

Prior to the office visit, prepare the patient and clinical team:

- Review the hospital discharge summary.
- Clarify outstanding questions with the sending physician.
- Place a follow-up appointment reminder call to the patient or caregiver.

During the office visit, start a new care plan or revise an existing one:

- Ask the patient about his or her goals, and what factors contributed to the hospital admission or ER visit.
- Determine the need to adjust medications or dosages, follow up on test results and do monitoring or testing, discuss advance directives and future treatments.
- Instruct patient in self-management and have him or her repeat back instructions.
- Discuss warning signs and how to respond, and provide instructions for seeking emergency and non-emergency after-hours care.

At the end of the office visit, communicate and coordinate an ongoing care plan:

- Print a dated medication list and provide a copy to the patient or caregiver.
- Communicate revisions to the care plan.
- Ensure the next follow-up appointment is made.

For more information, here are some current initiatives targeted at reducing readmissions:

- The Re-Engineered Hospital Discharge (RED) – also known as Project RED, involves 11 components proven to reduce readmissions and increase patient satisfaction.
- State Action on Avoidable Re-hospitalizations – an IHI initiative to reduce re-hospitalization rates in states and regions.
- The Partnership for Patients initiative – goal is to decrease preventable hospital readmissions within 30 days of discharge by 20 percent or almost 1.6 million in 2013, compared with 2010 rates.
- Hospital to Home – developed by the American College of Cardiology to reduce readmission rates. An estimated 1,500 hospitals are currently enrolled in this national initiative.

Health Net encourages you to review your practices and take action to help reduce avoidable readmissions.


PREVENTING DUPLICATE CLAIMS

Keeping unnecessary health care costs low is a responsibility of all members of the health care community. Help reduce costs by not submitting duplicate claims. Duplicate claims occur when providers resubmit already-processed claims. In many instances, these claims have already processed for payment. In other situations, claims have been processed for partial payment or denied. Providers should feel confident that TRICARE pays claims promptly. In the TRICARE North Region, 99.99% of retained and adjusted claims are processed in fewer than 30 days, with many claims processed in fewer than 15 days. Submitting duplicate claims adds unnecessary processing costs that must be paid by the government, not to mention additional administrative costs to your practice.

CLR Tip – Know Where to Fax Your Report

Upon receipt of a prior authorization or referral from Health Net, providers will receive a letter containing the secure fax number for sending Clearly Legible Reports (CLRs) – specialty care consultation/referral reports, operative reports and discharge summaries – to the referring military treatment facility (MTF). All network providers must follow the instructions provided within the approval from Health Net.

Health Net requests network providers fax all CLRs directly to the secure fax line of the requesting MTF within seven business days of the date of service. You may view our CLR Fax Matrix online at www.hnfs.com > I’m a Provider > Clearly Legible Reports. The CLR Fax Matrix also lists contact information, should you have any CLR questions.

Tips for Durable Medical Equipment Claims

When filing durable medical equipment (DME) claims, remember to include a Certificate of Medical Necessity (CMN) or prescription sign by an MD or DO. This ensures your claim will be handled in a timely and efficient manner, allowing you to receive faster payment. If there is not an authorization on file and a DME claim is submitted without the above documentation, it may be rejected pending a signed prescription or CMN. In addition, please use appropriate HCPCS codes instead of miscellaneous codes, when available.

As a reminder, Health Net does not require a referral for DME items with a purchase price under $2,000 when provided by a network provider. These claims will always require supporting documentation. Active duty service members must have a Health Net authorization for all civilian DME, regardless of the cost.