

TRICARE Expands Breast Cancer Screening Options

Because the best way to contain breast cancer is to detect it early, TRICARE has expanded the screening options available for women at high risk of developing the disease.

A change in TRICARE policy has added coverage for magnetic resonance imaging (MRI) screening for breast cancer as a clinical preventive service for women in high-risk groups.

“An MRI is a clearly superior tool for screening the highest risk women for breast cancer,” said Army Maj. Gen. Elder Granger, deputy director of the TRICARE Management Activity. “We want these women to have every chance to detect any cancer at the earliest possible stages.”

Breast cancer is the third most common cancer among TRICARE beneficiaries and the second most common cause of cancer death for women in the United States.

Asymptomatic TRICARE Prime beneficiaries age 30 or older, and asymptomatic TRICARE Standard beneficiaries age 35 or older, can now receive breast MRIs as an annual screening procedure if they are considered at high risk of developing breast cancer by American Cancer Society® guidelines. The guidelines include women with a:

- BRCA1 or BRCA2 gene mutation
- First-degree relative (parent, child or sibling) with a BRCA1 or BRCA2 gene mutation
- Lifetime risk approximately 20 percent to 25 percent or greater as defined by BRCAPRO or other models that are largely dependent on family history
- History of chest radiation between age 10 and age 30
- History of Li-Fraumeni, Cowden or Bannayan-Riley-Ruvalcaba syndrome, or a first-degree relative with one of these syndromes

“The availability of MRI screenings does not reduce the importance of regular examinations,” Maj. Gen. Granger stressed. “All women over 39 years old need to get those annual mammograms. The key to dealing with cancer is early detection.”

TRICARE coverage of breast MRIs is retroactive to March 1, 2007. Anyone who meets the criteria for a breast MRI is covered. If a qualified beneficiary received a breast MRI on or after March 1, 2007, and the claim was denied, the provider can contact TriWest and ask to have the claim reconsidered.

TRICARE Prime enrollees may receive TRICARE-covered clinical preventive services from any network provider without a referral or prior authorization. If a service is not available from a network provider, an enrollee may receive that service from a non-network provider with a referral from their primary care manager and prior authorization from TriWest.

For clinical preventive services, TRICARE Prime enrollees have no copayment, while TRICARE Standard beneficiaries are responsible for a deductible and cost-share.

For more information on TRICARE coverage for clinical preventive services, including MRIs for breast cancer screening, refer to the *TRICARE Policy Manual*, Chapter 7, Section 2.1 (for TRICARE Standard) and Section 2.2 (for TRICARE Prime). The manual can be accessed online at <http://manuals.tricare.osd.mil>. ■



National Patient Safety Goals Updated for 2008

The Joint Commission, formerly known as the Joint Commission on Accreditation of Healthcare Organizations, or JCAHO, annually approves and updates the National Patient Safety Goals, which help health care organizations address specific areas of concern regarding patient safety.

For 2008, The Joint Commission added three new goals, revised two goals and retired one goal.

New Goals for 2008

- **New Goal 3E** specifies that health care organizations must reduce the likelihood of patient harm associated with the use of anticoagulation therapy. The new 3E requirement applies to ambulatory facilities, critical access hospitals (CAH), home care, hospitals, long-term care facilities and office-based surgery. This requirement supports Goal 3, which is to improve the safety of using medication by reducing drug-related medical errors.
- **New Goal 16** states that health care organizations must improve recognition and response to changes in a patient's condition.
- **New Goal 16A** specifies that organizations select a suitable method that enables health care staff members to directly request additional assistance from a specially trained individual(s) when a patient's condition appears to be worsening. The new 16A requirement applies to CAHs and hospitals.

The new 3E, 16 and 16A requirements have a one-year phase-in period that includes defined expectations for planning, development and testing ("milestones") at regular intervals of 3, 6 and 9 months during 2008. The Joint Commission expects full compliance with and implementation of Goals 3E, 16 and 16A by January 2009.

Goals Revised for 2008

- **Goal 2C** now also applies to long-term care facilities. Goal 2C requires applicable health care organizations to measure and assess, and if appropriate, take action to improve the timeliness of reporting, and the timeliness of receipt by the responsible licensed caregiver, of critical test results and values.
- **Goal 7A** previously mandated that health care organizations comply with the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines (www.cdc.gov/handhygiene) in an effort to reduce and prevent the spread of infections in hospitals. With the update to Goal 7A, health care organizations may now comply with either CDC or current World Health Organization hand hygiene guidelines. (Go to www.who.int/patientsafety and search "hand hygiene.")

One Goal Retired in 2008

- **Goal 3B**, which required a health care organization to standardize and limit the number of drug concentrations used by the organization, has been "retired." The retired status indicates that the requirement was formally integrated into the official accreditation standards of The Joint Commission.

For a complete list of the 2008 National Patient Safety Goals, visit www.jointcommission.org/PatientSafety. For more information or to submit a question, call the Standards Interpretation Group at 1-630-792-5900 between 8:30 a.m. and 5:30 p.m. Central Time. All telephone inquiries will be responded to within eight business hours, not including weekends and holidays. Or, submit your question online at www.jointcommission.org/Standards/OnlineQuestionForm. ■

A "New" TriWest.com

An enhanced TriWest.com was recently unveiled for TRICARE West Region beneficiaries, providers and government partners. Web site improvements were made based on significant market research, including firsthand feedback from providers and beneficiaries. The result is a cleaner, more user-friendly site.

The new TriWest.com features new sections in Provider Connection like *In the Spotlight*, *Quick Links* and *Popular Links* that offer easier navigation to the information that providers use most frequently, including:

- TRICARE reimbursement rates
- NPI information
- *TRICARE Provider Handbook*
- Claims information
- Referral and authorization information
- Resource library

Additional enhancements will be made to reorganize the content under the various sections to make it easier to find related articles. In addition, registered providers will now be able to access Provider Connection without leaving the secured site.

We value your feedback! Please e-mail your comments on the new site or suggestions for further improvement to feedback@triwest.com. ■

Assistant Surgeons and TRICARE

TRICARE Management Activity (TMA) limits the types of providers authorized to function as assistant surgeons and when they can be covered by TRICARE.

Whether a hospital, a surgeon or an ambulatory surgery center, a provider arranging for an assistant surgeon needs to be aware of the provider types recognized by TRICARE. A requesting provider may only coordinate with other providers who meet TRICARE's assistant surgeon requirements.

TMA recognizes these providers as assistant surgeons:

- Physicians
- Certified physician assistants
- Dentists
- Nurse practitioners
- Podiatrists
- Certified nurse midwives

TMA does **not** accept these providers as assistant surgeons:

- Certified registered nurse first assistants (CRNFA)
- Registered nurses (RN)
- Licensed surgical assistants (LSA)

TMA covers services performed by assistant surgeons:

- Based on the surgical procedure's complexity and when the seriousness warrants an assistant surgeon
- When services can't be accomplished by operating room nurses or other operating room personnel

- When interns, residents or other hospital personnel are not available to assist
- When the assistant is actively involved in the procedure; standby assistant surgeon services are not reimbursed by TRICARE

TRICARE uses ClaimCheck®, its auditing software, to determine whether an assistant surgeon is needed. Assistant surgeons' reimbursement rates are determined by:

- The lower of billed charges or 16% of the prevailing charge (CHAMPUS maximum allowable charge, or CMAC) for the surgery, less any contractual discount
- Whether the assistant is involved in multiple surgeries; if so, the same rules that apply to the primary surgeon would apply
- Provider type: Physician assistants (PA) and nurse practitioners (NP) are reimbursed at 85% of the prevailing charge for a physician serving as an assistant surgeon, less any contractual discount. In other words, a PA or NP would be reimbursed at 85% of the 16% of the prevailing charge for the surgery, less any contractual discount.

For further information regarding assistant surgeons, please refer to the *TRICARE Reimbursement Manual*, Chapter 1, Section 6 and Chapter 1, Section 17. The manual can be accessed online at <http://manuals.tricare.osd.mil>. ■

Clarifying the Specialty Referral Process

TriWest has received several requests to clarify the process that applies when a referring specialist must refer a patient to a second specialist.

Consider this example: If a TRICARE beneficiary is referred to a cardiologist by his or her primary care manager (PCM) and the cardiologist determines that cardiovascular surgery is necessary, the cardiologist (referring specialist) can request a referral to the surgeon (second specialist) since the additional services required are for the same diagnosis.

In the example above, the cardiologist would submit his or her referral request to TriWest and indicate the need for a second specialist in the consult report. Furthermore, the consult report would be used to keep the PCM apprised of the beneficiary's condition and the need for a second specialist. However, there is no need for the beneficiary to return to his or her PCM to obtain a referral.

When the specialist's diagnosis differs from the initial diagnosis or the required services are not within the scope of the initial consult, the TRICARE beneficiary must be directed back to his or her PCM.

For example, if a TRICARE beneficiary is referred to a cardiologist by his or her PCM and the cardiologist determines that the beneficiary has type 2 diabetes, the beneficiary would need to be treated by an endocrinologist or his or her PCM. In this case, the beneficiary would be directed back to the PCM and the PCM would request a referral to an appropriate physician from TriWest.

For further information on the referral process, visit www.triwest.com, call 1-888-TRIWEST (1-888-874-9378) or contact your TRICARE representative. ■

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TriWest Customer Service
1-888-TRIWEST
www.triwest.com

TRICARE Alaska Office
(Alaskan providers only)
1-907-743-1800

Wisconsin Physicians Service
(Electronic claims set up only)
1-800-782-2680

Express Scripts, Inc. (ESI)
(Pharmacy inquiries)
1-866-DoD-TRRX
1-866-DoD-TMOP
www.express-scripts.com/TRICARE

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Recognizing Seasonal Affective Disorder

Each year as the weather turns cold and the skies turn gray, so does the mood of many people who suffer from Seasonal Affective Disorder (SAD). SAD is a form of depression that is brought on by seasonal conditions, most commonly during the winter months.

SAD can affect anyone—adult or adolescent, man or woman—but like other forms of depression, it occurs more often in women than in men.

Symptoms of SAD include:

- Depressive symptoms that coincide with a seasonal change (usually the beginning of fall or winter)
- Full remissions that also occur at a characteristic time of year (e.g., depression disappears in the spring)
- Loss of interest in work or everyday activities
- Withdrawal from social activities

- Cravings for carbohydrates
- Weight gain resulting from heartier appetite
- Decreased energy level
- The need for more sleep, particularly during the day

Some experts believe that a variety of factors, including hormone levels, body temperatures and light (or the lack of it), contribute to the disorder. Others attribute SAD solely to the shorter days and decreased daylight in fall and winter, which can cause a drop in serotonin levels, resulting in mood and behavioral changes.

For most people with SAD, symptoms become less severe and eventually disappear with the arrival of spring. In severe cases, however, treatment may be recommended.

If you have a TRICARE beneficiary who exhibits symptoms of SAD, or any other

type of depression, and you believe the symptoms would be alleviated by seeing a behavioral health provider, the beneficiary may self-refer for the first eight behavioral health outpatient visits per fiscal year (Oct. 1–Sept. 30) from a network provider. TRICARE behavioral health providers can be identified by visiting www.triwest.com and clicking on “Find a Provider.”

Note: Active duty service members must have a referral and prior authorization before seeking any behavioral health care outside of a military treatment facility.

If you have questions, call TriWest at 1-888-TRIWEST (1-888-874-9378).

For more information on depression, visit the Behavioral Health Portal on the TriWest Web site: Go to www.triwest.com, click on “Provider,” then “Behavioral Health.” ■