

Eight Self-Referred Behavioral Health Care Visits Renew with Fiscal Year

The first day of the new TRICARE fiscal year, Oct. 1, renews the behavioral health care outpatient visit count for all TRICARE beneficiaries except active duty service members. The first eight outpatient behavioral health care visits to network providers* per fiscal year do not require prior authorization or a referral from the beneficiary's primary care manager or TriWest Healthcare Alliance Corp. (TriWest). Prior authorization is required for the ninth and subsequent visits for all beneficiaries. A physician referral is not required for these visits, but authorization is required to establish medical necessity.

There are certain providers, however, for which a **physician referral** and supervision are **always** required, even for the first eight visits. These providers include licensed professional counselors, licensed mental health counselors and pastoral counselors.

Remember, active duty service members **always** need a referral from their primary care manager (or service point of contact if enrolled in TRICARE Prime Remote) and authorization from TriWest before obtaining civilian behavioral health care.

For more information on behavioral health care and prior authorization requirements, visit TriWest's Web site at www.triwest.com. ■

* If a beneficiary chooses to self-refer to a non-network provider, point of service fees will apply.

Faster, Easier Process for Hospice Providers

Hospice is a concept of care designed to provide comfort and support to TRICARE beneficiaries and their families when a life-limiting illness no longer responds to cure-oriented treatments. The steps required to initiate TRICARE-covered hospice care have been streamlined by TriWest Healthcare Alliance Corp. (TriWest) and are much more customer-friendly for providers.

Hospice Referral Process

To initiate hospice services for TRICARE beneficiaries:

1. The patient and his or her doctor will determine the right time for hospice care. The patient's family may also be involved.
2. The patient's physician will refer the patient to a network hospice provider. No referral or authorization request should be submitted to TriWest at this time. If a network hospice provider is not available, a TRICARE-certified non-network provider may be selected.
3. The hospice provider will schedule an evaluation visit with the patient. The initial hospice evaluation does not require an authorization; however, authorization is required to receive hospice services.
4. The hospice provider submits an authorization request to TriWest (after the patient elects hospice services).

Hospice Authorizations

There are two initial 90-day benefit periods followed by an unlimited number of 60-day periods. Each period requires prior authorization from TriWest.

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Faster, Easier Process for Hospice Providers

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TriWest requires the following information to be submitted at the time initial authorization or recertification is requested. It is the hospice provider's responsibility to provide the documentation to TriWest.

- Initial hospice authorization:
 - The hospice provider should submit a completed authorization request to TriWest. Hospice providers can register at www.triwest.com/provider to submit their authorization requests online using the secure provider Web site. Providers may also go to www.triwest.com/provider, select "Find a Form," and download the *Hospice Authorization Form*.

- The hospice provider should also submit a signed, dated patient hospice election form (also called hospice consent) to TriWest. Note that TriWest does not supply this form; hospice providers have their own forms. This form can be scanned and sent electronically with the authorization request.
- Recertification: Each benefit period requires a separate authorization. The hospice provider must submit a new authorization request to TriWest. The patient hospice election form does not need to be resubmitted with the recertification request.

For more information, please refer to an overview of the TRICARE hospice benefit, available in the "Program Benefits" section at www.triwest.com/provider, or call 1-888-TRIWEST (1-888-874-9378). ■

New "Present On Admission" Indicator Requirement for Hospital Claims

Inpatient acute care hospitals that are paid under the TRICARE diagnosis-related group (DRG) payment system are now required to report a "present on admission" (POA) indicator for every diagnosis on inpatient acute care hospital claims. This policy change is effective for admissions on or after Oct. 1, 2009.

POA is defined as "present at the time the order for inpatient admission occurs." Including POA indicators on claims will allow conditions that were acquired while a patient was in the hospital—and that could have been reasonably prevented—to be tracked. As a result of this policy change, TRICARE reimbursement will be made using the POA indicator in conjunction with the diagnosis code to determine payment amount.

Providers will report POA indicators to TRICARE the same way they are reported to the Centers for Medicare & Medicaid Services, and in accordance with the *UB-04 Data Specifications Manual* and *ICD-9-CM Official Guidelines for Coding and Reporting*. The five POA indicator reporting options are:

- Y = The condition was present on admission.
- W = The provider has determined, based on data and clinical judgment, that it is not possible to document when the onset of the condition occurred.
- N = The condition was not present on admission.
- U = Documentation is insufficient to determine if the condition was present at the time of admission.
- 1 = The hospital is exempt from POA reporting.

The following hospitals are exempt from the TRICARE POA indicator requirement:

- Critical access hospitals
- Long-term care hospitals
- Maryland waiver hospitals
- Cancer hospitals
- Children's inpatient hospitals
- Inpatient rehabilitation hospitals
- Psychiatric hospitals
- Sole community hospitals
- Veterans Health Administration hospitals

Effective Oct. 1, 2009, TRICARE will deny any claim from a non-exempt hospital that does not report a valid POA indicator for each diagnosis on the claim. The DRG payment is considered payment in full, and the hospital cannot bill a beneficiary for any charges related to a hospital-acquired condition. TRICARE grouper software will be modified to ensure that hospital-acquired condition logic is not applied to claims from exempt hospitals.

Hospital-acquired conditions and their respective diagnosis codes will be posted at www.tricare.mil/drgrates around September 2009.

For more information on the POA indicator requirement, refer to the *TRICARE Reimbursement Manual* (Chapter 6, Section 8). ■

Encourage Diabetic Retinal Exams

According to a study by the Centers for Disease Control and Prevention, the number of Americans with diabetic retinopathy is expected to increase from 5.5 million to 16 million by the year 2050.¹ Diabetic retinopathy is already the leading cause of adult blindness in the United States. The good news, according to the American Academy of Ophthalmology, is that 95 percent of vision loss due to retinopathy could be avoided if treated early.²

Since early intervention is so vital and diabetic retinopathy often has no early warning signs, it is crucial that all patients with diabetes receive a comprehensive dilated eye exam once per year from an eye care professional. An annual dilated retinal examination is included in the American Diabetes Association's clinical recommendations and is also a Healthcare Effectiveness Data and Information Set (HEDIS) standard for comprehensive diabetes care. This exam will help uncover signs of retinopathy before symptoms appear and provide an opportunity for treatment to prevent vision loss and increase the number of healthy years for people with diabetes.

A recent study by TriWest Healthcare Alliance Corp. (TriWest) showed that 37 percent of diabetic TRICARE Prime beneficiaries in the TRICARE West Region had a dilated retinal exam in the previous year. TriWest is taking steps to raise that rate toward the HEDIS benchmark of 64 percent, including reminder calls to beneficiaries through an interactive voice response system and targeted intervention letters to primary care managers of TRICARE beneficiaries with diabetes.

A primary care physician recommendation may motivate patients with diabetes to get dilated retinal examinations. TRICARE covers one comprehensive eye exam every year for TRICARE Prime beneficiaries with diabetes. A referral is not needed to see a military treatment facility or network optometrist or ophthalmologist, and there is no copayment for these exams. TRICARE also covers annual routine eye exams for active duty service members and active duty family members.

Note: Routine eye examinations are **not** covered for TRICARE Standard retired service members and their families, except for beneficiaries younger than age 6 under the well-child benefit.

For more information about TRICARE's vision coverage, visit www.tricare.mil or refer to your *TRICARE Provider Handbook* (Section 5) or the *TRICARE Policy Manual* (Chapter 7, Section 6.1), available at <http://manuals.tricare.osd.mil>.

Do you have ideas about how to increase retinopathy screening rates or concerns about barriers preventing your patients with diabetes from receiving this vital exam? If so, TriWest wants to hear from you! Please contact Tracy Lenartz, Health Coach at TriWest, at tlenartz@triwest.com. ■

¹ Saaddine JB, Honeycutt AA, Venkat Narayan KM, Zhang X, Klein R, Boyle, JP. Projection of Diabetic Retinopathy and Other Major Eye Diseases Among People With Diabetes Mellitus: United States, 2005–2050. *Archives of Ophthalmology* 2008;126(12):1740-1747.

² www.eyecareamerica.org/eyecare/conditions/diabetic-retinopathy/condition.cfm.



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1-888-TRIWEST
www.triwest.com

TRICARE Alaska Office
1-907-743-1800

Wisconsin Physicians Service
(Electronic claims set up)
1-800-782-2680
www.wpsic.com

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



Want A Quick Response to Your Referral and Authorization Requests?

Most referral and authorization requests are processed immediately when you submit them online. All registered providers on the secure provider portal at www.triwest.com now have the ability to submit referrals and authorizations online. And it's fast and easy!

In most cases, the requests are processed to completion and the status is available online for the referring provider, the servicing provider and the TRICARE beneficiary immediately.

To take advantage of this and many other benefits, you must become a registered user of the secure provider portal. Just go to www.triwest.com/provider and click on "Register Today!" to sign up and enjoy the following benefits:

- Verify patient eligibility
- Submit referrals and authorizations online
- Determine the status of referrals and authorizations
- Submit claims online
- View and check the status of claims
- Download explanations of benefits

Once you are registered, you can log in to the secure portal by clicking on "My Account." Then go to the "Referrals & Authorizations" section and click on the "Learn to Submit Requests" button. There is a short online tutorial to assist you with getting started and answer common questions about using the tool. Additional online help is also available.

For more information, visit www.triwest.com/provider or call 1-888-TRIWEST (1-888-874-9378). ■

