

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.

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

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From the Desk of the CMO

*Russell W. Jenna, Jr., MD
VP and Chief Medical Officer
TriWest Healthcare Alliance*

I want to personally thank you for the outstanding care you provide for our TRICARE beneficiaries. Six months ago, TriWest Healthcare Alliance assumed responsibility of supporting health care delivery for TRICARE beneficiaries in Washington, Oregon, northern Idaho, California, Hawaii, Alaska and Yuma, Arizona.

Our transition was completed four months later when the former Central

Region states joined us under the West Region contract. This expansion brought both challenges and opportunities. Your patience while we worked through various issues has made the difference in successfully completing this transition.

I also want to make you aware of the many resources available to all of TriWest's providers as they care for our TRICARE beneficiaries. TriWest offers case management services that will assist you in managing the care of beneficiaries with complex, catastrophic, and short-term and/or long-term health care needs. We also have diabetic and cardiac disease programs available through our

Population Health Improvement Department (PHID) to assist providers and beneficiaries in meeting the special needs that accompany these diseases.

Please refer to the articles in this newsletter for more information about how to access these services.

As Chief Medical Officer, I am very proud of all the effort, patience and care given by our TRICARE network providers. The medical directors and staff at TriWest remain committed to ensuring that providers' issues are addressed promptly and that, as a team, TriWest, our military providers and our civilian providers continue to serve those who have served us and those who continue to serve. ■



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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. ■

^{1,2} 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)

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

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Cancer Trials Available to TRICARE Beneficiaries

Nearly 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

Prior authorization is required to participate in an NCI clinical trial. Before beginning the evaluation or any treatment under the clinical trial, contact the DoD Cancer Clinical Trials Demonstration Project Coordinator at TriWest, Mary Lou Klippel, RN, at 1-866-427-6610 from 8 a.m. to 5 p.m. Mountain Standard Time.

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 additional clinical trials available, contact the demonstration project coordinator. ■

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

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These Indicators were chosen based on their ability to motivate action, the availability of data to measure progress and their importance as public health issues.

Consider the impact you can have on TRICARE beneficiaries' overall health and wellness by implementing health promotion programs and prevention education around these Leading Health Indicators. Coupled with your continued focus on high-quality medical intervention for disease and injury, such programming can really make a difference.

Publications are available at www.healthypeople.gov that provide extensive resources for implementing Healthy People 2010 initiatives. Additionally, as several Leading

Health Indicators have the same focus as the *Healthy Choices for Life* campaign, look to the "Healthy Choices for Life" department in this newsletter to bring you information and ideas that will assist you in your health promotion endeavors.

The end results will be improved military readiness, a healthier population, lower health care costs and more satisfied patients—all of which will help TRICARE remain a U.S. health care leader.

For more information on Healthy People 2010 objectives or if you would like to become a Healthy People 2010 partner, visit www.healthypeople.gov or call 1-800-367-4725. ■

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 (or non-network provider if a network provider is not available) 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 authorization from TriWest. 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 TriWest.

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 about 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.

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FAQs: TRICARE Vision Coverage

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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.

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 cost-shared 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 (contact lenses only), 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 referrals 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. 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 TriWest at 1-888-TRIWEST. ■

For Those Who Can't Do It Alone

TRICARE providers in the West Region can depend on TriWest's case management department to assist with those beneficiaries who need help managing their health care.

What Is Case Management?

Case management is a program for patients facing complex medical conditions and adverse psychosocial issues that inhibit their abilities to properly manage their own health care needs. Case managers are registered nurses who are available to answer any questions that a beneficiary has about his or her illness and are there to assist the provider with coordinating complex conditions and treatments that a patient might require.

Why Case Management?

There are times when acute medical or psychological circumstances prevent a beneficiary from properly managing his or her own health. In those instances, case management is there to help you make sure TRICARE beneficiaries' needs are met both in and out of your office.

What Does Case Management Do?

Case managers provide many services that will assist you in providing care, such as:

- Decreasing providers' administrative tasks by assisting with referrals and authorizations and locating specialty providers

- Identifying and facilitating needed services and equipment, in collaboration with the primary care manager, for optimal health care delivery
- Assisting in communication with caregivers on behalf of the beneficiary, providing a point of contact to assist with problem solving, and acting as the beneficiary's advocate
- Educating the beneficiary on TRICARE benefits and systems
- Identifying community resources
- Educating the beneficiary on his or her disease process and promoting lifestyle changes that can positively affect the management of the disease (e.g., diet, exercise, compliance with the recommended treatment plan, stress management and keeping appointments)

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TRICARE Benefits Improve for Reservists and Their Families

The National Defense Authorization Act for 2005 (NDAA 2005) improves the overall health benefits available to members of the Guard and Reserve and their families, and it makes permanent several of the TRICARE benefits authorized "temporarily" under 2004 defense legislation.

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 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.

More information about these changes authorized under the NDAA 2005 will be available on the TRICARE Web site at www.tricare.osd.mil and the reserve affairs Web site at www.defenselink.mil/ra. ■

Helping the Best Doctors Deliver the Best Care

TriWest is committed to ensuring TRICARE patients receive the highest quality care possible. Utilization management is one way TriWest can verify that guarantee.

Essentially, three types of utilization management review ensure patients receive the right care at the right time, and that no additional treatment opportunities are being missed.

Prospective Review

Prospective review is conducted in cases where you or your staff submits beneficiary care information to TriWest (e.g., referrals, authorizations), but before the beneficiary actually receives the treatment. This review evaluates the medical necessity and appropriateness of the treatment and ensures the service is a TRICARE-covered benefit. Both you and the beneficiary will be notified concerning the results of the prospective review.

Concurrent Review

Concurrent review takes place in cases where a TRICARE beneficiary is in an inpatient setting. In these instances, clinicians specializing in medical-surgical and/or behavioral health care supplement a primary review board. In addition to a review of the general quality and appropriateness of care, utilization management will also establish the need for any post-discharge services. Utilization management will then authorize such services, but cannot schedule them for the beneficiary. You will be notified in writing only if the beneficiary is recommended to enter case management, or in the rare occurrence that the case is denied completely.

Retrospective Review

Retrospective review is conducted in cases where the care has already been rendered. Nurses review any instances where questions arise about the treatment that was administered. You will be notified in writing concerning the results of the retrospective review.

A Process You Won't Even Notice

As long as your office submits all required documents and authorizations in a timely manner, nothing more should be required from you or your staff for utilization management to take place. If any questions or errors with your submissions arise, you will then be contacted for further information. Otherwise, unless your patient is recommended for another program, such as case management, the process should be virtually invisible to you. ■

PHID Aims to Educate

A well-informed TRICARE beneficiary means you both get more out of the brief time you spend together in your office. TriWest's Population Health Improvement Department (PHID) is available to help beneficiaries learn more about their health care needs.

Demand Management

The demand management program within PHID offers general health care education and healthy living tips via telephone and Web site. The program is available to all TRICARE-eligible beneficiaries, regardless of medical condition. The information line is available 24 hours a day by calling 1-888-259-9375 and by visiting www.triwest.com. A crisis line is also available for behavioral health issues at 1-888-TRIWEST.

Disease Management

The disease management program within PHID is available to all TRICARE beneficiaries diagnosed with diabetes or ischemic heart disease. Disease management is individualized for each patient and is based on the patient's specific needs.

Beneficiaries participating in the disease management program are educated about their illnesses, including how to have constructive discussions with their physicians. PHID reinforces the statement that "you are in charge of you," encouraging TRICARE beneficiaries to take a hands-on approach to their health care.

While the program is currently limited to patients with diabetes or ischemic heart disease, TriWest plans to expand the program to other diseases, including a depression program starting this year.

Referring a Patient to PHID

As a TRICARE provider, you are the beneficiary's primary channel for receiving disease management services through PHID.

If you are referring the beneficiary to another physician or specialist, PHID will obtain the beneficiary's name and contact information from the diabetes or ischemic heart disease ICD-9 code on the referral form. PHID will then send that beneficiary an introductory packet inviting him or her to call and opt-in to the program.

If you are not making a referral to another practitioner, you may direct the beneficiary to PHID through a referral form, which is available through TriWest's Web site at www.triwest.com under Find a Form. ■

Thinking Collection Agency for a Beneficiary Claim?

Avoid Debt Collection and Understand the Role of the DCAO

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 staff to learn claim submission pitfalls and avoid sending unpaid beneficiary claims to a costly 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, hassle-free 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. Far too often service members must 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.

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 explanation of benefits (EOB) statement when it arrives; if a claim is rejected, it will state the reason why.
2. If the EOB 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. If an EOB does not arrive within 45 days, this may mean that there has been a problem in submission of the claim. Contact your TRICARE regional contractor, TriWest, or if the patient has Medicare, contact the TRICARE dual-eligible fiscal intermediary, Wisconsin Physicians Service (WPS), at 1-866-773-0404.
4. Contact TriWest if you have additional or corrected information regarding a rejected claim.

“It’s important for providers to read and understand the explanation of benefits. 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 explanation of benefits.”

Eliminate Mistakes that Lead to Rejected Claims

Many times claims are rejected because of mistakes made in entering the following common information. Awareness of these 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.

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For Those Who Can't Do It Alone

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The goal of case management is to help beneficiaries become more independent in the management of their own health care. After a beneficiary has been a program participant for some time, case management will encourage the beneficiary, if medically able, to take on more responsibility for his or her treatment plan.

How Can I Refer a Patient to Case Management?

There are no pre-determined qualifications for case management. Every beneficiary referred to the program is evaluated on a case-by-case basis.

If you encounter a TRICARE beneficiary you believe meets the medical and psychosocial requirements, you may refer the beneficiary to case management. Case management will then review the beneficiary's situation and determine if he or she is eligible for the program.

The referral form can be found on TriWest's Web site at www.triwest.com. ■

Reporting Catastrophic Conditions

Please report the following catastrophic conditions to TriWest at 1-888-TRIWEST within 24 hours of diagnosis, within 24 hours of admission to any acute care facility, or by the business day following admission. Case managers will work with you and the beneficiary.

- Head trauma
- Spinal cord injury
- Acute HIV/AIDS
- Neoplasms and malignancy
- Bone marrow procedures
- Transplant and dialysis procedures
- Burns (third degree or extensive second degree)
- Cardiovascular conditions
- Respiratory dependency conditions
- Neurological conditions involving intensive care or unconsciousness for more than 48 hours
- All admissions to a neonatal intensive care unit
- Obstetrical conditions that require hospitalization prior to delivery
- Previous history of intensive care for an infant
- Expected multiple birth

Thinking Collection Agency for a Beneficiary Claim?

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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, contact TriWest at 1-888-TRIWEST for assistance.

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

TriWest, assists providers with claims questions and problems through a claims priority unit. Contact the unit before initiating any collection action against a TRICARE beneficiary. Call 1-888-TRIWEST for more information about contacting a claims priority unit representative.

More information on claims submission requirements can be found in your *TRICARE Provider Handbook* or online at www.triwest.com. TriWest also offers provider training, workshops and briefings throughout the West Region. You can find more information about these educational opportunities online. ■

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.

Here's what you should know when you counsel your patients about hospice care.

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 short-term acute inpatient hospice 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 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.

To formally revoke a hospice election, the beneficiary's hospice medical file must contain a signed, dated statement of revocation. 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 remain in the patient's file. 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

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Understanding Hospice Care

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should initiate and obtain the prior authorization from TriWest 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 the regional contractor's provider directory. TriWest's provider directory is accessible online at www.triwest.com or by calling 1-888-TRIWEST.

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). ■



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CONTACTS

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1-888-TRIWEST
www.triwest.com

TRICARE Alaska Office
1-907-743-1800

Wisconsin Physicians Service
(Electronic claims set up)
1-866-773-0404
www.wpsic.com

Express Scripts
(Pharmacy inquiries)
1-866-DoD-TRRx
1-866-DoD-TMOP
www.express-scripts.com/TRICARE



The Importance of “An Important Message from TRICARE”

It is important that all inpatient facilities properly notify TRICARE beneficiaries of their rights prior to each admission. To do so, facilities must provide the letter titled “An Important Message from TRICARE” to the beneficiary.

The letter explains the beneficiary’s rights while in the hospital and includes TriWest’s contact information. The beneficiary needs to read and sign the letter before admission, and the facility needs to keep a copy of the entire letter on file.

Using Medicare’s similar letter will not meet TRICARE’s requirement because Medicare’s letter provides Medicare’s contact information, not TriWest’s. Another contractor’s letter also should not be used for the same reason. TRICARE beneficiaries need to be able to contact TriWest directly if they feel their rights are not being upheld (for example, they feel they are being discharged too soon).

If TriWest’s nurse reviewers or case managers request medical files for inpatient services, they will also look for a copy of this signed letter. They will need to see the entire letter, not just the signature page, to ensure the correct letter that includes TriWest’s contact information was provided to the beneficiary at the time of admission.

Facilities can find the “An Important Message from TRICARE” letter template on TriWest’s Web site at www.triwest.com under the Find a Form tab. The most current letter will always be on the Web site. ■

