

Some Prescriptions Have Special Requirements What to Know about Prior Authorizations and Quantity Limits

As you write prescriptions for your patients, it's important to be aware that some medications have special requirements that must be met before the prescription can be filled. Here's what you should know.

Prior Authorization

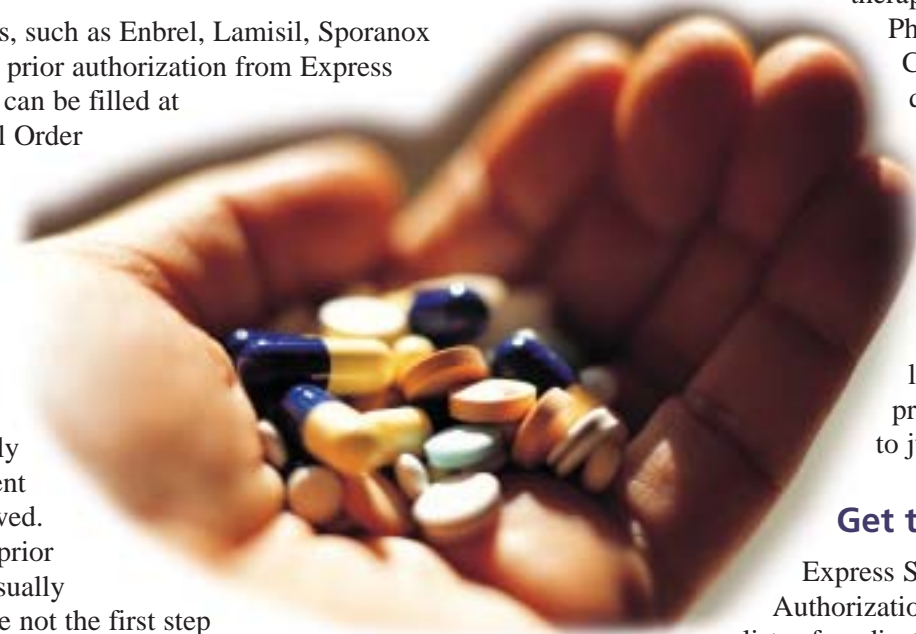
Certain medications, such as Enbrel, Lamisil, Sporanox and Viagra, require prior authorization from Express Scripts before they can be filled at the TRICARE Mail Order Pharmacy (TMOP) or network retail pharmacies under the TRICARE Retail Pharmacy (TRRx) Program. Prior authorization is necessary to ensure that clinically appropriate treatment regimens are followed. Drugs that require prior authorization are usually medications that are not the first step in a treatment regimen. The Department of Defense (DoD) Pharmacy and Therapeutics Committee determines the criteria for prior authorizations and which drugs are subject to those criteria.

Except for antifungal medications, prior authorizations are good for a year, even if several new prescriptions for the medication are submitted during that year. Prior authorizations for the antifungal medications used for fungal infections of the fingernails or toenails (itraconazole, terbinafine and ciclopirox) must be approved for each new course of therapy.

Quantity Limits

Quantity limits are a common practice in commercial health plans to help ensure beneficiaries receive the proper dose and recommended duration of therapy to optimize outcomes while minimizing potential for adverse events, inappropriate therapy and waste. The DoD

Pharmacy and Therapeutics Committee has established quantity limits on certain medications, which means the DoD will pay only for up to a specified quantity per 30-, 60- or 90-day supply. Exceptions to established quantity limits can be made if the prescribing physician is able to justify medical necessity.



Get the Details

Express Scripts Pharmacy Prior Authorization Forms and complete lists of medications that require prior authorization or are subject to quantity limits are available through the Express Scripts Web site at <http://member.express-scripts.com/dodCustom/home.do> (choose the link "Drugs that Require Prior Authorization" or "Drugs that Have Quantity Limits"). Or, you can call 1-866-DoD-TRRx. You can also visit the Provider Connection section of the TriWest Web site at www.triwest.com for more information about injectable medications. ■



The Necessity of Consult Tracking

Reports Due in 10 Business Days

TRICARE network providers in the West Region have a contractual obligation to submit required consult tracking reports to referring providers within 10 business days.

This consult tracking requirement is part of the West Region contract to facilitate continuity of care for all TRICARE beneficiaries. Both civilian and military treatment facilities (MTFs) referring providers need feedback to properly manage their patients' care. Additionally, MTFs must track current fitness for duty status of active duty service members at all times and specialty consultation is an important piece of the total picture.

Submitting Reports

TRICARE network providers have 10 business days from the beneficiary's date of service to submit specialty care consultation or referral reports, operative reports, discharge summaries, therapy reports or imaging studies.

Due to the time constraints, the preferred method of report submission is fax. Network providers should fax their reports to the fax number listed on the original referral/authorization approval letter. (If it is necessary to mail any reports, they should be sent to the address listed on the referral letter.)

It is requested that providers not submit their consult report directly to the MTF. This will assist the MTF with managing and tracking the flow of reports back to MTF PCMs. Additionally, direct submissions may result in misrouted or misplaced reports and delay the flow of information to the PCM.

Urgent/Emergent Situations

In urgent/emergent situations, a preliminary report of a specialty consultation should be conveyed to the beneficiary's referring provider within 24 hours of the encounter (unless best medical practices dictate less time is required for a preliminary report) with a formal written report provided within 10 business days.

Non-compliance with Required Time Frame

When consult reports are not submitted in the required time frame, TriWest staff members conduct weekly outbound calls to network providers to remind them that a report is due to the referring provider. These "Consult Tracking Representatives" complete a thorough review of the referral status in the medical management system before calling to verify whether a consult report was received from the Specialty Provider. The results of each call are entered into the medical management system for further tracking and follow up.

A "feedback" report is then faxed each week requesting information on whether the beneficiary's specialist appointment was kept or rescheduled. Network providers should fax their reports to the fax number listed on the original referral/authorization approval letter.

For every consult tracking report that is submitted later than 10 business days after the date of service, TriWest is assessed a penalty by the government. In addition, a second penalty is assessed for the same consult tracking report if it still has not been received within 30 days.



TriWest has chosen not to share these penalties with network providers, but TriWest does need your help to ensure that the government's timelines are met.

Track Consult Reports Online

To assist providers with meeting the 10 business day deadline, TriWest has a consult tracking report function on a secured portion of the TriWest Web site at www.triwest.com. Providers are encouraged to register for and use this valuable tool to review and update consult report status online. ■

IEP Forms Needed for PFPWD Claims Processing

TRICARE's Program for Persons with Disabilities (PFPWD) provides financial assistance to reduce the effects of mental or physical disabilities. It is not a stand-alone or enrollment program; subject to certain restrictions, it may be used concurrently with other TRICARE medical programs.

PFPWD serves active duty family members who have two kinds of serious disabilities: persons who have moderate or severe mental retardation and those who have a significant physical disability. The needs could be, but are not limited to, physical therapy, occupational therapy and speech therapy. If the qualifying condition existed prior to reaching age 21, the beneficiary retains eligibility as long as the sponsor remains on active duty.

In many communities, public funds are available for persons with disabilities. Beneficiaries first must get assistance from these community sources—e.g., a school system or community organization. If public help isn't available or isn't enough, TRICARE helps pay for covered services. All program benefits must be authorized in advance.

An Individual Educational Plan (IEP) must be submitted by providers who offer services for PFPWD beneficiaries aged 3 to 21. An IEP is developed by the local school system to meet the needs of children who require help and is necessary in order for TRICARE to determine whether or not an authorization can be issued.

Previously, it was the parent's responsibility to provide the IEP. However, TRICARE policy now states that it is the *provider's* responsibility to obtain the IEP. Providers must determine that the beneficiary is qualified before providing services.

The Special Education Benefit is described in Chapter 8, Section 1.11 of the *TRICARE Policy Manual*, Program for Persons with Disabilities. If you need further information, refer to the Manuals section of the TRICARE Web site at www.tricare.osd.mil/TRICAREManuals. PFPWD will be replaced by the Extended Care Health Option (ECHO) program in the near future. An anticipated implementation date is Sept. 1, 2005. ■

Reminder:

Conduct Medical Necessity Reviews via Telephonic Process

Hospitals and other health care facilities in the TRICARE West Region are reminded that TriWest Utilization Management (UM) nurses may perform medical necessity reviews of beneficiaries hospitalized in your facility. In order to improve continuity of care through a centralized medical management system, TriWest has implemented a telephonic review process.

UM nurses are the main point of contact and are available to assist in discharge planning.

Hospitals should fax the admitting face sheets to TriWest at 1-866-269-5892. If the beneficiary is enrolled in TRICARE Prime Remote (TPR), hospitals should fax to 1-866-312-5831.

Necessary documentation for admission reviews include:

- Brief history to include age, sex, admission source (e.g., elective, emergency department, etc.)
- Reason for admission
- Co-morbidity information
- Specific intensity of service (IS) and severity of illness (SI) criteria met (or not) or documented rationale for nursing judgment, if appropriate
- Length of stay, if discharged

- Discharge planning needs
- Hospital point of contact

Necessary documentation for continued stays includes:

- Specific IS criteria met, if appropriate
- Relevant changes in condition
- Discharge planning needs
- Hospital point of contact

If you have any questions regarding this process, contact TriWest at 1-888-TRIWEST. ■



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CONTACTS

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)
1-866-773-0404
www.wpsic.com

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



Reserve Component Members Are Covered for Line of Duty Injuries

When on military duty, members of the Reserve Component are covered for any injury, illness or disease incurred or aggravated in the line of duty (LOD). This includes any injury sustained while members are traveling directly to or from the place where they perform military duty.

LOD coverage is separate from any other TRICARE coverage received, including:

- Transitional health care under the Transitional Assistance Management Program (TAMP)
- Coverage under the TRICARE Reserve Select health plan

Most LOD care is provided at a military treatment facility (MTF), but if an MTF is not available, the Military Medical Support Office (MMSO) may coordinate nonemergency care through any TRICARE-authorized civilian provider for service members residing in remote areas.

All LOD claims that are not referred by an MTF are forwarded by TriWest to the MMSO for approval or denial. As a TRICARE provider, if you submit a LOD claim for

an injured member of the Reserve Component, the injury must be a service-related injury—pre-existing conditions are not covered.

The provider of care should submit medical claims directly to the regional contractor unless asked by the Unit Medical Representative to be submitted to the unit address. If a claim is denied by the MMSO for eligibility reasons, the provider's office should bill the member. MMSO may approve payment once the appropriate eligibility documentation is submitted.

It is the Reserve Component member's responsibility to ensure that appropriate eligibility documentation is submitted by the unit to the MMSO and that all follow up care is pre-authorized by the MMSO. ■