

Some Injectable Medications Require Authorization

Under the West Region contract, some injectable medications that require physician or health care professional administration and that are dispensed in a provider's office or by a home health agency may require authorization by TriWest Healthcare Alliance.

A list of injectable medications requiring prior authorization by TriWest is located at www.triwest.com. Providers can download the appropriate form to request authorization under the "Find a Form" tab. Please fill out the form completely and legibly and **fax to TriWest at 1-866-269-5892** along with any relevant clinical information.

After review and upon approval, the request is processed and the requesting provider and the beneficiary will receive an approval letter. The vendor will receive the Clinical Guideline and Prescription Form. Please allow five business days for TriWest to process your request.

Most other injectable medications are available at an Express Scripts Inc. (ESI) affiliated retail pharmacy under the TRICARE Retail Pharmacy (TRRx) program when physician or health care professional administration is not required.

Please note: Covered injectable medications and prior authorization requirements may vary between the TRRx

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From the Desk of the CMO

*Len Tamsky, M.D.
Senior Medical Officer
TriWest Healthcare Alliance*

TriWest is taking the lead in the development of an integrated health care model.

The TriWest Integrated Behavioral Health Program will access the expertise of medical/surgical and behavioral health providers to accurately identify and treat both the medical/surgical and behavioral health issues of beneficiaries and smoothly coordinate the delivery of medical/surgical and behavioral health services for a unified health care experience.

Integrated behavioral health combines behavioral health and medical/surgical expertise in all health care settings. This results in:

- Increased patient acceptance of behavioral health services as part of the health care process
- Improved quality of care by directly addressing behavioral health needs
- Decreased likelihood that somatic symptoms of behavioral health disorders will be mistaken for physical disorders and referred for more extensive medical evaluation
- Treating the patient as a whole
- Improved patient satisfaction
- Improved outcomes
- Decreased health care costs

A first step in this behavioral health leadership role is the creation of an

extensive behavioral health portal on our Web site. Here, we are creating a one-stop shop for beneficiaries and providers where they can find valuable behavioral health resources. Visit www.triwest.com to discover a new way to review the most common behavioral health issues.

Also in This Issue ...

Please take the opportunity to read the articles in this newsletter to gain a better understanding of TRICARE and TriWest. They include a clarification of family therapy and marriage counseling coverage; a descriptive chart noting behavioral health coverage in the TRICARE basic plans; information about

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Some Injectable Medications Require Authorization

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and TRICARE Mail Order Pharmacy (TMOP) programs. If TriWest receives a request for a drug that should be obtained from ESI through the TRRx or TMOP programs, the requesting provider will receive a letter from TriWest requesting that the provider contact ESI. ■



Important Pharmacy Contact Information

TriWest Healthcare Alliance	Call: 1-888-TRIWEST (1-888-874-9378) Fax Forms: 1-866-269-5892
Formulary Search Tool—Type in the brand name or generic name of the drug, and the tool will tell you if it is available through a retail pharmacy. The tool is updated weekly.	www.tricareformularysearch.org
Formulary Frequently Asked Questions	www.tricare.osd.mil/pharmacy/faq.cfm
Express Scripts/TRICARE Retail Pharmacy (TRRx)	Call: 1-866-684-4488 doctor's line Fax: 1-866 684-4477 doctor's line www.tricare.osd.mil/pharmacy/retailnetwork.cfm
Express Scripts/TRICARE Mail Order Pharmacy (TMOP)	Call: 1-877-283-3858 Fax: 1-877-895-1900 www.tricare.osd.mil/pharmacy/tmop.cfm
Speak to an Express Scripts Pharmacist	Call: 1-866-363-8667
Express Scripts Customer Service for Beneficiaries	Beneficiary Web site: www.express-scripts.com/TRICARE

From the Desk of the CMO

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injectable medications; the specialty referral process; a new version of ClaimCheck; information to have available prior to calling TriWest regarding a claims inquiry and what to do if you receive a denial on a claim;

and an update on the spring 2006 educational seminars for providers.

As Senior Medical Officer, I am very proud that 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. ■

Tips to Resolve Claims Issues and Avoid Debt Collection

Involving a debt collection agency to resolve a claim issue is stressful for both providers and beneficiaries. Fortunately, TRICARE offers assistance that you can take advantage of prior to sending a bill to a collection agency.

“It is never TRICARE’s intent not to pay the provider or send someone to collection,” says Francine Forestell, director of TRICARE beneficiary services and staff training. “It’s about following up and finding out what, if anything, went wrong, and then taking steps to resolve it.”

Most rejected claims are due to a simple error. Do the following first to determine what might have gone wrong:

- Read the TRICARE Summary Payment Voucher, otherwise known as the remittance notice. If the claim is rejected, the denial codes will explain why.
- Make sure all beneficiary information is up to date. If patient or sponsor information is incorrect, contact the beneficiary and get the information needed. Then find out if it’s an eligibility issue. If so, call your regional contractor, TriWest, to get eligibility information.

Even if a provider is unwilling to accept assignment, it is a good practice to submit claims for TRICARE patients. Few beneficiaries understand the claims submission process and long delays in payment may occur as the beneficiary attempts to get adequate information to submit a claim.

It also helps to ask your staff to double-check for errors before submitting claims. The following are the most common mistakes:

- Incorrect beneficiary address
- Incorrect Social Security number (SSN)—Do **not** submit under the beneficiary’s SSN **unless** that person is the military ‘sponsor’ or the person is an eligible former spouse.
- Wrong procedure and diagnosis codes (For example, V70.0 is not an appropriate diagnosis code; V72.6 is not appropriate for a lab test. If the care was preventive, use a preventive diagnosis code. Unclassified [Physician’s] Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes should be used **only** with a clear description of what is being billed.)
- Unpaid copayment

When to Call TRICARE for Help

If you discover a problem, take quick action to resolve it within the TRICARE system rather than sending the issue to collections. TriWest is your first point of contact for resolving claims issues. In most instances, TriWest will be able to resolve your issue or concern. Call 1-888-TRIWEST (1-888-874-9378).

If the problem cannot be resolved at the regional contractor level, TRICARE providers can refer beneficiaries to beneficiary counseling and assistance coordinators (BCACs) first, then to debt collection assistance officers (DCAOs) if necessary. Both will help the beneficiary understand what’s going on with the claims issue and try to resolve it.

DCAOs help beneficiaries evaluate the validity of collection agent claims and/or the negative credit reports that sometimes result from them. DCAOs are well equipped to deal with these situations and, in the process, help ease the stress on service members and their families. For example, it’s the DCAO’s job to initiate contact with the collection agency and assure the agency that action is being taken to resolve the issue.

Sometimes, when acting as the beneficiary representative, the DCAO may even contact you. “Then any information you as a provider can give to help resolve an outstanding claim issue is greatly appreciated,” notes Forestell.

Where to Find BCACs and DCAOs

BCACs and DCAOs are located at TRICARE Regional Offices and at military treatment facilities (MTFs). To find a BCAC or DCAO near you, call your local MTF or go online to the BCAC/DCAO Locator directory at www.tricare.osd.mil/bcacdcao. ■



Clarifying the Specialty Referral Process

There has been some confusion about whether a TRICARE Prime beneficiary needs to return to his/her primary care manager (PCM) or if a TRICARE Prime Remote (TPR) beneficiary needs to return to his/her primary care physician (PCP) when a specialist suggests a referral to another specialist. The following information gives some clarification on who is responsible for requesting the referral from TriWest when a second specialist is needed.

Here are two examples of the correct referral process:

- A TRICARE Prime/TPR beneficiary is referred to a cardiologist by his/her PCM/PCP. The cardiologist determines that cardiovascular surgery is necessary. In this case, the cardiologist submits a

request to TriWest for a referral to a cardiovascular surgeon. The cardiologist's consult report would indicate the need for a second specialist. The consult report would keep the PCM/PCP aware of the need for a second specialist and the beneficiary's condition, but there is no need for the beneficiary to return to his/her PCM/PCP to obtain the referral.

- A TRICARE Prime/TPR beneficiary is referred to a cardiologist by their PCM/PCP. The cardiologist determines during their consultation that the beneficiary has tested positive for Type II Diabetes, which requires the services of an endocrinologist or their PCM. In this case, the beneficiary should be directed back to the PCM/PCP, and the PCM/PCP needs to request the referral from TriWest for the appropriate physician.

If the additional services required are for the same diagnosis as referred to the initial referral specialist, the specialist can request the referral to the second network specialist. If it is not the same initial diagnosis, the TRICARE Prime/TPR beneficiary needs to be directed back to his or her PCM because the services required are not within the scope of the initial specialist.

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

New Version of ClaimCheck Now in Place

TriWest has implemented ClaimCheck 8.5, an updated Web-based version of the current bundling software, which is used to ensure appropriate coding and reimbursement of non-institutional claims.

One of the many upgrades to this software is the ability to read up to four modifiers on each claim line; the previous version could only read one modifier billed in the first position.

Another new feature is the ability to treat Healthcare Common Procedure Coding System (HCPCS) codes the same way as [Physician's] Current Procedural Terminology (CPT) codes. This feature alerts providers that even though the provider bills with HCPCS codes, the system will crosswalk the HCPCS codes to the comparable CPT code, and the claim will process the same as if the comparable CPT code had been used.

The new version of ClaimCheck allows TriWest to update the bundling edits as soon as the new American Medical Association (AMA) or Centers for Medicare and Medicaid Services (CMS) codes are established or change.

The process for ClaimCheck appeals has not changed. Providers should submit their appeals in writing, with supporting documentation, to: TriWest Healthcare Alliance, ClaimCheck Appeals, P.O. Box 42090, Phoenix, AZ 85080. ■

TriWest Announces Spring 2006 Provider Seminar Schedule

TriWest's Provider Services staff is pleased to invite providers and their staff to attend one of our upcoming civilian provider seminars. The seminars will begin in March and be held through early summer.

The seminar agenda includes information on Outpatient Prospective Payment System (OPPS), TRICARE programs and updates, TRICARE eligibility and benefits, referral/authorization processing, claims/billing tips, electronic claims filing, consult report tracking and much more.

To find out the dates, times and locations of seminars in your state, go to www.triwest.com, Provider Connection, then click the registration link in the Take the First Step Today section, and select your state and seminar type from the drop-down menu.

By registering online, you will receive an immediate confirmation by e-mail, as well as reminder e-mails a few days before your seminar. ■

Streamline Your Claims Calls to TriWest

When placing a call to 1-888-TRIWEST (1-888-874-9378) regarding a claims inquiry, it is important to have the necessary information available. This helps TriWest customer service representatives respond more quickly to your inquiry and saves you time searching for essential information needed to address your inquiry.

Please have the following information readily available:

- Sponsor identification number
- Patient name
- Provider’s tax identification number
- Date of service

- Billed charge amount on the claim
- Referral or authorization number (if applicable)
- Claim number if you are questioning a particular claim

Appealing Denials

The table explains the top 10 explanation of benefits (EOB) denial codes sent out by TriWest, their accompanying messages, the documentation needed if you do not agree with the denial code and want to appeal the determination, and where to send the documentation. ■

EOB CODE	MESSAGE	REVIEW DOCUMENTATION NEEDED	WHERE TO SEND
003	If you disagree with the amount paid, please send correspondence to fee reviews.	Letter explaining the reason you feel the payment is not correct. It is helpful to include the EOB and remittance advice with your request.	WPS P.O. Box 77029 Madison, WI 53707-7029
018	Provider not TRICARE Authorized for this service.	Letter explaining your disagreement with this denial and supporting documents.	WPS P.O. Box 77029 Madison, WI 53707-7029
020	This charge included in a paid service.	Letter and documentation that support the procedure as separate and distinct from other procedures or services rendered or performed.	TriWest Healthcare Alliance P.O. Box 42090 Phoenix, AZ 85080
028	Requested information not received.	Letter with requested information attached. If the requested information is not known, please call 1-888-874-9378 for more information.	WPS P.O. Box 77029 Madison, WI 53707-7029
032	Non-covered services	If the service is an exclusion of the TRICARE program, the claim is not appealable. However, if you have received authorization, or if you feel the service was medically necessary, please write a letter and include any prior authorization letters you may have received and/or any additional documentation to support the service.	TriWest Healthcare Alliance P.O. Box 43770 Phoenix, AZ 85080
067	Services rendered or supplies provided are not medically necessary.	Letter and medical documentation to support the medical or psychological need for the service rendered.	TriWest Healthcare Alliance P.O. Box 86159 Phoenix, AZ 85080
083	Services rendered or supplies provided are not covered because records submitted do not meet medical documentation requirements.	Letter and medical documentation to support the medical or psychological need for the service rendered.	WPS P.O. Box 77029 Madison, WI 53707-7029
143	The service billed requires prior authorization. Since we have no record of this being obtained, this claim is denied.	Letter and medical documentation to support the medical or psychological need for the service rendered.	TriWest Healthcare Alliance P.O. Box 86159 Phoenix, AZ 85080
192–199	ClaimCheck Denials	Documentation that supports the procedure code is separate and distinct from other services billed. This can include any argument that supports additional reimbursement for the claim.	TriWest Healthcare Alliance P.O. Box 42090 Phoenix, AZ 85080
260	Service Point of Contact (SPOC) has reviewed these services and has denied authorization of the care.	Service denied by the SPOC must be appealed to the appropriate branch of service for the sponsor.	See remittance advice for the correct address for appeal.

Still Rebuilding After Hurricane Katrina

Hurricane Katrina affected the lives of many TRICARE beneficiaries and providers in Alabama, Louisiana and Mississippi. After Hurricane Katrina, more than 136,000 beneficiaries moved to new locations across the country for safe haven and, in some cases, to start over.

What we've achieved to date could not have been accomplished without the help of the soldiers, airmen, sailors and countless other volunteers who answered the call to help restore order and hope to the Gulf Coast. But we also owe a debt of gratitude to you, our TRICARE providers, for once again supporting our troops and their families in such a time of need.

Answering the Call

As recovery and relocation efforts were underway in the aftermath of Hurricane Katrina, the Department of Defense (DoD) launched an aggressive outreach to nearly 360,000 active duty military personnel, retirees and their families who were affected by the storm.

From the South Region, beneficiaries were relocated to approximately 474 evacuee sites across the United States. TRICARE dispatched staff to a number of sites to provide face-to-face counseling, to advise beneficiaries on how to access care, and to answer their questions about their health benefit options. Humana Military Healthcare Services, the TRICARE South Region contractor, completed a five-day outreach campaign to 586 American Red Cross shelters throughout the southern United States to assist displaced beneficiaries.

Health Net Federal Services, Inc., the North Region contractor, and TriWest Healthcare Alliance, the West Region contractor, also visited numerous shelters in their regions to locate and assist beneficiaries.

What Lies Ahead

While progress continues daily, a couple of South Region facilities were devastated and are still waiting to reopen.

For the latest information about access to health care during the aftermath, facility closures and re-openings, and much more, visit the Humana Military Web site at www.humana-military.com/South/katrinaupdates.htm. ■

Q&A

Where do I send my claim if I provide services to a beneficiary displaced by Hurricane Katrina?



Providers in all regions should submit claims for displaced beneficiaries from the South to the South Region. Use the beneficiary's permanent address (where they used to live prior to being displaced) rather than a temporary address.

Be aware that some beneficiaries may have made their temporary address permanent since they cannot return home and have transferred their TRICARE eligibility information to the new address. In those situations, be sure to verify with the patient what their **permanent** address was at the time of care and send your claim to the appropriate regional contractor based on that address.

If a provider treats a TRICARE beneficiary from another TRICARE region, the provider should submit the claims to the TRICARE region where the beneficiary resides and/or is enrolled in TRICARE Prime to expedite payment. TRICARE pays based on where the beneficiary resides or is enrolled, whereas Medicare pays based on where the services are rendered. TRICARE For Life beneficiary claims are automatically forwarded by the Medicare carriers.

Please mail your claims for South Region beneficiaries to: TRICARE South Region, Claims Department, P.O. Box 7031, Camden, SC 29020-7031. Questions can be directed to the South Region's claims contractor, PGBA, at 1-800-403-3950.

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Still Rebuilding After Hurricane Katrina—Q&A

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How is Humana Military handling referrals and authorizations for displaced beneficiaries needing routine and urgent care services that normally require a referral?

From Sept. 1 through Nov. 30, Humana Military waived referral/authorization requirements for routine and urgent care for beneficiaries who resided in specific ZIP codes impacted by Hurricane Katrina. Now that the authorization for blanket referrals has expired, providers will need to verify with their patients their permanent address at the time of care in order to request a referral or authorization from the appropriate source.

If the beneficiary's eligibility is still linked to the South Region, med/surg providers should contact Humana Military at 1-800-444-5445 to request prior authorization; behavioral health providers should call 1-800-700-8646; or all providers can fax their requests to 1-877-548-1547.

What should I do if displaced beneficiaries contact me for guidance on their TRICARE benefits?

Direct beneficiaries to contact the Humana Military call center at 1-800-444-5445. Customer service representatives will assist them.

What do I tell beneficiaries who have decided to permanently move to the West Region?

They should contact TriWest Healthcare Alliance at 1-888-TRIWEST (1-888-874-9378). ■

Web Site Established to Assist Service Members

Military officials established a Web site to help provide service members with information about loved ones who may have been displaced by the hurricanes that hit the Gulf Coast this season.

Anyone providing shelter to a military family is encouraged to visit

www.militaryfamilylocator.org or www.guardfamilylocator.org.

Through the Web site, an initiative of the military Family Programs offices, military officials are able to help deployed service members learn the whereabouts and condition of family members affected by the hurricane.

Affected individuals may also call the following numbers:

National Guard	1-888-777-7731
Active Army	1-800-833-6622
Reservists	1-877-464-9330
Marines	1-888-777-7731
Navy	1-877-414-5358
Air Force	1-800-435-9941 ■



TRICARE Behavioral Health Care Plan Comparison

Behavioral health benefits are a component of the overall TRICARE program and are subject to TRICARE copays, cost-shares and deductibles. Pages 8 through 10 of this newsletter offer a breakdown of behavioral health benefits under each TRICARE program option.

CARE FOR BEHAVIORAL HEALTH AND SUBSTANCE USE DISORDERS	Beneficiary Category	TRICARE Prime	TRICARE Extra	TRICARE Standard
	All TRICARE Eligibles	From Civilian Network (Contracted) Behavioral Health Provider Chosen by Patient	From Civilian Network (Contracted) Behavioral Health Provider Chosen by Patient	From Any TRICARE-certified Behavioral Health Provider Chosen by Patient

ANNUAL DEDUCTIBLE (Applies to all TRICARE services, including outpatient behavioral health)	Beneficiary Category	TRICARE Prime	TRICARE Extra	TRICARE Standard
	Active Duty Family Members of E4 and below	None	\$50 Individual \$100 Family	\$50 Individual \$100 Family
	Active Duty Family Members of E5 and above	None	\$150 Individual \$300 Family	\$150 Individual \$300 Family
	Retirees and Family Members	None	\$150 Individual \$300 Family	\$150 Individual \$300 Family

NOTE: Deductibles are based on the government’s fiscal year, Oct. 1–Sept. 30.

CATASTROPHIC CAP (Does not include Point of Service)	Beneficiary Category	TRICARE Prime	TRICARE Extra	TRICARE Standard
	Active Duty Families	\$1,000 / fiscal yr	\$1,000 / fiscal yr	\$1,000 / fiscal yr
	Retiree Families	\$3,000 / enrollment yr	\$3,000 / fiscal yr	\$3,000 / fiscal yr

NOTES: (1) Point of Service deductibles and cost-shares do not contribute toward the catastrophic cap.
(2) Catastrophic cap applies to the family.

POINT OF SERVICE (Option applies only to TRICARE Prime enrollees treated by non-network providers)	Beneficiary Category	TRICARE Prime	TRICARE Extra	TRICARE Standard
	Active Duty Family Members (all ranks) and Retirees and Family Members	Deductible \$300 Individual \$600 Family Cost-Share 50% of Allowed Charges	Not Applicable	Not Applicable

NOTES: (1) Applies to all non-emergency inpatient and outpatient services received by Prime enrollees from non-network providers without “out-of-network” authorization.
(2) Point-of-service deductibles are based on the enrollment year.
(3) Point-of-service deductibles and cost-shares do not have a catastrophic cap.

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TRICARE Behavioral Health Care Plan Comparison

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INPATIENT HOSPITALIZATION (Behavioral Health and Substance Use Disorders, Also applies to RTC)	Beneficiary Category	TRICARE Prime	TRICARE Extra	TRICARE Standard
	Active Duty Family Members (all ranks)	None	\$20 per day	\$20 per day
	Retirees and Family Members	\$40 per day	20% of institutional and professional charges	Lesser of per diem copay/day or 25% of institutional and professional charges

BENEFITS:

Behavioral Health Disorder

- (1) Benefits are limited to 30 days per fiscal year or per admission for acute inpatient care for ages 19 and older.
- (2) Benefits are limited to 45 days per fiscal year or per admission for acute inpatient care for ages under 19.
- (3) Benefits are limited to 150 days per fiscal year or per admission for care in TRICARE-approved residential treatment centers for ages under 19. (TRICARE policy says under 21, but as of 9/05, no RTCs in our region accept patients once they turn 18.)

Substance Use Disorder

Acute I/P Care

- (1) Covered for complications of alcohol and drug abuse or dependency and detoxification only when the patient's condition is such that the personnel and facilities of a hospital are required.
- (2) Days count toward the 30/45-day behavioral health inpatient limits.

Rehabilitation

- (1) Benefits are limited to 21 days per benefit period (combined partial and/or inpatient).
- (2) Benefit period starts the first day of covered treatment and ends 365 days later.
- (3) Up to 7 days of detoxification are allowed in addition to the 21 rehabilitative days.
- (4) Days count toward the 30/45 day behavioral health inpatient limits.

- NOTES: (1) Emergency admissions require post treatment authorization. TriWest must be notified within 72 hours of the admission. Clinical information must be provided.
- (2) All nonemergency admissions require prior authorization.
 - (3) Standard/Extra beneficiaries living in designated catchment areas before receiving nonemergency acute inpatient services must obtain a nonavailability statement (NAS).

PARTIAL HOSPITALIZATION (Behavioral Health and Substance Use Disorders)	Beneficiary Category	TRICARE Prime	TRICARE Extra	TRICARE Standard
	Active Duty Family Members (all ranks)	None	\$20 per day	\$20 per day
	Retirees and Family Members	\$40 per day	20% of institutional and professional charges	Lesser of per diem copay/day or 25% of institutional and professional charges

BENEFITS:

- (1) All services require medical necessity review and prior authorization.
- (2) Minimum of 3 hours therapeutic services, up to 5 days per week.

Behavioral Health Disorder

- (1) Benefits are limited to 60 treatment days per fiscal year.
- (2) The 60 treatment days are not offset by or counted toward the 30/45-day inpatient limit.
- (3) Care must be provided in a TRICARE-certified behavioral health Partial Program.

Substance Use Disorder

- (1) Benefits are limited to 21 treatment days (full day or partial day) per benefit period (combined partial and/or residential).
- (2) Benefit period starts the first day of covered treatment and ends 365 days later.
- (3) Days count toward the 60-day behavioral health partial hospitalization limit.

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TRICARE Behavioral Health Care Plan Comparison

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ROUTINE OUTPATIENT SERVICES	Beneficiary Category	TRICARE Prime	TRICARE Extra	TRICARE Standard
(Behavioral Health and Substance Use Disorders)	Active Duty Family Members (all ranks)	None	15% Allowable Charge	20% Allowable Charge
	Retirees and Family Members	\$12 Initial Evaluation (90801) \$25 Individual \$17 Group	20% Allowable Charge	25% Allowable Charge

BENEFITS:

Behavioral Health Evaluation and Therapy

- (1) Benefits are limited to 2 routine therapy sessions per week; more frequent visits require additional authorization.
- (2) Each beneficiary is allowed 8 routine therapy sessions per fiscal year without a medical necessity review; sessions beyond the initial 8 require a medical necessity review and prior authorization. Active duty service members (ADSMs) are NOT eligible for the initial 8 visits. They must have referral from their MTF or from TPR Dept.

NOTES: (1) Routine outpatient behavioral health does **not** require a PCM referral; beneficiaries may self-refer. (ADSM may not self refer as noted above.)

- (2) An MHC (LPC) requires a physician referral and ongoing supervision with the referring physician in order to be paid. This does NOT have to be from the beneficiary's PCM. This information must be included on the CMS claim form in blocks #17 and #19.
- (3) Providers are allowed one initial evaluation (90801) per beneficiary per year with no authorization. The 90801 does not count as a therapy session within the initial 8 visits.
- (4) Crisis intervention (90808, 90809) always requires authorization; request as soon as possible after services are rendered.

Substance Use Disorders

- (1) Benefits are limited to 60 group therapy sessions and 15 family therapy sessions per benefit period.
- (2) Individual therapy is not a covered benefit for beneficiaries with a primary diagnosis of substance abuse.
- (3) Benefit period begins with the first day of covered treatment and ends 365 days later, regardless of the total services actually used within the year.
- (4) Services must be rendered by institutional providers only and always require prior authorization.

OTHER OUTPATIENT SERVICES	Beneficiary Category	TRICARE Prime	TRICARE Extra	TRICARE Standard
(Psychological Testing, Medication Management, Electro-Convulsive Therapy, Intensive Outpatient (IOP))	Active Duty Family Members (all ranks)	None	15% Allowable Charge	20% Allowable Charge
	Retirees and Family Members	\$12 Other Outpatient \$17 IOP	20% Allowable Charge	25% Allowable Charge

BENEFITS:

- (1) Psychological testing is generally limited to 6 hours/year and requires a medical necessity review and prior authorization.
- (2) Medication Management Checks (90862) do not require medical necessity review or authorization, up to 2 visits per month and do not count as a therapy session.
- (3) ECT always requires medical necessity review and prior authorization.
- (4) IOP (90899) always requires medical necessity review and prior authorization.

Clarifying Marriage Counseling and Family Therapy

The purpose of this article is to describe the differences between marriage counseling and family therapy and to clarify the coverage of these services under TRICARE.

Under TRICARE, marriage counseling is an excluded benefit. TRICARE policy states that counseling services that are not medically necessary in the treatment of a diagnosed medical condition are not a covered benefit. Examples of counseling services that are not medically necessary and are therefore not a TRICARE benefit include educational counseling, vocational counseling and counseling for socioeconomic purposes, stress management and lifestyle modification.

Family Therapy Defined

Family therapy is considered outpatient psychotherapy, and is a TRICARE authorized benefit when it is determined to be medically or psychologically necessary for treatment of a diagnosed behavioral health disorder.

If there is a diagnosed mental disorder for the sponsor or spouse that is causing marital problems, family therapy may occur.

As stated in the *TRICARE Policy Manual*, Chapter 7, Section 3.14, family therapy is a form of psychotherapy directed toward the family as a unit, instead of toward a single individual. The therapy is based on the assumption that the mental or emotional illness and the functional impairment of the identified patient are related to family interactions and therefore, the family is the unit that should be treated. Problems and dysfunctional behaviors are dealt with as responsibilities of all family members and are not necessarily focused on any one individual.

Family therapy may involve the complete or partially available family unit and normally would involve the same therapist or treatment team. For the purposes of coverage, the family generally would include the husband or wife of the patient, his or her children or, in the case of a child patient, the parents, step-parents and siblings. When it is determined appropriate, other family members residing in the same household could also be included.

Policy Considerations

Outpatient psychotherapy is limited to a maximum of two psychotherapy sessions per week in any combination of individual, family, collateral or group sessions. This number can be increased with prior authorization in specific situations. Note: Two consecutive family therapy sessions with the same family members present is considered to be a single session and not two distinct sessions with a different focus (e.g., a different child being the focus of each session). In such cases, the reimbursement will be treated as if the therapy had occurred at a single session.

Family therapy (CPT code 90847) can be considered under the initial eight self-referred visits for family members. Visits beyond the initial eight require a medical necessity review and prior authorization. Active duty service members (ADSMs) must have referral from their primary care manager (PCM) for all behavioral health services. They are not eligible for the initial eight self-referred visits.

For further information, contact TriWest at 1-888-TRIWEST (1-888-874-9378) or www.triwest.com. ■



TriWest Healthcare Alliance
P.O. Box 42049
Phoenix, AZ 85080

CONTACTS

TriWest Customer Service
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
(Pharmacy inquiries)
1-866-DoD-TRRx
1-866-DoD-TMOP
www.express-scripts.com/TRICARE

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TRICARE Reference Room: Eye Examinations

It's important for optometrist, ophthalmologist and primary care manager (PCM) offices to remember the details of TRICARE vision benefits. Here's a quick refresher:

Routine Eye Examinations

CPT Codes: 92002, 92004, 92012, 92014, 92015, 99172, 99173

A routine eye exam is an evaluation of the eyes (including, but not limited to, refractive services) that is not related to a medical or surgical condition or to the medical or surgical treatment of a covered illness or injury. Routine exams are covered annually for active duty service members (ADSMs) and active duty family members (ADFMs) at no cost.

A PCM referral or TriWest authorization is not required for TRICARE Prime beneficiaries in most cases unless care is received from a non-network provider. ADSMs must always have a referral.

The frequency of routine eye exams is tracked on a yearly basis. For example, if an ADFM received an exam on April 1, 2005, the next exam can be scheduled on or after April 1, 2006.

Clinical Preventive Eye Examinations

CPT Codes: 92002, 92004, 92012, 92014, 92015, 99172, 99173

A clinical preventive eye exam is a comprehensive screening for determination of vision on visual acuity, ocular alignment and red reflex, along with external examination for ocular abnormalities. Preventive eye exams are covered every two years for all TRICARE Prime enrollees at no cost. A PCM referral or authorization from TriWest is not required for TRICARE Prime beneficiaries in most cases unless care is received from a non-network provider. ADSMs must always have a referral.

The frequency of clinical preventive eye exams is tracked annually by calendar year. If a TRICARE Prime beneficiary received an exam on April 1, 2005, for example, the next exam can be scheduled on or after April 1, 2007.

Well-Child Vision Screenings

CPT Codes: 92002, 92004, 92012, 92015, 99172, 99173

The well-child benefit is available to all TRICARE beneficiaries from birth to age 6 and includes eye and vision screening by a PCM during a routine examination at birth and at approximately 6 months of age. Comprehensive eye examinations are authorized once every two years between ages 3 and 6.

If you have additional questions about TRICARE's vision coverage, visit www.triwest.com or call 1-888-TRIWEST (1-888-874-9378). ■