APRIL 2020

TRICARE® Provider NEWS

ISSUE HIGHLIGHTS

Public Safety Alert: Coronavirus Outbreak

Updating Provider Demographics

A Simple Way to Attest to Clinical Criteria for Limited Benefits

View Your Assigned Patients

Provider Education Updates Now Sent to Website Registration Email

Provider Location Limits in Network Directory

Authorization and Referral Submissions Made Easy

A Look at Emergency Care Basics

Choosing Wisely®

Benefit Corner

Claims Tips

TRICARE's Right of First Refusal

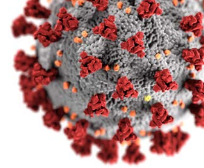
Clear and Legible Report Basics

Patient Safety Corner

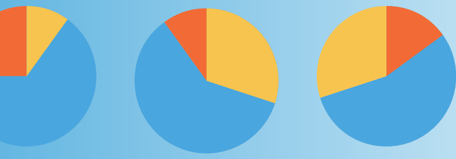
hnfs HEALTH NET FEDERAL SERVICES

TRICARE®

Public Safety Alert: Coronavirus Outbreak



The Centers for Disease Control and Prevention (CDC) continues to monitor the coronavirus strain, referred to as COVID-19. For the most up-to-date information, visit the CDC's website. For information specific to your TRICARE patients, including coverage for telemedicine and COVID-19 testing, visit www.tricare-west.com > *Provider*.



Updating Provider Demographics

Health Net Federal Services, LLC (HNFS) offers online tools for providers to easily update the demographic information that displays in our network directory, such as address, phone number and specialty type. Log in at www.tricare-west.com to get started. If you have not yet registered on our website, have a delegated credentialing agreement or are an applied behavior analysis (ABA) provider, your process for submitting demographic updates to us is slightly different. Be sure to read below for details.

Online tools

1. **Update Demographics Tool**

   Credentialed network providers who display in our directory can use our Update Demographics tool to:

   - change your address, phone or fax number
   - add a location to a group
   - update practitioner affiliation
   - update Tax Identification Numbers

   We offer a step-by-step user guide at www.tricare-west.com > *Provider* > *Education/Quick Reference Charts*.

   ABA provider exception: Already-credentialed BCBAs and BCBA-Ds may use the Update Demographics tool. All other ABA provider types are to send updates to us via a TRICARE Provider Group Roster, available at www.tricare-west.com > *Provider* > *Forms*.

2. **Update Specialty Tool**

   Before logging in to our Update Specialty tool, first make sure your information is listed correctly in the National Plan & Provider Enumeration System at https://nppes.cms.hhs.gov/#/. Then, go to www.tricare-west.com > *Provider* > *Secure Tools*.

Not registered on our website?

If you do not have a www.tricare-west.com account, submit demographic updates to us using a Provider Information Form or TRICARE Provider Group Roster (for 20 or more providers). Go to www.tricare-west.com > *Provider* > *Resources* > *Forms*. Allow up to 21 days for processing.

ABA provider exception: Submit a TRICARE Provider Group Roster, rather than an individual Provider Information Form, regardless of group size.

Delegated providers

If your provider group has a delegated credentialing agreement with us, you have two options for submitting your required quarterly rosters:

- Online using CAQH® ProView for Groups
- Via email using our TRICARE Provider Group Roster

A Simple Way to Attest to Clinical Criteria for Limited Benefits

Certain TRICARE benefits are limited and subject to specific clinical criteria. Common examples include radiofrequency ablation, laboratory developed tests, CT angiography of the heart, and breast MRIs (*list is not all inclusive*). When Health Net Federal Services, LLC (HNFS) receives an authorization request for a limited-benefit service, we must first verify the patient meets the clinical requirements as determined by TRICARE policy. To expedite this process, HNFS offers a suite of letters of attestation (LOAs) providers can complete and submit with their initial authorization request. Use these LOAs in place of submitting separate clinical documentation.

Did you know? CareAffiliate®, HNFS' preferred online authorization submission tool, allows for attachments. We encourage providers to use CareAffiliate to attach LOAs with limited-benefit requests so we can begin our clinical review upon receipt. You must be registered at **www.tricare-west.com** to use CareAffiliate, so if you haven't already, be sure to start the registration process today.

If you submit limited-benefit authorization requests using HNFS' other online authorization tool, the Web Authorization Referral Form (WARF), the request will automatically pend as WARF does not allow for attachments. HNFS will contact you with instructions on how to return an LOA or supporting documentation so we may complete the clinical review.

LOAs are not available for all services; however, as additional limited benefits are identified for which an LOA is appropriate, HNFS will add them to the list.

Find all available LOAs at **www.tricare-west.com** > *Provider* > *Authorizations* > *Letters of Attestation*. Be sure to use the most recent copy when submitting a request, as the requirements and benefits can change.

View Your Assigned Patients

Using the PCM Enrollee Roster

Did you know primary care managers (PCMs) can view all TRICARE West Region beneficiaries assigned to them? Simply log in at **www.tricare-west.com** to access our PCM Enrollee Roster. This tool can be used by network providers who have enrolled beneficiaries. If you are a non-network provider, or you do not have any TRICARE beneficiaries enrolled to you, no data will populate.

Verifying eligibility

Having a beneficiary listed on a PCM Enrollee Roster report is not enough to prove eligibility. Providers are still expected to verify beneficiaries' eligibility prior to rendering services. Verify patient eligibility online (log in required) or through the automated self-service tools at 1-844-866-WEST (1-844-866-9378).

Provider Education Updates Now Sent to Website Registration Email

Health Net Federal Services, LLC (HNFS) has made it easier for you to receive the latest TRICARE updates. By registering on our website, www.tricare-west.com, you will now receive important TRICARE-related communications sent to the email address tied to your web account. We average one program education email send per week, and you can opt out at any time.

In addition to giving you access to all of our secure self-service tools, website registration means you'll get timely TRICARE and HNFS-specific updates. New accounts are set to automatically receive education emails. Once you have your login/password, you can log in to update your preference. (If you registered before Jan. 22, 2020, we will soon be changing your account to default to receiving education emails from us. You can always log in to update your preference.)

Registering online

To register for an account at www.tricare-west.com, click the "Register" link at the top of most pages. This will direct you to a Website Registration Form for you to complete and fax to us. (Please allow 10 business days for processing.)

Managing notification preferences

To manage your notification preferences, log in, click "My Account" in the top right corner of the page and then click "Manage Preferences." The two options we currently offer are "Education" and "Ask Us."

Manage Preferences

* = required field

Please select how you want to receive notices when you use our Ask Us Secure Email tool. When a response is ready we will send an email or text. More preference options may be added in the future.

Notification Category	Receive Email Notification	Receive Text Notification
Ask Us	☑	☐
Education	☑	

*** Email Address**

Website Font Medium

*** Confirm Email Address**

Mobile Number

UPDATE

SMS Text Terms & Conditions

- *Ask Us*: A way to submit claims-related questions to HNFS. You can choose to receive a text or email when the response is ready to be viewed in your Secure Inbox.
- *Education:* TRICARE Provider News newsletter, "In Case You Missed It" recaps, TRICARE Program and benefit updates.

In addition to updating your preferences, you can opt out of HNFS' education emails by clicking the opt-out link at the bottom of our emails. Please note, opting out of education emails does not mean you're opting out of all communication from HNFS.

Provider Location Limits in Network Directory

Whether you are a TRICARE beneficiary looking for a local doctor or TRICARE provider looking to refer your patient for specialty care, our online Network Provider Directory helps you easily locate network providers in the TRICARE West Region. To help reduce the risk of beneficiaries being appointed to incorrect provider offices, we have limited the number of locations listed for each provider to five (5). This change took effect Feb. 1, 2020.

We recognize some provider groups have more than five locations. However, a key function of HNFS' Network Provider Directory is to list practitioner locations available for patient appointing; it is not intended to display:

- Locum tenens (temporary physician staffing)
- Hospitalists
- Potential locations for the purpose of filling in for another provider
- Providers' billing addresses

Verify Provider Demographics

We recommend you verify and/or update your current demographic information:

- Visit our Network Provider Directory at **www.tricare-west.com** > *Provider* > *Public Tools* to ensure your appropriate appointing locations are listed. Log in to use HNFS' Update Demographics tool or use the Suggest Changes option within the directory if you find inaccuracies.
- If you have practitioners who accept appointments at more than five (5) locations, notify your Provider Network Manager.
- If you have a delegated credentialing agreement with HNFS, review your current provider rosters to ensure no more than five (5) locations are selected to be published in the Network Provider Directory. Notify your delegated auditor via email at **HNFS_delegated@hnfs.com** of any updates.

Find detailed instructions on how to add and update location information on our website. Visit **www.tricare-west.com** > *Provider* > *Take Me To… Update My Demographics.*

Authorization and Referral Submissions Made Easy

Follow these steps to easily and quickly submit authorization and referral requests to HNFS. Remember, network providers are required to submit all requests online.

1. Check requirements

Take out the guess work. Use our Prior Authorization, Referral and Benefit tool to quickly determine if an authorization or referral is required. While this tool does not provide the approval, you can print a copy of the results for your records.

2. Use a Letter of Attestation

If the benefit you're requesting approval for is a limited TRICARE benefit, clinical documentation will likely be required when you submit the request to HNFS. To expedite the review process, we offer numerous Letters of Attestation that can be attached to your request in lieu of clinical documentation. Go to **www.tricare-west.com** > *Provider* > *Resources* > *Forms* > *Letters of Attestation.*

3. Submit your request

If you've determined HNFS approval is required, submit your request online (non-network providers may submit inpatient requests via fax). We offer two online submission tools: CareAffiliate and the Web Authorization/Referral Form (WARF). The preferred method is CareAffiliate, as it can be used for inpatient and outpatient requests, and allows for attachments.

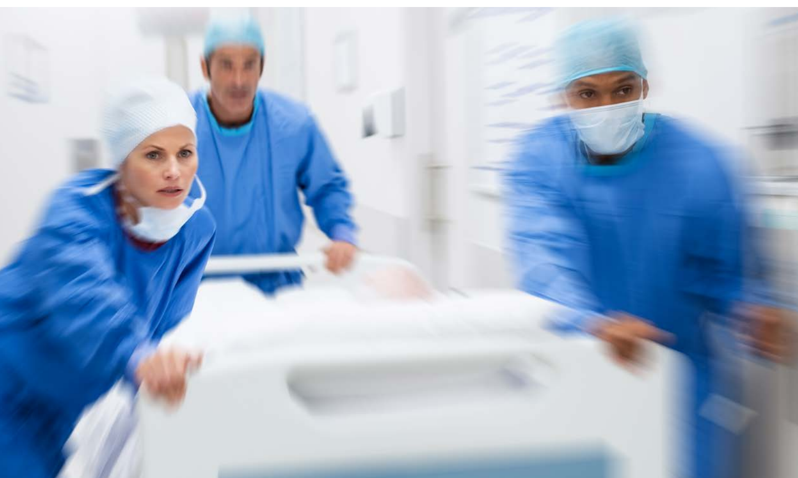
For additional details, visit **www.tricare-west.com** > *Provider* > *Authorizations* > *Submit a Request.* We also offer several training guides at **www.tricare-west.com** > *Provider* > *Education/Quick Reference Charts.*

A Look at Emergency Care Basics

Emergencies can happen anywhere, any time. That's why TRICARE covers emergency care with no prior approval requirement. Take a moment to review these emergency care basics so you can provide the best care to your TRICARE patients.

Emergency care defined

Emergency conditions are those that immediately threaten life, limb or eyesight; and can include medical, maternity or psychiatric problems.



Emergency care follow up

Depending on the TRICARE plan type, patients who have been treated for emergency care must follow certain after care procedures in order to avoid unexpected charges.

- **TRICARE Prime beneficiaries:** All follow-up care must be coordinated by the primary care manager (PCM). If the beneficiary does not have an assigned PCM, he or she must coordinate all follow-up care with HNFS. Follow-up care that is not coordinated with the PCM or HNFS may be subject to point-of-service fees. Emergency room providers should not issue referrals for follow-up care to beneficiaries who are enrolled in TRICARE Prime. These referrals must come from the assigned PCM or HNFS.
- **TRICARE Select, TRICARE For Life and beneficiaries with other health insurance:** Follow-up care does not need to be coordinated with a primary doctor or HNFS, but beneficiaries should notify their family physician of all emergency room visits.

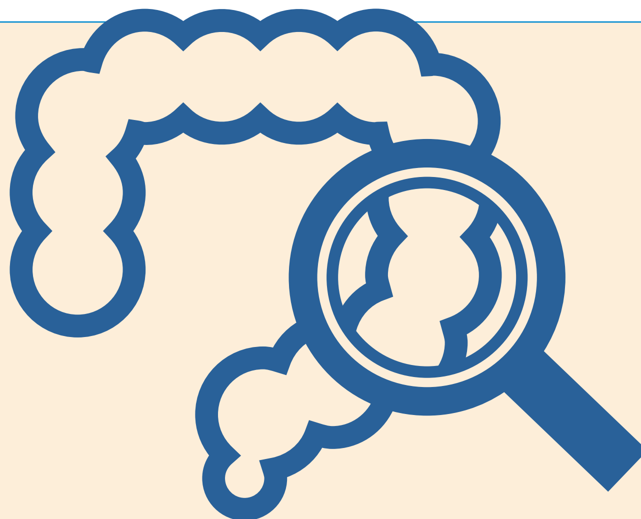
For more information on emergency care, visit www.tricare-west.com > *Provider* > *Benefits & Copays* > *Benefits A–Z* > *Emergency Care*.

Choosing Wisely®

Guidelines for Colonoscopy Screening

Colonoscopy screening is the most accurate exam used to detect and prevent cancer of the colon and rectum. Although colorectal cancer grows slowly, screenings can find cancer early and save lives. But, even a very good exam can be done too often. Below are some guidelines:

- Patients not at high risk should be screened every 10 years beginning at age 50.
- Another exam will not be needed for 10 years unless the exam finds adenoma polyps or cancer, or the patient is at an increased risk for colon cancer.
- Patients may need an exam more often if they have inflammatory bowel disease; ulcerative colitis or Crohn's disease; have a history of multiple, large, or high-risk polyps; or have a parent, sibling or child who has had colorectal cancer or polyps.
- If one or two low-risk polyps are removed, another exam isn't usually needed for five years.
- If more serious polyps are found, another exam may be needed sooner than five years. Very high-risk patients may need the test in just one to three years.
- If a patient's life expectancy is less than 10 years, they are asymptomatic and have no family or personal history of colorectal neoplasia, screening may not be appropriate when the risks exceed the benefit.



For information on supporting evidence and sourcing for these recommendations, visit Choosing Wisely at www.ChoosingWisely.org > *Getting Started* > *Lists of Recommendations*.

These recommendations are provided solely for informational purposes and are not intended as a substitute for consultation with a medical professional. Patients with any specific questions about these recommendations or their individual situation should consult their physician.

Source:

1. www.choosingwisely.org clinician list at http://www.choosingwisely.org/clinician-lists/american-college-surgeons-colorectal-cancer-screening-tests/.
2. www.choosingwisely.org clinician list at http://www.choosingwisely.org/clinician-lists/american-college-surgeons-repeat-colonoscopy-for-small-polyps/ .
3. www.choosingwisely.org patient list at http://www.choosingwisely.org/patient-resources/colonoscopy/ .

3-D Screening Mammograms Covered Under Provisional Coverage Program

As of Jan. 1, 2020, TRICARE covers annual 3-D mammography screenings through its provisional coverage program. Previously, TRICARE only covered 3-D mammograms for diagnostic purposes. Because this is a provisional benefit, ***prior authorization is required regardless of TRICARE plan type***.

As with 2-D screening mammograms, 3-D screening mammograms are covered for women who are:

- Age 40 or older, or
- Age 30 or older and at high risk (We offer a Letter of Attestation you can submit in lieu of clinical documentation for this category. Visit www.tricare-west.com > *Provider* > *Authorizations* > *Letters of Attestation*.)

High-risk indicators include:

- a lifetime risk of breast cancer of 15 percent or greater using standard risk assessment models such as: Gail model, Claus model or Tyrer-Cuzick
- history of breast cancer
- known BRCA1 and BRCA2 gene mutation
- a parent, child or sibling with a BRCA1 or BRCA2 gene mutation and the beneficiary has not had genetic testing for this mutation
- radiation therapy to the chest between 10 and 30 years of age
- history of LiFraumeni, Cowden or Bannayan-Riley-Ruvalcaba syndrome, or a parent, child or sibling with a history of one of these syndromes

TRICARE covers screening mammograms annually (every 12 months with a 30-day grace period). Active duty service members require an approval from HNFS for 2-D screening mammograms. All other beneficiaries do not require an approval for 2-D screening mammograms when seeing a network provider.

TRICARE continues to cover 3-D mammograms for diagnostic purposes.

For additional benefit details, please visit www.tricare-west.com > *Provider* > *Benefits A–Z* > *Mammograms*. Find information about TRICARE's provisional coverage program in the TRICARE Policy Manual, Chapter 13, Section 1.1.

TRICARE Adopts Skilled Nursing Facility Patient Driven Payment Model

On Oct. 1, 2019, the Centers for Medicare and Medicaid Services (CMS) replaced its skilled nursing facility (SNF) Resource Utilization Groups (RUG)-IV classification system with a new case-mix classification model called the Patient-Driven Payment Model (PDPM). Under PDPM pricing, the focus shifts from the volume of services provided to the diagnosis, severity of illness and other variables associated with the specific patient. According to CMS, this change aims to improve payment accuracy and appropriateness by focusing on the patient, rather than the volume of services provided.

Visit www.tricare-west.com > *Provider* > *Benefits A–Z* > *Skilled Nursing Facility Care* for additional PDPM pricing details.

Release of held claims

We have been holding SNF claims with dates of service on or after Oct. 1, 2019, while we implement the claim system updates mandated by the Defense Health Agency. We anticipate these updates to complete in April 2020. At that time, we will begin releasing held claims.

Providers must split any claims for SNF services that span before and after Oct. 1, 2019, and use PDPM codes for dates of service on or after Oct. 1. Any claims received with RUG-IV codes for dates on or after Oct. 1 will be rejected.

Authorization requirements

With PDPM pricing came a change to authorization requirements. Previously, only beneficiaries enrolled in TRICARE Prime required approval from HNFS. As of Oct. 1, 2019, all TRICARE beneficiaries, except those dual eligible for TRICARE and Medicare where Medicare is primary, require HNFS approval for skilled nursing facility admissions.

- Please include all applicable clinical information when submitting your request.
- TRICARE patients who are dual eligible for TRICARE and Medicare require an approval on day 101 when TRICARE becomes the primary payer. Submit these requests directly to Wisconsin Physicians Services (WPS) – Military and Veterans Health, not HNFS, for review and approval. Learn more at www.tricare4u.com.

Find more information about PDPM pricing, including fact sheets, FAQs and training presentations, at www.cms.gov.

Benefit Corner

Laser Treatment Therapy for Pseudofolliculitis Barbae of Face and Neck

To help ensure the medical readiness of our active duty service members (ADSMs), TRICARE now allows for civilian dermatologists to perform laser treatment therapy on ADSMs diagnosed with pseudofolliculitis barbae (PFB) of the face and neck, when recommended by the ADSM's military hospital or clinic. The ADSM must meet all coverage criteria, which includes first consulting with a military dermatologist who can determine the appropriateness of referring the care outside of the military facility. The consultation and referral requirement applies to all ADSMs, including those enrolled in TRICARE Prime Remote.

Network dermatologists in our TRICARE West Region network may see an increase in requests for this specific treatment. All referrals for laser treatment of PFB for ADSMs must come from military hospitals or clinics. The military facility must attest the TRICARE requirements for this benefit have been met before we can authorize the care.

Continuous Glucose Monitoring Systems

Continuous glucose monitoring systems (CGMSs) allow for automatic blood sugar level readings at set intervals (for example, every 10 minutes). This can be helpful for diabetic patients who need to closely track their blood sugar levels. TRICARE beneficiaries diagnosed with diabetes may be authorized to receive a CGMS when ordered by a TRICARE-authorized provider and the beneficiary meets all coverage criteria.

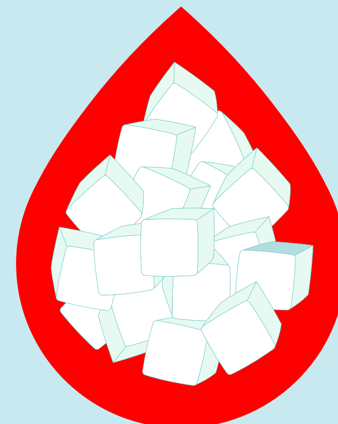
TRICARE will cover therapeutic (replaces fingerstick testing) and non-therapeutic (compliments fingerstick testing) devices; however, therapeutic and non-therapeutic devices and supplies may not be billed on the same claim. Please bill per month rather than every 30 days. This will help reduce claim rejection errors for non-30-day months. Refer to TRICARE Policy Manual, Chapter 8, Section 5.3, paragraph 6.0 for specific billing guidelines.

TRICARE will cover U.S. Food and Drug Administration (FDA)-approved CGMS devices when:

- There is documentation the beneficiary was diagnosed with diabetes prior to the CGMS being prescribed;
- The ordering provider has examined the beneficiary in person and evaluated the beneficiary's diabetes control within six months prior to ordering the CGMS; and
- The ordering provider has documented the beneficiary meets coverage criteria outlined in TRICARE Policy Manual, Chapter 8, Section 5.3.

Durable medical equipment prior authorization rules apply. If an approval is not required, you must submit documentation with the claim showing the beneficiary meets all coverage criteria. To expedite the review process, we offer a Letter of Attestation that can be submitted in lieu of clinical documentation.

Find additional benefit details at **www.tricare-west.com** > *Provider > Benefits A – Z > Diabetic Supplies and Equipment*.



Claims Tips

Reimbursement for Injectable Drugs, Home Infusion Drugs and Vaccines

TRICARE covers most drugs and immunizations administered in a provider's office or in a home infusion setting. For medications administered non-orally, the type of drug and how it's administered will determine how claims are paid. TRICARE's reimbursement for injectable drugs, home infusion drugs and vaccines follows Medicare's reimbursement guidelines. This pricing, including TRICARE's recently updated vaccine reimbursement policy, is outlined below.

Per the TRICARE Reimbursement Manual, Chapter 1, Section 15, paragraph 3.3:

Injectable and home infusion (other than vaccines)

- Except for home infusion, drugs administered other than orally, including chemotherapy drugs, are priced using the TRICARE Injectable Drugs/Biological CHAMPUS Maximum Allowable Charge (CMAC) rates file.
- Drugs that do not appear on the TRICARE Injectable Drugs/Biological CMAC rates file are priced at the lesser of billed charges or 95% of the average wholesale price (AWP).
- Home infusion drugs (except those infused through durable medical equipment [DME]) that are not available under TRICARE's pharmacy benefit are priced at the lesser of billed charges or 95% of the AWP.
- Effective Jan. 1, 2017, drugs (including home infusion drugs) infused through DME are priced at TRICARE Injectable Drugs/Biological CMAC rates + 6%. The equipment must meet TRICARE's definition of DME (TRICARE Policy Manual, Chapter 8, Section 2.1).

Home infusion therapy requires prior authorization for all beneficiaries except those with other health insurance. Visit our **Home Infusion Therapy** benefit page for details.

Vaccines

- Vaccines provided under the State Vaccine Program (SVP) are priced based on the vaccine price list for each SVP program.
- Vaccines that appear on the Medicare Average Sale Price (ASP) list or the Centers for Disease Control and Prevention (CDC) Private Sector Vaccine Price List are reimbursed based on the allowable amount provided in the TRICARE Injectable Drugs/Biological CMAC rates file, which includes the 6% add on. CDC rates are effective Feb. 1, 2020.
- Vaccines that do not appear on the TRICARE Injectable Drugs/Biological CMAC rates file are priced at the lesser of billed charges or 95% of the average wholesale price (AWP).

Medicare updates its pricing file on a quarterly basis. Visit **www.cms.gov** and **www.ReimbursementCodes.com** for Medicare pricing resources. For TRICARE network providers, HNFS will use the contracted rate to calculate allowed amounts.

Home Health Agency Claims

Total Performance Score/Payment Adjustment Reports

The Defense Health Agency (DHA) is updating the TRICARE manuals to include a Home Health Value-Based Purchasing (HHVBP) Demonstration and Patient-Driven Groupings Model (PDGM) based on the Centers for Medicare & Medicaid Services (CMS) HHVBP and PDGM pricing. The HHVBP offers financial incentives to home health agencies (HHAs) who perform efficient, higher quality care. This model was rolled out by CMS in 2016 to nine states, four of which are in the TRICARE West Region: Arizona, Iowa, Nebraska, and Washington. While we continue to hold claims from all West Region HHAs as described below, providers in the four listed states may submit their calendar year 2020 (CY20) Total Performance Score (TPS) and Payment Adjustment Report (PAR) to us in advance. Although we are prepared to receive CY20 reports, we cannot process held HHA claims until we have direction from DHA to complete the required system updates.

HHA claims held

We anticipate TRICARE's HHVBP Demonstration and PDGM reimbursement to be effective retroactive to Jan. 1, 2020. As we await the TRICARE manuals to publish and the pricing updates from DHA, we are holding home health agency claims for new episodes of care that started on or after Jan. 1 (as determined by the "From Date" on the claim) for all West Region states. Due to the complexity of HHA pricing and the expected new billing requirements, we are taking this step to help providers avoid having to resubmit claims.

TPS/PAR request letters

Upon direction from DHA, and as a courtesy during this initial year of implementation, we will mail letters to home health agencies in the four impacted West Region states who have previously submitted claims to us, requesting CY20 TPS and PAR reports. (Exception: If you have already submitted these to us, you will not get a letter.) If you receive a letter, please submit your reports to us as soon as possible per the instructions in the letter

In future years, we will not mail TPS/PAR request letters. It will be the responsibility of HHAs in Arizona, Iowa, Nebraska, and Washington to submit these reports to us by Dec. 1 each year in order to avoid financial penalty.

TRICARE's Right of First Refusal

As a TRICARE requirement, when a TRICARE Prime beneficiary is referred for specialty care, HNFS will first attempt to coordinate care at a military hospital or clinic, even if the beneficiary is enrolled to a civilian primary care manager. This process is known as TRICARE's right of first refusal. Here's how it works:

- Local military hospitals or clinics will first determine if they can provide the services. If they cannot, HNFS will coordinate the care with a TRICARE network provider.
- In limited circumstances, a TRICARE Prime beneficiary may see a non-network provider if there are no network providers available.
- Providers should include as much clinical documentation or details as possible when submitting referrals in order for the military hospital or clinic to reasonably determine if they have the ability to effectively treat the beneficiary.
- Providers should review the details of the determination letters issued by HNFS with your TRICARE patients. Each determination letter issued by HNFS will specify the approved specialty provider.
- If a beneficiary sees a provider other than the one indicated on the determination letter, Point of Service charges may apply.

A review of TRICARE referral basics can be found online at www.tricare-west.com > *Provider* > *Authorizations.*

Clear and Legible Report Basics

TRICARE network providers are required to submit clear and legible reports – which includes consultation reports, operative reports and discharge summaries – to the referring* military hospital or clinic within specified timeframes. The requirement to submit CLRs applies to care referred by a military hospital or clinic, and to care received at an urgent care center.

** Network urgent care centers should submit CLRs to the beneficiary's assigned military hospital or clinic, as there may not be a referring provider.*

Why send CLRs?

- It is a requirement of your TRICARE contract.
- They help expedite treatment and ensure continuity of care for your TRICARE patients.
- They meet The Joint Commission standards.

Submittal time frames

- Most CLRs must be submitted within seven (7) business days of delivering care.
- Urgent care centers must submit within two (2) business days.
- Urgent and emergency situations, a preliminary report must be submitted within 24 hours of the urgent or emergent care.
- Mental health providers are required to submit brief initial assessments to the referring military hospital or clinic within seven (7) business days.

HNFS offers an online CLR Fax Matrix that lists military hospital or clinic secure CLR fax numbers and mailing addresses. To access the CLR Fax Matrix and for detailed instructions on submitting CLRs, visit www.tricare-west.com > *Provider* > *Take Me To … Clear and Legible Reports.*

Prescribing Opioids: A Continuing Education Opportunity

Opioid addiction has become an epidemic in the United States. In a study published by the National Center for Biotechnology Information, a representative sample of cancer-free adults who had not been chronically receiving a prescription for opioid pain relievers had an increased likelihood of chronic opioid use with each additional day of medication supplied starting on the third day. The sharpest increases in chronic opioid use was observed after the fifth and thirty-first day; a second prescription or refill; 700 morphine milligram equivalents cumulative dose; or an initial 10- or 30-day supply. The highest probability of continued opioid use at one and three years was observed among patients who started on a long-acting opioid followed by patients who started on tramadol.[1]

The Center for Disease Control and Prevention (CDC) has developed guidelines for prescribing opioids for chronic pain.[2] The CDC guidelines address determining when to initiate or continue opioids for chronic pain; opioid selection, dosage, duration, follow-up and discontinuation; and assessing risk and addressing harms of opioid use. The CDC has developed a continuing education module, *CDC Interactive Training Series, Applying CDC's Guideline for Prescribing Opioids*[3], to assist practitioners in applying these guidelines.

[1]Anuj Shah, Corey Hayes, et al, Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015, downloaded from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5657867/

[2]CDC Guideline for Prescribing Opioids for Chronic Pain, can be found at https://www.cdc.gov/drugoverdose/prescribing/guideline.html

[3]CDC Interactive Training Series, Applying CDC's Guideline for Prescribing Opioids, can be found at https://www.cdc.gov/drugoverdose/training/online-training.html

CONTACTS

Health Net Federal Services, LLC
1-844-866-WEST (1-844-866-9378)
www.tricare-west.com

Express Scripts, Inc.
Pharmacy inquiries
1-877-363-1303
www.express-scripts.com/TRICARE

PGBA, LLC
EDI/EFT Help Desk
1-800-259-0264

Visit us at www.tricare-west.com and Facebook

HN0320x017