

# TRICARE Claims and Billing Tips



West Region Claims Filing Information	
<b>Claims Processing</b>	Network providers ( <i>except in Alaska</i> ) are required to file claims electronically, including secondary payer claims. All other non-network providers file electronically or on UB-04 or CMS-1500 paper claim forms. Do not submit authorizations, referrals, or medical records with claims.  Wisconsin Physicians Service (WPS) is TriWest's partner for claims processing.
<b>Claims Status</b>	To verify claims status via TriWest's secured Web site, register at <a href="http://www.triwest.com/provider">www.triwest.com/provider</a> . Allow 30 days to receive payment or a provider explanation of benefits (EOB). See "Tracer Claims" below.
<b>HIPAA National Provider Identifier (NPI) Compliance</b>	Effective May 23, 2008, all covered entities must use their NPIs on HIPAA standard electronic transactions in accordance with the <i>Implementation Guide</i> .
<b>Outpatient Prospective Payment System (OPPS)</b>	The TRICARE reimbursement methodology was implemented on May 1, 2009, and is mandatory for both network and non-network providers. Under OPPS, payments of 510 and 760 series revenue codes are based on the HCPCS codes billed on the claim. See Section 9 of the <i>TRICARE Provider Handbook</i> for details.
<b>Tracer Claims</b>	Please avoid submitting tracer ( <i>duplicate</i> ) claims. Use the secure area of <a href="http://www.triwest.com/provider">www.triwest.com/provider</a> to verify claims status or call <b>1-888-TRIWEST (1-888-874-9378)</b> for the status of previously submitted claims. All claims submitted are acknowledged either with a payment, a provider EOB, or, in rare instances, returned with a specific request for additional information. All received claims will be acknowledged.  You may check the status of your claims in the secured area of <a href="http://www.triwest.com/provider">www.triwest.com/provider</a> , regardless of how your claim was submitted.

Tips for Filing Claims	
<b>Billing with Unlisted Procedures</b>	Some procedures may not be found in any level of the Current Procedural Terminology (CPT®) or the Healthcare Common Procedure Coding System (HCPCS). When using an unlisted procedure code, providers must supply a detailed description of the service/item for TriWest to properly price the claim. Unlisted codes with a cumulative amount of more than \$100 require prior authorization. Claims submitted with unlisted codes that require but do not have prior authorization will be denied. Claims received with documentation but without prior authorization will be reviewed. If approved, you will be penalized at least 10 percent for non-compliance with the authorization requirement.
<b>Signature on File</b>	When a beneficiary has signed a Release of Information statement, providers should indicate "signature on file" in Box 12 of the CMS-1500. A new signature is required every year for professional claims submitted on a CMS-1500 and for each admission for claims submitted on a UB-04. A signature is required in Form Locator (FL) 80 ("Remarks") of the UB-04 form, if submitted by a non-network provider. Failure to sign will result in the form being returned.
<b>Lab and Radiology Billing</b>	<b>For lab or radiology services rendered in a hospital setting:</b> Modifier 26 should be used to indicate billing for the professional component only. The hospital will submit claims for the technical component. <b>For lab services rendered in an office setting:</b> If sending the lab services out, providers should use modifier 26 to indicate the professional component; check "yes" in Box 20 of the CMS-1500 or 837 transaction to allow payment to the laboratory for the technical component. If a provider does not use a modifier or does not check "yes" in Box 20 of the CMS-1500 form, payment will be made for the global fee to the professional provider only.
<b>Venipuncture</b>	Venipuncture is considered for cost-sharing based on the setting where the service is provided. Specify "yes" or "no" in Box 20 of the CMS-1500 or 837 transaction to indicate if an outside laboratory was utilized. If the labs are drawn in a provider's office but read in an outside laboratory, TRICARE cost-shares the venipuncture.
<b>Outpatient Institutional Claims</b>	Hospitals, birthing centers, and ambulatory surgery centers reporting outpatient services on a UB-04 should indicate the HCPCS codes that best describe the services rendered in FL 44. HCPCS Level I codes and revenue codes are required for all services except supplies and certain drugs. HCPCS Level II codes are required for drugs administered by injection or infusion, but not for other prescription drugs.
<b>Proper Treatment Room Billing</b>	<b>Revenue Code 076x</b> —Providers may indicate revenue code 076x for the actual use of a treatment room in which a specific procedure has been performed or a treatment rendered. Revenue code 076x should not be used when the claim is submitted with a type of bill 083x and ambulatory surgery center (ASC) procedure codes. <b>Revenue Code 051x</b> —Facilities billing with revenue code series 051x will be reimbursed.
<b>Claims for NATO Beneficiaries</b>	Eligible family members of active duty members of the foreign NATO nations who are stationed in the U.S. in connection with their official duties are eligible for outpatient services under TRICARE Standard or TRICARE Extra. A copy of the family member ID card will have a foreign identification number (FIN) ( <i>issued by DEERS</i> ), and indicate on the reverse, "Outpatient Services Only." Claims submission procedures are the same as for American active duty family members.



# TRICARE Claims and Billing Tips

## TRICARE and Other Health Insurance

<b>Second Payer</b>	TRICARE is the secondary payer to all health benefits and insurance plans, except for Medicaid, the Indian Health Service, and other programs as identified by the TRICARE Management Activity.
<b>Referrals and Prior Authorizations</b>	TRICARE beneficiaries who have other health insurance (OHI) are not required to obtain referrals or prior authorizations for covered services, except for adjunctive dental care, stem cell and solid organ transplants, behavioral health care services, and Extended Care Health Option services. If OHI benefits are exhausted, TRICARE becomes the primary payer and prior authorization requirements may apply.
<b>OHI Status</b>	Providers are encouraged to ask the beneficiary about OHI so that benefits can be coordinated. Because OHI status can change at any time, it is important to obtain this information on a routine basis.
<b>Point of Service (POS) Option</b>	POS cost-sharing and deductible amounts do not apply if a TRICARE Prime beneficiary has OHI.
<b>Calculating Payments</b>	Payments from the OHI and TRICARE may not exceed the lowest of the patient liability, the contracted rate, or the TRICARE-allowable charge. The primary OHI information must be filed with the TRICARE claim.

## Returning Incorrect Payments

If you receive an overpayment for a claim for TRICARE Standard, TRICARE Extra, TRICARE Reserve Select, TRICARE Prime, or TRICARE Prime Remote beneficiaries, please return it with a copy of the EOB and a cover letter explaining why the money is being returned. If an EOB is not included, provide information about the beneficiary and the claim to ensure the refund is credited to the correct claim.

**Return duplicate payments or overpayments (except TFL) to:**

Wisconsin Physicians Service  
P.O. Box 77029  
Madison, WI 53707-1029

## Continued Health Care Benefit Program

- For questions and assistance with Continued Health Care Benefit Program (CHCBP) claims, call PGBA at **1-800-403-3950**. TriWest will not be able to answer any CHCBP claims questions.
- File CHCBP claims electronically at [www.myTRICARE.com](http://www.myTRICARE.com).
- File all corresponding paper claims to:

**CHCBP Adjunctive Dental Claims**  
P.O. Box 7037  
Camden, SC 29020-7037

**CHCBP Behavioral Health Claims**  
P.O. Box 7034  
Camden, SC 29020-7034

**All other CHCBP Claims**  
P.O. Box 7031  
Camden, SC 29020-7031

## Out-of-Region Claims

<b>North Region</b>	Health Net Federal Services, LLC c/o PGBA, LLC/TRICARE P.O. Box 870140 Surfside Beach, SC 29587-9740 <b>1-877-TRICARE (1-877-874-2273)</b> <a href="http://www.healthnetfederalservices.com">www.healthnetfederalservices.com</a>
<b>South Region</b>	PGBA South Region Claims Department P.O. Box 7031 Camden, SC 29020-7031 <b>1-800-403-3950</b> <a href="http://www.myTRICARE.com">www.myTRICARE.com</a>
<b>Overseas Region</b>	See Section 8 of the <i>TRICARE Provider Handbook</i> for details on filing claims for overseas beneficiaries.

## Medicare and TRICARE Claims

WPS is the claims processor for all TRICARE For Life (TFL) claims, regardless of where the services are received in the U.S. If you submit Medicare claims on your patient's behalf, Medicare will submit claims directly to WPS. If you do not participate in Medicare or the services you perform are not Medicare benefits, you must submit paper claims to WPS. Do not contact TriWest for TFL claims issues.

<b>Appeals</b>	WPS TRICARE For Life Attn: Appeals P.O. Box 7490 Madison, WI 53707-7490
<b>Claims Submission</b> <i>(Submit claims to Medicare first.)</i>	WPS TRICARE For Life P.O. Box 7890 Madison, WI 53707-7890
<b>Customer Service</b>	WPS TRICARE For Life P.O. Box 7889 Madison, WI 53707-7889
<b>Online</b>	<a href="http://www.TRICARE4u.com">www.TRICARE4u.com</a>
<b>Program Integrity</b>	WPS TRICARE For Life Attn: Program Integrity P.O. Box 7516 Madison, WI 53707-7516
<b>Refunds</b>	WPS TRICARE For Life Attn: Refunds P.O. Box 7928 Madison, WI 53707-7928
<b>Third-Party Liability</b>	WPS TRICARE For Life Attn: TPL P.O. Box 7897 Madison, WI 53707-7897
<b>Telephone</b>	<b>1-866-773-0404 (toll-free)</b> <b>1-866-773-0405 (toll-free TDD)</b>
<b>Return TFL Duplicate Payments or Overpayments<sup>1</sup></b>	Wisconsin Physicians Service Attn: TDEFIC P.O. Box 7928 Madison, WI 53707-7928

1. If you have received an overpayment letter from PGBA, overpayments should be returned to PGBA at the address on the letter to ensure proper credit.