

You Can Help Prevent Fraud and Abuse

Health care fraud and abuse not only are costly, dishonest and deceptive, but they also are preventable. Identifying and preventing fraud and abuse helps save valuable benefit dollars and also ensures that TRICARE beneficiaries receive the quality of care that they are entitled to receive.

Fraud is defined as the intentional deception or misrepresentation of facts, resulting in unauthorized benefits or payments. When undetected, fraud can negatively impact patient care. Examples of fraud include the following:

- Billing for services at a higher level than provided or necessary
- Collecting amounts from TRICARE beneficiaries that exceed the TRICARE-allowable amount
- Failing to disclose coverage under other health insurance (OHI)
- Falsifying claims or medical records
- Falsifying eligibility
- Misrepresenting the dates, frequency, duration or description of services rendered
- Misrepresenting who provided the services
- Submitting claims for services not rendered/used

continued on page 2

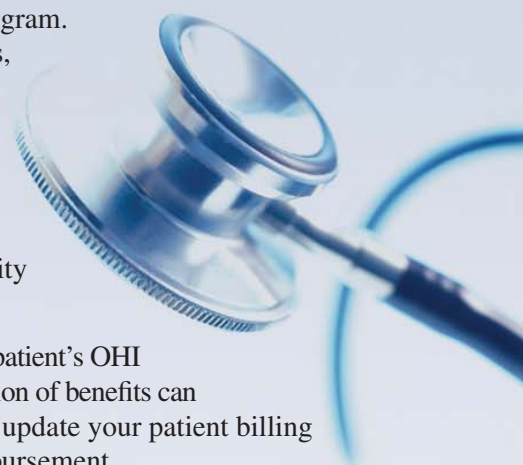
TRICARE and Other Health Insurance

Understanding how a TRICARE patient's other health insurance (OHI) complements TRICARE benefits can help ensure that you receive timely and correct claims payments.

OHI is any non-TRICARE health insurance that a beneficiary—excluding active duty service members (ADSMs)—may receive from an employer or other public or private insurance program. TRICARE pays last after all OHI plans, except in the following instances:

- Medicaid
- The Indian Health Service
- Other programs or plans as identified by the TRICARE Management Activity (TMA)

Make sure you confirm your TRICARE patient's OHI status on a regular basis so that coordination of benefits can occur. If OHI status changes, you must update your patient billing records to avoid delays in claims reimbursement.



Coordinating Referrals and Authorizations with OHI

TriWest Healthcare Alliance Corp. (TriWest) does not require referrals or prior authorizations when a beneficiary's OHI is the primary payer, except for the following covered services:

- Adjunctive dental care
- All behavioral health care services, except for the initial eight outpatient visits
- Solid organ and stem cell transplants
- TRICARE Extended Care Health Option (ECHO) benefits

continued on page 2



You Can Help Prevent Fraud and Abuse

continued from page 1

Abuse is practicing improper or inappropriate actions, having less than acceptable standards of professional conduct or performing services that are not medically necessary. Examples of abuse include the following:

- A pattern of claims for services not medically necessary
- A pattern of waiving cost-shares and/or deductibles
- Failure to maintain adequate medical or financial records
- Improper billing practices
- Refusal to furnish or allow access to medical records

To report suspected fraud or abuse by another provider or a TRICARE beneficiary, call the TriWest Healthcare Alliance Corp. (TriWest) Fraud Hotline at 1-888-584-9378 or contact the TRICARE Program Integrity Office at:

TRICARE Management Activity
 Attn: Program Integrity
 16401 East Centretech Parkway
 Aurora, CO 80011-9066
 Fax: 1-303-676-3981
 E-mail: fraudline@tma.osd.mil
 Web: www.tricare.mil/fraud

TRICARE strives to bring quality, affordable health care to all of its beneficiaries. Preventing fraud and abuse is one way to keep costs down and ensure that all beneficiaries receive the optimal care they deserve. We ask for your cooperation in preventing and reporting fraud and abuse. ■

TRICARE and Other Health Insurance

continued from page 1

However, if the OHI benefits are exhausted and TRICARE becomes the primary payer by default of a denial for payment from the primary carrier, additional referral and prior authorization requirements may apply.

Submitting OHI Claims

When TRICARE is the secondary payer, submit the claim electronically to the primary insurer first. To coordinate benefits, a provider may submit an electronic claim or Web claim that includes the following information (specific technical requirements are available in the 837 Companion Guide):

- Amount allowed by primary carrier
- Amount paid by primary carrier
- Reason code explaining the amount paid by the primary carrier

Remember, if a patient has OHI, payments from the OHI and TRICARE will never exceed the lesser of the patient liability, the contracted rate or the TRICARE-allowable charge.

For more information on filing OHI claims for TRICARE beneficiaries, refer to “TRICARE and Other Health Insurance” in Section 8 of the *TRICARE Provider Handbook*, or call TriWest at 1-888-TRIWEST (1-888-874-9378). ■



TRICARE Policy for Crisis Intervention Billing

TRICARE Policy Manuals define Current Procedural Terminology (CPT) codes 90808 and 90809 as “Crisis Intervention.”* A behavioral health provider may see a patient in his or her office for a crisis session; however, the service needs to be authorized and billed with appropriate CPT codes in order to be reimbursed by TRICARE.

Because crises cannot be anticipated, providers may request authorization after the service is provided. Providers must request the authorization via the *TRICARE Preauthorization for Outpatient Treatment Request Form* immediately following the session. This form can be found online under the Find a Form section at www.triwest.com/provider. TRICARE requires that the documentation on the authorization request reflect the crisis nature of the visit. Fax the completed form to 1-866-269-5892.

If the service is provided and the claim is submitted without a request for authorization, the records will be requested before the claim is paid. If the documentation does not substantiate the crisis service, the claim may be denied.

CPT codes 90808 and 90809 should be used only for a crisis visit and not an extended office visit. A crisis session does **not** qualify as one of the initial eight self-referred behavioral health visits, and therefore requires authorization.

For more information about crisis intervention billing, please refer to the *TRICARE Policy Manual*, Chapter 7, Section 3.13, which can be found at <http://manuals.tricare.osd.mil>, or call TriWest Healthcare Alliance Corp. at 1-888-TRIWEST (1-888-874-9378). ■

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Clarifying Physician Attestation Requirements

When submitting TRICARE claims, it is not necessary to submit a signed physician attestation form with each claim submitted for payment. However, any TRICARE institution submitting claims for an attending physician must have a signed and dated acknowledgement from the attending physician on file, indicating that the physician has received the following notice:

“Notice to Physicians: TRICARE payment to hospitals is based in part on each beneficiary’s principal and secondary diagnoses and the major procedures performed on the beneficiary, as attested to by the beneficiary’s attending physician by virtue of his/her signature in the medical record. Anyone who misrepresents, falsifies or conceals essential information required for payment of federal funds may be subject to fines, imprisonment or civil penalty under applicable federal laws.”

The physician should sign this acknowledgement at the time he or she is granted admitting privileges. The signed and dated acknowledgement remains in effect as long as the physician has admitting privileges at the institution.

Note: The facility may use the Medicare physician attestation form and modify it to cover both Medicare and TRICARE. Any existing acknowledgements signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital. The attestations may be audited/reviewed and the absence of an attestation may result in non-payment/recoupment.

For more information about physician attestation requirements, call TriWest Healthcare Alliance Corp. at 1-888-TRIWEST (1-888-874-9378). ■

TriWest Healthcare Alliance Corp.
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, Inc. (ESI)
(Pharmacy inquiries)
1-866-DoD-TRRX
1-866-DoD-TMOP
www.express-scripts.com/TRICARE

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TRICARE Coverage of Orthotics for Diabetics

Under TRICARE coverage, orthotics (therapeutic shoes and inserts) for diabetics are a limited benefit. Healthcare Procedure Coding System (HCPCS) codes A5500 through A5513 may be reimbursed for eligible TRICARE beneficiaries when the following conditions apply.

According to the *TRICARE Policy Manual*, Chapter 8, Section 8.2, coverage of extra-depth shoes with inserts or custom-molded shoes with inserts is allowed for TRICARE beneficiaries with diabetes who have one or more of the following conditions:

- Previous amputation of the foot or part of the foot
- History of previous foot ulceration
- Pre-ulcerative callus formation, or peripheral neuropathy with a history of callous formation, foot deformity, or poor circulation

Coverage of the footwear and inserts for each individual is limited to one of the following within one calendar year:

- One pair of custom-molded shoes (including inserts provided with such shoes) and two pairs of multi-density inserts
- One pair of extra-depth shoes (not including inserts provided with such shoes) and three pairs of multi-density inserts

Modification of custom-molded or extra-depth shoes may be substituted for one pair of inserts, other than the initial pair of inserts. The most common modifications available are for rigid rocker bottoms, roller bottoms, metatarsal bars, wedges or offset heels.

For more information about TRICARE-covered orthotics, refer to the *TRICARE Policy Manual*, which can be found at <http://manuals.tricare.osd.mil> or call TriWest Healthcare Alliance Corp. at 1-888-TRIWEST (1-888-874-9378). ■