

TRICARE and Other Health Insurance Coordinating Health Coverage for Your TRICARE Patients

As a TRICARE provider, understanding some general guidelines regarding other health insurance (OHI) and TRICARE can help ensure that you receive correct payments in a timely manner.

OHI is any non-TRICARE health insurance that a beneficiary may receive through an employer or other public or private source. Federal law requires that TRICARE is the secondary payer to OHI, except for Medicaid, TRICARE Supplements, the Indian Health Service and other programs/plans as identified by the TRICARE Management Activity.

Coordinating Referrals and Authorizations with OHI

TriWest does not require referrals and prior authorizations for TRICARE beneficiaries who have OHI, except for the following covered services:

- Adjunctive dental care
- Home health services
- Hospice care
- Extended Care Health Option (ECHO) benefits
- Stem cell and organ transplants
- Behavioral Health Services
 - All nonemergent inpatient admissions for substance abuse or behavioral health
 - Psychotherapy after the initial eight outpatient visits
 - Psychoanalysis

- Intensive outpatient treatment programs, partial hospitalization programs and residential treatment center programs

Additionally, if the OHI benefits are exhausted, TRICARE becomes the primary payer, and additional authorization requirements may apply.

Updating OHI Status

TRICARE beneficiaries are advised to notify their providers if they have OHI; however, it is recommended that you ask your patients if they have OHI so their benefits can be coordinated and the appropriate authorizations can be obtained.

Submitting OHI Claims

When TRICARE is the secondary insurance, submit the claim to the primary insurance first. When filing claims with TRICARE as the secondary insurance, you can transmit the required information electronically. TriWest will need to know the amount the primary insurance paid. If the primary insurance is a preferred provider organization (PPO), health maintenance organization (HMO) or other insurance where there is a limited liability for the patient, then you also need to send the OHI-allowed amount.

To coordinate benefits, supply the following information:

- Indicate the insured's name in Box 4 (CMS-1500) or Locator 58 (UB-92)
- Indicate the primary payer in Box 9 (CMS-1500) or Locator 50 (UB-92)
- Mark "Yes" in Box 11D (CMS-1500) or Locator 34 (UB-92)

- Indicate the amount paid by the other carrier in Box 29 (CMS-1500) or Locator 54 (UB-92)

If a beneficiary is entitled to Medicare part A & B, Medicare pays first, and the claims are then automatically transferred to Wisconsin Physicians Service (WPS) for TRICARE payment. However, if a Medicare beneficiary has OHI in addition to TRICARE, Medicare will make its payment and forward the claim to the OHI. The beneficiary then must file a paper claim with TRICARE for any remaining out-of-pocket expenses.

Calculating Payments

Payments from both the primary insurance and TRICARE as the secondary insurance will not collectively exceed the TRICARE allowable charge.

Providers may not collect any out-of-pocket costs from beneficiaries after payment of the claim unless TRICARE and the OHI combined **have** failed to pay: the negotiated rate to a network provider; the allowable charge to a participating non-network provider; or 115 percent of the allowable charge to a nonparticipating non-network provider.

If the primary insurance has paid more than what TRICARE would have allowed for the service, then no additional payment will be made. The beneficiary should not be charged the cost-share when the explanation of benefits (EOB) shows no patient responsibility.

For more information about how TRICARE coordinates with OHI, contact TriWest at 1-888-TRIWEST. ■



TRICARE Reference Room

Review Coverage Limitations and Exclusions

TRICARE covers most inpatient and outpatient care that is medically necessary and appropriate. However, there are special rules or limits on some types of care, while other services may not be covered at all. The following information offers a review of what’s covered and what’s not for your TRICARE patients.

Services Covered with Significant Limitations

Below is a table, listing medical, surgical and behavioral health care services that may be covered under TRICARE with significant limitations. This list is not intended to be all-inclusive.

Exclusions

In general, TRICARE excludes services and supplies that are not medically or psychologically necessary for the diagnosis or treatment of a covered illness (including behavioral disorder), injury, pregnancy or well-child care. All services and supplies (including inpatient institutional costs) related to a non-covered condition or treatment, or provided by an unauthorized provider, are excluded. The following specific services are excluded from TRICARE under any circumstance. This list is not intended to be all-inclusive.

- Acupuncture
- Artificial insemination

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Service/Supply	Description
Abortions	Abortions are only covered when the mother’s life is in danger. The attending physician must certify in writing that the abortion was performed because a life-threatening condition existed. Medical documentation must be provided.
Cardiac and Pulmonary Rehabilitation	Both are covered only for certain indications and in medically supervised settings.
Cosmetic, Plastic or Reconstructive Surgery	These services are only covered when used to restore function, correct a serious birth defect, restore body form after a serious injury, improve appearance of a severe disfigurement or after a medically necessary mastectomy.
Cranial Orthotic Device or Molding Helmet	Cranial orthotic devices are excluded for treatment of nonsynostotic positional plagiocephaly.
Dental Care and Dental X-Rays	Excluded, except if authorized adjunctive dental care. Note that dental benefits are available under separate TRICARE dental programs.
Dental Anesthesia and Facility Charges	These services are covered only to safeguard a patient’s life.
Education and Training	Outpatient diabetic self-management and training programs are covered when the services are provided by a TRICARE-certified/authorized individual provider who also meets national standards for diabetes self-management education programs recognized by the American Diabetes Association (ADA) or is Medicare-certified to provide outpatient self-management education services.
Eyeglasses or Contact Lenses	Active duty service members are covered for eyeglasses at military treatment facilities (MTFs) for no cost. For all other beneficiaries, both are covered under limited circumstances.
Food, Food Substitutes, Supplements or Vitamins	Excluded except when used as the primary source of nutrition for enteral, parenteral or oral nutritional therapy. Intraperitoneal nutrition (IPN) therapy is covered for malnutrition as a result of end stage renal disease. Nutritional therapy products are not covered solely to boost protein or caloric intake.
Gastric Bypass	Gastric bypass surgery is covered for individuals who are 100 pounds over ideal body weight and have co-morbidity or for those who are 200 percent over ideal body weight with no co-morbidity.
Genetic Testing	Genetic testing is only covered under certain conditions and is intended to confirm a suspected clinical diagnosis.
Intelligence Testing	Intelligence testing is only covered when medically necessary for the diagnosis or treatment planning of covered psychiatric disorders.
Marital Therapy and/or Couples Counseling	Beneficiaries for whom this treatment is authorized must have a behavioral health disorder as a primary diagnosis (as indicated in DSM-IV-R), and the marital or couples therapy must be medically necessary to treat the primary diagnosis.
Private Hospital Rooms	Private rooms are not covered unless ordered for medical reasons or a semi-private room is not available. Hospitals that are subject to the TRICARE diagnosis-related group (DRG) payment system may provide the patient with a private room but will only receive the standard DRG amount. The hospital may bill the patient for the extra charges if the patient requests a private room.
Weight Reduction	Services and supplies related to obesity or weight reduction are excluded except for certain gastric surgical procedures in connection with morbid obesity.

Balance Billing

Understanding Your Requirements

What is Balance Billing?

Balance billing occurs when a provider bills a TRICARE beneficiary for the remainder of a bill after TRICARE has paid the allowable charge. Network providers sign a contract to be paid at a negotiated rate, while non-network providers who accept assignment, also known as participating non-network providers, agree to accept the TRICARE allowable charge as payment in full.

Network providers and participating non-network providers are *prohibited* from balance billing.

What if a TRICARE beneficiary also has other health insurance (OHI)?

When OHI is involved, network and participating non-network providers may receive no more than the TRICARE allowable charge through payment by the other health insurer and TRICARE

combined. Network providers are required to accept the negotiated rate as payment in full. Participating non-network providers may not collect any amount from a beneficiary after payment of the claim unless TRICARE and the OHI combined have failed to pay the allowable charge. Non-network providers who **do not** participate in TRICARE, but do participate in OHI, may receive TRICARE payment up to the OHI allowable charge. If the provider **does not** participate in TRICARE and the OHI, then the provider may bill 115 percent of the TRICARE allowable charge.

What charges are beneficiaries required to pay?

Beneficiary charges appear in the “deductible” or “cost-share” column on the TRICARE Summary Payment Voucher or remittance. Additionally, non-covered services may be billed to

the beneficiary only if the beneficiary has agreed in advance and in writing to pay for those services.

TRICARE Prime beneficiaries are only responsible for a copayment when receiving primary, emergency, referred or prior authorized care regardless of whether the provider is network or non-network.

Note: Active duty service members (ADSMs) and their family members enrolled in TRICARE Prime and TRICARE Prime Remote (TPR)/TRICARE Prime Remote for Active Duty Family Members (TPRADFM) do not have a copayment, except when using the pharmacy benefit, the point-of-service option or if receiving benefits through the TRICARE Extended Care Health Option (ECHO).

Non-compliance with balance billing requirements may affect your TRICARE and/or Medicare status. ■

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- Autopsy services or postmortem examinations
- Care that is not medically or psychologically necessary
- Birth control (nonprescription)
- Camps (such as for weight loss)
- Care or supplies furnished or supplied by an immediate family member
- Diagnostic admissions
- Experimental or unproven procedures
- Laser/LASIK/Refractive corneal surgery
- Psychological testing for learning disabilities
- Megavitamins and orthomolecular psychiatric therapy
- Mind expansion and elective psychotherapy
- Naturopaths

- Sex changes or sexual inadequacy treatment
- Telephone counseling consultation

TRICARE beneficiaries may choose to obtain services that are not covered by TRICARE, but they must be informed in advance and in writing of specific services or procedures that are not covered by TRICARE before they are provided. Beneficiaries may choose to sign a Request for Non-Covered Services Form, which is a waiver agreeing to pay for non-covered services. To protect yourself, make sure you understand TRICARE’s “hold harmless” policy. Learn more in your *TRICARE Provider Handbook* in the section titled, “Provider Responsibilities.” You can also visit www.triwest.com or call 1-888-TRIWEST for more information. ■

TriWest Healthcare Alliance
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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

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Fall Provider Seminars Underway in West Region

A new round of provider seminars from TriWest is in progress throughout the 21-state West Region. Intended for providers and their staff, the sessions cover such new topics, as:

- Extended Care Health Option (ECHO)
- TRICARE Reserve Select
- Site of Service
- Online Claims Filing and Referral/Authorization Status
- Consult Tracking
- Third Party Liability
- Network Provider Responsibilities
- TRICARE For Life (TFL)

The seminars will also cover TRICARE program benefits, eligibility, referral and authorization requests, common claims issues, electronic claims filing, consult tracking and a question-and-answer session.

Medical/surgical seminars are appropriate for office staff or providers

in primary care offices, specialty offices and hospitals, as well as durable medical equipment (DME) suppliers, physical therapists, home health providers, outpatient surgery centers, skilled nursing providers, etc.

Behavioral health seminars are appropriate for office staff or providers in psychology and psychiatry offices, as well as behavioral health counselors and other behavioral health professionals. They also are appropriate for substance abuse and other behavioral health inpatient facilities or units within hospitals and behavioral health outpatient facilities.

Providers are encouraged to register online for a seminar. By registering online, you will receive an e-mail confirmation and a reminder notice prior to the scheduled seminar. Go to www.triwest.com for more information on upcoming provider education seminars. ■

Don't Forget to Register for Online Access to Referrals/Authorizations Status Check

Providers are only a click away from a new feature in the secured area of the TriWest Web site that enables them to check the status of referrals/authorizations online. Registration on www.triwest.com also allows providers to submit claims, check claim status, check eligibility online, as well as update consult tracking reports.

Access to this new feature is available only to providers who have registered on www.triwest.com. Completion of the registration process can take up to 10 days, so providers should register as soon as possible to ensure that they have access to this information. ■