

Prior Authorizations Required for Certain Services

A prior authorization or authorization is a process of reviewing certain medical, surgical and behavioral health services to ensure medical necessity and appropriateness of care prior to services being rendered.

If your patient needs a service or procedure that requires prior authorization, the authorization request must be submitted to TriWest Healthcare Alliance (TriWest) prior to services being rendered. When prior authorizations for medical and surgical services are approved they will have a beginning date and an end date. Prior authorizations approved for behavioral health services are valid for the number of visits specified and will have a beginning and an end date.

Network and non-network providers must obtain prior authorization for all required services, as defined by TriWest. Network provider claims submitted for services rendered without obtaining a required authorization are subject to a 10 percent penalty of the negotiated rate. In addition, some services may be excluded or have limited coverage under TRICARE, so it's important to know TRICARE coverage details as well.

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Clean Claims Mean Faster Payments

Providing world-class health care to TRICARE beneficiaries is an important part of being a TRICARE provider. Staying on top of the business side of your practice is a key component in your ability to care for TRICARE beneficiaries.

One of the easiest ways to keep your business moving is to avoid claim rejections and denials by submitting error-free TRICARE claims. If you are a TRICARE network provider, the first thing to remember about filing claims is that you **must** file your claims electronically. Electronic claims must be filed in the Health Insurance Portability and Accountability Act (HIPAA) compliant X12 ANSI837P (professional) 837I (institutional) formats.

Non-network providers can still use the CMS-1500 or UB-04 paper forms, but they are encouraged to submit claims electronically.

At least 95 percent of "clean claims" are processed within 30 days to help you keep your practice running smoothly. A "clean claim" complies with billing guidelines and requirements, has no defects or impropriety, includes substantiating documentation (where applicable) and does not require special processing.

Some of the ways to make sure your claims are submitted "clean" include:

- Use your National Provider Identifier on the HIPAA 837P or 837I electronic claim format, or the CMS-1500 or UB-04 paper forms.

- Always include your federal tax identification number in the HIPAA 837P or 837I electronic format; or in Box 25 of the CMS-1500 or Box 5 of the UB-04, your address and ZIP code in Box 32 of the CMS-1500 or Box 1 of the UB-04; and your "pay-to" address in Box 33 of the CMS-1500 if submitting by paper.
- If you are billing for care that may involve third-party liability (TPL)—diagnosis codes 800-999—include a *Statement of Personal Injury—Possible Third Party Liability* form, DD Form 2527. This form is completed by the patient and can be submitted in advance or at the time of submitting an electronic claim, or it can be attached to a paper claim.
- **Do not** use generic V codes for lab, radiology or preoperative services as a primary diagnosis.

Also, starting in the fall of 2007, the Outpatient Prospective Payment System (OPPS) reimbursement methodology is mandatory. OPPS will apply to outpatient services provided by covered network and non-network providers. **Note:** The implementation date may be impacted by legislation or other policy changes.

All TRICARE network providers under agreement with TriWest Healthcare Alliance must file claims within 90 days of the date care was provided. Non-network providers have up to one year from the date care was provided to file claims. ■



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Because prior authorization requirements may change, log on to the TriWest Web site www.triwest.com for the most up-to-date information. Simply select the “Provider” tab from the home page and click on “More.” You will then be directed to the “Provider Connection” page. There, under “Referrals and Authorization,” you will find a variety of information to help you with the prior authorization process including:

- Prior Authorization List
- TriWest prior authorization updates
- *TRICARE Patient Referral/Authorization* form
- List of non-covered services

- Authorization and referral reminders
- Referral authorization processing

You can also check the status of existing referrals and authorizations in a secure area of www.triwest.com that is available only to providers. To view this and other related authorization and referral information, such as the dates of service or the type of services requested, you must first register at www.triwest.com.

If you do not have Internet access and wish to get information on prior authorization requirements, please call TriWest at 1-888-TRIWEST (1-888-874-9378). ■

Who Pays What and When?

Dual-Eligible and TRICARE For Life Claims

When you are caring for TRICARE beneficiaries who are eligible for both Medicare and TRICARE, it is important to understand how to properly file claims for their care.

While most dual-eligible beneficiaries are age 65 and over and are covered by Medicare and TRICARE For Life (TFL), it is important to remember that some Medicare beneficiaries are younger. Beneficiaries under the age of 65 may be dual-eligible based on disability or end-stage renal disease.

TRICARE beneficiaries who are entitled to Medicare Part A, whether based on age, disability or end-stage renal disease, are required to enroll in Medicare Part B in order to retain TRICARE eligibility. If a person is an active duty family member, he or she is not required to enroll in Medicare Part B. In all cases where a service is covered by Medicare and TRICARE, TRICARE is the second payer for these claims to minimize out-of-pocket expense for these beneficiaries.

If a beneficiary is eligible for Medicare and has other health insurance (OHI), TRICARE will generally be the last payer after Medicare and any other coverage.

Identifying Your Dual-Eligible Patients

A dual-eligible patient must present a valid uniformed services or military identification card, as well as a

Medicare card prior to receiving services. You should copy both sides of the cards and retain the copies for your files.

If you have a question about a patient’s eligibility, please call TriWest Healthcare Alliance at 1-888-TRIWEST (1-888-874-9378) or visit www.triwest.com.

Submitting Dual-Eligible Claims

When Medicare is the primary payer, you should follow Medicare rules for claims processing and submit your dual-eligible claims to Medicare. Medicare will transfer these claims, regardless of the beneficiary’s age, directly to Wisconsin Physicians Service-TRICARE For Life (WPS-TFL) for processing.

If a beneficiary has OHI, he or she will need to file a paper claim (DD Form 2642, *TRICARE DoD/CHAMPUS Medical Claim Patient’s Request for Medical Payment*) with WPS-TFL after the OHI has paid. The beneficiary must include the Medicare Summary of Benefits and an explanation of benefits from their OHI.

If you have questions, WPS-TFL can be reached toll free at 1-866-773-0404. You can also visit WPS online at www.tricare4u.com. **Note:** TriWest is unable to assist with TFL claims issues. ■

Condition Management Program Now Available

TriWest Healthcare Alliance offers a beneficiary-focused Condition Management Program designed to help TRICARE West Region beneficiaries with specific conditions take a more active role in their own health care.

Previously known as the Disease Management Program, condition management focuses on educating patients on how to improve their health management skills while living with a chronic illness.

Available at no charge to TRICARE beneficiaries and their family members, condition management is a prospective, disease-specific approach to improving health care outcomes by providing one-on-one education to beneficiaries with a “clinical health coach,” specially trained in the targeted diseases. The goal of this program is to provide beneficiaries with skills to self-manage their health conditions, as well as skills to improve their quality of life.

TRICARE-eligible beneficiaries suffering from the following four conditions can benefit from participating in the Condition Management Program:

- Asthma (adults and children)
- Heart failure
- Diabetes (adults and children)
- Depression

Providers are encouraged to refer beneficiaries with the identified targeted conditions to the Condition Management Program. TRICARE beneficiaries may also self-refer into the program.

Once a beneficiary is enrolled in the Condition Management Program, a TriWest clinical health coach will:

- Schedule an appointment to review the patient’s health status
- Develop a customized educational plan based on the patient’s status and personal health goals
- Inform the patient’s physician of the patient’s program participation
- Work with the patient to reach established goals
- Continue to help the patient as long as they want to participate and work toward achieving wellness goals

In addition to automatic enrollment of beneficiaries by the TRICARE Management Activity, TriWest encourages providers to refer beneficiaries with the identified targeted conditions to our Condition Management Program. No referral or prior authorization is necessary.

Any patient coping with asthma, depression, diabetes or heart failure, who is eligible for TRICARE and is less than 65 years old, is eligible for referral. The programs average six to nine months in duration, depending on the amount of support and education the beneficiary may need.

To refer a TRICARE beneficiary to the program, go to www.triwest.com and click on the “Find a Form” tab for a *Condition Management Referral* form. For more information, contact TriWest’s condition management staff at 1-888-259-9378 or by fax at 1-866-312-5839. ■

New Fall Provider Seminars

Find out everything you ever wanted to know about TRICARE! This fall, TriWest Healthcare Alliance will host a comprehensive, brand-new series of TRICARE educational seminars for health care providers and staff throughout TRICARE’s 21-state West Region.

The fall 2007 seminars are packed with new information and resources just for West Region providers and staff, including the newest provider handbook and quick reference charts that contain up-to-date information. Attendees will also receive handouts filled with TRICARE tips designed to help you and your staff care for TRICARE beneficiaries even more efficiently than before.

TriWest’s TRICARE experts will present an interactive session, which covers the latest information about the TRICARE program and outlines resources available to providers.

Register online today at www.triwest.com and you will:

- Receive immediate e-mail confirmation of your registration
- Get e-mail reminders: two weeks, and three days before your seminar begins
- Be eligible for a prize drawing

If you have questions contact your local provider representative by e-mail at providerservices@triwest.com or call 1-888-TRIWEST (1-888-874-9378).

To register, go to the “Provider Connection” area of www.triwest.com to view a list of seminars near you. Then register online for the seminar of your choice. If you have difficulty in registering online for a seminar, e-mail pseminar@triwest.com. ■

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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



Consult Report Tracking Helps Providers and Beneficiaries

Consultation and treatment reports help facilitate continuity of care for all TRICARE beneficiaries. In addition, having a complete medical record is necessary for the military to assess the combat readiness and fitness for duty of troops. To help the service branches, both civilian and military treatment facility (MTF) referring providers need timely feedback to properly manage their patient's care, including active duty service members (ADSMs), retirees and their family members.

TriWest created a consult report tracking system to help you assist the MTF with receiving and tracking the reports. Both providers and TRICARE beneficiaries benefit when consult reports are submitted in a timely manner. These benefits include:

- Improving quality and continuity of care
- Assessing combat readiness and fitness for duty of ADSMs
- Ensuring all consult reports are received and routed to the referring provider for all beneficiaries (ADSMs, retirees and family members)

- Archiving consult reports electronically
- Providing the referring provider access to archived reports and decreasing duplicate report requests from the servicing provider
- Decreasing unnecessary work for servicing and referring providers

For your convenience, TriWest provides a cover sheet you should use to fax your consult reports. This cover sheet is attached to the referral/authorization approval letter faxed or mailed to the servicing provider. Using the cover sheet and faxing it to the referring provider fax number already pre-populated on your cover sheet will streamline the return of your consult reports to the referring provider.

For more information about the consult report tracking process, refer to the *TRICARE Provider Handbook*. The online version of the *TRICARE Provider Handbook* is available in the "Resource Library" section of the "Provider Connection" area of www.triwest.com. You may also call TriWest at 1-888-TRIWEST (1-888-874-9378). ■