

## Know When to Request Prior Authorizations for ADSMs

**A**ctive duty service members (ADSMs) using TRICARE Prime or TRICARE Prime Remote require prior authorization for all inpatient and outpatient services from a civilian network or non-network provider.

This is to ensure ADSMs continue to meet fitness-for-duty requirements as a result of outpatient visits, such as pregnancy (maternity) care, physical therapy, mental health services, family counseling and smoking cessation programs.

If you don't obtain a prior authorization when one is required, or exceed the scope of an approved prior authorization,

you risk not being paid or being charged a penalty.

### Obtaining Prior Authorization in the South Region

You can request a prior authorization in one of the following three ways:

1. Submit a request online via the Humana Military Healthcare Services Web site at [www.humana-military.com](http://www.humana-military.com).
2. Fax a completed Patient Referral Authorization Form (PRAF) to 1-877-548-1547.
3. Call a Health Care Finder at Humana Military's TRICARE Service Line at 1-800-444-5445.

Most authorization requests can be completed while you are on the phone or within 24 hours of receipt of all required information.

You can check the status of your prior authorization request online at [www.humana-military.com](http://www.humana-military.com) or by calling the TRICARE Service Line at 1-800-444-5445. Humana Military's referral/authorization staff also sends an autofax confirmation to providers to ensure they have received notification of a confirmed authorization for a TRICARE Prime beneficiary. ■



## CMAC Annual Update

**T**he TRICARE CHAMPUS maximum allowable charge, or "CMAC," pricing is updated annually after Medicare pricing is established.

CMAC is the maximum amount TRICARE will cover for professional services (e.g., physicians, nurse practitioners, physician assistants, anesthesiologists, etc.). CMAC pricing varies by provider location, and there are 90 localities based on ZIP code.

To verify CMAC rates in your area, visit [www.tricare.osd.mil/cmac](http://www.tricare.osd.mil/cmac). After accepting the end-user

agreement, click on "CMAC Procedure Pricing." The procedure pricing is calculated based on the "locality code." You can select a locality code from a drop-down menu for the geographic region you are querying, or you can look up locality codes by selecting a state, entering a catchment area code or entering a ZIP code.

For more information, visit the Humana Military Web site at [www.humana-military.com](http://www.humana-military.com) or call 1-800-444-5445. ■



## Tips for a Smooth Claims Filing Experience

**T**RICARE network providers must file patients' TRICARE claims, even when a patient has other health insurance, and all claims must be filed electronically. Here are a few tips to improve your claims filing success.

### Accurate Coding

When filing claims, you and your staff should use the current procedural terminology (CPT) or health care procedural coding system (HCPCS) codes that most accurately describe the procedure or service involved. You should not select codes that approximate the service involved. You should also avoid using unlisted or miscellaneous codes. Diagnosis code(s) must correlate with the procedure chosen. It is important to choose diagnosis codes to the 4th or 5th digit code specificity for clean claim processing justifying the services. Add screening codes where appropriate to assist in determining the reasons for the procedures performed.

### ClaimCheck Standards

When reviewing claims in the South Region, Humana Military and its claims-processing partner, PGBA, use ClaimCheck® software, which evaluates claims for coding appropriateness and seeks to eliminate overpayment on professional and outpatient claims.

ClaimCheck is designed to identify and reimburse services correctly. Please note the listed edits below for

an understanding of the ClaimCheck edit rationale. PGBA updates ClaimCheck annually with new coding based on current industry standards.

To prevent ClaimCheck from denying claims, follow CPT coding guidelines. If ClaimCheck makes any edits, the edits will be explained on the remittance advice. Edit categories include the following:

- Procedure unbundling
- Incidental procedure
- Mutually exclusive procedure
- Assistant surgeon requirements
- Age conflicts
- Gender conflicts
- Alternate code replacements
- Cosmetic procedures
- Unlisted procedures
- Modifier auditing
- Duplicate and bilateral procedures
- Preoperative and postoperative auditing billed
- Billed date(s) of service

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## Electronic Claims Filing Assistance

**T**RICARE requires all network providers to file claims electronically.

For assistance with any issues related to electronic media claims (EMC) submission for the TRICARE South Region, you can contact the PGBA EMC Help Desk at 1-800-325-5920, option 2.

You can also visit [www.humana-military.com](http://www.humana-military.com) or [www.myTRICARE.com](http://www.myTRICARE.com) for more information regarding electronic claims submission. ■

## Got Claims Questions? Here's Where You Can Find the Answers

PGBA, LLC 1-800-403-3950

For questions regarding claims status, eligibility, OHI, TPL and explanation of benefits

Wisconsin Physicians Service (WPS) 1-866-773-0404

For claims issues involving Medicare

ValueOptions 1-800-700-8646

For behavioral health claims issues

Humana Military 1-800-444-5445

For any claims question that involves authorizations issues for medical or surgical services ■

## Consult Reports Are Required within 10 Working Days

Consult reports are required to be returned to the primary care manager (PCM) or initiating provider within 10 working days of the patient encounter. For routine specialty referrals for initial office visits, all outpatient services and inpatient services, you must provide complete and legible documentation for these reports to be accurate and useful.

Returning consult reports, operative reports and discharge summaries to

the initiating provider is important for timely follow up and continuity of care. Please be responsive to the request when asked to return a consult report for TRICARE beneficiaries.

Providers who treat TRICARE beneficiaries coming from the local military treatment facility may receive a faxed reminder to return a consult report for a recent visit/service. Your office should return the consult

report, operative report or discharge summary requested and use the designated fax reminder as the cover sheet. Please use the fax number listed in the upper right corner of the reminder page. This fax number is shown only on the reminder fax to providers for each beneficiary consult return request. This is to avoid having providers send documentation on all other TRICARE beneficiaries. ■

## Sponsor ID Is the Key

When filing your TRICARE claims, make sure that the Social Security number (SSN) you use is the sponsor's SSN—whether the patient is the sponsor or any member of the sponsor's family.

The only exception to this rule is if the patient is the former spouse of a TRICARE sponsor. In that case, use the former spouse's SSN. ■

## Tips for a Smooth Claims Filing Experience

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### ClaimCheck Reconsiderations

In some cases, you may want a medical review to reconsider ClaimCheck edits. If so, you may request verification that the edit was applied correctly by asking for an explanation of ClaimCheck auditing logic. You can also submit documentation showing that unusual circumstances existed.

When seeking medical review or to provide additional documentation, you should write to:

TRICARE South Correspondence  
P.O. Box 7032  
Camden, SC 29020-7032

After medical review, Humana Military/PGBA may override the ClaimCheck edit and allow an additional amount to be paid. Remember, you are not permitted to bill TRICARE beneficiaries for amounts considered unbundled or incidental by ClaimCheck.

### ClaimReview

A module within ClaimCheck, called ClaimReview®, allows PGBA to ensure that the diagnosis and procedure codes match.

To avoid claim line denials, you should assign a diagnosis code that represents the reason why the procedure has been performed and any other diagnosis that would affect the patient's treatment plan.

### ClaimReview Reconsideration

If a line on the claim is rejected, you should review the medical documentation for any additional diagnosis, and if found, submit the documentation on a corrected claim. If after review, other diagnoses cannot be found, a reconsideration can be requested by sending supporting medical record information to the TRICARE South Correspondence address.

If you have questions regarding claims editing, contact PGBA directly at 1-800-403-3950 or visit the PGBA Web site at [www.myTRICARE.com](http://www.myTRICARE.com). ■

Humana Military Healthcare Services, Inc.  
P.O. Box 740044  
Louisville, KY 40201-7444

## CONTACTS

**Humana Military**  
1-800-444-5445  
[www.humana-military.com](http://www.humana-military.com)

**PGBA (claims)**  
1-800-403-3950

**ValueOptions (behavioral health)**  
1-800-700-8646

**Pharmacy Customer Service**  
1-866-DoD-TRRx (retail)  
1-866-DoD-TMOP (mail order)  
[www.express-scripts.com/TRICARE](http://www.express-scripts.com/TRICARE)

**National TRICARE Web Sites**  
[www.tricare.osd.mil](http://www.tricare.osd.mil)  
[www.tricareonline.com](http://www.tricareonline.com)

**Update DEERS**  
1-800-538-9552  
[www.tricare.osd.mil/DEERSAddress](http://www.tricare.osd.mil/DEERSAddress)

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## Policy Update: Maternity Benefits New Coverage for Electric Breast Pumps

To better serve the development needs of premature infants, an update issued Aug. 8, 2005, to *TRICARE Policy Manual* 6010.54-M, Aug. 1, 2002, covers heavy-duty hospital-grade (E0604) electric breast pumps (including services and supplies related to the use of the pump) for mothers of premature infants.

Premature infants miss some or all of the crucial transfer of immunoglobulins from their mothers during the last several weeks of gestation and suffer from underdeveloped immune systems. While maternal immunoglobulins are present in breast milk, many premature infants cannot breastfeed successfully. Using an electric breast pump ensures that these infants receive an adequate supply of breast milk to address their immunological challenges.

Under the policy, a hospital-grade electric breast pump is covered while the premature infant remains hospitalized during the immediate post-partum period, as defined by ICD-9 codes 765.0, 765.1, or 765.21–765.28. Electric breast

pumps may also be covered after the premature infant is discharged from the hospital with a physician-documented medical reason consistent with the above ICD-9 codes, such as the inability to breastfeed. This documentation is also required for premature infants delivered in non-hospital settings. Hospital-grade electric breast pumps are reimbursable as durable medical equipment after the hospital discharge.

Breast pumps of any type when used for reasons of personal convenience (e.g., to facilitate a mother's return to work) are excluded even if prescribed by a physician. Manual breast pumps (E0602) and basic (non-hospital grade) electric breast pumps (E0603) are also excluded.

Although no prior authorization is needed, a physician's prescription is required to obtain a breast pump. If the breast pump is not considered medically necessary upon review of the claim, the claim will be denied. ■