

TRICARE Claims and Billing Tips



HUMANA MILITARY
HEALTHCARE SERVICES
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Claims Filing Information	
Claims Processing	PGBA, LLC (PGBA) is the Humana Military Healthcare Services, Inc. (Humana Military) claims processing partner in the TRICARE South Region. TRICARE requires network provider claims to be filed electronically with the appropriate HIPAA-compliant standard electronic claims format. If a non-network provider must submit claims, TRICARE requires them to be submitted on either a CMS-1500 (<i>professional charges</i>) or a UB-04 (<i>institutional charges</i>) claim form. Non-network providers may also file claims electronically. For claims questions, call PGBA at 1-800-403-3950 . For electronic claims assistance, call 1-800-325-5920, option 2 .
Claims Deadlines	All TRICARE provider claims must be submitted to PGBA for payment within one year of the date the service was rendered.
Claims Status	Providers can check the status of submitted claims by accessing the Humana Military Web site at www.humana-military.com , or by contacting PGBA via www.myTRICARE.com or 1-800-403-3950 .
HIPAA National Provider Identifier (NPI) Compliance	Effective May 23, 2008, all covered entities must use their NPIs on HIPAA standard electronic transactions in accordance with the <i>Implementation Guide</i> .
Outpatient Prospective Payment System (OPPS)	The TRICARE OPPS was implemented on May 1, 2009. TRICARE uses OPPS to pay claims filed for hospital outpatient services. It is mandatory for both network and non-network providers. Under OPPS, payment 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.
Tips for Filing Claims	
Supporting Documentation	PGBA has a dedicated fax number to receive supporting documentation for electronically submitted claims. Call 1-800-325-5920, option 2 for additional information.
Other Health Insurance (OHI)	When filing electronically, include the amount the primary insurance paid. If the primary insurance is a PPO, HMO, Medicare, or other insurance where there is a limited liability for the patient, then you also need to indicate the OHI-allowed amount.
Provider IDs	Always include the correct TRICARE provider ID, which consists of your tax ID or Social Security number. A three-digit location suffix is assigned to each provider ID for electronic media claims (EMC) submission.
Common EMC Rejects	For a listing of common EMC reject reasons and solutions, visit www.humana-military.com .
HIPAA Transaction Standards and Code Sets	For your TRICARE claims, the following standard formats must be used: <ul style="list-style-type: none"> • ASC X12N 837—Health Care Claim: Professional, Version 4010 and Addenda • ASC X12N 837—Health Care Claim: Institutional, Version 4010 and Addenda
Provider Signature	When a beneficiary has signed a Release of Information statement, providers should indicate “signature on file” in Block 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 80 (“Remarks”) of the UB-04 form if submitted by a non-network provider. Failure to sign may result in the form being returned.
TRICARE and Other Health Insurance	
Second Payer	TRICARE is the secondary payer to all health benefits and insurance plans, except for Medicaid, TRICARE supplements, the Indian Health Service, and other programs, as identified by the TRICARE Management Activity.
Submitting OHI Claims	The explanation of benefits (EOB) from the primary insurer must accompany your claim submission to PGBA if you are not able to transmit the required information on your electronic claim. Indicate the amount paid by the other insurer and include a copy of the primary insurer’s EOB with TRICARE paper claims. The primary EOB must contain the following: <ul style="list-style-type: none"> • The definition of any “reason codes” utilized by the primary payer to describe how the claim was processed, when applicable • Information on the action taken by the primary payer for each specific date of service and charge, when applicable
Referrals and Prior Authorizations	TRICARE beneficiaries who have OHI are not required to obtain referrals or prior authorizations for covered services, except for: adjunctive dental care; stem cell and organ transplants; behavioral health; Extended Care Health Option (ECHO); home health; and hospice services. If OHI benefits are exhausted, TRICARE becomes the primary payer and prior authorization requirements may apply. A copy of the Humana Military OHI questionnaire is available at www.humana-military.com .
OHI Status	Because OHI status can change at any time, it is important to obtain OHI information on a routine basis.
Point of Service (POS) Option	POS cost-sharing and deductible amounts do not apply if a TRICARE Prime beneficiary has OHI.
Calculating Payments	Payments from the OHI and TRICARE may not exceed the total charges. 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 TRICARE-allowable charge (<i>if network or accepting assignment</i>) or 115 percent of the TRICARE-allowable charge (<i>if not accepting assignment</i>). In the case of a network provider, the negotiated rate is the TRICARE-allowable charge.



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Billing with V Codes

Generic V Codes	Generic V codes for lab, radiology, or preoperative services are not payable and should not be used as primary diagnoses.
Preventive Services	V codes are acceptable as primary diagnoses. Claims do not require additional diagnostic information.
School Physicals	Utilize V codes V70.0, V70.3, V70.5, and V70.9, and add the statement “required school physicals” in Box 19 or Box 24D after the procedure code on the CMS-1500 claim form.

Continued Health Care Benefit Program

- For questions and assistance with Continued Health Care Benefit Program (CHCBP) claims, call PGBA at **1-800-403-3950**.
- File CHCBP claims electronically at 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

Medicare and TRICARE Claims

Wisconsin Physicians Service (WPS) is the claims processor for all 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.

Appeals	WPS TRICARE For Life Attn: Appeals P.O. Box 7490 Madison, WI 53707-7490
Claims Submission <i>(Be sure to submit claims to Medicare first.)</i>	WPS TRICARE For Life P.O. Box 7890 Madison, WI 53707-7890
Customer Service	WPS TRICARE For Life P.O. Box 7889 Madison, WI 53707-7889
Online	www.TRICARE4u.com
Program Integrity	WPS TRICARE For Life Attn: Program Integrity P.O. Box 7516 Madison, WI 53707-7516
Refunds	WPS TRICARE For Life Attn: Refunds P.O. Box 7928 Madison, WI 53707-7928
Third-Party Liability	WPS TRICARE For Life Attn: TPL P.O. Box 7897 Madison, WI 53707-7897
Telephone	1-866-773-0404 (toll-free) 1-866-773-0405 (toll-free TDD)

Out-of-Region Claims

North Region	Health Net Federal Services, LLC c/o PGBA, LLC/TRICARE P.O. Box 870140 Surfside Beach, SC 29587-9740 1-877-TRICARE (1-877-874-2273) www.healthnetfederalservices.com
West Region	West Region Claims Wisconsin Physicians Service P.O. Box 77029 Madison, WI 53707-1029 1-888-TRIWEST (1-888-874-9378) www.TRICARE4u.com
Overseas Region	See Section 8 of the <i>TRICARE Provider Handbook</i> for details on filing claims for overseas beneficiaries.

TRICARE and Third-Party Liability Insurance

When a claim appears to have possible third-party involvement, the following will happen:

- The DD Form 2527 *Statement of Personal Injury—Third Party Liability* form will be mailed to the beneficiary.
- The claim is pended for up to 35 calendar days. If the DD Form 2527 is not received, the claim will be denied.
- The claim will be reprocessed when the DD Form 2527 is completed and returned by the beneficiary. Encourage the beneficiary to fill out and submit the form within the 35 calendar days to avoid payment delays.
- If the illness or injury was not caused by a third party but the diagnosis code(s) falls within 800 and 999, the beneficiary may still be responsible for filling out the form. If not returned, the claim will be denied.