TRICARE Provider News
A PUBLICATION FOR TRICARE PROVIDERS ISSUE 4: 2010

Preventive and Routine Health Care Services

TRICARE beneficiaries are covered for a variety of preventive and routine services to keep them healthy and help identify potential problems down the road. To provide the best care to beneficiaries, it is important for you to understand how TRICARE covers each of these services.

Preventive Care

Preventive care services are covered benefits that help patients stay healthy. They include services that are not designed to treat specific illnesses, injuries or symptoms, but are performed as periodic health screenings or assessments. Preventive care services include diagnostic procedures such as cancer and cardiovascular screenings, immunizations, well-child care, infectious disease screenings and clinical preventive medical exams.

TRICARE has established limitations on the frequency of preventive care for beneficiaries, and coverage varies depending on the beneficiary's TRICARE plan option (e.g., TRICARE Prime, TRICARE Standard). **Note:** When receiving care from a network provider, preventive care services do not require referrals, with the exception of active duty service members, who require prior authorizations for civilian care.

Routine Care

TRICARE defines routine care as any care that is not for an urgent or emergency situation. Many routine services are covered if there is an underlying medical necessity. TRICARE-covered routine services include individual provider services (e.g., office visits, diagnosis and treatment by specialists), allergy testing and treatment, and rehabilitation services, to name a few.

A referral or authorization may be required for some routine services. Refer to Health Net Federal Services, LLC's Web site at www.healthnetfederalservices.com for referral and authorization requirements.

When billing for these services, remember TRICARE coverage is based on medical necessity, which should be reflected in diagnoses billed. Be sure to use the correct Current Procedural Terminology (CPT®) and ICD-9 codes when billing, and select a specific diagnosis. For more information, refer to the "Medical Coverage" section of your *TRICARE Provider Handbook*. ■

Ambulance Service Coverage

In times of emergency, TRICARE covers ambulance services for the provision of your patients' health care. Please be aware that TRICARE covers ambulance services for the following conditions:

- Emergency transport to a hospital
- Transfer from one hospital to another hospital more capable of providing the required care as ordered by a physician
- Transfers between a hospital or skilled nursing facility (SNF) and another facility for outpatient therapy or diagnostic services ordered by a physician
- Transfers to and from a SNF when medically indicated

Note: Payment for ambulance transfers to and from a SNF may be included in the SNF prospective payment system (PPS).

Air or boat ambulances are only covered when the pickup point is inaccessible by a land vehicle, or when great distance or other obstacles are involved in transporting the patient to the nearest hospital with appropriate facilities, and the patient's medical condition warrants speedy admission or if a transfer by other means is contraindicated.

continued on page 2

Inside This Issue ...

TRICARE North

Ambulance Service Coverage

continued from page 1

TRICARE does **not** cover ambulance services for the conditions listed below:

- Nonemergency ambulance services used instead of a taxi service or other normal transportation means when the patient's condition permits
- Transport or transfer of a patient primarily for the purpose of having the patient closer to home, family, friends or a physician
- Any type of medicabs or ambicabs that function as public passenger services transporting patients to and from medical appointments

The benefit does allow consideration of medical necessity in complex cases.

For more information about ambulance services, refer to Chapter 8, Section 1.1 of the *TRICARE Policy Manual* at http://manuals.tricare.osd.mil. Visit Health Net Federal Services, LLC's Web site at www.healthnetfederalservices.com or call 1-877-TRICARE (1-877-874-2273). ■

Helpful Claims Processing Tips

Health Net Federal Services, LLC (Health Net) would like to share these tips to help you avoid common mistakes and ensure efficient TRICARE claims processing.

1. Use the Correct Social Security number (SSN)

When filing a claim for a TRICARE beneficiary, except a former spouse, use the TRICARE sponsor's SSN. If the patient is a sponsor's former spouse, use the patient's SSN. As the Department of Defense continues to remove SSNs from military identification cards, it becomes increasingly important to verify that the correct SSN is listed on the claim.

2. Verify the Patient's Address

During each visit, ask beneficiaries to update or confirm their personal information. If beneficiaries have moved, please remind them to update information in the Defense Enrollment Eligibility Reporting System (DEERS) by calling 1-800-538-9552 or visiting the DEERS Web site at www.dmdc.osd.mil/appj/address/.

3. Apply Accurate Procedure Codes

Apply the Current Procedural Terminology® (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes that accurately describe the service or procedure provided. Do not use approximate, miscellaneous or unlisted codes.

4. Use Proper V Codes

V codes are used to describe reasons other than disease or injury for health care visits. V codes are acceptable as primary diagnoses when used under preventive services. If a V code explains the reason for the visit (e.g., routine infant checkup, preventive service), it can be submitted as the only diagnosis. Although V codes may be acceptable primary diagnoses for outpatient claims, they are rarely acceptable for inpatient claims. The V code must match the CPT code. **Note:** Generic V codes for lab, radiology or preoperative services are **not** payable and should not be used as primary diagnoses.

Please use the appropriate DSM-IV/ICD-9 diagnostic codes for behavioral health services primary diagnoses. V codes for behavioral health services will not be reimbursed. To further explain treatment, V codes may be included as modifiers. For an unconfirmed diagnosis, submit the referring physician's working diagnosis.

5. Coordinate with Other Health Insurance (OHI)

During each visit, ask beneficiaries if they have OHI. For beneficiaries with OHI, submit claims to those insurers first. If OHI benefits are exhausted, TRICARE becomes the primary payer, and additional authorization requirements may apply. In these cases, please submit claims to TRICARE and include the OHI's explanation of benefits.

Find more information on claims submission in the *TRICARE Provider Handbook* and on Health Net's Web site at www.healthnetfederalservices.com. ■

Zostavax® Shingles Vaccine Available for TRICARE Beneficiaries

TRICARE covers a single dose of the shingles vaccine Zostavax® for beneficiaries age 60 and older, per recommended guidelines from the Centers for Disease Control and Prevention. Zostavax is covered under the TRICARE medical benefit and is not reimbursable under TRICARE's pharmacy benefit. Be aware that Medicare policy differs by covering Zostavax under the Medicare Part D prescription benefit.

Beneficiaries must have vaccinations administered in a provider's office or by a TRICARE-authorized provider. If the vaccine is not in stock in your office, there are other options available to provide the vaccine to TRICARE patients:

- You can order the vaccine as needed through CuraScript, a network specialty pharmacy. The vaccine will be delivered to your office, and CuraScript will bill TRICARE for the vaccine. To use this service, you must have an account with CuraScript, and you can order the vaccine by using the eCommerce function on CuraScript's Web site at www.curascript.com or by calling 1-888-773-7376. If you do not have an account with CuraScript, you must register prior to ordering medications.
- Most network Convenient Care Clinics (CCCs) carry the Zostavax vaccine. CCCs are civilian health care facilities capable of treating minor illnesses that may offer preventive services as well, such as immunizations. They are usually located in high-traffic, retail-based locations that can include some retail pharmacies (e.g., The Little Clinic [Kroger], Take Care Clinic [Walgreens]). While they are located in retail pharmacy locations, these CCCs are **not** considered to be part of the pharmacy network and are authorized by TRICARE to provide the Zostavax vaccine. **Note:** Beneficiaries should check with the CCC prior to seeking the immunization, as some CCCs may not stock this vaccine.

TRICARE will only cover a single dose of herpes Zostavax (shingles) vaccine for beneficiaries 60 years of age and older. TRICARE will not reimburse for vaccines purchased or administered at a pharmacy. Currently, Medicare only covers the Zostavax vaccine under Medicare Part D pharmacy program. If the beneficiary does not have Medicare Part D, TRICARE will cover the vaccine and applicable deductibles, and cost-shares will apply. If you have Medicare questions regarding the Zostavax vaccine, you may contact Medicare at 1-800-MEDICARE (1-800-633-4227). If you have questions regarding how TRICARE will pay after Medicare, you may contact the TRICARE For Life contractor, Wisconsin Physicians Service, at 1-866-773-0404. ■

When Alcohol Becomes a Problem

Alcohol can pose serious health and safety risks for many people, especially for those who use it in excess. If you have patients who are struggling with alcohol addiction, encourage them to seek help right away. They can also access information and resources by visiting Health Net Federal Services, LLC's "Healthy Living" page on the Health Net Web site at www.healthnetfederalservices.com. To access this resource, instruct your patients to click on "Beneficiary" and then on the "Healthy Living" tab. From there, they should select "Health Topics" in the "Find It Fast" section. ■

TRICARE Provider News

Health Net Federal Services, LLC
P.O. Box 2890
Rancho Cordova, CA 95741

CONTACTS

Health Net Customer Service
1-877-TRICARE
www.healthnetfederalservices.com

PGBA, LLC
(Electronic claims set up)
1-877-EDI-CLAIM

Wisconsin Physicians Service
TRICARE For Life
(Dual-eligible claims)
1-866-773-0404
TDD 1-866-773-0405

Express Scripts, Inc.
(Pharmacy inquiries)
1-877-363-1303
www.express-scripts.com/TRICARE

TRICARE Offers Substance Abuse Residential Rehabilitation

TRICARE covers rehabilitative care in TRICARE-authorized hospitals or substance use disorder facilities. These facilities may be freestanding or hospital-based, and the care is covered on either a residential or partial care basis.

Residential care is subject to the following:

- Care must be preauthorized.
- Coverage during a single benefit period is limited to no more than one inpatient stay in hospitals subject to diagnosis-related group (DRG) payment system, exclusive of DRG-894 (Alcohol Drug Abuse/Dependence, Left Against Medical Advice) or 21 days in a DRG-exempt facility for rehabilitation care, unless the limits are waived. The benefit period is defined as the federal fiscal year (FY) (Oct. 1–Sept. 30).
- If the patient is medically in need of chemical detoxification but does not require the personnel or facilities of a general hospital setting, detoxification services are covered in addition to rehabilitative care. In a DRG-exempt facility, detoxification services are limited to seven days.
- The medical and psychological necessity of the detoxification must be documented. Any detoxification services provided in the substance use disorder rehabilitation facility must be under general medical supervision.

The days of detoxification treatment must be counted toward the statutory day limit, limiting care for adults (age 19 and over) to 30 days per FY or 30 days in an admission and to 45 days per FY for children (age 18 and under).

Rehabilitation stays are subject to a limit of three benefit periods in a lifetime, unless this limit is waived. Preadmissions and continued stay authorizations are required for substance use disorder detoxification and rehabilitation. Rehabilitation stays are covered if preauthorized as medically or psychologically necessary. Days of rehabilitation must be counted toward the statutory day limit, restricting care for adults (age 19 and over) to 30 days per FY or 30 days in an admission and to 45 days per FY for children (age 18 and under).

Emergency and inpatient hospital services are covered when medically necessary for the active medical treatment of the acute phases of substance use withdrawal (detoxification), for stabilization and for treatment of medical complications of substance use disorders. **Note:** The concept of an emergency admission does not apply to rehabilitative care itself. ■

BU334PRN02100