CHAPTER 11
SECTION 14.1

# TRICARE CLAIMCHECK

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## I. APPLICABILITY

**THIS POLICY APPLIES ONLY TO THE CURRENT MANAGED CARE CONTRACTS AND UNTIL THOSE CONTRACTS EXPIRE.**

## II. ISSUE

What is TRICARE Claimcheck?

## III. DESCRIPTION

TRICARE Claimcheck is a fully automated cost containment program that is designed to ensure appropriate coding on professional claims. Edits do not apply to institutional claims except for ambulatory surgery facility claims. TRICARE Claimcheck is a reviewed, approved and customized version of the HBOC/GMIS ClaimCheck®. HBOC/GMIS develops its edits through a Clinical Information Services Department, with input from the Clinical Consulting Network. This includes yearly CPT updates, incorporation of Medicare guidelines and Specialty Society guidelines.

## IV. POLICY

### A. General.

1. Upon implementation of TRICARE Claimcheck, and only for claims subject to TRICARE Claimcheck, the appropriate reimbursement methodology will be applied in conjunction with TRICARE Claimcheck auditing guidelines. This may result in guidelines currently contained in the Policy Manual being superseded by TRICARE Claimcheck auditing guidelines.

2. Contractors are required to purchase TRICARE Claimcheck in accordance with the terms of their contract.

3. TRICARE Claimcheck will be applied to claims based on the date of processing.

4. TRICARE Claimcheck will be applied to adjustment claims except where:

a. The adjustment is to a claim that was not subject to TRICARE Claimcheck; or

b. The adjustment is a financial adjustment (e.g., add-pay).

5. Customization. TRICARE Claimcheck is customized to audit claims in accordance with TRICARE coverage and reimbursement policy. Each TRICARE Claimcheck update will be customized by GMIS based on direction from the TRICARE Claimcheck Project Officers. Contractors are not to customize or alter TRICARE Claimcheck in any way except as provided below:

a. When directed by the TRICARE Management Activity.

b. TRICARE Form 813. Contractor customization may occur to accommodate statutory or similar requirements (e.g., an edit that unreasonably reduces payments and could adversely affect provider networks) that arise between the normally scheduled updates. When these arise or when a contractor believes there is a need for customization, TRICARE Form 813 (Enclosure 1 to this section) is to be used to complete the process. After Form 813 has been appropriately approved, contractors will be directed to make the necessary changes through the normal change order process. In the interim, contractors may override affected claims until the necessary customization has been completed.

B. Edits. The following edits are considered when auditing claims:

1. Unbundling - The use of two or more CPT codes to describe a surgery performed when a single more comprehensive CPT code exists that accurately describes the surgery.

2. Incidental - A procedure that is carried out at the same time as a larger more complex primary procedure. It requires little additional physician resources and/or is an integral part of the primary procedure. Thus it should not be reimbursed separately on a claim.

3. Mutually Exclusive - The separate billing for two or more procedures that are usually not performed during the same patient encounter on the same date of service. Under TRICARE Claimcheck, only the most clinically intensive procedure is allowed.

4. Assistant Surgeons - When a procedure is submitted with an assistant surgeon modifier, -80, -81, or -82, TRICARE Claimcheck determines whether that procedure always, sometimes, or never requires an assistant surgeon to perform. When a procedure "sometimes" requires an assistant surgeon, the claim will be flagged for medical review.

5. Duplicate - TRICARE Claimcheck uses duplicate checking to identify those procedures which appear twice on a claim but can be performed only once in a patient's lifetime or on a single date of service. Contractors use duplicate checking to identify if a particular claim has been submitted before. Therefore, TRICARE Claimcheck duplicate edits are intended to enhance the contractor's existing duplicate edits.

6. Age Conflicts - An edit that is used to identify procedure codes that are inappropriate for a patient's age.

7. Sex Conflicts - An edit that is used to identify procedures that are inappropriate for a patient's sex.

8. Cosmetic Procedures - An edit which is used to identify procedures that are usually performed for cosmetic reasons.

9. Unlisted Procedures - An edit which is used to identify those CPT codes that are used for procedures that do not have a specific code assignment (usually -99 codes).

10. Unproven Procedures - An edit that is used to identify procedures that are not currently considered to be acceptable medical care under prevailing medical standards. Because many unproven procedures are identified by descriptive test rather than by a CPT code, TRICARE Claimcheck, which is code-based, would be ineffectual in identifying them. Therefore, the contractor is responsible for maintaining edits for unproven procedures.

11. Medical Visits - An edit that identifies medical visit codes that are not appropriate for separate reimbursement, since reimbursement would be included in the payment for another billed procedure.

12. Pre and Post Operative Care - An edit that identifies services billed within the assigned pre-operative (one day) or post-operative (10 or 90 days) periods that should be included in the surgical reimbursement.

C. Integration. TRICARE Claimcheck is to be fully integrated into the contractor's existing claims processing system. The pricing module in TRICARE Claimcheck will not be used and claims are to be priced using existing TRICARE methodologies.

D. Reports. The contractor will be required to provide reports as defined or requested by the TRICARE Management Activity.

E. Provider Number - TRICARE Claimcheck recognizes fifteen (15) characters for the provider number. If the contractor currently uses more than 15 characters, the contractor is to truncate the provider number at 15 characters.

F. Line items - TRICARE Claimcheck recognizes and applies edits to only the first forty (40) line items on a claim. The contractor cannot increase the 40-line limit.

G. Provider/Beneficiary Disagreements with TRICARE Claimcheck Determinations.

1. Payment reductions resulting from TRICARE Claimcheck auditing logic are not subject to the formal appeals process, and providers who agree to participate are not permitted to bill the beneficiary for the disallowed amounts.

2. Claims that are revised based on TRICARE Claimcheck auditing logic are allowable charge determinations and must be treated as such. Participating providers and beneficiaries may question the application of the TRICARE Claimcheck edits (as discussed below) and, when applicable, the amount allowed and request a review. The review may involve:

a. Questions to the contractor asking for verification that the edit was correctly applied to the claim or requests for an explanation of TRICARE Claimcheck auditing logic; or

b. Situations where the provider submits additional documentation that substantiates unusual circumstances existed (e.g., TRICARE Claimcheck determined a particular procedure to be incidental, but the additional documentation identifies substantial additional physician resources that were medically necessary and that warrant separate reimbursement). Following medical review, the contractor may override the TRICARE Claimcheck determination on that claim and allow additional amounts.

H. Modifiers - TRICARE Claimcheck recognizes all CPT and HCPCS modifiers. That is, inclusion of the modifier on a claim will not prevent the claim from being edited by TRICARE Claimcheck. However, TRICARE Claimcheck actually audits a limited number of modifiers (as described in the documentation for the version currently in use). Where TRICARE Claimcheck does not audit a particular modifier, contractors must ensure their claims processing systems contain internal edits to accommodate the modifiers. As new modifiers are created in CPT, contractors are expected to accommodate those new modifiers as part of their implementation of the annual procedure code updates. Modifiers are to be reimbursed in accordance with AMA guidelines.

I. Contractor Overrides. There are situation where the contractor may override TRICARE Claimcheck's auditing determination. The following situations involve contractor overrides of TRICARE Claimcheck.

1. On a claim-by-claim basis (for example, determinations as described in paragraph IV.A.5.b. and paragraph IV.G.2.b. above).

2. Type of Provider/Specialty. TRICARE Claimcheck does not recognize "type of provider" and may deny claims as a result. However, there may be situations where the "type of provider" would mandate that payment be allowed. Contractors must use their judgment, based on medical review if necessary, in these cases to determine if an override is appropriate. For example, any surgical pathology (CPT procedure codes 88304 and 88305) claim submitted by the operating physician is denied as incidental to the surgical procedure. However, dermatologists are qualified to perform surgical pathology, so any claim for surgical pathology from a dermatologist who is also the operating physician is to be allowed.

J. Balance Billing Limitation. A determination by TRICARE Claimcheck that a procedure is incidental or that it is rebundled into another procedure is considered to be an allowable charge reduction. Therefore, non-participating providers cannot bill separately for either an incidental or a rebundled procedure, and the balance billing limitation is to be applied to the allowable amount for the primary procedure. For example, if procedure B is incidental to procedure A, under the balance billing limitation a non-participating provider can bill the beneficiary only 115 percent of the allowable amount for procedure A and this amount covers both procedures A and B.

## V. EXCEPTIONS

The following claims are not subject to TRICARE Claimcheck:

A. Anesthesia;

B. Pharmacy;

C. Physical therapy;

D. Certain adjustments (see paragraph IV.A.3. of this section);

E. Institutional claims (except for ambulatory surgery facility claims).

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