CHAPTER 13
SECTION 13.2

MANAGED CARE CLAIMS

Issue Date: November 1, 1989
Authority: 32 CFR 199.8 and 32 CFR 199.12

I. DESCRIPTION

Managed Care Claims relate to claims received from a beneficiary who has coverage under a health or medical plan that usually provides comprehensive services at discounted rates or a set co-payment depending on the type of service or supply provided. Such plans include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Paid Prescription plans.

II. ISSUE

Since these plans usually provide care at either reduce rates or fixed co-payments, how will TRICARE reimburse claims received from a managed care health plan as described above?

III. POLICY

A. TRICARE will reimburse these claims for the amount for which the beneficiary is liable. The standard TRICARE cost-shares and deductible are to be applied to the claims; i.e., if a claim is received showing a $10 co-payment which is the beneficiary's actual liability, TRICARE shall reimburse this amount, minus a 20 or 25 percent cost-share, and whatever deductible amount has not been met.

EXAMPLE: $10.00 billed charge for HMO claim
- 2.50 @25 percent cost-share (deductible has been met)
$ 7.50 TRICARE payment

EXAMPLE: $3.50 billed charge for discounted prescription
- .87 @25 percent cost-share (deductible has been met)
$2.63 TRICARE payment

Generally, Managed Care claims are processed using the normal charges as calculated above. However, if the beneficiary submits a claim which shows the actual charges (not the discounted rate), and the claim shows the amount covered by the PPO, the claim should then be processed using the double coverage procedures (refer to Chapter 13, Section 12.1 and OPM Part Two, Chapter 3 and 4).

EXAMPLE: $25.00 actual charges for service
- 20.00 amount covered by the PPO
$ 5.00 beneficiary responsibility

Step 1: $25 x 75 percent cost share = $18.75 (deductible has been met)

Step 2: $25 (billed charge) minus $20 (amount covered by PPO) = $5

Step 3: $5 represents TRICARE payment which is the lesser of the two amounts.

B. Since Managed Care plans rarely provide beneficiaries with itemized receipts which show (1) actual services received, and (2) actual charges/costs to provide the service or supply, development for itemization is not required except in the following circumstance:

1. If a claim appears to be for a service or supply that is excluded from TRICARE coverage, development will be necessary. In such cases, the CONTRACTOR must request a written statement describing the service/supply provided to the beneficiary. When possible, the CONTRACTOR should request a CPT-4 or ICD-9 coding number.

2. As with all medical, health or insurance plans, TRICARE will only cost-share billed charges when the managed care plan does not provide a particular service or supply needed by the beneficiary. The service must be medically necessary and a benefit under TRICARE, and it must be documented in writing that the service/supplies are not available through the primary plan.

IV. POLICY CONSIDERATIONS

A. Other managed care claims (HMO and Paid Prescription plans) may also follow the PPO payment calculation, depending on whether the actual charge for the prescription is submitted.

B. When a managed care claim appears to be for a service or supply that is not a benefit under TRICARE, and the CONTRACTOR is not able to obtain written documentation to verify the type of service/supply rendered, the claim is to be denied as non-covered.

V. EFFECTIVE DATE

Effective for claims processed on or after approval date.

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