Chapter 8
Section 11

Explanation Of Benefits (EOBs) Summary Vouchers

1.0. EXPLANATION OF BENEFITS (EOB)

1.1. Beneficiary, Parent/Guardian

The contractor shall issue and mail an appropriate EOB to the beneficiary (parent/guardian for minors or incompetents) for each claim processed to a final determination. In those circumstances where the beneficiary has no “out of pocket” expenses, including deductibles or cost-shares, and there are no denied charges included on the claim for which he/she is, or may be, responsible, issuance of an EOB may be waived. (For the purpose of issuing EOBs, Prime beneficiary copayments are not considered out-of-pocket expenses.) When an EOB is required, it must be issued to the beneficiary regardless of whether or not the provider is a participating provider and whether or not an actual payment is involved; e.g., allowed amount is applied to the deductible or payment is $.99 or less and no check is mailed.

1.2. Non-Participating Provider

The EOB shall be provided to the non-participating provider with the amount allowed so that he/she can determine what amount may be billed to the beneficiary under the balance billing provision (115% of the TRICARE allowable charge). When a claim for service from a non-participating provider is allowed at the billed charge, the EOB, at the contractor’s discretion, need not be sent to the non-participating provider since the balance billing provision does not apply. Only the charges of the non-participating provider would normally appear on the EOB; however, the non-participating provider should only be provided with information where there is a “need to know”. This means that if other information appears on the EOB that does not pertain to the non-participating provider, the TRICARE contractor is to suppress printing or remove it before sending the EOB to the non-participating provider. The non-participating provider will receive only the EOB and the beneficiary will receive the TRICARE payment.

1.3. Participating Providers

Contractors shall also issue EOBs to participating providers or issue summary vouchers covering multiple claims and beneficiaries in lieu of issuing multiple EOBs. Sufficient information must be included on the vouchers to identify each beneficiary and explain the payment for each line item on each claim. Use of a summary voucher does not change the requirement for a separate EOB to be sent to each beneficiary for each claim. Each contractor shall include adequate identification of the fiscal year involved applicable to the various charges listed on the EOB to help keep the deductible information clear to the beneficiary. (See the ADP Manual, Chapter 2, for HCSR requirements.)

1.4. Network Providers

Network providers will be paid according to the agreements and administrative procedures established with the contractor.

1.5. State Medicaid Agency

If the claim is from a state Medicaid agency, the copy usually sent to a participating provider will be sent to the state agency. The contractor will include the same information on the copy sent to the state as it normally sends to participating providers. If the state has a need which cannot be accommodated except at extra expense, the contractor may negotiate with the state, if it chooses, and if the state is willing to pay for the accommodation.

1.6. TRICARE For Life

From October 1st, 2001 to September 30th, 2002, special EOBs/stuffers shall be issued for TRICARE For Life (TFL) claims for which the beneficiary has insurance other than Medicare and TRICARE. The EOBs/stuffers shall show the beneficiary what TRICARE would have paid if they did not have other health insurance (OHI). The EOB/stuffer shall follow the specifications as outlined in *TRICARE Reimbursement Manual, Chapter 4, Section 3*.

1.7. EOB Issuance Exceptions

1.7.1. TRICARE Prime

The issuance of an EOB is optional only in TRICARE Prime when the beneficiary is not liable for payment of any out-of-pocket expense. (For the purpose of issuing EOBs, Prime beneficiary copayments are <u>not</u> considered out-of-pocket expenses.) At all other times it is required. In case of doubt, the contractor shall obtain approval from the contracting officer for waiver.

1.7.2. Abortion, AIDS, Alcoholism, Drug Abuse Or Venereal Disease

1.7.2.1. Contractors shall not issue EOBs to beneficiaries (parents/guardians of minors or incompetents) when claims involve services related to the following diagnostic codes:

	ICD-9-CM
Abortion	634-639.9[2]; 779.6
AIDS	079.53; 042
Alcoholism	291-291.9[2]; 303-303.9[2]; 305[3]
Drug Abuse	292-292.9[2]; 304-304.9[2]; 305.2-305.9[3]
Venereal Disease	090-099.9[2]; 294.1
[1] Including 4th digits [2] Including 4th and 5th digits [3] Including 5th digits	

1.7.2.2. EOBs must be issued to participating providers, except as noted above. The contractor shall provide an EOB to a beneficiary upon request. When a request is made for a normally suppressed EOB, the copy provided may be a facsimile or a hand-produced copy. It must, however, include the required data and be certified by the contractor.

1.7.2.3. When a service(s) is denied due to an abortion, a letter of explanation shall be sent, but only when the denial is questioned by the beneficiary. Chapter 8, Addendum A, Figure 8-A-9 provides suggested wording for abortion claims that are denied. **The explanation shall be provided only to the beneficiary and participating provider.** The special denial letter shall be sent in an envelope marked "personal". **It is EMPHASIZED that using an Explanation of Benefits is NOT acceptable for denial of abortion services.** Only an approved letter may be used.

1.7.3. Point Of Sale Pharmacy

No EOB is necessary for Point of Sale pharmacy claims.

1.7.4. Procedures For Informing The Beneficiary Of Claim Action

The handling of claims for the diagnostic or procedural codes listed above, requires sensitivity to the beneficiary's right to privacy. Because of the need for contractors to apply reasonable judgment on a case-by-case basis, TMA has not prescribed specific procedures except in the case of abortion claims. For claims involving services and supplies for the other diagnoses, a phone call to the beneficiary may serve to obtain information on how the beneficiary wishes to have the EOB handled in some instances. In other cases, a request that the provider serve as an intermediary, or a personal letter to the beneficiary, using a plain envelope, may be appropriate. Whatever approach is chosen, contractors must observe the intent, as well as the letter, of the Privacy Act.

1.8. EOB Format

The form design of the EOB is not specifically prescribed. Contractors shall design the form to fit their individual equipment and system needs. Prior to printing, however, the form must be approved by TMA. The following are required contents of the EOB:

1.8.1. Contractor Identification

The name or logo of the contractor and the region specific TRICARE logo must be present on the front of the EOB, even though it appears on a detachable check.

1.8.2. Form Title

"EXPLANATION OF BENEFITS" shall appear in a prominent place near the top of the EOB form in boldfaced type at least as large as the organization logo or name of the contractor, and in a type size and style which will make it clearly visible.

1.8.3. **Form Subheadings**

The subheadings "THIS IS A STATEMENT OF THE ACTION TAKEN ON YOUR TRICARE CLAIM," and "KEEP THIS NOTICE FOR YOUR RECORDS," shall also appear near the top of the form in a **boldfaced** type slightly smaller than the title of the form.

1.8.4. **Data Required On Front Of EOB Form**

Provisions shall be made on the front of the form for inclusion of the following elements:

1.8.4.1. The Internal Control Number (ICN)

1.8.4.2. The Date the EOB is prepared (Run Date)

1.8.4.3. Check Number

1.8.4.4. The contractor's address and telephone number. The contractor's telephone number for the state or locality of the beneficiary or provider may be computer-printed.

1.8.4.5. Sponsor's Social Security Number

1.8.4.6. Beneficiary's Name and Sponsor's Name

1.8.4.7. The sponsor's last name and first name or initial, and the beneficiary/patient's **full first name** must be shown on the EOB.

1.8.4.8. **Payee's Name and Address**

This space is used when payment is made to someone other than the beneficiary (parent/legal guardian of minor or incompetent); e.g., the provider, administrator of an estate or a Medicaid agency. The full name of the payee must be used, if available.

1.8.4.9. Procedure Code and a short description of services. (Not required for claims paid under the TRICARE/CHAMPUS DRG-based payment system.)

1.8.4.10. Date of Service or From - To Dates for combined services.

1.8.4.11. **Number of Services**

Enter number of services provided when services are combined. (Not required for claims paid under the TRICARE/CHAMPUS DRG-based payment system.)

1.8.4.12. **Name of Provider of Service**

Since prescription drugs are paid as billed, you may use "your pharmacy" for non-assigned prescription drug claims instead of developing for the name and address of each provider. In addition, "Your Provider" or "Your Supplier" may be used when **all** of the following conditions are met:

- A valid name/number cannot be assigned from the information at hand.
- The claim is totally denied
- The claim is non-assigned

1.8.4.13. **Amount Billed**

Enter amount billed by provider.

1.8.4.14. **Amount Allowed**

Enter amount allowed by TRICARE. For claims paid under the TRICARE/CHAMPUS DRG-based payment system, this will be a total amount for the entire claim and need not relate to individual line items. If, under a program approved by the Director, TMA, a provider has agreed to discount his or her normal billed charges below the profiled amounts, the amount allowed may not be more than the negotiated or discounted charges.

1.8.4.15. **Payment Reduction Amount**

If applicable, enter the amount of the payment reduction as provided in the *TRICARE Reimbursement* Manual, *Chapter 1, Section 29*.

1.8.4.16. **Reduction Days**

If applicable enter the number of days subject to the payment reduction as provided in the *TRICARE Reimbursement* Manual, *Chapter 1, Section 29*.

1.8.4.17. **Amount Paid By Beneficiary To Provider**

Enter the amount, if any, paid by beneficiary to provider on participating claims.

1.8.4.18. **Amount Allowed By Other Insurance**

If applicable enter the amount allowed by the other health insurance (OHI). See the *TRICARE Reimbursement* Manual, *Chapter 1, Section 29*.

1.8.4.19. **Paid By Other Insurance**

Enter amount paid by other insurance (if applicable)

1.8.4.20. **Total Payment**

Enter total amount paid on the claim

1.8.4.21. **Amount Accrued Toward Deductible Amount**

Enter the amount of the individual deductible which has been satisfied for the fiscal year, including the amount applied on the current claim, and the amount of the family deductible which has been satisfied for the fiscal year.

1.8.4.22. Amount Deductible This Claim

Enter the amount of the deductible satisfied by the current claim.

1.8.4.23. Remarks/Action Section

1.8.4.23.1. Enter reasons for disallowance or reduction in this space. (If codes are used, the corresponding messages must appear on the EOB.)

1.8.4.23.2. When appropriate, enter the following: "Our records show XX days of inpatient mental health services have been used in calendar year XXXX." (If a contractor finds it more cost effective to send a separate letter or notice showing inpatient mental health days used, a copy of the proposed letter shall be sent to the Operations Directorate, TMA, for review and approval.)

1.8.4.23.3. The contractor shall develop and maintain a list of EOB messages that explain what adjudication occurred on each claim, in language that can be understood by the average person.

1.8.5. Reverse Of The EOB Form

All of the following information must be on the reverse of the EOB.

1.8.5.1. Time Limit For Filing Claims

1.8.5.1.1. All claims submitted under TRICARE must be filed no later than one year after the date the service or supply was provided or one year from the date of discharge from an inpatient admission for facility charges only.

EXAMPLE:

FOR SERVICE OR DISCHARGE	RECEIVED BY THE CONTRACTOR
March 1, 2001	No later than March 1, 2002
December 31, 2001	No later than December 31, 2002

1.8.5.1.2. If your claim was denied because it was not filed on time and you believe you were not at fault, contact us or your health benefits advisor for assistance. In limited circumstances, exceptions may be made.

1.8.5.2. Sponsor, Patient, Or Family Member Not Enrolled Or Not Eligible On DEERS

If the Defense Enrollment Eligibility Reporting System (DEERS) indicates that the sponsor, patient and/or family member is not enrolled or eligible for TRICARE benefits, you should contact your Health Benefits Advisor or your service personnel office. Claims will be denied if you are not enrolled in DEERS. If the claim was denied and the sponsor has recently gone on active duty, resubmit the claim with a copy of the duty orders and a photocopy of the patient's identification (ID) card (or parent's ID for family member under ten (10) years of age). If the sponsor is retired, resubmit the claim with the sponsor's retirement papers and a photocopy of the patient's ID card. If the sponsor is deceased, report to any service personnel

office to get enrolled or call 800-538-9552 (in California, 800-334-4162; in Alaska or Hawaii, 800-527-5602).

1.8.5.3. Identification Card (ID) Or Eligibility Expired on DEERS

The Defense Enrollment Eligibility Reporting System (DEERS) indicates that the patient's ID card or eligibility has expired. To get a new ID card or extend eligibility, if sponsor is active duty, report at once to your parent service personnel office; if sponsor is retired or deceased, contact any service personnel office. If the claim was denied, when the patient obtains a current ID card, resubmit the claim with a photocopy of the new ID card. In an emergency, call 800-538-9552 (in California, 800-334-4162; in Alaska or Hawaii, 800-527-5602) for assistance.

NOTE: Contractors may shorten messages (2) and (3) by eliminating the 800 numbers which do not apply to their region(s).

1.8.5.4. Right To Appeal

If you disagree with the determination on your claim, you have the right to request a reconsideration. Your signed written request must state the specific matter with which you disagree and **MUST** be sent to the following address no later than 90 days from the date of this notice. If the postmark on the envelope is not legible, then the date of receipt is deemed the date of filing. Include a copy of this notice. On receiving your request, all TRICARE claims for the entire course of treatment will be reviewed.

(Contractor's Address)

1.8.5.5. TRICARE Outpatient Deductible

Effective for care provided on or after April 1, 1991, a TRICARE beneficiary is responsible for the payment of the first $150.00 of the TRICARE-determined allowable costs or charges on processed claims for covered outpatient services or supplies provided in any one fiscal year. When outpatient services are provided to more than one beneficiary member of a family, the aggregate outpatient deductible amount paid by two or more beneficiary members of the family who submit claims shall not exceed $300.00 during any fiscal year. Deductible amounts remain unchanged for family members of active duty E-4s and below; $50.00 per beneficiary or $100.00 for two or more family members. Sponsors/beneficiaries are required to ensure that the proper pay grade/rank is on the DEERS records.

1.8.5.6. If Payment Not Based On The Full Amount Billed

The amount TRICARE may allow is limited by law to the lowest of:

1.8.5.6.1. The CHAMPUS Maximum Allowable charge; which for most procedures is equal to the Medicare fee schedule amount; OR

1.8.5.6.2. The amount the provider actually charges for the service or supply (to include a discounted charge that a participating provider has agreed to accept under a special program).

NOTE: Under some circumstances, the contractor responsible for payment for care in the region will negotiate rates with preferred providers which will be different than the CHAMPUS Maximum Allowable Charge or the provider's usual charge. In such a case, the agreement made by the contracted provider, establishing allowable charge levels will prevail. In this instance, the provider will be participating and payment will be made directly to the provider who will be limited to the agreed charge level in full payment.

1.8.5.7. **Important Notices**

1.8.5.7.1. Always Give Your Social Security Number When Writing About Your Claim.

NOTE: If inquiring about this claim, please provide the Internal Control Number located on the front of this form.

1.8.5.7.2. **You Can Use This Explanation Of Benefits:**

1.8.5.7.2.1. As a deductible certificate to show your providers the amount of the outpatient deductible met as of the date of this notice.

1.8.5.7.2.2. As a record of bills paid or denied. (If you submitted other medical expenses not shown on this form, you will receive a separate notice.)

1.8.5.7.2.3. To collect other insurance. This notice may be used to claim benefits from a secondary insurance policy. Since the insurance company may keep this notice, it is advisable that you keep a record of this information.

1.8.5.7.3. Claims payments are subject to the provision that the beneficiary cost-share is collected by the provider, whenever appropriate. The provider's failure to collect the cost-share can be considered a false claim and/or may result in reduction of payment.

1.8.5.7.4. If you need more information:

1.8.5.7.4.1. Check your TRICARE Standard Handbook.

1.8.5.7.4.2. See the health benefits advisor or health care finder at the nearest Military Treatment Facility (MTF) or TRICARE Service Center (TSC).

1.8.5.7.4.3. Contact us at the address shown on the front of this form.

1.8.5.7.5. Please review the services shown on the front side of the Explanation of Benefits (EOB). If you find that the payment consideration has been made for any services that you did not receive or that services were charged by a healthcare professional you did not see, please call the "800" telephone number on the front side of the EOB form.

2.0. SUMMARY VOUCHER INFORMATION

The summary voucher must contain the following:

- Form Title: "TRICARE Summary Payment Voucher"
- Contractor's Name, Address, and Telephone Number.

- Date of Notice.
- Name, Complete Address including zip code, and identification number of payee.
- Name of Beneficiary
- Sponsor's Social Security number
- Internal Control Number
- Date of Service
- Procedure Code and Brief Description of Service
- Number of Services
- Amount Billed
- Amount Allowed
- Denial code or reason for the denial. If codes are used, print the corresponding messages on the back of the form.
- Deductible applied (the amount applied to the deductible).
- Summary total to include billed charges, allowed charges, and amount to deductible or cost-share.
- Total TRICARE payment made by this voucher to the payee.
- Remarks (Enter longer explanation messages in this space.)
- Other statements. (See paragraph 1.8.5.). The statements are not required on summary vouchers if a copy of the EOB is included with the voucher.
- DRG Number
- Amount paid by other health insurance

3.0. EXPLANATIONS OF DIFFERENCES BETWEEN BILLED AND ALLOWED AMOUNTS

Each disallowance or reduction must be clearly explained on EOB's and summary vouchers using codes referring to statements on the reverse or using printed messages on the face. The messages used on the EOB must be compatible with those on the summary voucher.