CHAPTER 8
SECTION 8

OTHER CLAIMS PROCESSING REQUIREMENTS

1.0. AUTOMATED ELIGIBILITY, DEDUCTIBLE, AND CLAIMS HISTORY DATA REQUIREMENTS

1.1. File Function And Content

The contractor must maintain, on the automated data system, all the necessary data elements to ensure the ability to reproduce both Health Care Service Records (HCSRs) and Explanations of Benefits (EOBs), if necessary, and to operate an effective duplicate detection system. The automated system must be able to accurately identify each beneficiary and his or her history. Unless the beneficiary is enrolled in TRICARE Prime, the system must correctly apply deductibles and reflect deductible status and deductible history for the current year and two prior years for both individuals and families. When the beneficiary is enrolled in TRICARE Prime, the system must be capable of recording the enrollment fees, copayments and/or any deductible/cost-share variations and retain the flexibility to handle the enrollment to and disenrollment from TRICARE Prime. When different members of a family are enrolled in different regions, the family is responsible for tracking enrollment year catastrophic cap accumulations for all family members and for providing evidence that the catastrophic cap has been met when a claim is filed (see the *TRICARE Reimbursement* Manual, *Chapter 2, Section 2*). Regardless of enrollment status, the system must be capable of calculating and displaying a cumulative total of the amounts (enrollment fees, deductibles, cost-shares and copayments) accumulated by the entire family toward the catastrophic loss protection threshold (catastrophic cap). On January 1st of each year, the contractor shall carry not less than 15 months of claim history and shall add data each month throughout the year for a total of not less than twenty-seven months of claim history on file on December 31st.

1.2. Special File Requirements

The automated system must also provide for records of other health insurance, or a system of flagging, which will ensure proper identification and review of double coverage claims and accurate application of other health insurance payments. In addition, flags or other records must provide screening for:

1.2.1. Authorization/preauthorization of residential treatment and Program for Persons with Disabilities.

1.2.2. Utilization Controls

1.2.3. Psychiatric/psychological services consistent with the Policy Manual.

1.3. Audit Trail And History File

The contractor shall ensure that the history file accurately reflects all transactions pertaining to care received, cost-shares, deductible, copayments, and adjustments. The contractor shall maintain the integrity of the audit trail and protect the confidentiality and integrity of the files.

2.0. HCPCS CODING - OUTPATIENT THERAPIES

Outpatient rehabilitation services that require HCPCS coding are outpatient physical therapy services, outpatient speech-language pathology services, and outpatient occupational therapy service. The following providers must use HCPCS codes to bill outpatient rehabilitation services when provided to their outpatients:

- Hospitals
- Outpatient therapy providers
- Skilled nursing facilities
- Home health agencies
- Comprehensive outpatient rehabilitation agencies

3.0. HEALTH CARE SERVICE RECORD DETAIL LINE ITEM - COMBINED CHARGES

Combining charges for the same procedures having the same billed charges under the contractor's "at-risk" operation, for health care service records, is optional with the contractor if the same action is taken with all. However, for example, if the claim itemizes services and charges for daily inpatient hospital visits from 03/25/1999 to 04/15/1999 and surgery was performed on 04/08/1999, some of the visits may be denied as included in the surgical fee (post-op follow-up). The denied charges, if combined, would have to be detailed into a separate line item from those being allowed for payment. Similarly, the identical services provided between 03/25 and 03/31, inclusive, would be separately coded from those rendered in April. The option to combine like services shall be applied to those services rendered the same calendar month. Refer to the ADP Manual, Chapter 2.

4.0. RELATIONSHIP EDITING FOR ACCURACY OF DATA INPUT

Each claim processed shall be edited for consistency of information in such a way that all payments and health care service record submittals will meet both accuracy and timeliness requirements. The ADP Manual contains information which may be used by contractors in meeting program requirements. These edits are intended for TMA use to validate the accuracy of submitted data, but are made available to contractors to assist in ensuring accuracy of health care service record submissions.

5.0. PAYMENT TO PROVIDER OR BENEFICIARY IS 99 CENTS OR LESS

5.1. Effective for all contracts awarded in FY 94 and thereafter, summary voucher payments or individual claim payment checks for $.99 or less, shall be written by the contractor, but not mailed to the beneficiary or provider, using an appropriate EOB message. The checks shall be voided and processed as outlined in Chapter 3, Section 8, paragraph 1.0.

5.2. If the provider/beneficiary demands payment of $.99 or less, advise him/her that it is TRICARE policy not to issue checks for $.99 or less.

5.3. At the end of the year when the contractor issues the provider's Form 1099, the withheld amounts shall NOT be shown on the Form 1099.

6.0. UNDELIVERABLE/RETURNED MAIL

6.1. Time Requirements For Research/Remailing

Contractors must accomplish all research for the correct address/addressee and remail within five work days of the receipt of the returned mail, if necessary.

6.2. Procedures For Handling Returned Mail

When a provider's/beneficiary's EOB, EOB and check, or letter is returned as undeliverable, the contractor shall verify the accuracy of the address on all returned mail and remail if a better address is located. Do not remail if the previous address is the best address available. The EOB or correspondence shall be maintained on-line or in hardcopy for audit purposes, and the check shall be voided.

7.0. CLAIMS SPLITTING

As a general rule under HCSRs, claims should not be split (unless otherwise indicated) but should be reported using the same ICN with a different suffix. Single claims may be split in accordance with the following rules:

HCSRs	1. A claim covering services and supplies for more than one beneficiary (other than conjoint therapy, etc.) should be split into separate claims, each covering services and supplies for a specific beneficiary. This must be split under HCSRs for different beneficiaries.
HCSRs	2. A claim for the lease/purchase of durable medical equipment that is paid by separately submitted monthly installments will be split into one claim for each monthly installment. The monthly installment will exclude any approved accumulation of past installments (to be reimbursed as one claim) due on the initial claim. Must be split under HCSRs.
HCSRs	3. A claim that contains services, supplies or equipment covering more than one contractors jurisdiction shall be split. The claim and attached documentation shall be duplicated in full, and identification shall be provided on each document as "processed" by the contractor and then mailed to the other appropriate contractor having jurisdiction. The contractor splitting the claim counts the remaining material as a single claim, and the contractor receiving the split material for its jurisdiction, counts it as a single claim, unless the split material meets one or more of the other criteria for an authorized split.
HCSRs	4. A claim that contains more than $999,999.99 may be split. This includes DRG claims with submitted charges exceeding $999,999.99.

HCSRs	5. An inpatient maternity claim which is subject to the TRICARE/CHAMPUS DRG-based payment system and which contains charges for the mother and the newborn shall be split, only when there are no nursery/room charges for the newborn. See the *TRICARE Reimbursement* Manual, *Chapter 1, Section 32*.
HCSRs	6. A claim with procedures which require an NAS as well as procedures which do not require an NAS shall be split, because there will be both institutional and non-institutional services.
HCSRs	7. A claim submitted with both inpatient and outpatient services requiring a Non-availability Statements may be split, because there would be both institutional and non-institutional services.
HCSRs	8. Hospice claims that contain both institutional and physician services shall be split for reporting purposes. Institutional services (i.e., routine home care - 651, continuous home care - 652, inpatient respite care - 655, and general inpatient care - 656) shall be reported on an institutional claim format while hospice physician services (revenue code 657 and accompanying CPT codes) shall be reported on a non-institutional format. See the *TRICARE Reimbursement* Manual, *Chapter 11, Section 4*.
HCSRs	9. A claim submitted on behalf of a non-participating provider with dates of service on and after November 1, 1993, shall be multi-suffixed to account for the balance billing limitation based upon the dates of service effective with processed to completion date on or after November 1, 1993.
HCSRs	10. A claim for ambulatory surgery services submitted by an ambulatory surgery facility (either freestanding or hospital-based) may be split into separate claims for (1) charges for services which are included in the prospective group payment rate, (2) charges for services which are not included in the prospective group payment rate and are separately allowable, and (3) physician's fees which are allowable in addition to the facility charges. (See the *TRICARE Reimbursement* Manual, *Chapter 9, Section 1*.)

8.0. PHARMACY DATA TRANSACTION SERVICES (PDTS)

The contractor (and its subcontractors, as appropriate) shall participate in the reporting and exchange of pharmacy services data in support of DoD's Pharmacy Data Transaction Services (PDTS). The PDTS is intended to serve as an integrated record of all pharmacy services received by DoD beneficiaries, regardless of the source of those services.

8.1. Technical specifications, communications protocols and business rules for the data exchange with the contractor are contained in the Interface Control Document (ICD) which can be accessed on the internet (http://www.milmed.net) via the Livelink® PDTS user name and password which has been established for each Managed Care Support contractor and claims processing subcontractor.

8.2. Edits, alerts and rejections returned to the Managed Care Support contractor by the PDTS contractor, secondary to the contractor's internal Prospective Drug Utilization Review (ProDUR) system routines, shall be treated as informational only. Managed Care Support contractors shall continue to follow their own currently established policies and procedures for pharmacy services review and adjudication.

9.0. FORMER SPOUSES WITH PRE-EXISTING CONDITIONS

The former spouse will be coded as ineligible on DEERS. A Memorandum of Authorization issued by the military service must be attached to the claim to provide the period of eligibility and identify the specific pre-existing condition for which TRICARE benefits are authorized. If the Memorandum of Authorization is attached, the contractors shall override the DEERS eligibility response and the NAS requirements and process the claim. If the Memorandum of Authorization is not attached, the claim shall be denied as eligibility expired on DEERS.

10.0. TRICARE FOR LIFE AND TRICARE SENIOR PHARMACY ELIGIBILITY EXCEPTIONS

10.1. The contractor shall process all TFL and TSRx claims and point-of-sale pharmacy requests recognizing DEERS response code of 70NE as eligible for TRICARE through July 31, 2002. Claims processed to completion on and after August 1, 2002 shall be denied when a DEERS response code of 70NE is received.

10.2. If the beneficiary who was denied prescriptions at the point of sale pharmacy because of the 70NE status then submits receipts on paper, paper claim submissions shall be permitted for network pharmacies for this exception only.

10.3. All TFL and TSRx claims denied from the implementation date of these programs based on a DEERS response of 70NE shall be reprocessed within sixty (60) calendar days of the date of this change. These claims shall be submitted to TMA as new claims.

10.4. The following message shall be used on all Explanations of Benefits for claims processed through July 31, 2002, with a DEERS response of 70NE:

> **IMPORTANT NOTICE: Your military ID Card has expired. Please call 1-800-361-2620 to determine your eligibility. You must immediately update your eligibility by calling this number or visiting a nearby military base. If you do not call, you will not be able to use your military health benefit.**

The contractor may use this message in standard TFL EOB font until such time as the message is programmed to print two (2) font sizes larger and in bold.

10.5. No later than February 1, 2003, the contractor shall verify the eligibility of each TFL/TSRx beneficiary for whom a claim was paid with a DEERS response code of 70NE. If at the time of verification the beneficiary's eligibility for TFL and/or TSRx is not confirmed by DEERS, the contractor shall initiate recoupment actions following the procedures specified in Chapter 11, Section 4. Recoupment actions will consolidate all TFL and/or TSRx claims paid for an individual beneficiary into a single recoupment action.