CLAIMS PROCESSING FOR DUAL ELIGIBLES

1.0. GENERAL

Claims under the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFFIC) will be adjudicated under the rules set forth below. In general, TRICARE is last payer after Medicare and any other coverage.

2.0. DETERMINING PAYMENTS DUE AFTER COORDINATION WITH MEDICARE

Special double coverage procedures are to be used for all claims for beneficiaries who are eligible for Medicare, including active duty dependents who are age 65 and over as well as those beneficiaries under age 65 who are eligible for Medicare for any reason. For specific instructions, refer to the TRICARE Reimbursement Manual, Chapter 4, Section 4.

3.0. OTHER HEALTH INSURANCE (OHI) AND TIMELY CLAIMS FILING

3.0.1. The contractor may grant exceptions to the claims filing deadline requirements, if the beneficiary submitted a claim to a primary health insurance, i.e., double coverage, and the OHI delayed adjudication past the TRICARE deadline.

3.0.2. These claims must have been originally sent to the OHI prior to the TRICARE filing deadline or must have been filed with a TRICARE contractor prior to the deadline but returned or denied pending processing by the OHI.

3.0.3. The beneficiary must submit with the claim a statement indicating the original date of submission to the OHI, and date of adjudication, together with any relevant correspondence and an Explanation of Benefits or similar statement.

3.0.4. The claim form must be submitted to the contractor within 90 days from the date of the OHI adjudication.

4.0. CLAIMS DEVELOPMENT REQUIREMENTS

4.1. Medicare Providers

4.1.1. The contractor shall accept the Medicare certification of providers who have a like class of providers under TRICARE without further authorization. Providers without a like class (i.e. chiropractors) under TRICARE shall be denied.

4.1.2. TRICARE claims which TRICARE processes after Medicare, do not need to be developed to the individual provider level for home health or group practice claims.

4.2. Civilian Services Rendered To MTF Inpatients

Civilian claims for TRICARE dual eligible beneficiaries shall be processed by Medicare first without consideration of the Supplemental Health Care Program.

4.3. Inpatient Mental Health Preauthorizations

Inpatient mental health requires preauthorization, and, if necessary, reviewing of waivers of the day limits (care in excess of 30 days) for beneficiaries eligible for Medicare Part A and enrolled in Medicare Part B. As second payer, TRICARE will rely on and not replicate Medicare's determination of medical necessity and appropriateness in all other circumstances where Medicare is primary. In the event that inpatient mental health services were not preauthorized, the contractor shall obtain the necessary information and complete a retrospective review. Non-Availability Statement requirements also apply to inpatient mental health admissions.

5.0. UTILIZATION MANAGEMENT

Any utilization management provisions applied under the TRICARE Managed Care Support Services contracts, except for those specifically required by the Policy Manual, Reimbursement Manual or Operations Manual, shall not apply under the TDEFIC contract. Region-specific requirements shall not apply.

6.0. END OF PROCESSING

6.1. Beneficiary Cost Shares

Beneficiary costs shares shall be based on the network status of the provider. Where TRICARE is primary payer, cost shares for services received from network providers shall be TRICARE Extra cost shares. Services received from non-network providers shall be TRICARE Standard cost shares.

6.2. Application Of Catastrophic Cap

Only the actual beneficiary out-of-pocket liability remaining after TRICARE payments will be counted for purposes of the annual catastrophic loss protection.

6.3. Appeals And Grievances

6.3.1. TRICARE For Life Initial Determinations

Services and supplies denied payment by Medicare will not be considered for coverage by TRICARE if the Medicare denial of payment is appealable under the Medicare appeal process. If, however, a Medicare appeal results in some payment by Medicare, the services and supplies covered by Medicare will be considered for coverage by TRICARE. Services and supplies denied payment by Medicare will be considered for coverage by TRICARE, if the Medicare denial of payment is not appealable under the Medicare appeal process. The appeal procedures set forth in Chapter 13 are applicable to initial denial determinations by TRICARE under the TDEFIC contract.

6.3.2. Grievance System

The contractor shall develop and implement a grievance system, separate and apart from the appeal process. The grievance system shall allow full opportunity for aggrieved parties to seek and obtain an explanation for and/or correction of any perceived failure of contractor or subcontractor personnel to furnish the level or quality of service to which the beneficiary may believe he/she is entitled. Any TRICARE beneficiary, sponsor, parent, guardian, or other representative who is aggrieved by any failure or perceived failure of the contractor or subcontractor to meet the obligations for timely, quality service may file a grievance. All grievances must be submitted in writing. If the written complaint reveals a TRICARE appealable issue, the correspondence shall be forwarded to the contractor's appeals unit for a reconsideration review. If the complaint reveals a Medicare appealable issuer or regards care for which Medicare was the Primary payer and the issue does not involve any actions by a TRICARE contractor, the complaint shall be forwarded to Medicare for resolution. The beneficiary shall be notified that the complaint was forwarded to Medicare and the address and phone number of where the complaint was forwarded.

7.0. TED SUBMISSION

For every claim processed to completion, the TDEFIC contractor shall submit a TRICARE Encounter Data (TED) record to TMA in accordance with the requirements of the TRICARE Systems Manual 7950.1-M.