# Chapter 8 Section 1

# General

## 1.0 PURPOSE

The purpose of the TRICARE claims processing procedures is to help ensure that all claims for care received by TRICARE beneficiaries are processed in a timely and consistent manner and that Government-furnished funds are expended only for those services or supplies authorized by law and Regulation. The contractor shall review all claims submitted and accept Health Insurance Portability and Accountability Act (HIPAA) transaction and code sets. The review must ensure that sufficient information is submitted to determine:

- The patient is eligible.
- The provider of services or supplies is authorized under the TRICARE Program.
- The service or supply provided is a benefit.
- The service or supply provided is medically necessary and appropriate or is an approved TRICARE preventive care service.
- The beneficiary is legally obligated to pay for the service or supply (except in the case of free services).
- That the claim contains sufficient information to determine the allowable amount for each service or supply.

In this context, "beneficiary" includes authorized agents, see Chapter 19.

## 2.0 WHO MAY FILE A CLAIM

### 2.1 Beneficiary/Provider

Any TRICARE eligible beneficiary or any individual who meets the requirements for eligibility under TRICARE, as determined by one of the Uniformed Services, may file a claim. Any institutional or individual professional provider certified under TRICARE may file a claim on a participating basis for services or supplies provided to a beneficiary and receive payment directly from TRICARE. The contractor shall deny any charge imposed by the provider relating to completing and submitting the applicable claim form (or any other related information). Such charges shall not be billed separately to the beneficiary by the provider nor shall the beneficiary pay the provider for such charges. These charges are to be reported as noncovered charges and denied as such.

### 2.2 State Agency

A state agency who administers the Medicaid Program may submit a claim, if there has been an agreement signed between the agency and Defense Health Agency (DHA). (Refer to the TRICARE Reimbursement Manual (TRM), Chapter 1, Section 20.)

### 2.3 Participating Provider - Agency Agreement With A Third Party

**2.3.1** Occasionally, a participating provider may enter into an agency agreement with a third party to act on its behalf in the submission and the monitoring of third party claims, including TRICARE claims. Such arrangements are permissible as long as the third party is not acting simply as a collection agency. There must be an agency relationship established in which the agent is reimbursed for the submission and monitoring of claims, but the claim remains that of the provider and the proceeds of any third party payments, including TRICARE payments, are paid to the provider. The contractor can deal with these agents in much the same manner as it deals with the provider's accounts receivable department. However, such an entity is not the provider of care and cannot act on behalf of the provider in the filing of an appeal unless specifically designated as the appealing party's representative in the individual case under appeal. Questions relating to the qualifications of any such business entity should be referred to the DHA Office of General Counsel (OGC), through the Contracting Officer (CO), for resolution.

**2.3.2** On a monthly basis, DHA's Office of Program Integrity (PI) provides each contractor with an updated data file of excluded third party billing agents. Based on this file, the contractor shall not accept any claims from excluded third party billing agents. Any claim received from an excluded third party billing agent shall be returned to the provider, instructing the provider that the submission of a valid claim cannot be done through a sanctioned entity, and to resubmit the claim directly, or through an approved third party billing agent. The contractor shall inform the provider that the third party billing agent has been excluded by Health and Human Services (HHS)/Centers for Medicare and Medicaid Services (CMS) and that no claims will be accepted from the third party billing agent until it has been reinstated. The contractor shall also provide notification to the third party billing agent that no claims will be accepted from it until it has been reinstated by HHS/CMS.

## 3.0 TRICARE CLAIM FORMS

### 3.1 Acceptable Claim Forms

**3.1.1** A properly completed acceptable claim form must be submitted to the contractor before payment may be considered. For paper claims, the contractor shall accept the latest mandated version of the following claim forms for TRICARE benefits: the DoD Document (DD) Form 2642, the CMS 1500 Claim Form, and the CMS 1450 UB-04. The American Dental Association (ADA) claim forms may be used in the processing and payment of adjunctive dental claims. Electronic claims shall be accepted in HIPAA-compliant standardized electronic transactions (see Chapter 19).

**3.1.2** DD Form 2642, "Patient's Request For Medical Payment" (Addendum A, Figure 8.A-1). This form is for beneficiary use only and is for submitting a claim requesting payment for services or supplies provided by civilian sources of medical care. See Appendix B for a definition of "medical." Those include physicians, medical suppliers, medical equipment suppliers, ambulance companies, laboratories, Extended Care Health Option (ECHO) providers, or other authorized providers. If a DD

Form 2642 is identified as being submitted by a provider for payment of services, the form shall be returned to the provider with an explanation that the DD Form 2642 is for beneficiary use only and that the services must be resubmitted using either the CMS 1500 Claim Form or the CMS 1450 UB-04, whichever is appropriate. The form may be used for services provided in a foreign country but only when submitted by the beneficiary. Contact the DHA Administrative Office to order the DD Form 2642.

## 4.0 CLAIMS RECEIPT AND CONTROL

All claims shall be controlled and retrievable. The face of each hardcopy TRICARE claim shall be stamped with an individual Internal Control Number (ICN), which will be entered into the automated system within five workdays of actual receipt. For both hardcopy and Electronic Media Claim (EMC), the ICN shall contain the Julian date indicating the actual date of receipt. The Julian date of receipt shall remain the same even if additional ICNs are required to process the claim. If a claim is returned, the date of the receipt of the resubmission shall be entered as the new date of receipt. All claims not processed to completion and supporting documentation shall be retrievable by beneficiary name, sponsor's Social Security Number (SSN), Defense Enrollment Eligibility Reporting System (DEERS) family ID, or ICN within 15 calendar days following receipt.

## 5.0 NEWBORN CLAIMS - BEFORE JANUARY 1, 2018

**5.1** Claims for newborns can be processed without eligibility on DEERS as long as:

- The newborn date of birth is within 365 days of the contractor's eligibility query; and
- The sponsor is/was eligible for TRICARE for the dates of care on the newborn claim.

**5.2** A newborn or adoptee will be deemed to be enrolled in Prime as of the day of birth or adoption if one family member is already enrolled in Prime. A responsible representative has 60 days to officially enroll the child to the Prime option. If the newborn or adoptee is formally enrolled in Prime within the 60 day period, the effective date of enrollment will be the first of the month following the date of birth or adoption. (The 20th of the month enrollment rule is waived, if necessary.) If the newborn or adoptee is not formally enrolled during the 60 day calendar period, the newborn or adoptee will revert to a non-enrolled beneficiary effective the 61st day. If the decision is made to continue Prime coverage, an official enrollment request (enrollment form, Beneficiary Web Enrollment (BWE) transaction, or telephonic request) must be completed on behalf of the child. For retirees or their family members or survivors who decide to continue enrollment for the child, the unused portion (prorated on a monthly basis) of the single enrollment fee they paid will be applied toward a new family enrollment period. For newborns and newly adopted children enrolled under this provision, Point of Service (POS) cost-sharing does not apply through the 60th day or the effective date of enrollment, whichever is earlier. All services shall be processed with the Prime copayment even in the absence of referrals or authorizations. The TRICARE Regional Director (RD) may extend the deemed period up to 120 days, on a case-by-case or regional basis.

- Newborns/adoptees in overseas locations are deemed to be enrolled for 120 days following birth/adoption w.hen one other family member, to include the sponsor, is enrolled in TRICARE Overseas Program (TOP) Prime or TOP Prime Remote

- For additional information on newborns under the TRICARE Retired Reserve (TRR) and TRICARE Reserve Select (TRS) programs, see Chapter 22, Sections 2 and 1 respectively.

## 6.0 NEWBORN CLAIMS - ON OR AFTER JANUARY 1, 2018

See the TRICARE Policy Manual (TPM), Chapter 10, Section 3.1.

## 7.0 CLAIMS PROCESSING EXEMPTION DURING CALENDAR YEAR (CY) 2018 ENROLLMENT PERIOD - EFFECTIVE JANUARY 1, 2018

### 7.1 Policy

During the CY 2018 enrollment grace period, an individual who is eligible to enroll in TRICARE Prime or TRICARE Select but does not elect to enroll in such programs will only be eligible for space-available care at military treatment facilities. If claims are received for these individuals that would otherwise be cost shared under the TRICARE program, the claims will be cost shared by TRICARE for that initial Episode Of Care (EOC) only. This exemption to established TRICARE claims processing rules expires on December 31, 2018.

### 7.2 Managed Care Support Contractors (MCSCs), Overseas Contractor, and TRICARE Dual Eligible Fiscal Intermediary Contractor (TDEFIC)

**7.2.1** Use the DEERS eligibility response to determine which purchased care claim(s) apply to beneficiaries who are eligible for but have not enrolled in TRICARE Prime or TRICARE Select.

**7.2.2** Valid Health Care Delivery Program (HCDP) Plan Coverage Code of beneficiary for Direct Care (DC) of 002, 004, 006, 008, 014, 016, or 030, and one of the following:

**7.2.2.1** If OGP type code A or B are both be present; route to the TDEFIC or overseas contractor (as applicable) for processing.

**7.2.2.2** If the OGP type code does not indicate any form of Medicare coverage and the Member Relationship Code is one of the following, process the claim as TRICARE Select:

- **A** = Self,
- **B** = Spouse,
- **C** = Child/Step Child,
- **E** = Ward,
- **G** = Surviving Spouse,
- **H/I/J/K** = Former Spouse, or
- **O** = Newborn.

**7.2.2.3** Otherwise, deny the claim and respond with an explanation of benefits.

**7.2.3** Use best business practice to determine the claims that are applicable to the EOC.

**7.2.4** Process those claims at the TRICARE Select network or out-of-network rate, as applicable.

**7.2.5** Notify the individual in writing within 10 business days with an explanation of benefits or similar correspondence, and include the following:

**7.2.5.1** Only claims related to this initial episode of purchased care services (as defined by the contractor, including a date range) will be cost-shared by TRICARE. The date range must be specified in the written notification;

**7.2.5.2** Future claims not related to the determined EOC will be denied;

**7.2.5.3** If TRICARE Prime or TRICARE Select coverage is desired, he/she may enroll in such coverage at any time during CY 2018, and provide instructions on how to enroll; and

**7.2.5.4** After December 31, 2018, he/she may only enroll in TRICARE Prime or TRICARE Select during an annual open enrollment period or if a member of the family experiences a Qualifying Life Event (QLE).

**7.3** Pharmacy contractor will:

**7.3.1** Upon receipt of a TRICARE pharmacy claim for retroactive reimbursement that includes a copy of the written notification from a contractor as listed above as required by paragraph 7.2.5, process the claim at the network or out-of-network rate, as applicable, for the time frames as listed in the written notification.

Refills are limited to the time-frame specified in the notification letter.

**7.3.2** Notify the individual in writing within 10 business days with an Explanation of Benefits (EOB) or similar correspondence and include the following:

**7.3.2.1** Only pharmacy claims related to this initial episode of purchased care services will be cost-shared by TRICARE.

**7.3.2.2** Future claims or refills not related to the determined EOC will be denied until the individual is enrolled in TRICARE coverage.

- END -