Chapter 20 Section 3

Claims Processing For Dual Eligibles

1.0 GENERAL

Claims under the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) will be adjudicated under the rules set forth below. In general, TRICARE pays secondary to Medicare and any other coverage.

2.0 DETERMINING PAYMENTS DUE AFTER COORDINATION WITH MEDICARE

2.1 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 (TRM), Chapter 4, Section 4.

2.2 Claims Auditing Software

The contractor is not required to have the claims auditing software described in the TRM, Chapter 1, Section 3.

3.0 EXCEPTIONS TO TIMELY CLAIMS FILING

3.1 Medicare

The contractor may grant exceptions to the claims filing deadline if Medicare accepted the claim as timely. If submitted by the beneficiary, the claim must be submitted within 90 calendar days from the date of Medicare's adjudication to be considered for a waiver.

3.2 Other Health Insurance (OHI)

Reference Chapter 8, Section 3, paragraph 2.4.

4.0 CLAIMS DEVELOPMENT REQUIREMENTS

4.1 Medicare Providers

4.1.1 The contractor shall accept the Medicare certification of individual professional providers who have a like class of individual professional providers under TRICARE without further authorization. An exception to this general rule occurs if there is information indicating Medicare, TRICARE or other federal health care program integrity violations by the physician or other health care practitioner. In such cases the contractor shall seek guidance from Defense Health Agency (DHA) Program Integrity (PI) prior to accepting the Medicare certification as valid for TRICARE

purposes. Individual professional providers without a like class (e.g., 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.

4.1.3 Electronic "cross over" claims received from Medicare after Medicare completes its claims processing do not need a beneficiary or provider signature. For paper claims, when TRICARE is second pay to Medicare and a Medicare EOB is attached, the contractor does not need to develop for provider or beneficiary signature. Signature on file requirements of Chapter 8, Section 4 apply.

4.2 Civilian Services Rendered To Military Treatment Facility (MTF) Inpatients

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

4.3 Preauthorization Requirements

Special authorization/preauthorization services outlined in Chapter 7, Section 2 and in the TRICARE Policy Manual (TPM), Chapter 1, Section 7.1 require preauthorization, and if necessary, review of waivers of the day limits for dual eligible beneficiaries when TRICARE is the primary payer. As secondary payer, TRICARE will rely on and not replicate Medicare's determination of medical necessity and appropriateness in all circumstances where Medicare is primary payer (see the TRM, Chapter 4, Section 4). In the event that TRICARE is primary payer for these services and preauthorization was not obtained, the contractor shall obtain the necessary information and perform a retrospective review. Skilled Nursing Facility (SNF) preauthorizations shall be tracked separately from the required preauthorizations noted in Chapter 7, Section 2 and TPM, Chapter 1, Section 7.1.

4.4 Provider Locator Assistance/Referral Requirements

4.4.1 Dual eligible beneficiaries can contact a regional Managed Care Support Contractor (MCSC) for assistance in locating a network provider. The MCSC shall provide the TDEFIC beneficiary with the name, telephone number, and address of network providers of the appropriate clinical specialty located within the beneficiary's geographic area. The MCSC is not required to make appointments with network providers.

4.4.2 The TDEFIC contractor is not responsible for obtaining or verifying that a Prime-enrolled dual eligible beneficiary has a referral for care not provided by their Primary Care Manager (PCM). Dual eligible beneficiaries who are enrolled in Prime are not subject to Point of Service (POS) cost-sharing.

4.5 Resource Sharing Or Clinical Support

The contractor shall not process a claim from any civilian provider practicing in an MTF under the Resource Sharing or Clinical Support Agreement (CSA) programs.

5.0 UTILIZATION MANAGEMENT (UM)

Any UM provisions applied under the TRICARE Managed Care Support Contracts (MCSCs), except for those specifically required by the TPM, TRM, or TRICARE Operations Manual (TOM), shall not apply under TDEFIC. Region-specific requirements shall not apply.

6.0 END OF PROCESSING

6.1 Beneficiary Cost-Shares

End Of Processing. Beneficiary cost-shares shall be based on the following when TRICARE is the primary payer. If the services were received by a TRICARE Prime enrollee (as indicated in DEERS), the contractor shall calculate the Prime copayments applicable on the date services were received. For a beneficiary who is not a Prime enrollee, if a provider is known to be a network provider (e.g., Veteran Health Administration (VHA) medical facilities) the Extra cost-shares shall be applied to services received prior to January 1, 2018; if the provider is not a known network provider, the TRICARE Standard cost-share shall be applied. For a beneficiary who is a TRICARE Select enrollee, services received from a known network provider on or after January 1, 2018, will have the TRICARE Select network copayments applied; if the provider is not a known network provider, the TRICARE Select out-of-network cost-share shall be applied. For a TRICARE For Life (TFL) beneficiary who is not a Prime enrollee, services received on or after January 1, 2018, shall have the TRICARE Standard/Extra cost-shares (see the TRM, Chapter 2) applied as if TRICARE Standard/Extra were still being implemented.

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

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 12 are applicable to initial denial determinations by TRICARE under TDEFIC. Appeals of SNF preauthorizations follow concurrent review procedures.

7.0 TED SUBMISSION

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

8.0 TRICARE PROCESSING STANDARDS

All TRICARE Processing Standards in Chapter 1, Section 3 apply except for Chapter 1, Section 3, paragraphs 1.2, 1.3, 1.4, and 4.1.

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