

DOUBLE COVERAGE REVIEW AND PROCESSING OF CLAIMS

ISSUE DATE:

AUTHORITY:

I. DEVELOPMENT

A. All Claims Require Double Coverage Review

All claims, regardless of dollar amount, require review for possible double coverage with the following exceptions: (a) claims for the services of internal resource sharing providers (OPM, [Chapter 16, Section 3, paragraph 5.2.](#)); (b) claims for resource support providers (OPM, [Chapter 16, Section 4, paragraph 2.2.](#)); (c) claims for services provided to active duty service members; and (d) claims for all Supplemental Health Care Program inpatients (OPM, [Chapter 21, Section 3, paragraph 1.3.2.](#)). The contractor must maintain double coverage documentation in its files. Double coverage information must be obtained through any means that will provide a documented record or the claim may be returned with a request for the needed information.

B. The MCS contractors shall provide a weekly listing of all beneficiaries, CONUS and OCONUS, covered by Other Health Insurance (OHI) on CD-ROM to the Pharmacy Data Transaction Service (PDTS) Customer Service Support Center. The contractor shall provide the listings weekly, reflecting OHI status for the previous month. The listings shall identify the sponsor by name and SSAN, other health insurance company name, covered beneficiary by sponsor SSAN (or DEERS Patient Identifier once deployed), patient name, birth date if known, and DEERS Dependent Suffix (or relationship and person code), whether the OHI includes a pharmacy benefit, and the OHI coverage dates (start to end). If the data is available, the contractor shall also include the group, plan and service codes, as well as the OHI co-pay amount. The first report shall be submitted by December 15, 2002 covering the month of November 2002. Updated reports shall be submitted weekly thereafter through the life of the contract, or until directed to stop by the Contracting Officer. Reports shall be submitted in a **flat file** and shall be sent to: WebMD, ATTN: PDTS Support, 2045 Midway Drive, Twinsburg, OH 44087.

II. PROCESSING OF CLAIMS

With the exceptions noted in [paragraph I.A.](#), above, the contractor shall have proof of any double coverage payments prior to adjudication of the claim.

A. No Evidence Of Double Coverage

If there is no information to suggest the claim could be covered by another health insurance plan or there is no information on the claim to suggest that the charges have been submitted to or paid by other insurance, the claim shall be processed.

B. Double Coverage Is Known

1. Whether it is a network or non-network claim, payment must be obtained from the primary insurance coverages or plans. The contractor shall include procedures to ensure this requirement is met in all agreements with its network providers of care. If the provider of care is owned or operated by the contractor or is in a clinic or other facility operated by the contractor as an employee or subcontractor, the other health insurance (OHI) shall also be collected by the contractor or its designee. If the claim indicates no OHI coverage, but the contractor's file indicates otherwise, a signed statement by the beneficiary or sponsor furnishing the termination date of the other coverage will be necessary for the contractor to inactivate the positive OHI record. The contractor must obtain acceptable evidence of processing by the double coverage plan prior to processing the claim.

2. The contractor shall take appropriate action to ensure that a sample of all Electronic Media Claims (EMC) is audited on a no less than annual basis with verification obtained from the provider to corroborate the submission of a zero OHI payment amount. In addition, no less than annually, the contractor shall audit past EMC submissions to identify all providers who may show a pattern of submissions with OHI payment amounts of zero or of a nominal amount (e.g., \$.01, \$1.00, \$5.00, etc.). All EMC providers who demonstrate a possible pattern of "plugging" nominal OHI payment amounts shall be referred to the contractor's Program Integrity staff for further investigation.

3. Except for EMC claims, when Medicare is the primary payer, an Explanation of Medicare Benefits (EOMB) is required. This will enable the contractor to determine whether the provider accepted assignment under Medicare; if the provider accepts assignment, the provider cannot bill for any difference between the billed charge and the Medicare allowed amount. In addition, it will identify cost-share and deductible amounts as well as any allowable charge reductions.

4. For double coverage situations which do not involve the routine issuance of an EOB, such as Preferred Provider Organization (PPO) prescription claims, the following may be accepted in lieu of an EOB:

- a. Documentation that the beneficiary belongs to the PPO;
- b. Documentation that there is a liability beyond the amounts paid to the PPO by the primary payor;
- c. Documentation that the liability is specified in the PPO contract; and
- d. Documentation of total liability on the prescription claim.

5. If a contractor becomes aware of the possible existence of OHI through means other than the adjudication of a pending claim (e.g., a provider returns all or a part of

TRICARE payment because of payment by OHI), the contractor shall establish an OHI record for the patient and request completion of a double coverage questionnaire. Depending upon the circumstances of the individual occurrence, reopening and adjustment of prior claims and/or a Program Integrity referral may also be appropriate. All affected claims must be adjusted appropriately, although adjustment action may be temporarily deferred at the request of Program Integrity staff if such adjustment would compromise their investigation.

C. DRG-Based System

This also applies to claims from higher volume mental health hospitals and units subject to the TRICARE Inpatient Mental Health Per Diem Payment System that are authorized to bill for institution-based professional services. The contractor must be able to identify OHI payments for all separately-billable components of the inpatient services on a claim. If the OHI EOB does not adequately identify the payments for each separately-billable component, or if claims for their charges are not received, the entire OHI payment is to be applied to the inpatient operating costs.

D. Medicare Claims

Claims processed on or after October 1, 2001 on which Medicare is primary payer require review for possible double coverage. Contractors are required to build other health insurance files on these beneficiaries that identify coverages (primarily Medicare supplements) that may be primary to TRICARE. Contractors may use any reasonably reliable indicator to identify other coverages including crossover claims received from Medicare carriers and fiscal intermediaries, crossover files received from Medicare carriers and fiscal intermediaries, paper claims, information resulting from refunds, information from providers, the Beneficiary Information Update Form (used in TRICARE For Life start-up), etc. During the TRICARE For Life start-up period when the Beneficiary Information Update Form is used to collect OHI information, contractors will act on the beneficiaries' expressed intent regarding their termination of OHI; i.e., on October 1, 2001, a date after October 1, 2001, or not at all. If a beneficiary notes they intend to terminate their OHI on or after October 1, 2001, the contractor shall ensure claims processed after this expressed termination date process with TRICARE as secondary payer. Claims for beneficiaries who have Medicare supplemental coverage are to be adjudicated and an informational EOB/stuffer and provider voucher issued, but the claim is to be denied and no payment is to be made. An informational EOB/stuffer is a temporary measure designed to educate beneficiaries on how much TRICARE would have paid had they not had OHI and also provide a means for the beneficiary to inform the contractor that they have terminated their OHI. Contractors are required to issue informational EOBs/stuffer from October 1, 2001 until September 30, 2002. Also, contractors must ensure that providers are aware that if they receive any TRICARE payments that duplicate payments made by another coverage, they must return the TRICARE payment. Since TRICARE remains secondary payer to all other coverages, contractors must recover all payments that they subsequently identify as duplicating a payment made by any coverage, including Medicare supplements, that is primary to TRICARE.

E. Skilled Nursing Facility (SNF) Prospective Payment System (PPS)

Payment under the SNF PPS is dependent upon the PPS-specific information submitted by the provider with the TRICARE Claim (see [Chapter 8, Section 2](#)). However, if

the beneficiary has other health insurance (OHI) which has processed the claim as primary payer, it is likely that the information necessary to determine the TRICARE PPS payment amount will not be available. Therefore, special procedures have been established for processing SNF claims involving OHI. These claims will not be processed as PPS claims. Such claims will be allowed as billed unless there is a provider discount agreement. TRICARE payment will be the difference between the billed charge and the OHI payment. The only exception to this is cases when there is evidence on the face of the claim that the beneficiary's liability is limited to less than the billed charge (e.g., the OHI has a discount agreement with the provider under which the provider agrees to accept a percentage of the billed charge as payment in full). In such cases, the TRICARE payment is to be the difference between the limited amount established by the OHI and the OHI payment.

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