

DOUBLE COVERAGE REVIEW AND PROCESSING OF CLAIMS

1.0. DEVELOPMENT

1.1. 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 (*Chapter 16, Section 3, paragraph 5.2.*); (b) claims for resource support providers (*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 (*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.

2.0. PROCESSING OF CLAIMS

With the exceptions noted in [paragraph 1.1.](#) above, the contractor shall have proof of any double coverage payments prior to adjudication of the claim.

2.1. 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.

2.2. Double Coverage Is Known

2.2.1. 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.

2.2.2. 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.

2.2.3. 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.

2.2.4. 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:

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

2.2.5. 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.

2.3. 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.