

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 *individual professional* providers who have a like class of *individual professional* providers under TRICARE without further authorization *unless there is information indicating Medicare, TRICARE or other federal health care program integrity violations by the physician or other health care practitioner. Individual professions* 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.

4.2. 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 (*SHCP*).

4.3. *Preauthorization Requirements*

Services outlined 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 TRICARE Reimbursement Manual (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.

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.

8.0. CONTINUED TRICARE COVERAGE FOR DUAL ELIGIBLE BENEFICIARIES UNDER AGE 65

8.1. The FY05 National Defense Authorization Act has extended TRICARE coverage to those individuals who, because of disability or end stage renal disease, are eligible for Medicare Part A but did not obtain Part B. The new legislation provides the authority to waive collection of prior payments and to continue TRICARE coverage of benefits for these individuals for a period of July 1, 1999 and ending on December 31, 2004. In a future Centers for Medicare and Medicaid Services (CMS) Special Enrollment Period, these individuals without Part B will automatically be enrolled in Part B unless they specifically opt out. If an individual does disenroll from Medicare Part B, he or she will lose all TRICARE coverage effective with the date of disenrollment. However, individuals will be given an opportunity to change the effective date of Medicare Part B enrollment to any month in 2004. Effective January 1, 2005, any TRICARE beneficiary under the age of 65, except for dependents of active duty members, who are or become eligible for Medicare and do not purchase Part B, will lose TRICARE coverage.

8.2. On a date to be announced, DMDC will load the most current Medicare status for all beneficiaries under age 65. The DEERS query response for Other Government Programs (OGP) will list the Medicare entitlement and reflect either Part A or both Part A and Part B effective dates. DMDC has temporarily modified the "benefits rules" within DEERS during this waiver period to show these beneficiaries with Part A or gaps in effective dates between Part A and Part B as TRICARE eligible. Treat these individuals as fully TRICARE dual

eligible even if there is a gap in effective dates between Part A and Part B and accept the Health Care Delivery Plan returned from DEERS.

8.3. The following direction applies:

8.3.1. Pay the allowable amount on all claims and reprocess any claims denied for lack of Medicare Part B since April 1, 2004 until December 31, 2004. Pay if otherwise allowable. TRICARE will be secondary to Medicare Part A coverage unless the beneficiary has exhausted his/her Medicare benefits. Pay as primary for all non-institutional claims for any coverage period without Part B until December 31, 2004 unless the individual has private other health insurance. Timely filing requirements apply.

8.3.2. Contractors are not required to search their claim systems and reprocess any claims processed and paid prior to April 1, 2004. An exception will be made on a case-by-case basis if authorized by the Beneficiary and Provider Services Office, TMA-Aurora.

8.3.3. The DoD determines health care eligibility/benefits and DEERS is the eligibility system of record for DoD. The eligibility/benefit response returned by DEERS will be accepted, used by the contractors to process each claim, and not be modified by proprietary system edits. Discrepancies will continue to be reported to DMDC.

8.3.4. Contractors will be notified when Medicare automatically enrolls these individuals in Part B, and DEERS receives and loads these enrollments. At that point, TRICARE will revert to paying secondary to Medicare. If an individual disenrolls from Medicare Part B, coverage will continue until December 31, 2004 at which time no further TRICARE coverage is authorized. For any claim with dates of service after December 31, 2004 and DEERS indicates the individual, except for dependents of active duty members, has or continues to only have Medicare Part A, contractors shall deny the claim.