CHAPTER 4
SECTION 3

COORDINATION OF BENEFITS

ISSUE DATE:
AUTHORITY: 32 CFR 199.8

I. DISPUTES OVER PRIMARY PAYOR STATUS

The contractor shall attempt to resolve any disputes over primary payor status with the double coverage plan. The contractor should call the double coverage plan and explain that under Federal Law, Title 10, U.S.C., Chapter 55, Section 1079, TRICARE is always second pay, except to Medicaid. In no case should the contractor compromise that position without direction from the TRICARE Management Activity (TMA).

II. COMPUTATION OF TRICARE PAYMENT

In double coverage situations, the TRICARE contractor will pay the lower of:

A. The amount TRICARE would have paid as primary payor; or

B. The amount remaining after the double coverage plan has paid its benefits.

NOTE: Generally, the provider's billed charge will be used in determining the amount remaining after the double coverage plan has paid (Step 2 of the Three Step Computation or Steps 3 and 4 of the DRG/Inpatient Mental Health Per Diem claims computation). There are two exceptions. By law, when a professional provider does not participate, the provider can be paid, from all sources, no more than 115% of the TRICARE allowable charge. Therefore, for nonparticipating professional providers, the lower of the billed charge or 115% of the TRICARE allowable charge is to be used. Similarly, the law forbids TRICARE payment when the beneficiary or sponsor has no legal obligation to pay (see Chapter 4, Section 1, paragraph I.H.) Therefore, when the beneficiary's liability is limited under the other health insurance (OHI) (e.g., due to an OHI negotiated rate) and the OHI allowed amount plus charges for any services denied by the OHI for which the beneficiary is responsible is lower than the billed charge or 115% of the TRICARE allowable charge (not to exceed the billed charge), the OHI allowed amount plus charges for any services denied by the OHI for which the beneficiary is responsible shall be used. This limitation of legal liability must be clearly evident on the EOB from the OHI. If it is not clearly evident, the claim is to be processed as if no such agreement exists. The provider's billed charge, the amount allowed by OHI, and the OHI payment together with other necessary data shall be entered on the payment record as required by the TRICARE Systems Manual, Chapter 2.

III. THREE STEP COMPUTATION

For all claims except those subject to the TRICARE DRG-based payment system or the TRICARE Inpatient Mental Health Per Diem Payment System, the last-pay share of charges is computed as follows:

STEP 1: Determine the amount that TRICARE would have paid in the absence of double coverage. In determining this amount, take into account non-covered services, and services provided outside the period(s) of eligibility, discounts, reasonable charge reductions, payment reduction (due to the provider's noncompliance with the utilization review requirements), deductible and cost-share.

STEP 2: From the billed charge (or, if applicable, 115% of the allowable charge but not to exceed the billed charge or the OHI allowed amount if the beneficiary's liability is limited under the OHI deduct:

- Any charges that duplicate previous or current charges and all other disallowed charges.
- Charges for services/supplies for which evidence of processing by the double coverage plan is not provided.
- The actual amount(s) paid by all double coverage plans. For inpatient mental health claims only, this should be limited to the amount(s) paid for only those days covered by TRICARE.

NOTE: The contractor is not required to analyze the OHI's specific coverage provisions for the claimed services. Nevertheless, where it is possible, based on information available from the face of the claim, the contractor should ensure that the OHI payment applies only to those services included on the TRICARE claim (whether covered by TRICARE or not). For example, some services may be included in the OHI payment but do not pertain to the current TRICARE claim. These services must be deducted from the total OHI paid amount before subtracting the OHI payment from the currently billed charges as required in this step. Conversely some of the services on the TRICARE claim may not have been processed by the OHI. In this case, the contractor is to deduct the charges for those services from the amount billed TRICARE before subtracting the OHI payment from the billed amount as required in this step.

STEP 3: Compare the amounts in Steps 1 and 2 and pay the lower.

IV. SECONDARY PAYMENT CALCULATION FOR CLAIMS SUBJECT TO THE TRICARE DRG-BASED PAYMENT SYSTEM OR THE TRICARE INPATIENT MENTAL HEALTH PER DIEM PAYMENT SYSTEM

When this computation is used for claims subject to the TRICARE Inpatient Mental Health Per Diem Payment System, the per diem amount is to be used in lieu of the DRG-based amount.

STEP 1: Determine the DRG-based amount TRICARE would allow minus any TRICARE discounts, payment reduction (due to the provider's non-compliance with the utilization review requirements), and the beneficiary cost-sharing amounts.

STEP 2: Determine the DRG-based amount TRICARE would allow minus any TRICARE discounts and the actual amount paid by the OHI.

STEP 3: From the hospital's charges or the OHI allowed amount if lower and if the beneficiary's liability is limited under the OHI (or when lower, the amount the hospital is obligated to accept as payment in full) subtract the actual amount paid by the OHI.

STEP 4: From the provider's charges or the OHI allowed amount if lower and if the beneficiary's liability is limited under the OHI (or when lower, the amount the hospital is obligated to accept as payment in full) subtract any applicable beneficiary cost-sharing amounts.

STEP 5: Compare the amounts in Steps 1 through 4 and pay the lowest.

V. THE TRICARE DEDUCTIBLE IN DOUBLE COVERAGE

In the initial claim(s) each fiscal year, the calculation in Step 1 must include appropriate deductions for the TRICARE deductible. This satisfies the TRICARE deductible requirement even in those cases in which the combined payments by TRICARE and the double coverage plan result in payment of the full billed charge.

EXAMPLE 1: (Deductible Amount For Family Member Of Active Duty E-4 Or Below)

STEP 1:

$ 100.00	- Allowable charge
- 50.00	- TRICARE deductible
50.00	
x 80%	- TRICARE portion
$ 40.00	- Amount payable by TRICARE in the absence of double coverage.

STEP 2:

$ 100.00	- Billed charge
- 100.00	- Paid by OHI
$ 0.00	- Unpaid balance

STEP 3: TRICARE makes no payment on this claim, since the double coverage plan paid the bill in full. The beneficiary's individual TRICARE deductible for the fiscal year has been satisfied. Beneficiaries should be encouraged to submit claims to TRICARE even when the double coverage plan has paid the bill in full, since a credit to the TRICARE deductible or the catastrophic cap is possible.

Amounts paid by the OHI are to be credited to the deductible, even if the claim does not require a deductible (e.g., a pharmacy claim when a Standard beneficiary goes to a network pharmacy.

EXAMPLE 2:

STEP 1:

$ 240.00	-	Allowable charge for a prescription from a network pharmacy
- 3.00	-	TRICARE cost-share and deductible (no deductible is charged because the beneficiary went to a network pharmacy)
$ 237.00	-	TRICARE payment in absence of double coverage

STEP 2:

$ 240.00	-	Billed charge
- 180.00	-	Amount paid by double coverage
$ 60.00	-	Unpaid balance

STEP 3: TRICARE pays the $60 balance, since it is the lower of Steps 1 and 2. The beneficiary's bill has been paid in full, and the beneficiary's individual deductible for the fiscal year has been satisfied.

Charges applied to the double coverage plan's deductible may also be applied to the TRICARE deductible if the charge was incurred in the appropriate fiscal year and if the TRICARE deductible is unmet at the time the charge is submitted.

EXAMPLE 3:

STEP 1:

$ 50.00	-	Allowable charge
- 50.00	-	TRICARE deductible
$ 0.00	-	TRICARE payment in absence of double coverage

STEP 2:

$ 50.00	-	Billed charge
- 0.00	-	Amount paid by OHI - total billed charge credited to double coverage plan's deductible.
$ 50.00	-	Unpaid balance

STEP 3: The beneficiary is responsible for paying the $50.00 unpaid balance. The full billed charge was credited to the deductible by both TRICARE and the double coverage plan. TRICARE pays nothing on this claim, since the TRICARE payment in the absence of double coverage is zero. However, the beneficiary's TRICARE deductible for the fiscal year is satisfied.

If information concerning the double coverage plan's deductible is not submitted with the claim, contractors are not required to develop for it. Neither are they required to adjust a previously processed claim if the TRICARE deductible was satisfied from a claim other than the one from which the double coverage plan's deductible was satisfied.

EXAMPLE 4: Date of Service, July 2002 (Deductible amount for family member of active duty E-4 or below)

STEP 1:

$ 60.00	-	Allowable charge
- 50.00	-	TRICARE deductible
$ 10.00		
x 80%	-	TRICARE portion
$ 8.00	-	Amount payable by TRICARE in the absence of double coverage

STEP 2:

$ 60.00	-	Billed charge
- 0.00	-	Paid by double coverage - total billed amount credited deductible
$ 60.00	-	Unpaid balance

STEP 3: TRICARE pays $8.00 on this claim since it is the lower of STEPS 1 and 2. The beneficiary is responsible for paying the $7.00 remainder of the bill. The beneficiary's TRICARE individual deductible for the fiscal year is satisfied.

EXAMPLE 5: Above beneficiary has additional care with date of service, April 2002, and this claim is received after the claim for the July services.

STEP 1:

$ 200.00	-	Allowable charge
x 80%	-	TRICARE portion
$ 160.00	-	Amount payable by TRICARE in the absence of double coverage

STEP 2:

$ 200.00	-	Billed charge
- 75.00	-	Paid by OHI - $100 was credited to the OHI's deductible and $25 to the OHI cost-share.
$ 125.00	-	Unpaid balance

STEP 3: TRICARE pays the $125.00 balance, since it is not more than it could have paid in the absence of double coverage. The beneficiary's bill has been paid in full. No adjustment is made to the claim for the July services to give credit for the April double coverage plan deductible.

VI. EXAMPLES OF COMPUTATION OF THE TRICARE SHARE

In the following examples, "allowable charges" means that all non-covered charges have been deducted.

EXAMPLE 1: The total bill for outpatient care for a retiree is $1,000.00, of which $800.00 is considered allowable by TRICARE. The double coverage plan paid $600.00 of the bill. The provider who is a participating, non-network provider submits a claim for $1,000.00 to the contractor along with an EOB from the double coverage plan. The beneficiary's deductible has been met.

STEP 1:

$ 800.00	-	Allowable charges
x 75%	-	TRICARE portion for retirees
$600.00	-	Amount payable by TRICARE in the absence of other coverage

STEP 2:

$ 1,000.00	-	Billed charges
- 600.00	-	Paid by OHI
$ 400.00	-	Unpaid balance

STEP 3: TRICARE pays the $400.00 balance, since it is less than the $600.00 which TRICARE would have paid in the absence of double coverage. No deduction is made for the patient's cost-sharing portion of 25% since the $600 paid by the double coverage plan satisfies this.

EXAMPLE 2: The total bill for outpatient services provided by a participating, non-network provider to a retiree is $400.00. This includes four separate services, each of which has a billed charge of $100.00. The TRICARE allowable amount for these services is $300.00 ($100.00 for each of three services. The claim did not contain sufficient information to process the fourth service; and the information was not received upon development). The double coverage plan paid $200.00 ($50.00 for each service). The TRICARE deductible had been met. The beneficiary submits the claim to TRICARE along with the OHI EOB which clearly indicates that it paid $50.00 for each service.

STEP 1:

$ 300.00	-	Allowable charge
x 75%	-	TRICARE portion for retirees
$ 225.00	-	Amount payable by TRICARE in the absence of other coverage

STEP 2:

$ 400.00	-	Billed charge
- 100.00	-	Charge for service not allowed
$ 300.00	-	Net billed charge
- 150.00	-	OHI payment applicable to allowed services
$ 150.00	-	Unpaid balance

STEP 3: TRICARE pays $150.00, since it is the lower of the two computations.

If the claim is subsequently submitted with the information necessary to process the fourth service, it would be processed as follows:

STEP 1:

$ 100.00	-	Allowable charge (the first three services would be deleted since they duplicate previously processed services)
x 75%	-	TRICARE portion for retirees
$ 75.00	-	Amount payable by TRICARE in the absence of other coverage

STEP 2:

$ 400.00	-	Billed charge
- 300.00	-	Duplicate charge
$ 100.00	-	Net billed charge
- 50.00	-	OHI payment applicable to allowed service
$ 50.00	-	Unpaid balance

STEP 3: TRICARE pays $50.00, since it is the lower of the two computations.

EXAMPLE 3: The total bill for outpatient care for a retiree from a network provider is $1,000.00, of which $800.00 is considered allowable by TRICARE based on the provider's network agreement. The double coverage plan paid $600.00 of the bill. The provider submits a claim for $1,000.00 to the contractor along with an EOB from the double coverage plan. The beneficiary's deductible has been met.

STEP 1:

$ 800.00	-	Allowable charges
x 75%	-	TRICARE portion for retirees
$ 600.00	-	Amount payable by TRICARE in the absence of other coverage

STEP 2:

$ 1,000.00	-	Billed charges
- 600.00	-	Paid by OHI
$ 400.00	-	Unpaid balance

STEP 3: TRICARE pays the $400.00 balance, since it is less than the $600.00 which TRICARE would have paid in the absence of double coverage. No deduction is made for the patient's cost-sharing portion of 25%, since the $600.00 paid by the double coverage plan satisfies this.

EXAMPLE 4: The total bill for outpatient care for a retiree from a nonparticipating provider is $1,000.00, of which $800.00 is considered allowable by TRICARE. The double coverage plan paid $600.00 of the bill. The beneficiary submits a claim for $1,000.00 to the contractor along with an EOB from the double coverage plan. The beneficiary's deductible has been met.

STEP 1:

$ 800.00	-	Allowable charges
x 75%	-	TRICARE portion for retirees
$ 600.00	-	Amount payable by TRICARE in the absence of other coverage

STEP 2:

$ 920.00	-	115% maximum billable amount
- 600.00	-	Paid by OHI
$ 320.00	-	Unpaid balance

STEP 3: TRICARE pays the $320 balance, since it is less than the $600 which TRICARE would have paid in the absence of double coverage. No deduction is made for the patient's cost-sharing portion of 25% since the $600 paid by the double coverage plan satisfies this. Even though only $920 of the $1,000 bill has been paid, the beneficiary owes nothing, since the provider has collected the maximum amount allowed under the balance billing limits.

EXAMPLE 5: The total bill for outpatient care for a retiree from a nonparticipating provider is $1,000.00, of which $800.00 is considered allowable by TRICARE. The double coverage plan allowed $1,000.00 and paid $950.00 with $50.00 being the beneficiary's cost-share. The beneficiary submits a claim for $1,000.00 to the contractor along with an EOB from the double coverage plan. The beneficiary's deductible has been met.

STEP 1:

$ 800.00	-	Allowable charges
x 75%	-	TRICARE portion for retirees
$ 600.00	-	Amount payable by TRICARE in the absence of other coverage

STEP 2:

$ 920.00	-	115% maximum billable amount
- 950.00	-	Paid by OHI
$ 0.00	-	Unpaid balance

STEP 3: TRICARE pays nothing, since the OHI has paid an amount greater than the balance billing limited amount. Even though only $950.00 of the $1,000.00 bill has been paid and TRICARE has paid nothing on the claim, the beneficiary owes nothing, since the provider has collected the maximum amount allowed under the balance billing limits.

EXAMPLE 6: The billed charge for five days of inpatient care in April 2002 for a retiree is $5,000.00. The claim is subject to the TRICARE DRG-based payment system, and the DRG-based amount is $4,000.00. The retiree cost-share under the DRG-based system is the lesser of $2,070 (5 days at $414/day) or $1,250 (25% of the billed charge). The double coverage plan paid $3,000.00. The hospital submits a claim for $2,000.00 along with an EOB from the double coverage plan.

STEP 1:
$ 4,000.00 - DRG-based amount
- 1,250.00 - Cost-share
$ 3,750.00

STEP 2:
$ 4,000.00 - DRG-based amount
- 3,000.00 - OHI payment
$ 1,000.00

STEP 3:
$ 5,000.00 - Hospital's charge
- 3,000.00 - OHI payment
$ 2,000.00

STEP 4:
$ 5,000.00 - Hospital's charge
- 1,250.00 - Cost-share
$ 3,750.00

STEP 5: TRICARE pays $1,000.00, since it is the lowest amount of Steps 1 - 4. The beneficiary owes nothing, since the full DRG-based amount has been paid to the hospital.

EXAMPLE 7: The billed charge for five days of inpatient care in July 2002 for a retiree is $5,000.00. The claim is subject to the TRICARE DRG-based payment system, and the DRG-based amount is $6,000.00. The retiree cost-share under the DRG-based system is the lesser of $2,070 (5 days at $414/day) or $1,250 (25% of the billed charge). The double coverage plan paid $1,000.00. The hospital submits a claim for $4,000.00 along with an EOB from the double coverage plan.

STEP 1:
$ 6,000.00 - DRG-based amount
- 1,250.00 - Cost-share
$ 4,750.00

STEP 2:
$ 6,000.00 - DRG-based amount
- 1,000.00 - OHI payment
$ 5,000.00

STEP 3:
$ 5,000.00 - Hospital's charge
- 1,000.00 - OHI payment
$ 4,000.00

STEP 4:
$ 5,000.00 - Hospital's charge
- 1,250.00 - Cost-share
$ 3,750.00

STEP 5: TRICARE pays $3,750.00, since it is the lowest amount of Steps 1 - 4. The beneficiary is responsible for paying the hospital the remaining $250.00 cost-share.

EXAMPLE 8: The billed charge for five days of inpatient care in July 2002 for a retiree is $5,000.00. The claim is subject to the TRICARE DRG-based payment system, and the DRG-based amount is $6,000.00. The hospital has agreed to a 10% discount off the DRG amount. The retiree cost-share under the DRG-based payment system is $1,250.00, which is 25% of the billed charges. (This is lower than the per diem of $414.00 reduced by the 10% discount and multiplied by 5 days.) The double coverage plan paid $1,000.00. The hospital submits a claim for $4,000.00 along with an EOB from the double coverage plan.

STEP 1:

$ 6,000.00	- DRG-based amount
- 600.00	- 10% Discount
$ 5,400.00	- DRG reduced by the discount
- 1,250.00	- Cost-share
$ 4,150.00	

STEP 2:

$ 5,400.00	- DRG-based amount adjusted by the discount
- 1,000.00	- OHI payment
$ 4,400.00	

STEP 3:

$ 5,000.00	- Hospital's charge
- 1,000.00	- OHI payment
$ 4,000.00	

STEP 4:

$ 5,000.00	- Hospital's charge
- 1,250.00	- Cost-share
$ 3,750.00	

STEP 5: TRICARE pays $3,750.00, since it is the lowest amount of Steps 1 - 4. The beneficiary is responsible for paying the hospital the remaining $250.00 cost-share.

EXAMPLE 9: The bill for inpatient mental health care for a retiree is $32,310.00. This includes $28,125.00 for daily room charges for 75 consecutive days (at $375.00/day). The remaining charges all occurred during the first 60 days and are allowable. The provider is a higher volume hospital with a TRICARE per diem rate of $330, and it submitted the claim on a participating basis along with an EOB from the double coverage plan indicating it had paid $23,148.00. The OHI payment consisted of $19,800.00 (at $264.00/day for a11 75 days) and $3,348.00, which is 80% of the ancillary charges of $4,185.00. The provider submitted a claim for $9,162.00. No waiver to the 60-day limit has been granted by the Director, TRICARE, so the amounts for days 61 - 75 must be subtracted in Steps 1, 2, 3

and 4 and the OHI payment in Steps 2 and 3 must be reduced by the amount for days 61 - 75.

STEP 1:

$ 23,985.00	-	Allowable amount ($330/day for days 1 - 60 plus $4,185 for ancillary charges)
x 75%	-	TRICARE portion for retirees
$ 17,988.75	-	Amount payable by TRICARE in the absence of other coverage

STEP 2:

$ 23,985.00	-	Allowable amount (excluding days 61 - 75)
- 19,188.00	-	OHI payments applicable to days 1 - 60
$ 4,797.00		

STEP 3:

$ 26,685.00	-	Billed charges applicable to days 1 - 60
- 19,188.00	-	OHI payments applicable to days 1 - 60
$ 7,497.00		

STEP 4:

$ 26,685.00	-	Billed charges
x 75%	-	TRICARE portion for retirees
$20,013.75		

STEP 5: TRICARE pays $4,797.00 since this is the lowest amount in Steps 1 - 4. The beneficiary owes nothing for days 1 - 60 but owes the remaining $1,665 for days 61 - 75.

EXAMPLE 10: The billed charge for inpatient care for a retiree is $600.00 per day. The claim is subject to the TRICARE Inpatient Mental Health Per Diem Payment System, and the regional per diem is $475.00 per day. (The retiree per diem cost-share under the per diem-based payment system is $142.00.) The double coverage plan paid $200.00. The provider submits a claim for $600.00 along with an EOB from the double coverage plan.

STEP 1:

$ 475.00	-	Per diem amount
- 142.00	-	Cost-share
$ 333.00	-	Amount payable by TRICARE in the absence of other coverage

STEP 2:

$ 475.00	-	Per diem amount
- 200.00	-	OHI payment
$ 275.00		

STEP 3:

$ 600.00	-	Billed charge
- 200.00	-	OHI payment
$ 400.00		

STEP 4:

$ 600.00	-	Billed charges
- 142.00	-	Cost-share
$ 458.00		

STEP 5: TRICARE pays $275, since it is the lowest amount of Steps 1 -4. The beneficiary owes nothing, since the full per diem amount has been paid.

EXAMPLE 11: The billed charge for inpatient care for a retiree is $300.00 per day. The claim is subject to the TRICARE Inpatient Mental Health Per Diem Payment System,

and the regional per diem amount is $332.00 per day. (The retiree per diem cost-share under the per diem payment system is $142.00.) The double coverage plan paid $300.00. The provider submits a claim to the contractor along with an EOB from the double coverage plan.

STEP 1:

$ 332.00	- Per diem
- 75.00	- Cost-share (25% of $300.00)
$ 257.00	- Amount payable by TRICARE in the absence of other coverage

STEP 2:

$ 332.00	- Per diem
- 300.00	- OHI payment
$ 32.00	- Unpaid balance

STEP 3:

$ 300.00	- Billed charge
- 300.00	- OHI payment
$ 0.00	

STEP 4:

$ 300.00	- Billed charge
- 75.00	- Cost-share
$ 225.00	

STEP 5: TRICARE pays nothing since the full billed charge has been paid to the provider. The beneficiary owes nothing.

EXAMPLE 12: The billed charge for inpatient care for a retiree is $300.00 per day. The claim is subject to the TRICARE Inpatient Mental Health Per Diem Payment System, and the regional per diem amount is $332.00 per day. The provider has agreed to a discount of 5% off the regional per diem amount. (The retiree fixed daily amount under the per diem payment system is $142.00, which is further reduced by the 5% discount to $134.90. In this example; however, the fixed daily amount, even though reduced by a discount, is still higher than 25% of the billed charges and is not used.) The double coverage plan paid $300.00. The provider submits a claim to the contractor with an EOB from the double coverage plan.

STEP 1:

$ 332.00	- Per diem
- 16.60	- 5% discount
$ 315.40	
- 75.00	- Cost-share (25% of $300)
$ 240.40	- Amount payable by TRICARE in the absence of OHI

STEP 2:

$ 315.40	- Per diem reduced by discount
- 300.00	- OHI payment
$ 15.40	

STEP 3:

$ 300.00	- Billed charge
- 300.00	- OHI payment
$ 0.00	

STEP 4:

$ 300.00	- Billed charge
- 75.00	- Cost-share
$ 225.00	

STEP 5: TRICARE pays nothing since it is the lowest amount of Steps 1 - 4.

EXAMPLE 13: The billed charge for the facility portion of ambulatory surgery services is $385.00, and the provider does not participate. The services are subject to the ambulatory surgery prospective payment rates. The beneficiary, (a retiree who has met the annual deductible) has other health insurance which paid $200.00 on the claim. The TRICARE ambulatory surgery group payment rate for the procedure performed is $335.00.

STEP 1:

$ 335.00	-	Group payment rate
x 75%	-	TRICARE portion for retirees
$ 251.25	-	Amount payable by TRICARE in the absence of other coverage

STEP 2:

$ 385.00	-	Billed charge
- 200.00	-	OHI payment
$ 185.00	-	Unpaid balance

STEP 3: TRICARE pays the $185.00 balance, since it is less than what TRICARE would have paid in the absence of double coverage.

EXAMPLE 14: The billed charge for the facility portion of ambulatory services is $385.00, and the provider does not participate. The services are subject to the ambulatory surgery prospective payment rates. The beneficiary (a retiree who has met the annual deductible) has other health insurance which paid $200.00 on the claim. The TRICARE ambulatory surgery group payment rate for the procedure performed is $445.00.

STEP 1:

$ 445.00	-	Group payment rate
- 96.25	-	TRICARE cost share for retirees using 25% of the billed charge (since this is less than 25% of the group payment rate)
$ 348.75	-	Amount payable by TRICARE in the absence of other coverage

STEP 2:

$ 385.00	-	Billed charge
- 200.00	-	OHI payment
$ 185.00	-	Unpaid balance

STEP 3: TRICARE pays $185.00, since it is less than what TRICARE would have paid in the absence of double coverage. The beneficiary owes nothing since the full billed charge has been paid.

EXAMPLE 15: The billed charge for the facility portion of a surgical procedure performed in the outpatient department of a hospital is $2,450.00. The surgical procedure is subject to the wage adjusted national payment rate for the Ambulatory Payment Classification (APC) group to which it is assigned. The beneficiary receiving the services is an active duty family member enrolled under Prime, and as such, is not subject to any deductibles or cost-sharing. The beneficiary has other health

insurance which has paid $1,645.00 on the claim. The wage adjusted TRICARE APC rate for the procedure performed is $1,235.00.

STEP 1:

$ 1,235.00	-	APC allowed amount
- 0.00	-	Deductible and cost-sharing not applied since beneficiary is a Prime active duty family member
$ 1,235.00	-	Amount payable by TRICARE in the absence of other coverage

STEP 2:

$ 2,450.00	-	Billed charge
- 1,645.00	-	OHI payment
$ 805.00	-	Unpaid balance

STEP 3: TRICARE pays $805.00 balance, since it is less than what TRICARE would have paid in the absence of double coverage.

NOTE: The above COB methodology for hospital outpatient services will not go into effect until implementation of the hospital outpatient prospective payment system. This new reimbursement system is tentatively scheduled to become effective 60 days from publication of the Outpatient Prospective Payment System (OPPS) Interim Final Rule (IFR).

VII. EXAMPLES OF COMPUTATION OF THE TRICARE SHARE WHEN THE BENEFICIARY'S LIABILITY IS LIMITED UNDER THE OHI

EXAMPLE 1: The bill for outpatient care for an active duty dependent is $200.00, which is considered allowable by TRICARE. The TRICARE deductible has been met. The provider submitted the claim on a participating basis, along with an EOB from the OHI. The OHI discounted rate is $100.00 and it paid $90.00. The beneficiary's liability is limited to $100.00 under the OHI, and this is evident on the EOB from the OHI. The provider submitted a claim for $200.00.

STEP 1:

$ 200.00	-	Allowable charges
x 80%	-	TRICARE portion for active duty dependents
$ 160.00	-	Amount payable by TRICARE in the absence of other coverage

STEP 2:

$ 100.00	-	OHI amount allowed
- 90.00	-	Paid by OHI
$ 10.00	-	Unpaid balance

STEP 3: TRICARE pays $10.00 to the provider since this is the lower of the two computations. The beneficiary owes nothing, since the full legal liability has been paid.

EXAMPLE 2: A provider's normal charge for an outpatient service is $160.00. The provider is a network provider and has a negotiated discount rate of 10% off the CMAC amount which is $145.00. The provider also has a discounted rate of $110.00 with the OHI and receives no OHI payment due to application of OHI deductible. The beneficiary is a retiree who is enrolled in Prime. The

beneficiary's liability is limited to $110.00 under the OHI, and this is evident on the EOB from the OHI.

STEP 1:

$ 160.00	-	Billed amount
$ 145.00	-	CMAC amount
$ 130.50	-	Negotiated rate (10% off the CMAC amount)
- 12.00	-	TRICARE Prime copay for retirees
$ 118.50	-	Amount payable by TRICARE in the absence of other coverage

STEP 2:

$ 110.00	-	OHI amount allowed
- 0.00	-	Paid by OHI
$ 110.00	-	Unpaid balance

STEP 3: TRICARE pays $110.00 since this is the lower of the two computations, and the beneficiary owes nothing.

EXAMPLE 3: The billed charge for seven days of inpatient care in March 2002 for a retiree is $5,000.00. The claim is subject to the TRICARE DRG-based payment system, and the DRG- based amount is $6,000.00. The hospital has agreed to a 10% discount off the DRG amount. The retiree cost-share under the DRG-based payment system is $1,250.00, which is 25% of the billed charges. (This is lower than the per diem of $414.00 reduced by the 10% discount and multiplied by 7 days.) The OHI discounted rate is $4,200.00 and it paid $4,000.00. The beneficiary's liability is limited to $4,200.00 under the OHI, and this is evident on the EOB from the OHI. The hospital submits a claim for $1,000.00 along with an EOB from the OHI.

STEP 1:

$ 6,000.00	-	DRG-based amount
- 600.00	-	10% discount
$ 5,400.00	-	DRG amount reduced by the discount
- 1,250.00	-	Cost-share
$ 3,150.00		

STEP 2:

$ 5,400.00	-	DRG amount reduced by the discount
- 4,000.00	-	OHI payment
$ 1,400.00		

STEP 3:

$ 4,200.00	-	OHI amount allowed
- 4,000.00	-	OHI payment
$ 200.00		

STEP 4:

$ 4,200.00	-	OHI amount allowed
- 1,250.00	-	Cost-share
$ 2,950.00		

STEP 5: TRICARE pays $200.00, since it is the lowest amount of Steps 1 - 4. The beneficiary owes nothing, since the full legal liability has been paid.

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