



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY
AURORA, COLORADO 80011-9066

TRICARE
MANAGEMENT ACTIVITY

OD

CHANGE 34
6010.56-M
FEBRUARY 14, 2011

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE OPERATIONS MANUAL (TOM), FEBRUARY 2008**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

CHANGE TITLE: THIRD PARTY BILLING AGENCIES

CONREQ: 15157

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change clarifies procedures to be followed by Managed Care Support Contractors (MCSCs) relative to third party billing agents excluded by Health and Human Services (HHS)/Centers for Medicare and Medicaid Services (CMS).

EFFECTIVE AND IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

Reta M. Michak
Director, Operations Division

ATTACHMENT(S): 5 PAGES
DISTRIBUTION: 6010.56-M

CHANGE 34
6010.56-M
FEBRUARY 14, 2011

REMOVE PAGE(S)

CHAPTER 8

Section 1, pages 1 - 3

CHAPTER 13

Section 6, pages 3 and 4

INSERT PAGE(S)

Section 1, pages 1 - 3

Section 6, pages 3 and 4

General

1.0 PURPOSE

The purpose of the TRICARE claims processing procedures is to help ensure that all claims for care received by TRICARE beneficiaries are processed in a timely and consistent manner and that Government-furnished funds are expended only for those services or supplies authorized by law and Regulation. The contractor shall review all claims submitted and accept Health Insurance Portability and Accountability Act (HIPAA) transaction and code sets. The review must ensure that sufficient information is submitted to determine:

- The patient is eligible.
- The provider of services or supplies is authorized under the TRICARE Program.
- The service or supply provided is a benefit.
- The service or supply provided is medically necessary and appropriate or is an approved TRICARE preventive care service.
- The beneficiary is legally obligated to pay for the service or supply (except in the case of free services).
- That the claim contains sufficient information to determine the allowable amount for each service or supply.

In this context, "beneficiary" includes authorized agents, see [Chapter 19](#).

2.0 WHO MAY FILE A CLAIM

2.1 Beneficiary/Provider

Any TRICARE eligible beneficiary or any individual who meets the requirements for eligibility under TRICARE, as determined by one of the Uniformed Services, may file a claim. Any institutional or individual professional provider certified under TRICARE may file a claim on a participating basis for services or supplies provided to a beneficiary and receive payment directly from TRICARE. The contractor shall deny any charge imposed by the provider relating to completing and submitting the applicable claim form (or any other related information). Such charges shall not be billed separately to the beneficiary by the provider nor shall the beneficiary pay the provider for such charges. These charges are to be reported as noncovered charges and denied as such.

2.2 State Agency

A state agency who administers the Medicaid Program may submit a claim, if there has been an agreement signed between the agency and TRICARE Management Activity (TMA). (Refer to the TRICARE Reimbursement Manual (TRM), [Chapter 1, Section 20](#).)

2.3 Participating Provider - Agency Agreement With A Third Party

2.3.1 Occasionally, a participating provider may enter into an agency agreement with a third party to act on its behalf in the submission and the monitoring of third party claims, including TRICARE claims. Such arrangements are permissible as long as the third party is not acting simply as a collection agency. There must be an agency relationship established in which the agent is reimbursed for the submission and monitoring of claims, but the claim remains that of the provider and the proceeds of any third party payments, including TRICARE payments, are paid to the provider. The contractor can deal with these agents in much the same manner as it deals with the provider's accounts receivable department. However, such an entity is not the provider of care and cannot act on behalf of the provider in the filing of an appeal unless specifically designated as the appealing party's representative in the individual case under appeal. Questions relating to the qualifications of any such business entity should be referred to the TMA Office of General Counsel (OGC), through the Contracting Officer (CO), for resolution.

2.3.2 On a monthly basis, TMA's Office of Program Integrity (PI) provides each contractor with an updated data file of excluded third party billing agents. Based on this file, the contractor shall not accept any claims from excluded third party billing agents. Any claim received from an excluded third party billing agent shall be returned to the provider, instructing the provider that the submission of a valid claim cannot be done through a sanctioned entity, and to resubmit the claim directly, or through an approved third party billing agent. The contractor shall inform the provider that the third party billing agent has been excluded by Health and Human Services (HHS)/Centers for Medicare and Medicaid Services (CMS) and that no claims will be accepted from the third party billing agent until it has been reinstated. The contractor shall also provide notification to the third party billing agent that no claims will be accepted from it until it has been reinstated by HHS/CMS.

3.0 TRICARE CLAIM FORMS

3.1 Acceptable Claim Forms

3.1.1 A properly completed acceptable claim form must be submitted to the contractor before payment may be considered. For paper claims, the contractor shall accept the following claim forms for TRICARE benefits: the DoD Document (DD) Form 2642, the CMS 1500 (08/2005), and the CMS 1450 UB-04. The American Dental Association (ADA) claim forms may be used in the processing and payment of adjunctive dental claims. Electronic claims shall be accepted in HIPAA-compliant standardized electronic transactions (see [Chapter 19](#))

3.1.2 DD Form 2642, "Patient's Request For Medical Payment" ([Addendum A, Figure 8.A-1](#)). This form is for beneficiary use only and is for submitting a claim requesting payment for services or supplies provided by civilian sources of medical care. See [Appendix B](#) for a definition of "medical." Those include physicians, medical suppliers, medical equipment suppliers, ambulance companies, laboratories, Extended Care Health Option (ECHO) providers, or other authorized providers. If a DD

Form 2642 is identified as being submitted by a provider for payment of services, the form shall be returned to the provider with an explanation that the DD Form 2642 is for beneficiary use only and that the services must be resubmitted using either the CMS 1500 (08/2005) or the CMS 1450 UB-04, whichever is appropriate. The form may be used for services provided in a foreign country but only when submitted by the beneficiary. Contact the TMA Administrative Office to order the DD Form 2642.

4.0 CLAIMS RECEIPT AND CONTROL

All claims shall be controlled and retrievable. The face of each hardcopy TRICARE claim shall be stamped with an individual Internal Control Number (ICN), which will be entered into the automated system within five workdays of actual receipt. For both hardcopy and Electronic Media Claim (EMC), the ICN shall contain the Julian date indicating the actual date of receipt. The Julian date of receipt shall remain the same even if additional ICNs are required to process the claim. If a claim is returned, the date of the receipt of the resubmission shall be entered as the new date of receipt. All claims not processed to completion and supporting documentation shall be retrievable by beneficiary name, sponsor's Social Security Number (SSN) or ICN within 15 calendar days following receipt.

- END -

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 13, Section 6

Provider Exclusions, Suspensions, And Terminations

- Conviction related to fraud in non-health care programs. Minimum period: 3 years.
- Misdemeanor conviction related to obstruction of an investigation. Minimum period: 3 years.
- Misdemeanor conviction relating to a controlled substance. Minimum period: 3 years.
- License revocation or suspension. Minimum period: No less than the period imposed by the state licensing authority.
- Fraud, kickbacks, and other prohibited activities. Minimum period: None.
- Entities controlled by a sanctioned individual or individuals controlling a sanctioned entity. Minimum period: Same as length of individual's exclusion.
- Entities controlled by a family or household member of an excluded individual and where there has been a transfer of ownership/control. Minimum period: Same as length of individual's exclusion.
- Failure to disclose required information, supply requested information on subcontractors and suppliers; or supply payment information. Minimum period: None.
- Failure to take corrective action. Minimum Period: None.
- Default on health education loan or scholarship obligations. Minimum period: Until default has been cured and obligations have been resolved to Public Health Service's satisfaction.
- Individuals controlling a sanctioned entity. Minimum period: Same period of entity.
- Failure to meet statutory obligations of practitioners and providers to provide medically necessary services meeting professionally recognized standards of health care (e.g., peer review, organization findings). Minimum period: 1 year.
- Claims for excessive charges, unnecessary services, or services which fail to meet professionally recognized standards of health standards of health care, or failure of an Health Maintenance Organization (HMO) to furnish medically necessary services. Minimum period: 1 year.
- Exclusion or suspension under a Federal or State health care program. Minimum period: No less than the period imposed by Federal or state health care program.

3.1.2.2 DHHS/OIG authority for permissive exclusions applies where the action (e.g., conviction, license revocation, etc.) took place after August 21, 1996, under Federal or State law. DHHS/OIG authority does not apply if this condition is not met. In these cases, TMA PI may initiate action to exclude.

3.1.2.3 Aggravating factors may be considered as a basis for lengthening the period of exclusion.

3.1.3 The contractor is required to provide written notice to TMA PI of any situation involving a TRICARE provider or pharmacy who meets the criteria under the mandatory or permissive exclusion authority granted DHHS/OIG.

3.1.4 TMA PI is responsible for requesting DHHS/OIG initiate mandatory and permissive exclusions of TRICARE providers or pharmacies and will provide appropriate documentation needed to initiate separate sanction action (e.g., indictment, plea agreement, conviction document, sentencing document).

3.1.5 TMA PI will advise DHHS/OIG of TRICARE imposed sanctions and is responsible for supplying DHHS/OIG with the appropriate documentation needed to initiate separate sanction action.

3.2 Notice, Effective Date, Period Of Exclusion, And Appeals Process

DHHS/OIG has sole responsibility for issuing a written notice of its intent to exclude a provider, pharmacy, or entity, the basis for the exclusion, the effective date, the period of exclusion, and the potential effect of exclusion. DHHS/OIG will handle appeal of exclusions under [paragraph 3.0](#). See also [Chapter 8, Section 1, paragraph 2.3.2](#), relative to exclusion of third party billing agents.

3.3 Requests For Reinstatement

DHHS/OIG has sole authority for terminating an exclusion imposed under their authority. DHHS/OIG will handle notifications of approval/denial of a request for reinstatement and are responsible for reversing or vacating decisions.

3.4 Program Notification Of Exclusion/Reinstatement

DHHS/OIG exclusions and reinstatements are issued on a monthly basis. DHHS/OIG will provide TMA PI with immediate access to this information via disk, which will then be forwarded to each contractor.

3.5 Scope and Effect Of The Exclusion

Exclusions taken by DHHS/OIG are binding on Medicare, Medicaid, and all Federal health care programs with the exception of the Federal Employee Health Benefit Program (FEHBP) (42 USC 1320a-7b(f)). No payment will be made for any item or service furnished on or after the effective date of exclusion until an individual or entity is reinstated by DHHS/OIG, and subsequently meets the requirements under [32 CFR 199.6](#).

4.0 TMA APPLICATION OF SANCTION AUTHORITY

4.1 Sanction Authority

4.1.1 TMA may exclude any individual or entity based on [32 CFR 199.9](#) provisions including:

- Criminal and/or civil fraud involving TRICARE.
- Administrative determination of fraud and/or abuse under TRICARE.