

## Claims Processing For Dual Eligibles

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### 1.0 GENERAL

Claims under the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) will be adjudicated under the rules set forth below. In general, TRICARE pays secondary to Medicare and any other coverage.

### 2.0 DETERMINING PAYMENTS DUE AFTER COORDINATION WITH MEDICARE

**2.1** 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 (TRM), [Chapter 4, Section 4](#).

### 3.0 EXCEPTIONS TO TIMELY CLAIMS FILING

#### 3.1 Medicare

The contractor may grant exceptions to the claims filing deadline if Medicare accepted the claim as timely. If submitted by the beneficiary, the claim must be submitted within 90 calendar days from the date of Medicare's adjudication to be considered for a waiver.

#### 3.2 Other Health Insurance (OHI)

Reference [Chapter 8, Section 3, paragraph 2.4](#).

### 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. An exception to this general rule occurs if there is information indicating Medicare, TRICARE or other federal health care program integrity violations by the physician or other health care practitioner. In such cases the Managed Care Support Contractor (MCSC) shall seek guidance from TRICARE Management Activity (TMA) Program Integrity (PI) prior to accepting the Medicare certification as valid for TRICARE purposes. Individual professional 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.

**4.1.3** Electronic “cross over” claims received from Medicare after Medicare completes its claims processing do not need a beneficiary or provider signature. For paper claims, when TRICARE is second pay to Medicare and a Medicare EOB is attached, the contractor does not need to develop for provider or beneficiary signature. Signature on file requirements of [Chapter 8, Section 4](#) apply.

#### **4.2 Civilian Services Rendered To Military Treatment Facility (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**

Special authorization/preauthorization 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 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.

**4.3.1** The TDEFIC contractor shall develop a communication/education plan for Skilled Nursing Facilities (SNFs) and TRICARE dual eligible beneficiaries related to the SNF preauthorization requirement and the general SNF benefit. In addition to the initial education, this plan shall accommodate periodic SNF education (not to exceed two per year) that the contractor will conduct at the request of the TMA. The plan shall be coordinated with TMA.

**4.3.2** The TDEFIC contractor preauthorization standards for SNFs shall be as follows: 90% of all requests for preauthorization/authorization will be completed within five working days following receipt of the request and all required information, and 100% of such requests will be completed within eight working days following receipt of the request and all requested information. As such, SNF preauthorizations should be tracked separately from the required preauthorizations noted in [Chapter 7, Section 2](#). A SNF preauthorization shall not be extended for more than 30 days per instance.

#### **4.4 Referral Requirements**

The TDEFIC contractor is not responsible for obtaining or verifying that a Prime-enrolled dual eligible has a referral for care not provided by their Primary Care Manager (PCM). Dual eligibles who are enrolled in Prime are not subject to Point of Service (POS) cost-sharing.

#### **5.0 UTILIZATION MANAGEMENT**

Any utilization management provisions applied under the TRICARE Managed Care Support Services (MCSS) contracts, except for those specifically required by the TPM, TRM, or TRICARE Operations Manual (TOM), shall not apply under TDEFIC. Region-specific requirements shall not apply.

## **6.0 END OF PROCESSING**

### **6.1 Beneficiary Cost-Shares**

End Of Processing. Beneficiary cost-shares shall be based on the following when TRICARE is the primary payer. If the services were received by a TRICARE Prime enrollee (as indicated on DEERS), the contractor shall apply the Prime copayments. For a TRICARE Standard beneficiary, if a provider is known to be a network provider (e.g., Veteran Affairs Medical Center (VAMC)), the Extra cost-shares shall be applied. In all other cases, the TRICARE Standard cost-shares shall be applied.

### **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 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 12](#) are applicable to initial denial determinations by TRICARE under TDEFIC.

#### **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 issue 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 (TSM).

**8.0 TRICARE PROCESSING STANDARDS**

All TRICARE Processing Standards in [Chapter 1, Section 3](#) apply except for [Chapter 1, Section 3, paragraph 1.2](#), and the following wording replaces the [Chapter 1, Section 3, paragraph 1.7.1](#), Claim Payment Errors, requirements: "The absolute value of the payment errors shall not exceed 1.5% of the total billed charges."

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