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TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 125
6010.55-M
JANUARY 28, 2011**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE REIMBURSEMENT MANUAL (TRM), AUGUST 2002**

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

CHANGE TITLE: STATE AGENCY BILLING

CONREQ: 14981

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change updates and clarifies state agency billing requirements.

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

This change is made in conjunction with Aug 2002 TOM, Change No. 112.

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Acting Chief, Medical Benefits and
Reimbursement Branch**

**ATTACHMENT(S): 5 PAGE(S)
DISTRIBUTION: 6010.55-M**

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT.

**CHANGE 125
6010.55-M
JANUARY 28, 2011**

REMOVE PAGE(S)

CHAPTER 1

Section 20, pages 1 through 5

INSERT PAGE(S)

Section 20, pages 1 through 5

STATE AGENCY BILLING

ISSUE DATE: June 1, 1999

AUTHORITY: 32 CFR 199.8

I. DESCRIPTION

General: When a beneficiary is eligible for both TRICARE and Medicaid, 32 CFR 199.8 establishes TRICARE as the primary payor. To implement this provision, the contractor shall arrange Coordination Of Benefits (COB) procedures with those states that have current executed state agency billing agreements to facilitate the flow of claims and to try to achieve a reduction in the amount of effort required to reimburse the states for the funds they erroneously disbursed on behalf of the TRICARE-eligible beneficiary. Claims shall be signed by the recipient/beneficiary (patient) or by a designated state official on behalf of the patient. The state official may sign each claim individually or attach a signed statement to each batch of claims submitted for reimbursement. The contractor shall make disbursement directly to the state agency following established TRICARE claims processing guidelines and requirements (see the TRICARE Operations Manual (TOM), Chapter 8). The contractor shall verify the signatures under the same rules and criteria as exist for verification of provider facsimile or authorized representative signatures (see the TOM, Chapter 8, Section 4. Medicaid claims are subject to normal claims processing requirements for establishment of eligibility.

II. POLICY

A. Claims Processing Requirements/Exceptions

1. Claims Submission Procedures

a. The state agency must submit claims on an acceptable claim form, and attach a computer printout of the state agency's record of the services and/or copies of the original bills. All required processing data must be submitted in an acceptable format. When the state agency and the contractor have the capability to exchange the data for claims processing in an electronic format, this shall be defined and included in the agreement between the applicable Managed Care Support Contractor (MCSC), TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) contractor, and the state agency.

b. Each batch of claims (if each claim is not individually signed) must be certified by an authorized state official. A transmittal document signed by an authorized state official identifying the claims covered by the certification shall accompany each batch of claims. For electronic claims, an encrypted or password protected e-mail (transmitted in a secure

TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 1, SECTION 20

STATE AGENCY BILLING

manner) with an electronic signature from an authorized state official identifying the claims covered by the certification shall either accompany the claims or be sent prior to submission. Patient names and sponsor Social Security Numbers (SSNs) shall also be included on the transmittal certification. When the password protected e-mail method is used, a subsequent e-mail message must be transmitted with the access password. For audit trail purposes, the contractor shall enter the Julian calendar date of receipt on the transmittal document and ensure that all included claims also receive the same Julian calendar date in the Internal Control Number (ICN).

c. The transmittal documents shall be retained in a readily accessible file or may be microcopied with the claims, if the contractor is microfilming its claims at the front end of its processing system.

2. Claims Adjudication

Except for the following, claims submitted by state agencies are subject to all applicable TRICARE requirements, limitations and definitions.

CONDITION	PROCEDURE
Durable Medical Equipment - Prescriptions Missing	Do not develop for this information unless there is no reasonable correlation between the diagnosis and the equipment on the claim. If the diagnosis is missing and there is no documentation on file to support the claim, return the claim for supporting diagnosis or prescription. Amount of payment will follow the basic guidelines of Chapter 1, Section 11. As a general rule, if the state is paying rental on the equipment, TRICARE will pay the rental. If the state has paid for purchase, assume that to be cost advantageous and reimburse the state accordingly.
No COB Information	Waive if the state coordinates. Accept the certification from the authorized state official for documentation that, in absence of Other Health Insurance (OHI) information, there is no known OHI. If other insurance is present, it is necessary to know the amount paid by the OHI to properly reimburse the state for the amount they have actually paid, but not to exceed the amount TRICARE would have paid. If the contractor detects that OHI does exist, processing will be terminated and the claim will be returned to the state agency for action. It is the state agency's responsibility to determine if an error has been made in submission or if the patient or provider may have committed a fraudulent act.

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TRICARE REIMBURSEMENT MANUAL 6010.55-M, AUGUST 1, 2002

CHAPTER 1, SECTION 20

STATE AGENCY BILLING

CONDITION	PROCEDURE
Lack of itemization on inpatient hospital bills; i.e., hospital detail is lacking	Beginning and ending dates of hospital stay are required. Breakdown of detailed services and supplies must be detailed enough to determine the Revenue Code major category. Contractors may assume the charges are for a semi-private room, in absence of evidence to the contrary, and report with Revenue Code "12X." In every instance, the Revenue Code in the Institutional Record must comply as required by the TRICARE Systems Manual (TSM), Chapter 2, Sections 3 through 8. Waiver of the requirement to develop for the breakdown of services does not excuse the contractor from coding the detail which is present on the claim.
No breakdown of service detail; e.g., multiple office visits or multiple lab services, etc.	Waive: For TEDs, the contractor is authorized to estimate frequency of the charge by using a reasonable approximation. For example, June 1 - 8, CPT ¹ procedure code 90050 with a \$57.00 charge. Assume two office visits @ \$28.50.
Quantity, strength, etc., missing on drug claims.	Waive: Pay as billed and assume that the state agency has a control system in place. If evidence develops to refute this assumption, contact the state agency for development of appropriate controls. Process drug claims from state agencies as if they were consolidated drug claims.
Diagnosis Missing	<u>Waive</u> on office visits (unless services appear to be for a routine physical or related to other excluded services); consultations; drugs; lab; x-ray; assistant surgeon and anesthesiology. Use ICD code 799.9 in absence of a correct code.
Diagnosis Missing	<u>Require</u> on hospital, surgery and mental health. For DME, if the record provides information other than a diagnosis which can reasonably support the payment, proceed. Return the incomplete claim, which requires a diagnosis, to the state for supporting information.
Timely filing limits.	The state shall file no later than one year following the date of service: one year after the date the prescription was filled; one year after the date of discharge if the services were rendered during an inpatient admission; or one year after the state received the results of the annual data match from the Defense Manpower Data Center (DMDC), Defense Enrollment Eligibility Reporting System (DEERS) Division. For waivers, see the TOM, Chapter 8, Section 3, paragraph 2.0.

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3. **TRICARE Encounter Data (TED)** Reporting of State Agency Claims

Claims received for state agencies will be processed with the Special Processing Code '1' on TEDs (see the **TSM, Chapter 2**). TED coding will follow the basic requirements for a participating claim with the state Medicaid agency designated as the payee. The amount paid by the government must be reported in the Amount Paid by Government Contractor field.

4. Development with State Agencies

States are obligated to provide the data needed to process the claims they submit, including eligibility and other beneficiary information. In some cases, the contractor will need to develop data through DEERS or other in-house information to accurately process the claim. For other required data, or in case of failure to locate essential information, the contractor will return the claim to the state agency. If a state routinely fails to submit required data on its claims, the contractor shall contact the state agency and request cooperation. **TRICARE Management Activity (TMA)** shall be advised of any such problems and the results of any contacts.

5. Duplicate Checking

Contractors **shall** ensure that precautions are taken to prevent duplicate payments, as provided in the TOM, **Chapter 8, Section 9**. In cases where the exact type of service data has not been provided, but a duplication of types of service is apparent; e.g., apparent duplication of lab and office services, the contractor shall attempt to resolve the case with the data available in-house. If the matter cannot be resolved, assume duplication and deny the claim. If the state agency has information to the contrary, it may resubmit with the necessary documentation to refute the assumption. If a beneficiary or provider has submitted claims for services directly to TRICARE and the same services have also been sent to the state for Medicaid payment, the possibility of fraud must be considered. Since the patient would have been TRICARE-eligible, any fraud would have been an offense against the state program. Return the claim to the state agency and advise them of the facts including that payment has been made by TRICARE. The contractor shall cooperate in any state investigation to the extent possible under TRICARE guidelines. In any case of doubt about what information can be released in an investigation, contact TMA for instructions.

6. Nonavailability Statement (NAS)

The state must include the address of the beneficiary on the claim and the contractor **shall** verify whether a Nonavailability Statement is required, using normal processing rules, including a check of the related history files to determine if an NAS is on file. If an NAS is required, and none is available, the claim will be denied and the State Medicaid Agency notified on the **Explanation of Benefits (EOB)**. No further action is required by the contractor.

7. Providers

Providers must be TRICARE-approved or TRICARE-eligible in accordance with the TOM, **Chapter 2**. If the provider named on the claim is not on the contractor provider

files, but is in a category which is normally acceptable under TRICARE; e.g., a physician, psychologist, hospital, etc., the contractor shall follow normal procedures to certify. If the provider is not in a certifiable category under the contract, return the claim to the state.

8. Third Party Liability (TPL)

When submitting claims to TRICARE for recovery of payments made, the state agency should attach information regarding possible "Third Party Liability" (TPL) for those claims which carry a diagnosis requiring development (see the TOM, [Chapter 11](#)). However, if the TPL data submitted is not adequate to provide all the information required, return the claim to the state agency to obtain the necessary information. It is expected that the state agency will have a fully developed file to establish or to rule out possible TPL. If TPL is involved, the state should have exercised its subrogation rights and the state's beneficiary claim file should reflect complete data, including the amount paid under TPL. Where TPL does exist, the TRICARE claim liability should be minimal. The contractor should not contact the beneficiary or the provider(s).

B. Reimbursement Procedures and Requirements

The contractor shall reimburse the State Medicaid Agency directly for all claims submitted by the agency **providing** an EOB for each claim, unless arrangements and agreement between the contractor and the state agency provide for a summary payment voucher. No EOB or other notice will be sent to either the beneficiary or the provider. The allowance determination **shall** be based on the amount billed to the Medicaid Agency by the provider of care. The contractor shall calculate the net amount which would have been payable by TRICARE including, when appropriate, the COB reduction, deductible and cost-share amounts in the determination. The state **shall** be paid the lesser of the amount it actually paid or the amount that TRICARE would have paid. The Medicaid billing by a provider is frequently less than the provider's customary charge. These charges **shall** not be included in the determination of the prevailing charges for an area. If a provider of care subsequently bills, requesting payment for the difference between the Medicaid payment and the amount customarily billed, the claim shall be denied as a duplicate. No additional payment **shall** be made. If a service which would be allowable by TRICARE has been denied by Medicaid and is subsequently submitted by a provider of care, the charge shall be considered as any other claim.

- END -

