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TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 129
6010.55-M
MARCH 10, 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: DOUBLE COVERAGE AND COMPETITIVE BIDDING PROGRAM (CBP)

CONREQ: 15173

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change explains TRICARE's double coverage procedures for those TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) beneficiaries affected by Medicare's CBP.

EFFECTIVE DATE: January 1, 2011.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

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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 129
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REMOVE PAGE(S)

CHAPTER 4

Section 4, pages 3 through 6

INSERT PAGE(S)

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and pay the claim as the primary payer. In most cases, under served areas will be identified by zip codes for Health Professional Shortage Areas (HPSAs) and Physician Scarcity Areas (PSAs) on the **Centers for Medicare and Medicaid Services (CMS)** web site at <http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/> and will automatically be paid as primary payer. In cases where the zip code for an underserved area is not identified on the CMS web site, or in areas where there are no or limited Medicare participating providers, a written waiver request with justification identifying the county where the service was received and a copy of the provider's private contract will be required by the contractor to pay the claim as the primary payer. TRICARE contractors will identify HPSA or PSA zip codes or the county for underserved areas on the above CMS web site and identify opt out providers based on the Medicare Part B carriers web sites.

NOTE: Under the TRICARE Provider Reimbursement Demonstration Project for the State of Alaska, TRICARE will pay as primary payer for the services of Medicare opt-out providers.

f. If the service or supply normally is a benefit under both Medicare and TRICARE, but Medicare denies payment based on their Competitive Bidding Program (CBP) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), the TRICARE contractor shall process the claim as second payer for otherwise covered items of DMEPOS. In such cases, the TRICARE payment shall be the amount TRICARE would have paid had Medicare processed and paid the claim. Public use files containing the competitive bid single payment amounts per Healthcare Common Procedure Coding System (HCPCS) code are posted on the CMS' competitive bidding contractor's web site: <http://www.dme.competitivebid.com/palmetto/cbic.nsf/DocsCat/Home>. TRICARE contractors shall identify the competitive bid single payment amount using the above CMS web site to identify what Medicare would have allowed had the beneficiary followed Medicare's rules. Implementation of Medicare's DMEPOS CBP pricing is effective January 1, 2011.

2. Services that are a benefit under Medicare but not under TRICARE. TRICARE will make no payment for services and supplies that are not a benefit under TRICARE, regardless of any action Medicare may take on the claim.

3. Services that are a benefit under TRICARE but not under Medicare. If the service or supply is a benefit under TRICARE but not under Medicare, TRICARE will process the claim as the primary payer assessing any applicable deductibles and cost-shares. If the contractor knows that a service or supply on the claim is not a benefit under Medicare, the contractor can process the claim without evidence of processing by Medicare for that service or supply.

4. Services that are provided in a non-**Department of Defense (DoD)** government facility. If services or supplies are provided in a TRICARE authorized non-DoD government facility, such as a Veterans Administration (VA) hospital pursuant to the TRICARE Policy Manual (TPM), **Chapter 11, Section 2.1**, Medicare will make no payment. In such cases TRICARE will make payment as the primary payer assessing all applicable deductibles and cost-shares.

NOTE: In order to achieve status as a TRICARE authorized provider, VA facilities must comply with the provisions of the **TPM, Chapter 11, Section 2.1**.

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5. Services provided by a Medicare at-risk plan. If the beneficiary is a member of a Medicare at-risk plan (for example, Medicare Plus Choice), TRICARE will pay 100% of the beneficiaries co-pay for covered services. A claim containing the required information must be submitted to obtain reimbursement.

6. 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. Network discounts shall only be applied when the discount arrangement specifically contemplated the TRICARE for Life (TFL) population.

7. 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.

D. End Stage Renal Disease (ESRD) in TRICARE beneficiaries less than 65 years of age - Medicare is the primary payer and TRICARE is the secondary payer for beneficiaries entitled to Medicare Part A and who have Medicare Part B coverage.

II. TRICARE AND MEDICAID

Medicaid is essentially a welfare program, providing medical benefits for persons under various state welfare programs (such as Aid to Dependent Children) or who qualify by reason of being determined to be "medically indigent" based on a means test. In enacting P.L. 97-377, it was the intent of Congress that no class of TRICARE beneficiary should have to resort to welfare programs, and therefore, Medicaid was exempted from these double coverage provisions. Whenever a TRICARE beneficiary is also eligible for Medicaid, TRICARE is always the primary payer. In those instances where Medicaid extends benefits on behalf of a Medicaid eligible person who is subsequently determined to be a TRICARE beneficiary, TRICARE shall reimburse the appropriate Medicaid agency for the amount TRICARE would have paid in the absence of Medicaid benefits or the amount paid by Medicaid, whichever is less. See [Chapter 1, Section 20](#).

III. MATERNAL AND CHILD HEALTH PROGRAM/INDIAN HEALTH SERVICE

Eligibility for health benefits under either of these two Federal programs is not considered to be double coverage (see [Chapter 4, Section 1](#)).

IV. TRICARE AND VA

Eligibility for health care through the VA for a service-connected disability is not considered double coverage. If an individual is eligible for health care through the VA and is also eligible for TRICARE, he/she may use either TRICARE or Veterans benefits. In addition, at any time a beneficiary may get medically necessary care through TRICARE, even if the beneficiary has received some treatment for the same episode of care through the VA. However, TRICARE will not duplicate payments made by or authorized to be made by the VA for treatment of a service-connected disability.

V. TRICARE AND WORKER'S COMPENSATION

TRICARE benefits are not payable for work-related illness or injury which is covered under a Worker's Compensation program. The TRICARE beneficiary may not waive his or her Worker's Compensation benefits in favor of using TRICARE benefits. If a claim indicates that an illness or injury might be work related, the contractor will process the claim following the provisions as provided in TRICARE Operations Manual (TOM), Chapter 11, Section 5, paragraphs 5.0. and 6.1. and refer the claim to the Uniformed Service Claims Office for recovery, if appropriate.

VI. TRICARE AND SUPPLEMENTAL INSURANCE PLANS

A. Not Considered Double Coverage. Supplemental or complementary insurance coverage is a health insurance policy or other health benefit plan offered by a private entity to a TRICARE beneficiary, that primarily is designed, advertised, marketed, or otherwise held out as providing payment for expenses incurred for services and items that are not reimbursed under TRICARE due to program limitations, or beneficiary liabilities imposed by law. TRICARE recognizes two types of supplemental plans, general indemnity plans and those offered through a direct service health maintenance organization (HMO). Supplemental insurance plans are not considered double coverage. TRICARE benefits will be paid without regard to the beneficiary's entitlement to supplemental coverage.

B. Income Maintenance Plans. Income maintenance plans pay the beneficiary a flat amount per day, week or month while the beneficiary is hospitalized or disabled. They usually do not specify a type of illness, length of stay, or type of medical service required to qualify for benefits, and benefits are not paid on the basis of incurred expenses. Income maintenance plans are not considered double coverage. TRICARE will pay benefits without regard to the beneficiary's entitlement to an income maintenance plan.

C. Other Secondary Coverage. Some insurance plans state that their benefits are payable only after payment by all government, Blue Cross/Blue Shield and private plans to which the beneficiary is entitled. In some coverages, however, it provides that if the beneficiary has no other coverage, it will pay as a primary carrier. Such plans are double coverage under TRICARE law, regulation and policy and are subject to the usual double coverage requirements.

VII. SCHOOL COVERAGE - SCHOOL INFIRMARY

TRICARE benefits shall be paid for covered services provided to students by a school infirmary provided that the school imposes charges for the services on all students or on all students who are covered by health insurance.

VIII. TRICARE AND PREFERRED PROVIDER ORGANIZATIONS

See [Chapter 1, Section 26](#).

IX. DOUBLE COVERAGE AND EXTENDED CARE HEALTH OPTION (ECHO)

All double coverage rules and procedures which apply to claims under the basic program are also to be applied to ECHO claims. All local resources must be considered and utilized before TRICARE benefits under the ECHO may be extended. If an ECHO beneficiary is eligible for other federal, state, or local assistance to the same extent as any other resident or citizen, TRICARE benefits are payable only for amounts left unpaid by the other program, up to the TRICARE maximums established in [TPM, Chapter 9](#). The beneficiary may not waive available federal, state, or local assistance in favor of using TRICARE.

NOTE: The requirements of [paragraph IX](#), notwithstanding, TRICARE is primary payer for medical services and items that are provided under Part C of the Individuals with Disabilities Education Act in accordance with the Individualized Family Service Plan and that are otherwise allowable under the TRICARE Basic Program or the ECHO.

X. PRIVATELY-PURCHASED, NON-GROUP COVERAGE

Privately-purchased, non-group health insurance coverage is considered double coverage.

XI. LIABILITY INSURANCE

If a TRICARE beneficiary is injured as a result of an action or the negligence of a third person, the contractor must develop the claim(s) for potential third party liability (TPL) (see the [TOM, Chapter 11, Section 5](#)). The contractor shall pursue the Government's subrogation rights under the Federal Medical Care Recovery Act ([FMCRA](#)), if the other health insurance does not cover all expenses.

XII. TRICARE AND PRE-PAID PRESCRIPTION PLANS

If the beneficiary has a "pre-paid prescription plan," where the beneficiary pays only a "flat fee" no matter what the actual cost of the drug, the contractor shall cost-share the fee and not develop for the actual cost of the drug, since the beneficiary is liable only for the "fee."

XIII. TRICARE AND STATE VICTIMS OF CRIME COMPENSATION PROGRAMS

Effective September 13, 1994, State Victims of Crime Compensation Programs are not considered double coverage. When a TRICARE beneficiary is also eligible for benefits under a State Victims of Crime Compensation Program, TRICARE is always the primary payer over the State Victims of Crime Compensation Programs.

XIV. SURROGATE ARRANGEMENTS

Contractual arrangements between a surrogate mother and adoptive parents are considered other coverage. TRICARE will cost share on the remaining balance of otherwise covered benefits related to the surrogate mother's medical expenses after the contractually agreed upon amount has been exhausted. This applies where contractual arrangements for payment include a requirement for the adoptive parents to pay all or part of the medical

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expenses of the surrogate mother as well as where contractual arrangements for payment do not specifically address reimbursement for the mother's medical care. If brought to the contractor's attention, the requirements of **TOM**, [Chapter 11, Section 5, paragraph 2.10](#). would apply.

- END -

