CHAPTER 4
SECTION 4

SPECIFIC DOUBLE COVERAGE ACTIONS

ISSUE DATE:
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I. TRICARE AND MEDICARE

A. Medicare Always Primary To TRICARE. In any double coverage situation involving Medicare and TRICARE, Medicare is always primary. When services are provided by a resource sharing provider in an MTF to a beneficiary age 65 years and older, reimbursement shall be in accordance with the resource sharing agreement. No TRICARE for Life funds are available for resource sharing within an MTF.

B. Premium Health Insurance. Certain persons age 65 years and older who were not previously entitled to Medicare Part A, "Hospital Insurance Benefits," became eligible to enroll in Part A after June 30, 1973, under the premium Health Insurance provision of the 1972 Amendment to the Social Security Act. Entitlement to Part A secured under these circumstances does not result in a loss of TRICARE benefits.

C. Procedures. TRICARE beneficiaries who become entitled to Medicare Part A, based on age, do not lose TRICARE eligibility if they are enrolled in Medicare Part B. Special double coverage procedures are used for these claims in order to minimize out- of-pocket expenditures for these beneficiaries. These special procedures are 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. The following sections set forth the amounts that TRICARE will pay if the beneficiary is covered by Medicare and TRICARE. If a third coverage is involved, TRICARE will be last payer and payments by the third coverage will reduce the amounts of TRICARE payment that are set forth below. In all cases where TRICARE is the primary payer, all claims processing requirements are to be followed. Additionally, when a beneficiary becomes eligible for Medicare during any part of his/her inpatient admission, the hospital claim shall be submitted to Medicare first and TRICARE/CHAMPUS payment (using non-financially underwritten funds) will be determined under the normal double coverage procedures.

1. Services that are a benefit under both Medicare and CHAMPUS.

a. If the service or supply is a benefit under both Medicare and TRICARE, the beneficiary will have no out-of-pocket expense. For these claims TRICARE will resemble a Medicare supplement. That is, the allowable amount under Medicare will be used as the TRICARE allowable, and TRICARE payment will equal the remaining beneficiary liability after Medicare processes the claim without regard to any TRICARE deductible and cost-

share amounts that would otherwise be assessed. For example, if it is the first claim of the year and the billed charge is $50 (which is also the amount both Medicare and TRICARE allow on the claim), Medicare will apply the entire amount to the Medicare deductible and pay nothing. In this case, TRICARE will pay the full $50 so that the beneficiary has no out-of-pocket expense. Similarly, if Medicare pays an amount that is greater than what TRICARE normally would allow for a network provider, TRICARE will still pay any Medicare deductible and cost-sharing amounts, even if that represents payments in excess of the normal TRICARE allowable amount.

NOTE: It is not necessary for the contractor to price these claims, since the Medicare allowable becomes the TRICARE allowable, and TRICARE payment is based on the remaining beneficiary liability. The contractor need only verify eligibility and coverage in processing the claim. Contractors will not be required to duplicate Medicare's provider certification, medical necessity, referral, authorization, and potential duplicate editing.

b. If the service or supply normally is a benefit under both Medicare and TRICARE, but Medicare cannot make any payment because the beneficiary has exhausted Medicare benefits, TRICARE will make payment as the primary payer assessing all applicable deductibles and cost-shares. For example, TRICARE is primary payer for inpatient care beyond 150 days.

c. If the service or supply normally is a benefit under both Medicare and TRICARE, but Medicare cannot make any payment because the beneficiary receives services overseas where Medicare will not make any payment, TRICARE will process the claim as a primary payer with any applicable deductibles and cost-shares. Since the contractor knows that Medicare cannot make any payment on such claims, the contractor can process the claim without evidence of processing by Medicare. Even though Medicare cannot make payment overseas, beneficiaries receiving care overseas must still purchase Part B of Medicare in order to maintain their TRICARE eligibility.

d. If the service or supply normally is a benefit under both Medicare and TRICARE, but Medicare does not make any payment because the service or supply is not medically necessary, TRICARE cannot make any payment on the claim. In such cases, the contractor is to deny the claim. The beneficiary/provider must file an appeal with Medicare. If Medicare subsequently reverses its medical necessity denial, Medicare will make payment on the claim and it can then be submitted to TRICARE for payment of any remaining beneficiary liability. If Medicare does not reverse its medical necessity denial, the claim cannot be paid by TRICARE. TRICARE will not accept appeals in any case but will advise the beneficiary to appeal through Medicare.

e. Effective for services on or after March 1, 2007, if the service or supply normally is a benefit under both Medicare and TRICARE, but Medicare does not make any payment because the provider has a private contract with the beneficiary (also referred to as "opting out" of Medicare), TRICARE will process the claim as a second payer. In such cases, the TRICARE payment will be the amount that TRICARE would have paid had the Medicare program processed the claim (normally 20% of the allowable charge). In cases where the beneficiary's access to medical care is limited (i.e., under served areas), the TRICARE contractor may waive the second payer status for the services of a Medicare opt-out provider 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.dmecompetitivebid.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.

g. Effective October 28, 2009, TRICARE beneficiaries under the age of 65 who became Medicare eligible due to a retroactive disability determination awarded upon appeal remain eligible and are considered to have coverage under the TRICARE program (see the TRICARE Operations Manual (TOM), Chapter 22, Section 1, paragraph 2.6.) for the retroactive months of their entitlement to Medicare Part A, notwithstanding the gap in coverage between Medicare Part A and Part B effective dates. For previously processed claims and claims for dates of service before the beneficiary's original Medicare Part B effective date (which corresponds with the date of issuance of the retroactive determination by the Social Security Administration), jurisdiction remains with the contractor that processed the claim. Recoupment actions shall not be initiated and existing actions should be terminated. Out-of-jurisdiction rules apply to claims for dates of service on or after the original Medicare Part B effective date. These claims should be forwarded to the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) contractor for action. Medicare becomes primary payer effective as of the original Medicare Part B effective date. Eligible beneficiaries are required to keep Medicare Part B in order to maintain their TRICARE coverage for future months, but are considered to have coverage under the TRICARE program for the retroactive months of their entitlement to Medicare Part A.

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 Department of Veterans Affairs (DVA) facility. If services or supplies are provided in a TRICARE authorized DVA hospital pursuant to the TRICARE Policy Manual (TPM), Chapter 11, Section 2.1, Medicare will make no payment. In such cases TRICARE will process the claim as a second payer. The TRICARE payment will be the amount that TRICARE would have paid had the Medicare program processed the claim (normally 20% of the allowable charge).

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

5. 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 (with the exception of a DVA hospital see paragraph I.C.4.), Medicare will make no payment. In such cases TRICARE will make payment as the primary payer assessing all applicable deductibles and cost-shares.

6. 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.

7. 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.

8. 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 TOM, Chapter 11, Section 5, paragraphs 5.0. and 6.0. 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 (IDEA) in accordance with the Individualized Family Service Plan (IFSP) 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 (OHI) 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. For pregnancies in which the surrogate mother is a TRICARE beneficiary, services and supplies associated with antepartum care, postpartum care, and complications of pregnancy may be cost-shared only as a secondary payer, and only 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 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.

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