

## STATE AGENCY BILLING

ISSUE DATE: June 1, 1999

AUTHORITY: [32 CFR 199.8](#)

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### 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 procedures with the various states 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. Such bills may be signed by authorized state officials and do not require a separate signature of either the beneficiary or the provider. The contractor should make disbursement directly to the state agency, following established TRICARE claims processing guidelines and requirements (see OPM, [Chapter 8](#)). The contractor will verify the signatures under the same rules and criteria as exist for verification of provider facsimile or authorized representative signatures (see OPM, [Chapter 8, Section 5](#)). 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 is responsible for submission of the claim in a form/format acceptable to the contractor. For example, the state must submit claims on an acceptable claim form, and attach a computer printout of the state'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 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 MCS contractor and the state.

b. Each batch of claims (if each claim is not individually signed) must be certified by an authorized state official as accurate. A covering transmittal document that identifies the claims covered by the certification must accompany each batch of claims. The patient names and sponsor SSNs must also be included on the transmittal certification. 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 <a href="#">Chapter 1, Section 11</a> . 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 insurance information (OHI), 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.
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 crossfoot as required by the ADP Manual, <a href="#">Chapter 3</a> through ADP Manual, <a href="#">Chapter 8</a> . 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.

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CONDITION	PROCEDURE
No breakdown of service detail; e.g., multiple office visits or multiple lab services, etc.	Waive: For Health Care Service records the contractor is authorized to estimate frequency of the charge by using a reasonable approximation. For example, June 1 - 8, CPT <sup>1</sup> 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 must file no later than one year following the date of service of the date of discharge if the services were rendered during an inpatient admission. For waivers, see OPM, <a href="#">Chapter 8, Section 4, paragraph 2.0</a> .
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### 3. HCSR Reporting of State Agency Claims

Claims received for state agencies will be processed with the Special Processing Code '1' on HCSRs (see the ADP Manual, [Chapter 2](#)). The reimbursement amounts the other HCSR 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. TMA shall be advised of any such problems and the results of any contacts.

## 5. Duplicate Checking

Contractors are expected to ensure that precautions are taken to prevent duplicate payments, as provided in OPM, [Chapter 8, Section 12](#). 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 will 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 EOB. No further action is required by the contractor.

## 7. Providers

Providers must be TRICARE-approved or TRICARE-eligible in accordance with [OPM Part Two, 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 OPM, [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 using 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 will 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 will 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 will 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 will 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.

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