

TRICARE Fundamentals Course

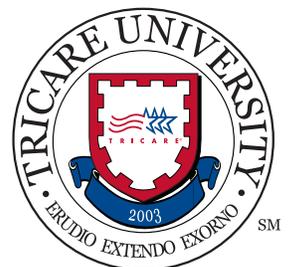
Claims and Appeals

11

Instructor Guide

References

32 CFR § 199.7, 199.10
2008 TRICARE Operations Manual, Chapter 8
2008 TRICARE Reimbursement Manual, Chapter 1, 2 (Addendum A)



Brain teasers

Each of the eight items below is a separate puzzle.

How many can you figure out?

<p>1.</p> <p>R E A D I I N G</p>	<p>2.</p> <div style="border: 1px solid black; padding: 10px; width: fit-content; margin: auto;"> <p>Go stand</p> </div>	<p>3.</p> <p>LANG4UAGE</p>	<p>4.</p> <p style="text-align: center;">N I A T P C A</p>
<p>5.</p> <p style="text-align: center;">dice dice</p>	<p>6.</p> <p style="text-align: center;">Dribble Dribble</p>	<p>7.</p> <p style="text-align: center;">GROUND</p> 	<p>8.</p> <p style="text-align: center;">FRIENDS STANDING FRIENDS miss</p>

1 Reading between the lines

2 Go stand in a corner

3 Foreign language

4 Captain Hook

5 Paradise

6 Double dribble

7 Six feet underground

8 A little misunderstanding between two friends

Module Objectives



Show slide #2

- Objectives
- Explain who can file claims and where claims should be submitted
 - Describe how to resolve claims issues
 - Identify three reasons why an Explanation of Benefits may be delayed
 - Distinguish between what can and cannot be appealed

- **Explain who can file claims and where claims should be submitted**
- **Describe how to resolve claims issues**
- **Identify three reasons why an Explanation of Benefits (EOB) may be delayed**
- **Distinguish between what can and cannot be appealed**

Show slide #3 for 1.0



Explain that the only time a claim is not required is when a beneficiary is seen by a provider in a MTF. In other words, civilian provider services outside an MTF require some kind of claim processing.

Show slide #4 for 2.0



2.0: Test Question

Disclaimer: The content in this module applies primarily to claims for health care services, and not to pharmacy or dental claims. See the Pharmacy and Dental modules for claims and appeals information for those services. Fraud information is provided for all contractors.

1.0 Claims

- Claims are filed to issue payment for services or supplies provided by civilian sources of medical care.
- Professional providers include physicians, whether independent providers or group practice, physical therapists, and other TRICARE-authorized providers.
- Institutional providers include:
 - Hospitals
 - Skilled nursing facilities
 - Pharmacies
 - Medical suppliers
 - Ambulance companies
 - Laboratories
 - Physical therapy
 - Veterans Affairs (VA) treatment facilities

2.0 Claims Filing

Providers of services or supplies and beneficiaries may file claims. **However, the beneficiary is ultimately responsible for making sure claims are filed no matter what type of provider he/she uses.**

2.1 Authorized Providers

- An authorized provider is a provider who meets TRICARE’s licensing and certification requirements and is certified to provide care to TRICARE beneficiaries.
- TRICARE denies claims from non-authorized providers, except in some emergency situations.
- There are two types of TRICARE-authorized providers: network and non-network.

2.1.1 Network Providers

- A network provider is a professional or institutional provider who has a contractual relationship with the TRICARE regional contractor to provide care at a negotiated rate.
- A network provider agrees to file claims and handle other paperwork for TRICARE beneficiaries, and typically administers care to TRICARE Prime enrollees and those TRICARE Standard beneficiaries using TRICARE Extra (the preferred provider option).
- A network provider accepts the negotiated rate as payment in full for services rendered.

2.1.2 Non-Network Providers

There are two types of non-network providers:

- **Participating Provider:** A non-network, authorized provider who participates/accepts the TRICARE allowable charge as payment in full for provided services. Non-network participating providers choose to participate on a claim by claim basis and indicate their “participation” status on the claim form.
- **Non-Participating Provider:** A non-network, authorized provider who does not accept the TRICARE allowable charge as payment in full for the covered services and can bill the beneficiary up to 15% above the TRICARE allowable charge.

2.2 Beneficiary

- Any TRICARE-eligible beneficiary may submit a claim using a *TRICARE DoD/CHAMPUS Medical Claim—Patient's Request For Medical Payment* (DD Form 2642). (See Section 7.0 of this module for more information on claim forms.)
- The spouse, parent, or legal guardian of a minor (under age 18) or incompetent beneficiary may submit a claim on behalf of the beneficiary, unless otherwise specified.

2.3 Filing Deadlines

- Beneficiaries should file claims as soon as possible after services are rendered.
- If claims are not filed by the deadlines below, claims will be denied.

United States and Puerto Rico	Overseas and All Other U.S. Territories
Within one year of the date of service or date of discharge for inpatient care	Within three years of the date of service or date of discharge for inpatient care

2.3: Test Question

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3.0 Submitting Claims

- Claims are submitted to the claims processor based on the beneficiary's residential address, except overseas. All claims for overseas care are submitted to and processed by the overseas claims processor.
- There are two major TRICARE claims processors:

North and South Regions	West/Overseas Regions and TRICARE for Life
Palmetto Government Benefits Administration (PGBA)	Wisconsin Physicians Service (WPS)

Claims Processors



3.0: Test Question

Inform participants that TRICARE makes every effort to supply the missing information from existing databases before rejecting the claim, whereas most of the private sector does not.

- If a beneficiary sees a network provider, the provider is responsible for filing the claim.
- If a beneficiary sees a non-network provider, the provider is not required to submit the claim, but may do so voluntarily.
 - The beneficiary is responsible for ensuring the claim is filed.
 - The beneficiary can be held liable for the charges if the non-network provider fails to timely file.
- If a claim is sent to the regional contractor instead of the regional claims processor, the regional contractor forwards the claim to the claims processor.
- If a claim is sent to the wrong claims processor, the claim is either forwarded to the appropriate claims processor, returned to the sender, or may be denied as "patient not eligible."
- TRICARE-eligible beneficiaries are responsible for keeping their personal contact information up to date with their providers and in the Defense Enrollment Eligibility Reporting System (DEERS) so claims go to the correct claims processor and related payment or other information can be sent to the beneficiary.

4.0 Claims Processing Procedures

TRICARE processes claims using specific procedures to ensure that all claims are processed in a timely manner and government-furnished funds are expended only for those services or supplies authorized by law and regulation.

4.1 Processing Criteria

Claims processors verify the following criteria in this order:

- The beneficiary is eligible.
- The beneficiary/provider filed the claim in a timely manner.
- The provider of services or supplies is TRICARE-authorized.

4. The service or supply provided is a TRICARE benefit.
5. The service or supply provided is medically necessary and appropriate or is an approved TRICARE clinical preventive service.
6. The beneficiary is legally obligated to pay for the service or supply (when appropriate).
7. The claim contains sufficient information to determine the TRICARE allowable charge for each service or supply.

4.2 Processing Criteria for Newborn Claims

- Claims for newborns not registered in DEERS can be processed as long as:
 - The newborn's date of birth is within 365 days of the contractor's eligibility query; **and**
 - The sponsor is/was eligible for TRICARE for the date(s) of care on the newborn's claim
- Exception: If the sponsor (and family) are enrolled in TRICARE Reserve Select (TRS) or TRICARE Retired Reserve (TRR), a *Reserve Component Health Coverage Request* form (DD Form 2896-1) must be received or postmarked no later than 60 days after the newborn's birth date for the newborn's claims to be paid as an eligible dependent. If the required forms are not received within 60 days, the newborn's claims are denied as "not eligible."
- See the *DEERS* module for more information on eligibility.

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5.0 Resolving Claims Issues

- The first action beneficiaries should take to resolve claims issues is to call their regional contractor's toll-free number and select the option for claims assistance, or visit a local TRICARE Service Center (TSC) if near a military treatment facility (MTF).
- If the claim issue remains unresolved, the beneficiary may contact an MTF or a TRICARE Regional Office (TRO)/TRICARE Area Office (TAO) Beneficiary Counseling and Assistance Coordinator (BCAC).
- If an unresolved debt results in a collection action, the beneficiary should first contact the regional contractor, and then an MTF, or TRO/TAO Debt Collection Assistance Officer (DCAO), if additional assistance is needed.
- Beneficiaries and BCACs/DCAOs must register for access to the regional claims processor's online system (www.myTRICARE.com or www.TRICARE4u.com) to review claim status information for their respective region.

5.0 Test question

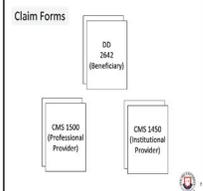
5.1 Assisting the Beneficiary with Claims Issues

When working with a beneficiary on a claims issue, consider the following questions:

- When was the date of service? What was the beneficiary's eligibility status or category at the time of service?
- What type of service did the beneficiary receive (e.g., medical appointment, hospitalization, medications administered in a provider's office, supplies)?
- Was this an inpatient or outpatient service?
- Did the beneficiary contact the claims processor for that benefit (regional, dental, pharmacy)? If yes, what was the result?
- Did the beneficiary bring his/her Explanation of Benefits (EOB), summary payment voucher, or bill?
- If the EOB is available, study the notes to determine how and why the claim processed as it did. For example:
 - Point of service (POS)
 - No authorization on file
 - Beneficiary was not eligible
 - Not a TRICARE benefit

Remind participants that OHI is the primary payer, and TRICARE pays second or last if there is more than one OHI.

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- If beneficiaries state they never received an EOB, look up claims information online if you are registered or call the claims processor to find out if the provider submitted a claim. If not, advise the beneficiary to contact the provider to request that the office file a claim or determine if and when the provider submitted the claim to the claims processor.

5.2 Working with Claims Processors

BCACs and DCAOs should try to work consistently with one key claims processor staff member to build rapport and maintain consistency in the communication process when researching/resolving beneficiary claim issues.

6.0 Other Health Insurance (OHI)

Special circumstances exist when beneficiaries have other health insurance (OHI). The beneficiary must follow the rules of their OHI; if they don't, TRICARE will deny payment.

- If a beneficiary has OHI, the beneficiary or the provider must file a claim with that health insurance plan before filing with TRICARE.
 - Exceptions: Medicaid, Indian Health Service, and certain other programs identified by the Director, TRICARE Management Activity (TMA) (e.g., State Victims Assistance Plans)
- After a claim is processed by the OHI, it can be filed with TRICARE along with a copy of the other health plan's payment determination and the itemized charges (bill).
- Beneficiaries must notify their regional contractor or the claims processor about OHI and any associated changes in carriers or coverage to avoid delays in claims processing or possible denials.

7.0 Claim Forms

7.1 Beneficiaries

Beneficiaries use *DD Form 2642* to submit claims for services or supplies provided by civilian sources of medical care and for prescription drugs. A *DD Form 2642* submitted by a provider will be returned to the provider.

- *DD Form 2642* is available online for download at:
 - TRICARE website: www.tricare.mil/forms
 - PGBA website: www.myTRICARE.com
 - WPS website: www.TRICARE4u.com
- Beneficiaries may request *DD Form 2642* by calling the regional contractor's toll-free number or visiting a local TRICARE Service Center.
- Beneficiaries must submit a separate claim and claim form for each:
 - Episode of care
 - Service provided by different providers
 - Family member, even if several family members visit the same provider on the same day
- For prescription drug claims, one claim form per family member is required; the claim may reflect more than one prescription medication.

Note: Box 13 on the *DD 2642* asks beneficiaries if they would like payment issued in local currency. The term "local" refers to the country where services were provided. If marked "yes," the payment is issued in that country's currency. If the box is marked "no" or neither "yes" or "no" box is checked, the payment is issued in U.S. dollars.

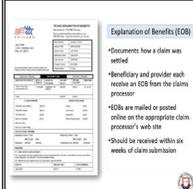
7.2 Providers

- Stateside:
 - Professional providers submit claims using the CMS 1500 08/2005, *Health Insurance Claim Form*.
 - Institutional providers submit a claim using the CMS 1450 UB-04, *Health Insurance Claim Form*.
- Overseas providers are asked to submit a *CMS 1500 (08/2005)*.

7.3: Test Question

The DD Form 2527, Statement of Personal Injury/Third Party Liability form should be submitted along with the DD Form 2642.

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7.3 Items That Accompany a Claim

Beneficiaries may need to include the following documents when filing a claim:

- An itemized list of charges for each service or supply, with the accompanying diagnosis; must be on the provider's letterhead or standard form along with the provider's tax ID number
- An itemized list of charges from the pharmacy; must be on the pharmacy's letterhead or billing form. (See the *Pharmacy* module for more information.)
- Proof of purchase for care received overseas or if a TOP Prime/Prime Remote enrollee
- OHI claim forms: The health plan's payment determination, denial statement, or EOB
- **Statement of Personal Injury—Possible Third-Party Liability (DD Form 2527)**
 - Required with *DD Form 2642* in instances where a beneficiary's condition is potentially accident related, work related, or both, and when certain procedure or diagnostic codes indicate there may be third-party liability involved.
 - Beneficiaries may submit *DD Form 2527* after the initial claim is submitted or as requested by the regional claims processor.
 - **Failure to submit form *DD Form 2527* within the time frame specified on the form may result in the beneficiary's claim being pended or denied.**

8.0 Explanation of Benefits (EOB)

- After submitting claims, the beneficiary and provider each receive a TRICARE EOB from the claims processor showing how the claim was settled.
- The EOB is mailed or posted online at either www.TRICARE4u.com or www.myTRICARE.com, depending on the region.

8.1 When to Expect an EOB

- For the majority of claims processed, the beneficiary and the provider should each receive an EOB within six weeks of submitting a claim.
 - Some complex claims may take 60 days or more to complete.
 - To determine if a claim was received, beneficiaries and providers may contact the claims processor or check the claims processor's website (beneficiaries must be registered users).
- If the beneficiary does not receive an EOB or cannot find the claim on the claim processor's website within six weeks of the date of service, he/she should contact the provider or facility to verify that a claim was submitted. This also ensures the claim does not miss the timely filing deadline.
- Remind beneficiaries to follow up with ambulance companies separately, as insurance information isn't typically shared between hospitals, physicians and ambulance companies.

8.2 Reasons for Delays in Processing a Claim or Receiving an EOB

- Wrong address
- Claim is incomplete
- Eligibility is being questioned or DEERS information is inaccurate
- Diagnosis is missing or inconsistent with services provided
- A Third-Party Liability form hasn't been received
- OHI forms are missing
- Claim is complex and requires an extensive review
- There is a government-directed delay (possibly because the provider is being investigated or because of fraud)
- Provider delayed submitting a claim

- Service is non-authorized
- Medical necessity is not documented
- Provider's unique Provider Identification Number or National Provider Identification is missing

8.3 Importance of Reviewing EOBs

- Beneficiaries should carefully compare each EOB against services they received and their bills, checking that the right provider(s) and right service(s) are billed.
 - Beneficiaries should contact the claims processor about charges for a service they did not receive. Incorrect charges may be due to a simple error in the provider's billing or entry in the claims system, or an indication of fraud.
- The beneficiary may contact the regional contractor or claims processor by phone, internet, or at the nearest TSC with questions about their EOB.
- Beneficiaries may also seek assistance from the nearest MTF or regional BCAC/DCAO if unable to get a claims issue resolved with the regional contractor.

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for 8.4



8.4 Components of an EOB

- **Claims Processor:** The claims processor that processed the claim and issued the EOB. This can be important. Example: A claim could be denied if it was submitted to the wrong processor. You should verify it was processed and denied by the correct region/claims processor for which the beneficiary is/was enrolled in for that date of service.
- **Date of Notice:** The date the claims processor prepared the TRICARE EOB.
- **Mail to Name and Address:** The TRICARE EOB is mailed to the patient's (or patient's parent's or guardian's) address as submitted on the claim.
- **Claim Number:** Each claim is assigned a unique tracking number as it's processed; should be used for reference if there are questions or concerns.
- **Sponsor SSN/Sponsor Name:** Claims are processed using the sponsor's SSN (active duty, retired, or deceased) or the individual's DoD health benefits number. The sponsor is the active duty service member (ADSM) or retiree through whom family members are eligible for TRICARE. Only the last four digits of the SSN appear on the EOB.
- **Beneficiary Name:** The patient who received the service/procedure and for whom the claim is filed.
- **Service Provided By:** This section lists who provided the care/services.
- **Services Provided:** This section describes the medical services provided on the claim by listing the specific procedure code and description of the service billed by the provider.
- **Date of Services:** This section lists the date the patient received the care.
- **Amount Billed:** The amount the provider charged for a particular service(s).
- **TRICARE Allowed:** This is the contracted amount allowed by TRICARE based on the date of service and the geographic location for the services billed.
- **See Remarks:** There is a code or a number here specific to a claims processing action; look at the "Remarks" section for the code description and explanation of how the claim processed.
- **Claim Summary/Beneficiary's Name:** A summary of totals on the entire claim/EOB. Includes the following: Total amount billed, total allowed amount by TRICARE, non-covered amount (if any), total amount OHI/Medicare paid (if applicable), total amount paid by TRICARE, total cost-share/copay (if any), total amount applied to the deductible (if any), patient responsibility (e.g., total of deductible, cost-share/copay, and possible non-covered services combined).
- **Out-of-Pocket Expense:** This section shows how much the patient/family has paid out of pocket and applied to the annual deductible and catastrophic cap (maximum out-of-pocket expense) to the date of the EOB. Claims processors calculate annual deductibles and catastrophic cap expenses by fiscal year.

- **Remarks:** Explanations of the codes or numbers listed in “See Remarks” appear here.
- **Paid To:** This field indicates who the check was issued to if payment was made. This can be the provider, sponsor, or beneficiary depending on the provider’s status and how the claim is billed. If the provider is a network provider, payment is issued to the provider. If a provider agrees to participate (by accepting assignment on a claim), the payment is issued to the provider unless he/she indicated on the claim that the patient paid the charges.
- **Amount Paid:** The amount that TRICARE pays on the claim.
- **Check Number:** A check number appears if payment is issued on the claim. This number identifies the check that the payment is issued against. (This can be helpful when one check is issued to a beneficiary or provider as payment for multiple claims.)
- **Toll-Free Telephone Number:** The toll-free number to the claims processor for questions about the EOB.

Continue to show slide #9 for 8.5

8.5 Application Exercises

8.5.1 Group Activity: Reading an EOB

Answer the questions below based on the fictitious sample EOB provided.

1. What is the date of notice on this EOB? **January 15, 2010**
2. Who is the sponsor? **John Smith**
3. Who is the beneficiary that received services? **Jane Smith**
4. Who provided the care and what type of care was received? **Pierce, Hunnicutt & Winchester, PC; Outpatient Office Visit (99214)**
5. How much was billed? **\$200.00**
6. How much did TRICARE cover, and what is the term for this approved amount? **\$80.00; TRICARE Allowable Charge**
7. What do the remark codes indicate? **01—Billed amount exceeds allowance; 02—You receive maximum benefits when you use a network provider. By law, a non-network provider may balance bill an additional 15% above the TRICARE allowable charge; 03—\$20.00 has been applied toward the catastrophic of \$3,000.00**
8. What amount was paid by TRICARE? **\$60.00**
9. How much (if any) was applied to the deductible? **\$0.00 (Deductible was met prior to visit)**
10. How much was the cost-share/copay? **\$0.00 (copay)/\$20.00 (cost-share)**
11. How much was the beneficiary’s responsibility? **\$20.00 (patient responsibility)**
12. Was payment made to the provider or the beneficiary? **Payment was made to the beneficiary**
13. What type of provider was this? **Non-network (based on remark code 02, which suggests that she would have received maximum benefits if she had used a network provider and the non-network provider may balance bill her 15% above the TRICARE allowable charge)**
14. Which TRICARE option was the beneficiary using? **How do you know? Retiree Family Member in TRICARE Standard, based on the 1) cost share—copays are associated with Prime/cost shares are associated with Standard; 2) catastrophic cap (which is listed as a limit of \$3,000, the maximum for a retiree.**

8.5.2 Practice Scenario Answer: Allow students to discuss scenario and give responses based on customer service perspective. There are no formal right/wrong answers but the needs of the beneficiary must be met.

8.5.2 Practice Scenario

Mrs. Jane Smith just walked into your office, irate and irrational. She recently had a visit at Pierce, Hunnicutt, & Winchester, P.C. She paid the doctor’s office \$200 at the time of service and was told that she could file with TRICARE for reimbursement of her payment. Mrs. Smith filed her reimbursement claim with the appropriate claims processor. She received her EOB, along with a check for \$60. She is upset because she was not reimbursed the full \$200 that she paid to the doctor’s office. Mrs. Smith wants to get this matter resolved and decided she needed to speak with someone face-to-face.

Based on what you just learned from reading her EOB and your knowledge of TRICARE claims, please assist Mrs. Smith with understanding why she was not reimbursed the full \$200 by TRICARE.



Jane Smith
123 S. Christmas Lane
Nice, SC 20315

If you have any questions about this notice, please call
1-800-123-4569 or visit us online at www.tricareu.com

TRICARE EXPLANATION OF BENEFITS

Administered by: TRICARE University

This is a statement of the action taken on your TRICARE claim. Keep this notice for your record.

Date of Notice	January 15, 2012
Sponsor SSN	XXX-XXX-XXXX
Sponsor Name	John Smith
Beneficiary Name	Jane Smith
Claim Number	345678901
Provider Number	XX-XX648
Check Number	512340

Explanation of Benefits		THIS IS NOT A BILL		Explanation of Benefits	
SERVICES PROVIDED BY	DATE OF SERVICE	SERVICES PROVIDED	AMOUNT BILLED	TRICARE ALLOWED	SEE REMARKS
Pierce, Hunnicutt, & Winchester, P.C.	11/29/2011	Outpatient Visit (99214)	\$200.00	\$80.00	01, 02, 03
Totals:			\$200.00	\$80.00	
CLAIMS SUMMARY			BENEFICIARY SHARE		
TRICARE Amount Billed	\$200.00		Copay		\$0.00
TRICARE Allowed	\$80.00		Cost-Share		\$20.00
TRICARE Paid	\$60.00		Deductible		\$0.00
Other Ins. Allowed	\$0.00		Patient Responsibility		\$20.00
Other Ins. Paid					
Other Ins. Patient Resp.					
OUT OF POCKET EXPENSES					
Beginning October 1, 2011			Beginning October 1, 2011		
	<u>Met To Date</u>	<u>Limit</u>		<u>Met To Date</u>	<u>Limit</u>
Deductible	\$150.00	\$300.00	Catastrophic Cap	\$170.00	\$3,000.00
REMARKS					
01—Billed amount exceeds allowance.					
02—You receive maximum benefits when you use a network provider. By law, a non-network non-participating provider may balance bill an additional 15% above the TRICARE-allowable charge.					
03—\$20.00 has been applied toward the catastrophic cap of \$3,000.00.					
PAID TO		AMOUNT PAID		CHECK NUMBER	
Jane Smith		\$60.00		512340	

Show slide #10
for 9.0



9.0 Appeals

- To appeal means to request that the contractor or TMA review coverage, authorization, or claims denial decision.
- The appeals process varies, depending on whether the denial involves:
 - Medical necessity
 - Factual determination
 - Dual-eligible beneficiary (Medicare-TRICARE eligible beneficiaries)
 - Provider sanction
- All initial denials and appeal denials explain how, where, and by when to file the next level of review.

9.1 Provider Sanction

A sanctioned provider is a provider who is denied approval as a TRICARE-authorized provider or who was terminated, excluded, suspended, or otherwise sanctioned.

- Providers may be sanctioned by TRICARE because of the following:
 - Failure to maintain credentials
 - Provider fraud
 - Abuse
 - Conflict of interest
 - Other reasons
- Only the provider or his/her representative can appeal the sanction.
- If the provider appeals the sanction, an independent hearing officer conducts a hearing administered by the TMA Appeals, Hearings, and Claims Collection Division in Aurora, Colorado.

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10.0 Who Can Appeal?

- The appealing party must be able to prove that he/she is eligible for TRICARE benefits including:
 - Any TRICARE beneficiary, or a parent or guardian of a beneficiary who is under 18 years of age
 - The guardian of a beneficiary who is not competent to act on their own behalf
 - A health care provider who was:
 - Denied approval
 - Suspended, excluded, or terminated as a TRICARE-authorized provider
 - Providers who participate in TRICARE and accept the TRICARE-allowable charge as their full fee
 - A representative, appointed in writing by a beneficiary or provider
- Certain individuals may not serve as beneficiary representatives due to a conflict of interest, including:
 - A legal officer (member of a uniformed services legal office)
 - BCAC/DCAO/Health Benefits Advisor (HBA)
 - Employee of the federal government, such as a uniformed service member, MTF provider, or an employee of a uniformed service, unless the representative is an immediate family member
- Non-participating providers and network providers cannot file appeals.

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for 11.0

What Can Be Appealed?

- Diagnosis
- Necessity for inpatient care
- Denial of preauthorization for services (including mental health services)
- Termination of previously authorized treatment/services
- Denial of payment for services or supplies
- Termination of payment for previously authorized treatment/services
- Denial or revocation of TRICARE-authorized status

11.0 What Can Be Appealed?

- The facts of a beneficiary's case that can be appealed:
 - The diagnosis
 - The necessity to be an inpatient
 - The denial of pre-authorization for services, including mental health
 - The termination of treatments or services that were previously authorized
 - The denial of TRICARE payment for services or supplies received
 - The denial of TRICARE payment for continuation of services or supplies that were previously authorized
 - The denial of a provider's request for approval as a TRICARE-authorized provider or expelling a provider from TRICARE

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for 12.0

What Cannot Be Appealed?

- Amount of TRICARE-determined costs or charges for a medical service
- Request by Regional Contractor or TMA for further information on claim or appeal
- Provider's status as TRICARE-authorized (beneficiary only, provider may appeal)
- Beneficiary's eligibility status for TRICARE (eligibility determined by branch of service, and reported in DEERS)

12.0 What Can't Be Appealed?

The following are examples of what can't be appealed:

- The TRICARE allowable amount for a particular medical service (The beneficiary may ask the regional contractor for an allowable charge review, but cannot file an appeal.)
- The decision by the regional contractor or TRICARE Management Activity (TMA) to ask the beneficiary for more information before taking action on the beneficiary's claim or appeal request
- Whether a provider is a network or authorized provider
- A decision relating to TRICARE eligibility
 - The services determine eligibility and DEERS reports it
 - Beneficiaries must appeal decisions regarding their eligibility through their branch of service

12.0 Test question

The TRICARE allowable charge cannot be appealed.

13.0 Appeals of Medical Necessity Determinations

- "Medical necessity" is based on whether, from a medical point of view, the care is appropriate, reasonable, and adequate for the beneficiary's condition, to include decisions on custodial and mental health care services.
- It may be necessary to show medical necessity for inpatient, outpatient, and specialty care.
- The beneficiary must send a package to the regional contractor, including a cover letter with relevant case information, a copy of the denial letter, and any associated EOBs, claims, bills, and/or documents that the beneficiary feels support overturning the denial decision.
 - Failure to include a copy of the denial letter may delay the review process or cause the appeal to be routed incorrectly.
 - If beneficiaries can't get all of the supporting documents in on time, they should send the appeal anyway and state in the cover letter their intention to submit additional information when it becomes available.
 - The beneficiary should keep originals of all paperwork related to the appeal.
- There are two kinds of medical necessity determination appeals:
 - Expedited
 - Non-expedited (most appeals are non-expedited)

13.1 Expedited Appeal

- An expedited appeal should only be submitted to reconsider approval of inpatient stays or prior authorization of services.
- A beneficiary must file a request for an expedited reconsideration of a pre-admission/pre-procedure denial within three calendar days after the date of the receipt of the initial denial determination.
- Beneficiaries are notified of a decision within three working days after the regional contractor receives the request.

13.1.1 Second Level Expedited Appeal

- If the contractor's reconsideration determination is less than fully favorable and \$50 or more remains in dispute, the contractor shall include a statement explaining the right of the beneficiary to request an appeal to the TRICARE Quality Monitoring Contractor (TQMC) for a second reconsideration.
- The beneficiary shall file the expedited appeal request with the TQMC within three calendar days after the date of receipt of the initial reconsideration determination.
- The TQMC will issue a second reconsideration determination within three working days of receipt of the reconsideration request.

13.2 Non-Expedited Appeal

- To file a non-expedited appeal, the beneficiary sends the information package (see Section 13.0 of this module for more information on information packages) to the regional contractor at the address specified in the determination notice of the beneficiary's right to appeal, included on their EOB or other notification.
- The package must be postmarked or received within 90 days of the date on the EOB or initial denial determination notice (usually a letter).
- The regional contractor reviews the case and issues a reconsideration review determination, either supporting or overturning the denial within 30 days of receipt of the reconsideration request.
- If the amount is less than \$50, the decision is final.

13.2.1 Second Level Non-Expedited Appeal

- If the denial is again upheld and the amount in dispute is greater than \$50, the beneficiary can appeal to the TQMC per instructions provided in the reconsideration review determination letter.
- The beneficiary sends a letter to the TQMC.
 - The letter must be postmarked or received within 90 days of the date on the regional contractor's reconsideration decision determination notice.
 - A copy of the reconsideration decision and any supporting documents not previously submitted must be included with the letter. If beneficiaries cannot get all of the supporting documents in on time, they should state in the cover letter their intention to submit additional information in the near future.
 - The beneficiary should keep the originals or copies of all paperwork submitted.
- The TQMC reviews the case and issues a second reconsideration decision within 30 calendar days of receipt of reconsideration request.

14.0 Appeals of Factual Determinations

Factual determinations involve issues other than medical necessity, such as coverage issues, provider authorization (status) requests, hospice care, foreign claims, and denial of a provider's request for approval as a TRICARE-authorized provider. Medical or peer review may be necessary to reach a factual determination.

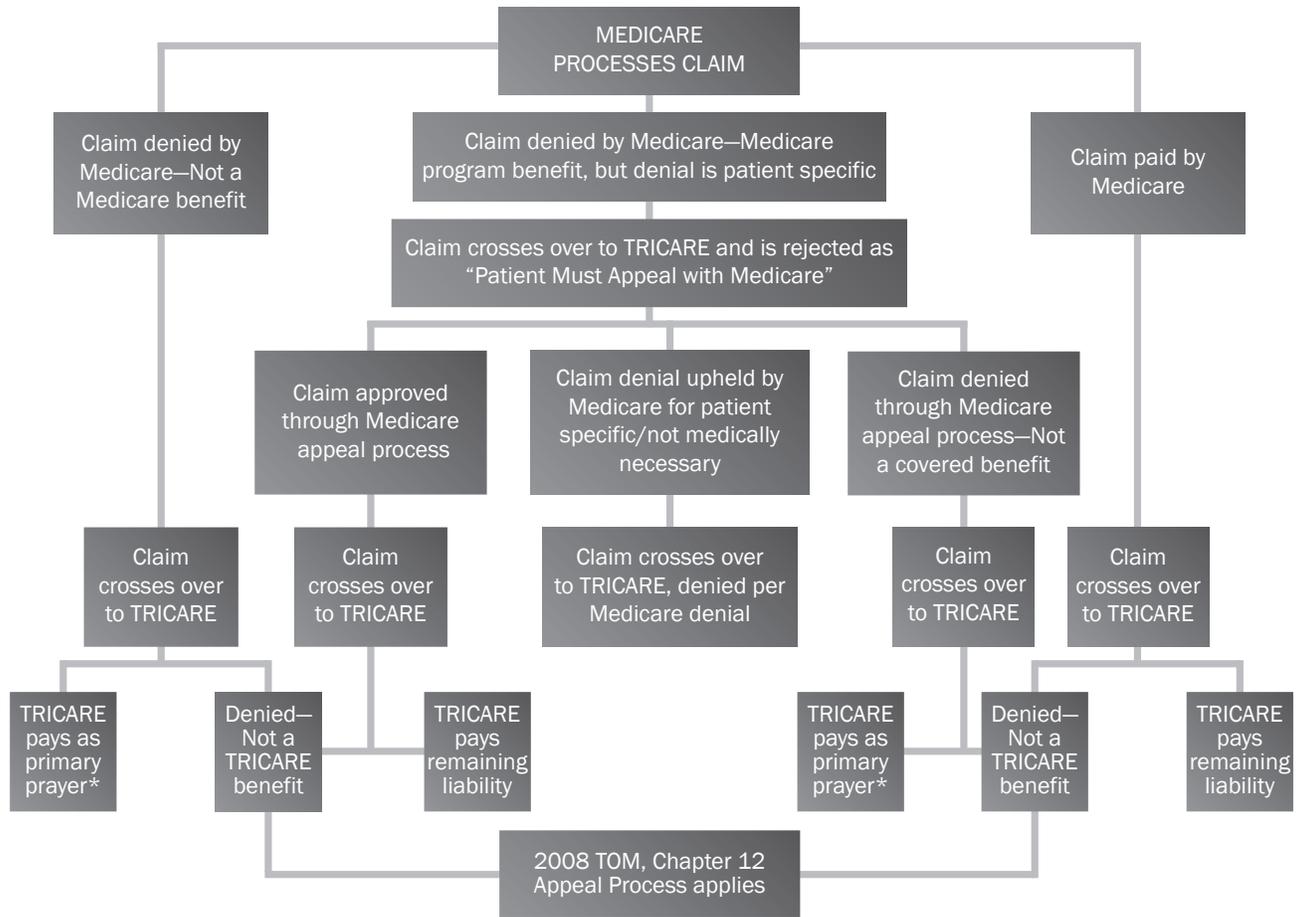
14.1 Factual Determination Appeal Process

- To file a factual determination appeal, the beneficiary submits the same kind of packet they would submit for a medical necessity appeal. (See Section 13.0 of this module for more information.)
- This reconsideration letter must be postmarked or received within 90 days of the date on the EOB or initial denial determination notice.
- The regional contractor issues a reconsideration determination of a factual appeal within 60 days of the beneficiary's request.
 - If the beneficiary appeals an amount less than \$50, the regional contractor's reconsideration (second) determination is final.
 - If the beneficiary appeals an amount greater than \$50, the regional contractor issues a determination, and if the denial is upheld, instructs the beneficiary to file a formal review request with TMA.
- To request a formal review, beneficiaries must send a letter to TMA within 60 days (postmarked or received) of the date on the factual reconsideration decision notice and include copies of the decision along with additional supporting documents.
- TMA typically issues a formal review decision within 90 days.
 - If the disputed amount is less than \$300, TMA's decision is final.
 - If the disputed amount is more than \$300, the beneficiary can request an independent hearing.
- To request an independent hearing, the beneficiary must send a request to TMA-Aurora within 60 days (postmarked or received) from the date of TMA's formal review determination.
- The beneficiary should include a copy of the formal review determination and any supporting documents not previously submitted.
- An independent hearing officer then conducts the hearing at a location convenient to both the requesting party and the government.
- The hearing officer makes a decision recommendation and the Assistant Secretary of Defense, Health Affairs issues the final decision.
- Factual appeals and appeal correspondence for the TMA should be addressed to:

TRICARE Management Activity
Appeals, Hearings and Claims Collection Division
16401 E. Centretch Parkway
Aurora, CO 80011-9066

15.0 Appeals for Dual Eligibility Determinations—Medicare-TRICARE Eligibles

- 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 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 Medicare.
- See the chart on the following page for additional information on claims for Medicare-TRICARE eligibles.



*If a TRICARE-covered benefit

16.0 TRICARE Prime Remote (TPR) Appeals

- If an active duty service member (ADSM) in a designated remote location (stateside or overseas) does not receive prior authorization for specialty care his or her claim may be denied:
 - The ADSM may appeal by first contacting the appropriate authorization authority:
 - The Military Medical Support Office (MMSO) Service Point of Contact (SPOC) if care was received in the United States or the U.S. Virgin Islands
 - MTF staff, if care was based on an MTF referral or the ADSM shows as enrolled in TRICARE Prime at an MTF on the date of service
 - The overseas regional contractor if care was received in an overseas location (other than the U.S. Virgin Islands)
 - ADSMs, their primary care manager (PCM), or network or TRICARE-authorized provider may send additional written information or documentation to the SPOC to support the ADSM's appeal request.
- If the request is denied on appeal, the ADSM may then appeal to their Surgeon General or the senior medical officer of their respective service. The address for this second appeal is provided to the ADSM upon denial of the first appeal.

16.1 Service Points of Contact (SPOCs) at the Military Medical Support Office (MMSO)

- ADSMs from the Army, Marine Corps, Navy, and Air Force may contact their SPOC at 1-888-MHS-MMSO/1-888-647-6676. Send written inquires to:

[Insert branch of service] Point of Contact
Military Medical Support Office (MMSO)
P.O. Box 886999
Great Lakes, IL 60088-6999
- ADSMs from the Coast Guard may contact their SPOC at 1-800-647-6676.
- U.S. Public Health Service (USPHS) and members may contact their Beneficiary Medical Program SPOC at 1-800-368-2777, option 2.
- National Oceanic and Atmospheric Administration (NOAA) members may contact their Beneficiary Medical Program SPOC at 1-800-224-6622

17.0 Program Integrity

- The TMA Office of Program Integrity:
 - Is the investigative arm of TMA
 - Provides management of the TMA anti-fraud program
 - Is responsible for national coordination and control of cases through their work with contractors, the Department of Justice, and investigative agencies
 - Provides oversight to all contractor program integrity units to ensure compliance in the area of anti-fraud activities
- Program Integrity is responsible for deterring fraud, waste, and abuse through:
 - Prevention
 - Detection
 - Coordination
 - Enforcement

17.1 What is Fraud?

- Fraud is any intentional deception or misrepresentation that an individual or entity does which could result in an unauthorized TRICARE benefit or payment.
- TRICARE considers the following fraudulent acts under the program:
 - Submitting claims for services not rendered or used
 - Falsified claims or medical records
 - Misrepresentation of dates, frequency, duration, or description of services rendered
 - Billing for services at a higher level than provided or necessary
 - Over-utilization of services
 - Breach of provider participation agreement

17.2 Who Commits Fraud?

- Dishonest health care providers and other health care professionals commit the majority of fraud (e.g., physicians, dentists, labs, hospitals, psychiatrists, ambulance companies, and clinics)
- Contractors and contract employees
- A lesser percent is attributed to beneficiary fraud

17.3 Fraud Indicators

- Excessive charges by provider
- Claims with excessive or vague documentation
- Correspondence for rapid adjudication
- Reluctance of provider to submit records
- Diagnosis or treatment inconsistent with patient's age or sex
- Illogical places of service
- Too many providers for same date of service
- Provider who uses post office boxes for the remit to address
- Erasures, cross-outs, or white outs
- Providers routinely billing the same procedures to every patient, regardless of diagnosis
- Overlapping services on the same date
- Provider is not in the same geographic area as the beneficiary, particularly when patterns occur
- Excessive billing by provider for low cost items or services
- High volume of treatment for a particular condition or diagnosis
- Claims handwritten in the same ink for both the beneficiary and provider portion of claim
- Conflicting dates of service
- Claims with misused or misspelled medical terms

17.4 Potential Outcome of Fraud Cases Referred to TRICARE

- Criminal conviction
- Civil settlement
- Administrative action by the contractor
- Termination action
- Exclusion action (i.e., removal from the TRICARE program)

17.5 Where to Report Potential Fraud Cases

<p>TRICARE Region North: Health Net Federal Services Fraud Hotline: 1-800-977-6761 E-mail: program.integrity@healthnet.com</p>	<p>TRICARE Region West: TriWest Healthcare Alliance 1-888-584-9378 E-mail: pi@trivest.com</p>
<p>TRICARE Region South: Humana Military Healthcare Services 1-800-333-1620 Online: http://infocenter.humana-military.com/south/bene/progintegreferral.asp</p>	<p>TMA Program Integrity Office: TRICARE Management Activity Attn: Program Integrity Office 16401 East Centretech Parkway Aurora, CO 80011-9066 Phone: 1-303-676-3824 Fax: 1-303-676-3981 E-mail: fraudline@tma.osd.mil</p>
<p>TRICARE Retiree Dental Program: Delta Dental 1-888-838-8737</p>	<p>TRICARE Overseas: 1-877-342-2503 International SOS: 1-800-834-5514 or 1-215-701-2800 (collect)</p>
<p>TRICARE Pharmacy Program: Express Scripts, Inc. 1-800-332-5455 E-mail: fraudtip@express-scripts.com</p>	<p>TRICARE for Life (TFL): 1-866-773-0404 E-mail: reportit@wpsic.com</p>
<p>TRICARE Dental Program: MetLife Fraud Hotline: 1-800-462-6565</p>	<p>Active Duty Dental Program: United Concordia Fraud Hotline 1-877-968-7455 Online: https://secure.ucci.com/non-ldap/forms/form.html</p>
<p>Online Reporting: www.tricare.mil/fraud/index.cfm?fuseaction=reportingfraud.showregionmap.pdf</p>	

18.0 Summary

18.1 Where to Get Additional Claims and Appeals Information for Beneficiaries

Direct beneficiaries to their:

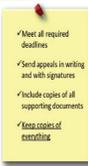
- Regional contractor or claims processor
- TRICARE Service Center (TSC)
- Nearest MTF
- Military Medical Support Office (stateside and Virgin Island TPR ADSMs only)
- BCACs/DCAOs at the TRO/TAO

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for 18.2

18.2 Beneficiary Appeals Checklist

- Meet all the required deadlines
- Send appeals in writing with signatures
- Include copies of all supporting documents with the appeal (If all paperwork is not available, send the letter within the deadline and note that more information will be sent; then send it in a timely manner.)
- Keep originals or copies of everything (e.g., EOB, Denied Authorization Letter)

Beneficiary Checklist



Module Objectives



Show slide #15

Module Summary

- Explain who can file claims and where claims should be submitted
- Describe how to resolve claims issues
- Identify three reasons why an Explanation of Benefits may be delayed
- Distinguish between what can and cannot be appealed

Summary:

- Explain who can file claims and where claims should be submitted
- Describe how to resolve claims issues
- Identify three reasons why an Explanation of Benefits (EOB) may be delayed
- Distinguish between what can and cannot be appealed

Show slide #16

Questions?

A red circular icon with a white question mark inside, set against a white background with a subtle shadow.

Show slide #17

The TRICARE logo, featuring a stylized blue star with red and white wavy lines to its left, and the word "TRICARE" in red capital letters below.

Appendix A: Claims Resources

North Region Claims Processor

North Region Locations
Connecticut, Delaware, the District of Columbia, Illinois, Indiana, Iowa (Rock Island area), Kentucky (except Fort Campbell), Maine, Maryland, Massachusetts, Michigan, Missouri (St. Louis area), New Hampshire, New Jersey, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Vermont, Virginia, West Virginia, and Wisconsin
PGBA P. O. Box 870140 Surfside Beach, SC 29587-9740 1-877-874-2273 www.myTRICARE.com

South Region Claims Processor

South Region Locations
Alabama, Arkansas, Florida, Georgia, Louisiana, Mississippi, Oklahoma, South Carolina, Tennessee, Texas (excluding the El Paso area) and Fort Campbell, Kentucky area
PGBA P.O. Box 7031 Camden, SC 29020-7031 1-800-403-3950 www.myTRICARE.com

West Region Claims Processor

West Region Locations
Alaska, Arizona, California, Colorado, Hawaii, Idaho, Iowa (excluding Rock Island Arsenal area), Kansas, Minnesota, Missouri (except the St. Louis area), Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Texas (the southwestern corner, including El Paso), Utah, Washington, and Wyoming
WPS P.O. Box 77028 Madison, WI 53707-7028 1-888-915-4001 www.TRICARE4u.com

TRICARE Eurasia-Africa Claims Processor

TRICARE Eurasia-Africa Locations
Africa, Europe, and the Middle East
TRICARE Overseas Program P.O. Box 8976 Madison, WI 53708-8976 1-877-678-1207 (Stateside) +44-20-8762-8384 (Overseas) www.TRICARE4u.com

TRICARE Latin America and Canada Claims Processor

TRICARE TLAC Locations
Canada, the Caribbean Basin, Central and South America, Puerto Rico, and the U.S. Virgin Islands
TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985 1-877-451-8659 (Stateside) +1-215-942-8393 (Overseas) www.tricare4u.com

TRICARE Pacific Claims Processor

TRICARE Pacific Locations
Asia, Guam, India, Japan, Korea, New Zealand, and Western Pacific remote countries
TRICARE Overseas Program P.O. Box 7985 Madison, WI 53707-7985 Singapore: 1-877-678-1208 (Stateside) +65-6339-2676 (Overseas) Sydney: 1-877-678-1209 (Stateside) +61-2-9273-2710 (Overseas) www.tricare4u.com

TRICARE for Life Claims

United States and U.S. Territories	Overseas
WPS TRICARE For Life (TFL) P.O. Box 7890 Madison, WI 53707-7890 1-866-773-0404 www.tricare4u.com	TRICARE Overseas Program (TOP) P.O. Box 7985 Madison, WI 53707-7985 www.tricare4u.com

Appendix B: Sample Explanation of Benefits Statements

The following pages list figures and reference details for the stateside regional contractor's explanation of benefits (EOB) statements.

North Region—Sample Explanation of Benefits

How to Read Your TRICARE EOB for the North Region

1. **PGBA, LLC (PGBA):** PGBA processes all TRICARE claims for the region where you live.
2. **Regional Contractor:** The name "Health Net Federal Services" and the Health Net Federal Services, LLC logo appear here.
3. **Date of Notice:** PGBA prepared your TRICARE EOB on this date.
4. **Sponsor SSN/Sponsor Name:** We process your claim using the Social Security number (SSN) or Department of Defense Benefits Number of the military service member (active duty, retired, or deceased) who is your TRICARE sponsor.
5. **Beneficiary Name:** This is the name of the patient who received medical care and who this claim was filed for.
6. **Mail-To Name and Address:** We mail the TRICARE EOB directly to the patient (or patient's parent or guardian for minors) at the address given on the claim. **Note:** Be sure your doctor has updated your records with your current address.
7. **Partial Benefits Were Payable To:** This field appears only if your doctor accepts assignment. This means the doctor accepts the TRICARE maximum-allowable charge as payment in full for the services you received.
8. **Claim Number:** We assign each claim a unique number. This helps us keep track of the claim as it's processed. It also helps us find the claim quickly whenever you call or write us with questions or concerns.
9. **Services Provided By/Date of Services:** This section lists who provided your medical care, the number of services, procedure codes, and the date(s) you received care.
10. **Services Provided:** This section describes the medical services you received and how many services are itemized on your claim. It also lists the specific procedure codes that doctors, hospitals, and labs use to identify the specific medical services you received.
11. **Amount Billed:** Your doctor, hospital, or lab charged this fee for the medical services you received.
12. **TRICARE Approved:** This is the amount TRICARE approves for the services you received.
13. **See Remarks:** If you see a code or a number here, look at the "Remarks" section (18) for more information about your claim.
14. **Claim Summary:** This is a detailed explanation of the action we took on your claim. You will find the following totals: amount billed, amount approved by TRICARE, non-covered amount, amount (if any) you already paid to the provider, amount your primary health insurance paid (if TRICARE is your secondary insurance), benefits we paid to the provider, and benefits we paid to the beneficiary. A check number will appear here only if a check accompanies your EOB.
15. **Beneficiary Liability Summary:** You may be responsible for a portion of the fee your doctor charged. If so, that amount will be itemized here. It will include any charges we applied to your annual deductible and any cost-share or copayment you must pay.
16. **Patient Responsibility:** This is the total amount you owe for this claim.
17. **Benefit Period Summary:** This section shows how much of the individual and family annual deductible and maximum out-of-pocket expense you have met to date. We calculate your annual deductible and maximum out-of-pocket expense by fiscal year. See the "Fiscal Year Beginning" date in this section for the first date of the fiscal year.
18. **Remarks:** Explanations of the codes or numbers listed in "See Remarks" section (13) appears here.
19. **Toll-Free Telephone Number:** If you have questions about your TRICARE EOB, please call PGBA toll-free at 1-877-TRICARE (1-877-874-2273). Our professional customer service representatives will gladly assist you.

1 PGBA, LLC
TRICARE NORTH REGION
P.O. BOX 870140
SURFSIDE BEACH, SC 29587-9740



2  **Health Net**
Federal Services
WWW.HNFS.COM

TRICARE EXPLANATION OF BENEFITS
This is a statement of the action taken on your TRICARE claim.
Keep this notice for your records.

3 Date of Notice: **October 22, 2011**
4 Sponsor SSN: *****-**-9898**
5 Sponsor Name: **TRICARE SPONSOR**
Beneficiary Name: **TRICARE BENE**

6 **TRICARE BENE**
5362 ANY STREET
ANYCITY XX 88888-9999

7 Partial benefits were payable to:
PATHOLOGY LABDOE
STE 999
9999 N JERGENS ST
TOLEDO OH 99999

8
Claim Number: 999999999-00-00

Services Provided By/ Date of Services	Services Provided	Amount Billed	TRICARE Approved	APC#	See Remarks
PATHOLOGY LABDOE 09/02/2011	001 Emergency dept visit (99282)	32.84		11111	1, 2, 3
09/02/2011	001 Repair superficial wound(s) (12002)	<u>161.84</u>	<u>161.84</u>	11111	1, 2
Totals:		194.68	161.84		

Claim Summary	Beneficiary Liability Summary	Benefit Period Summary
Amount Billed: 194.68	Deductible: 0.00	Fiscal Year Beginning: October 01, 2011
TRICARE Approved: 161.84	Copayment: 0.00	
Non-covered: 32.84	Cost Share: 0.00	Individual 0.00 Family 0.00
Paid by Beneficiary: 0.00	Patient Responsibility: 0.00	Catastrophic Cap: 0.00
Other Insurance: 0.00		
Paid to Provider: 161.84		
Paid to Beneficiary: 0.00		
Check Number: 6990666666		

Remarks:

- 1 - CHARGES ARE MORE THAN ALLOWABLE AMOUNT.
- 2 - YOUR CLAIM HAS BEEN PROCESSED UNDER THE SUPPLEMENTAL HEALTH CARE PROGRAM. IF YOU HAVE QUESTIONS ABOUT THE PROCESSING OF YOUR CLAIM PLEASE CALL PGBA AT 1-877-874-2273. IF YOU WISH TO APPEAL YOUR CLAIM YOU MUST SUBMIT YOUR REQUEST IN WRITING TO YOUR SERVICE POINT OF CONTACT.
- 3 - GREAT NEWS! PGBA IS MAKING TRICARE EASIER. YOU CAN NOW VIEW THE STATUS OF YOUR CLAIMS AT WWW.MYTRICARE.COM. FOR MORE INFORMATION VISIT OUR WEB SITE TODAY.

19 **1-877-TRICARE (1-877-874-2273)**

THIS IS NOT A BILL
If you have questions regarding this notice, please call or write us at telephone number/address listed above.



South Region—Sample Explanation of Benefits

How to Read Your TRICARE EOB for the South Region

1. **PGBA, LLC (PGBA):** PGBA processes all TRICARE claims for the region where you live.
2. **Regional Contractor:** The name “Humana Military Healthcare Services” and the Humana Military Healthcare Services, Inc. logo appear here.
3. **Date of Notice:** PGBA prepared your TRICARE EOB on this date.
4. **Sponsor SSN/Sponsor Name:** We process your claim using the Social Security number (SSN) or Department of Defense Benefits Number of the military service member (active duty, retired, or deceased) who is your TRICARE sponsor. For security reasons, only the last four digits of your sponsor’s SSN appear on the EOB.
5. **Beneficiary Name:** This is the name of the patient who received medical care and who this claim was filed for.
6. **Mail-To Name and Address:** We mail the TRICARE EOB directly to the patient (or patient’s parent or guardian for minors) at the address given on the claim. **Note:** Be sure your doctor has updated your records with your current address.
7. **Partial Benefits Were Payable To:** This field appears only if your doctor accepts assignment. This means the doctor accepts the TRICARE maximum allowable charge as payment in full for the services you received.
8. **Claim Number:** We assign each claim a unique number. This helps us keep track of the claim as it’s processed. It also helps us find the claim quickly whenever you call or write us with questions or concerns.
9. **Services Provided By/Date of Services:** This section lists who provided your medical care, the number of services, procedure codes, and the date(s) you received care.
10. **Services Provided:** This section describes the medical services you received and how many services are itemized on your claim. It also lists the specific procedure codes that doctors, hospitals, and labs use to identify the specific medical services you received.
11. **Amount Billed:** Your doctor, hospital, or lab charged this fee for the medical services you received.
12. **TRICARE Approved:** This is the amount TRICARE approves for the services you received.
13. **See Remarks:** If you see a code or a number here, look at the “Remarks” section (17) for more information about your claim.
14. **Claim Summary:** This is a detailed explanation of the action we took on your claim. You will find the following totals: amount billed, amount approved by TRICARE, non-covered amount, amount (if any) you already paid to the provider, amount your primary health insurance paid (if TRICARE is your secondary insurance), benefits we paid to the provider, and benefits we paid to the beneficiary. A check number will appear here only if a check accompanies your EOB.
15. **Beneficiary Liability Summary:** You may be responsible for a portion of the fee your doctor charged. If so, that amount will be itemized here. It will include any charges we applied to your annual deductible and any cost-share or copayment you must pay.
16. **Patient Responsibility:** This is the total amount you owe for this claim.
17. **Benefit Period Summary:** This section shows how much of the individual and family annual deductible and maximum out-of-pocket expense you have met to date. We calculate your annual deductible and maximum out-of-pocket expense by fiscal year. See the “Fiscal Year Beginning” date in this section for the first date of the fiscal year.
18. **Remarks:** Explanations of the codes or numbers listed in the “See Remarks” section (13) appear here.
19. **Toll-Free Telephone Number:** If you have questions about your TRICARE EOB, please call PGBA at this toll-free number. Our professional customer service representatives will gladly assist you.

1 PGBA, LLC
TRICARE SOUTH REGION
P.O. BOX 7032
CAMDEN, SC 29020-7032

TRICARE EXPLANATION OF BENEFITS

This is a statement of the action taken on your TRICARE claim.
Keep this notice for your records.

2 HUMANA MILITARY
HEALTHCARE SERVICES
★★★★★
www.humana-military.com

3 Date of Notice: October 1, 2011
4 Sponsor SSN: ***-**-6789
5 Sponsor Name: **NAME OF SPONSOR**
5 Beneficiary Name: **NAME OF BENEFICIARY**

6 PATIENT, PARENT/GUARDIAN
ADDRESS
CITY STATE ZIP CODE

7 Benefits were payable to:
PROVIDER OF MEDICAL CARE
ADDRESS
CITY STATE ZIP CODE

8
Claim Number: 9279X0000-00-00

Services Provided By/ Date of Services 9	Services Provided 10	Amount Billed 11	TRICARE Approved 12	See Remarks 13
PROVIDER OF MEDICAL CARE				
10/01/2011	001 Initial comprehensive preve (99381)	97.00	85.10	1, 2
10/01/2011	001 Diphtheria, tetanus toxoids, (90698)	101.00	78.84	1
10/01/2011	001 Pnuemococcal conjugate vacci (90669)	<u>110.00</u>	<u>95.48</u>	1
Totals:		308.00	259.42	

Claim Summary 14	Beneficiary Liability Summary 15	Benefit Period Summary 17
Amount Billed: 308.00	Deductible: 0.00	Fiscal Year Beginning: October 01, 2011
TRICARE Approved: 259.42	Copayment: 0.00	
Non-covered: 259.42	Cost Share: 0.00	Deductible: Individual 0.00 Family 0.00
Paid by Beneficiary: 259.42	Patient Responsibility: 16 0.00	Catastrophic Caps: 9.00
Other Insurance: 259.42		
Paid to Provider: 259.42		
Paid to Beneficiary: 0.00		
Check Number:		

Remarks: 18

1 - CHARGES ARE MORE THAN ALLOWABLE AMOUNT.
2 - VISIT WWW.HUMANA-MILITARY.COM AND WWW.MYTRICARE.COM TO MANAGE YOUR HEALTH CARE ONLINE. FIND A PROVIDER, READ YOUR BENEFITS INFORMATION, CHECK INDIVIDUAL CLAIM AND REFERRAL STATUS, ELIGIBILITY, AND MUCH MORE.

19 1-800-403-3950

THIS IS NOT A BILL
If you have questions regarding this notice, please call or write us at telephone number/address listed above.



West Region—Sample Explanation of Benefits

How to Read Your TRICARE EOB for the West Region

1. **Mail-to Name and Address:** We mail the TRICARE EOB directly to the patient (or patient's parent or guardian for minors) at the address given on the claim. **Note:** Be sure your doctor has updated your records with your current address.
2. **Date of Notice:** This is the date we prepared your TRICARE EOB.
3. **Sponsor SSN/Sponsor Name:** We process your claim using the Social Security number (SSN) or Department of Defense Benefits Number of the military service member (active duty, retired, or deceased) who is your TRICARE sponsor.
4. **Patient Name:** This is the name of the patient who received medical care and who this claim was filed for.
5. **Claim Number:** We assign each claim a unique number. This helps us keep track of the claim as it's processed. It also helps us find the claim quickly whenever you call or write us with questions or concerns.
6. **Check Number:** A check number only appears here only if a check accompanies your EOB.
7. **Toll-Free Number/Web Address:** This is how you can reach us (TriWest Healthcare Alliance) if you have questions.
8. **Services Provided By:** This shows who provided your medical care, the number(s) and type(s) of service(s), and the procedure code(s).
9. **Date of Service:** This is the date you received the care.
10. **Amount Billed:** Your doctor, hospital, or lab charged this fee for the medical services you received.
11. **TRICARE Allowed:** This is the amount TRICARE approves for the services you received.
12. **Remarks:** If you see a code or a number here, look at the "Remark Codes" section (16) for more information about your claim.
13. **Claim Summary:** This is a detailed explanation of the action we took on your claim. You will find the following totals: amount billed, amount approved by TRICARE, non-covered amount, amount (if any) you already paid to the provider, amount your primary health insurance paid (if TRICARE is your secondary insurance), benefits we paid to the provider, and benefits we paid to the beneficiary.
14. **Beneficiary Share:** You may be responsible for a portion of the fee your doctor charged. If so, that amount will be itemized here. It will include any charges that we applied to your annual deductible and any cost-share or copayment you must pay.
15. **Out-of-Pocket Expense:** This section shows how much of the individual and family annual deductible and maximum out-of-pocket expense you have met to date. We calculate your annual deductible and maximum out-of-pocket expense by fiscal year. See the "beginning" date in this section for the first date of the fiscal year.
16. **Remark Codes:** Explanations of the codes or numbers listed in the "Remarks" section (12) appear here.
17. **Paid To:** This is the name of the provider or facility to whom the claim was paid.



TRICARE EXPLANATION OF BENEFITS

Administered by: TriWest Healthcare Alliance
This is a statement of the action taken on your TRICARE claim. Keep this notice for your records.

1 John B. Nice
123 Apple Lane
Huntsville, WA 12345-6789

7 If you have any questions about this notice, please call toll-free at **1-888-TRIWEST** (874-9378). You can also visit us online at **www.triwest.com**.

2	Date of Notice	08/14/2011
3	Sponsor SSN	234567890
4	Sponsor Name	John B. Nice
5	Patient Name	John B. Nice
6	Claim Number	2002212 053 0017930
	Check Number	C0001545337
	Provider Number	752906887 76550 0001
	Provider Name	ABC Valley Clinic

THIS IS NOT A BILL

SERVICES PROVIDED BY 8	DATE OF SERVICE 9	AMOUNT BILLED 10	TRICARE ALLOWED 11	REMARKS 12
Michael Smith, MD	03/23/11–03/27/11	\$000,000.00	\$000,000.00	003
Total		\$000,000.00	\$000,000.00	

CLAIM SUMMARY 13		BENEFICIARY SHARE 14	
TRICARE Amount Billed	\$000,000.00	Cost-Share/Copay	\$000,000.00
TRICARE Allowed	\$000,000.00	Deductible	\$000,000.00
TRICARE Paid	\$000,000.00	Beneficiary Responsibility	\$000,000.00
Other Insurance Allowed	\$000,000.00		
Other Insurance Paid	\$000,000.00		
Other Insurance Patient Responsibility	\$000,000.00		
Amount Applied to Offset	\$000,000.00		

15 **OUT OF POCKET EXPENSE:**

	Beginning October 1, 2011		Beginning October 1, 2010		Beginning October 1, 2009	
	Limit	Met to Date	Limit	Met to Date	Limit	Met to Date
Individual Deductible	\$ 000.00	\$ 000.00	\$ 000.00	\$ 000.00	\$ 000.00	\$ 000.00
Family Deductible	\$ 000.00	\$ 000.00	\$ 000.00	\$ 000.00	\$ 000.00	\$ 000.00
Catastrophic cap	\$0,000.00	\$0,000.00	\$0,000.00	\$0,000.00	\$0,000.00	\$0,000.00

16 **Remark Codes:**
003: See item 5 on reverse. If you are not satisfied with our determination, you have the right to request a review within 90 days of the notice.

17 PAID TO	AMOUNT PAID	BENEFICIARY RESPONSIBILITY
Skagit Valley Clinic	\$000,000.00	\$000,000.00



Module Review Sheet

Question 1

What is the deadline for filing a claim?

Answer 1:

Claims must be filed within one year of the date of service or date of discharge

Question 2:

When a beneficiary has a problem with a claim, who should they contact?

Answer 2:

A BCAC, claims processor, or regional contractor

Question 3:

Can a non-network participating provider file a claim?

Answer 3:

Yes.

Exam Questions and Answers: Claims and Appeals

45) From the list below, identify the claims processing contractor for the overseas region.

- A. Wisconsin Physicians Service (WPS)
- B. Palmetto Government Benefits Administrators (PGBA)
- C. TRICARE Claims Agency
- D. TRICARE Management Activity

Answer: [A] Reference: Participant Guide, Claims and Appeals, Section 3.0

46) What is the overseas deadline for filing a claim for a TRICARE-covered service?

- A. 6 months
- B. 9 months
- C. 3 years (except in Puerto Rico)
- D. 1 year

Answer: [C] Reference: Participant Guide, Claims and Appeals, Section 2.3

47) Beneficiaries should do all of the following to resolve claims EXCEPT:

- A. Contact a Beneficiary Counseling and Assistance Coordinator
- B. Call the appropriate claims processor
- C. Contact the adjudicating staff judge advocate
- D. Call the regional contractor's toll-free number

Answer: [C] Reference: Participant Guide, Claims and Appeals, Section 5.0

48) Claim processing may be delayed when:

- A. The claim is filed within one year
- B. The DD Form 2527 (Statement of Personal Injury—Third-Party Liability Form) is required, but not submitted with the claim
- C. The service received was a TRICARE-covered benefit
- D. OHI forms are submitted with the claim

Answer: [B] Reference: Participant Guide, Claims and Appeals, Section 7.3

49) Which of the following CANNOT be appealed?

- A. The diagnosis
- B. The necessity to be an inpatient
- C. The denial of TRICARE payment for services received
- D. The amount of the TRICARE-allowable charge

Answer: [D] Reference: Participant Guide, Claims and Appeals, Section 12.0

50) The _____ is responsible for ensuring that claims are filed in a timely manner.

- A. Overseas Claims Processor
- B. Managed Care Support Contractor
- C. Beneficiary
- D. TOP Contractor

Answer: [C] Reference: Participant Guide, Claims and Appeals, Section 2.0