OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

JUL 06 2010

The Honorable Carl Levin
Chairman, Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

We are pleased to forward the enclosed annual report for fiscal year 2010, as required by Section 731 of the National Defense Authorization Act for Fiscal Year 2007. In the three previous reports, the Department identified 10 claims processing differences between the TRICARE program and the Medicare program. During this fiscal year, the Department conducted further analysis and identified two additional differences, which are discussed in the Business Case section of the report. Of the 12 differences, the Department provided business cases to retain four, two claims processing differences are now aligned with the Medicare program, and the remaining six claims processing differences are awaiting implementation—the most recent business cases are detailed in the report.

Thank you for your continued support of the Military Health System.

Sincerely,

Charles L. Rice, M.D.
President, Uniformed Services University of the Health Sciences
Performing the Duties of the Assistant Secretary of Defense (Health Affairs)

Enclosure:
As stated

cc:
The Honorable John McCain
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

JUL 06 2010

The Honorable James H. Webb
Chairman, Subcommittee on Personnel
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

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President, Uniformed Services University of the Health Sciences
Performing the Duties of the Assistant Secretary of Defense (Health Affairs)

Enclosure:
As stated

cc:
The Honorable Lindsey O. Graham
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

JUL 06 2010

The Honorable Daniel K. Inouye
Chairman, Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

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Charles L. Rice, M.D.
President, Uniformed Services University of the Health Sciences
Performing the Duties of the Assistant Secretary of Defense (Health Affairs)

Enclosure:
As stated

cc:
The Honorable Thad Cochran
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

JUL 06 2010

The Honorable Daniel K. Inouye
Chairman, Subcommittee on Defense
Committee on Appropriations
United States Senate
Washington, DC 20510

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The Honorable Thad Cochran
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

JUL 06 2010

The Honorable Ike Skelton
Chairman, Committee on Armed Services
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

We are pleased to forward the enclosed annual report for fiscal year 2010, as required by Section 731 of the National Defense Authorization Act for Fiscal Year 2007. In the three previous reports, the Department identified 10 claims processing differences between the TRICARE program and the Medicare program. During this fiscal year, the Department conducted further analysis and identified two additional differences, which are discussed in the Business Case section of the report. Of the 12 differences, the Department provided business cases to retain four, two claims processing differences are now aligned with the Medicare program, and the remaining six claims processing differences are awaiting implementation—the most recent business cases are detailed in the report.

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Charles L. Rice, M.D.
President, Uniformed Services University of the Health Sciences
Performing the Duties of the Assistant Secretary of Defense (Health Affairs)

Enclosure:
As stated

cc:
The Honorable Howard P. "Buck" McKeon
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

JUL 06 2010

The Honorable Susan Davis
Chairman, Subcommittee on Military Personnel
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Madam Chairwoman:

We are pleased to forward the enclosed annual report for fiscal year 2010, as required by Section 731 of the National Defense Authorization Act for Fiscal Year 2007. In the three previous reports, the Department identified 10 claims processing differences between the TRICARE program and the Medicare program. During this fiscal year, the Department conducted further analysis and identified two additional differences, which are discussed in the Business Case section of the report. Of the 12 differences, the Department provided business cases to retain four, two claims processing differences are now aligned with the Medicare program, and the remaining six claims processing differences are awaiting implementation—the most recent business cases are detailed in the report.

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Charles L. Rice, M.D.
President, Uniformed Services University of the Health Sciences
Performing the Duties of the Assistant Secretary of Defense (Health Affairs)

Enclosure:
As stated

cc:
The Honorable Joe Wilson
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

JUL 06 2010

The Honorable David R. Obey
Chairman, Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

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Charles L. Rice, M.D.
President, Uniformed Services University of the Health Sciences
Performing the Duties of the Assistant Secretary of Defense (Health Affairs)

Enclosure:
As stated

cc:
The Honorable Jerry Lewis
Ranking Member

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

HEALTH AFFAIRS

JUL 06 2010

The Honorable Norm Dicks
Chairman, Subcommittee on Defense
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

We are pleased to forward the enclosed annual report as required by Section 731 of the National Defense Authorization Act for Fiscal Year 2007. In the three previous reports, the Department identified 10 claims processing differences between the TRICARE program and the Medicare program. During this fiscal year, the Department conducted further analysis and identified two additional differences, which are discussed in the Business Case section of the report. Of the 12 differences, the Department provided business cases to retain four, two claims processing differences are now aligned with the Medicare program, and the remaining six claims processing differences are awaiting implementation—the most recent business cases are detailed in the report.

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President, Uniformed Services University of the Health Sciences
Performing the Duties of the Assistant Secretary of Defense (Health Affairs)

Enclosure:
As stated

cc:
The Honorable C. W. Bill Young
Ranking Member

Report to Congress

Fiscal Year 2010

Standardization of Claims Processing
Under TRICARE Program
and Medicare Program

REPORT TO CONGRESS
ON
STANDARDIZATION OF CLAIMS PROCESSING UNDER TRICARE PROGRAM AND MEDICARE PROGRAM

INTRODUCTION

This fourth annual report is in response to Section 731(d) of the National Defense Authorization Act for Fiscal Year (FY) 2007. This section requires the Secretary of Defense to submit an annual report beginning not later than October 1, 2007 to the congressional defense committees setting forth a complete list of the claims processing requirements under the TRICARE program that differ from the claims processing requirements under the Medicare program. Each report includes a business case for each claims processing requirement which is different between the two programs that justifies maintaining such requirement under the TRICARE program.

BACKGROUND

In the Department's FY 2007 report, the Department defined the scope of this project as covering claims processing from the point at which services have been rendered to the time the claims have been paid or denied. Three distinct phases were identified during the analysis of this process:

1. Provider or Beneficiary Claim Preparation and Submittal Requirements;

2. Claim Processing and Notification to Provider and/or Beneficiary; and

3. TRICARE Claims Data Requirements.

Analysis of each phase supported the identification of the commonalities and differences in the claims processing methodologies of the two programs. In the first report for FY 2007, seven differences were identified and detailed business cases were developed to determine the feasibility of changing TRICARE's claims processing methodologies to better align with those of Medicare. Of the seven claims processing requirements identified, the business cases for four supported the Department retaining the current TRICARE claims processing methodology. The review of those four business cases continues to support the Department's decision to retain those differences. The remaining three differences were addressed in the FY 2008 report and the Department committed to aligning two of the differences with Medicare's methodology after award of the Third Generation (T-3) TRICARE Managed Care Support (MCS) Contracts and concluded that the TRICARE out-of-area claims processing rules were aligned with those of the Medicare Advantage program. In the FY 2009 report, two more differences were identified and business cases developed. The Department committed to aligning two of

the differences with Medicare's methodology after award of the T-3 MCS Contracts and to make the necessary changes to the TRICARE Manuals in calendar year 2009 to align TRICARE's processing of interim bills with Medicare's process. During this past year, the Department conducted further analysis and identified three additional differences which are detailed in the Business Case section of this report.

CLAIMS PROCESSING REQUIREMENT DIFFERENCES RETAINED BASED ON FY 2007 REVIEW AND ANALYSIS

Electronic Claims Submission Requirement

The Department continues to encourage electronic claims submission through its MCS Contract requirements and has included it as a requirement in the T-3 contracts.

Nonstandard Claim Forms

The Department will continue to accept nonstandard claim forms due to the need to accept claims directly from TRICARE beneficiaries.

Other Health Insurance (OHI) Payment Calculation Program

Even though the TRICARE OHI calculation for claims processing is more extensive than Medicare's, the Department will not change to the Medicare OHI calculation as this would result in increased costs for the TRICARE beneficiaries and potentially increase the overall TRICARE program health care costs.

Explanation of Benefits (EOB)

There is insufficient justification for the Department to incur any additional costs by returning to prescriptive requirements for TRICARE EOBs. In the T-3 contracts although non-prescriptive with regards to the EOB format – the Department is allowing the contractors the choice of providing a monthly summary EOB in lieu of an EOB for each individual claim processed. This change is more in alignment with the summary EOB requirements of the Medicare program.

CLAIMS PROCESSING REQUIREMENT DIFFERENCES ADDRESSED IN THE FY 2008 REPORT

Claims Editing Software

In order to align with Medicare, the Department implemented the national Outpatient Prospective Payment System (OPPS), which includes the use of Medicare's National

Correct Coding Initiative (NCCI) software for auditing outpatient claims, on May 1, 2009.

Claims Processing Jurisdiction

In the T-3 MCS Contracts, the TRICARE program's out-of-area jurisdiction claims processing is aligned with the Medicare Advantage program out-of-area claims processing rules.

Institutional Outpatient Claims Processing

The Department will adopt Medicare's institutional outpatient claims processing methodology by requiring revenue codes to identify reimbursement for services in the T-3 contracts.

CLAIMS PROCESSING REQUIREMENT DIFFERENCES ADDRESSED IN THE FY 2009 REPORT

Use of National Provider Identifier (NPI) on Paper Claims

The Department will align with Medicare regarding the mandatory use of NPIs on all claim transactions once the T-3 contracts are awarded.

Edit for Number of Services by Procedure Code

Medicare's claims editing process for determining number of services for Healthcare Common Procedure Coding System (HCPCS)/Current Procedure Terminology (CPT) codes is more comprehensive than that currently used by TRICARE. The Department will adopt Medicare's Medically Unlikely Edit (MUE) program, aligning the number of services by HCPCS/CPT codes accepted by TRICARE with that accepted by Medicare and commercial health plans. This will reduce provider confusion on what is an allowable number of services per day for each HCPCS/CPT code. The change will be incorporated into the T-3 contracts once they are awarded.

Processing of Interim Bills

Changes to the TRICARE Systems Manual are in coordination that will direct the TRICARE contractors to submit all interim-interim and interim-final billings as unique claims rather than adjustments to the interim-interim claim.

CLAIMS PROCESSING DIFFERENCES IDENTIFIED DURING THE FY 2010 ANALYSIS

Ambulatory Surgical Center (ASC) Services Accepted on Center for Medicare and Medicaid Services (CMS) 1500 Claims Form

A detailed business case for this claims processing difference is provided in the next section of this report.

Use of Modifiers on Health Professional Shortage Area (HPSA) Claims

A detailed business case for this claims processing difference is provided in the next section of this report.

BUSINESS CASE

Provider or Beneficiary Claim Preparation and Submittal Requirements—ASC Services Accepted on CMS 1500 Claims Form

BACKGROUND:

Medicare

Medicare accepts the billing of services for free standing ASC on a CMS 1500 claim form and pays ASCs under OPPS.

TRICARE

TRICARE has not yet migrated freestanding ASCs to the OPPS payment methodology and requires these same services be billed using a Uniform Business (UB) – 04 claim form.

JUSTIFICATION FOR DIFFERENCE:

The use of the UB–04 claim form allows for ASCs to enter the revenue codes required in order to be correctly reimbursed, while the CMS 1500 claim form does not.

CONCLUSION:

The Department anticipates migrating freestanding ASCs to the OPPS ASC payment methodology. This will require a rule change and upon publication of the final rule in the Code of Federal Regulations, the Department will align with the Medicare program, allowing freestanding ASCs to submit services on the CMS 1500 claim form.

BUSINESS CASE

Provider or Beneficiary Claim Preparation and Submittal Requirements—Use of Modifiers on HPSA Claims

BACKGROUND:

Medicare

When it is determined that any given geographic area has a shortage of health professionals, a HPSA incentive program is established. On a quarterly basis, Medicare will pay providers practicing in these select areas an incentive. The incentive, a 10 percent increase in reimbursement of allowed services, is only applicable when and where a shortage is declared. Medicare uses a zip code file to pay the HPSA bonus payment and does not require the provider to use any modifier on the claim.

TRICARE

Since 2002, TRICARE has followed Medicare policy of providing bonus payments, in addition to the amount normally paid under the CHAMPUS Maximum Allowable Charge methodology, to providers in HPSAs. However, TRICARE requires the use of modifiers on HPSA claims in order for HPSA providers to receive their HPSA bonus payments.

JUSTIFICATION FOR DIFFERENCE:

When TRICARE first enacted its HPSA bonus payment system, the Medicare program did not have a publicly available database with eligible zip codes for HPSA payments.

CONCLUSION:

Upon review, the agency has determined that TRICARE will align with Medicare and use their methodology for determining HPSA bonus payments once the T-3 MCS Contracts are fully implemented in all three TRICARE regions.

SUMMARY

CLAIMS PROCESSING REQUIREMENT DIFFERENCES RETAINED BASED ON REVIEW AND ANALYSIS

1. Electronic Claims Submission. The Department does not plan to seek authority to require TRICARE providers to file claims electronically, but will continue to encourage this practice through the MCS Contract requirements in both the current and T-3 contracts.

2. Nonstandard Claims Forms. The Department already uses the standardized claims forms and formats from providers within the United States, but will continue to accept nonstandard claims forms from beneficiary claims.

3. OHI Payment Calculation. The Department will not change to the Medicare OHI calculation as this would result in increased costs to TRICARE beneficiaries and potentially increase the overall TRICARE program health care costs.

4. EOB. The Department is allowing the contractors the choice of providing a monthly summary EOB in lieu of an EOB for each individual claim processed, which is more in alignment with the summary EOB requirements of the Medicare program.

CLAIMS PROCESSING DIFFERENCES NOW ALIGNED WITH MEDICARE PROGRAM

5. Claims Processing Jurisdiction. The TRICARE program is in alignment with the Medicare Advantage program out-of-area jurisdiction claims processing.

6. Claims Editing Software. In order to further align with Medicare's claims processing methodologies, the Department will use the Medicare NCCI editing software along with commercial claims editing software, e.g., ClaimCheck® for institutional outpatient claims as part of the OPPS implementation. The Department implemented OPPS on May 1, 2009.

CLAIMS PROCESSING DIFFERENCES TO BE ADDRESSED

7. Processing of Interim Bills. The Department has drafted changes to the TRICARE Systems Manual to reflect changing the interim and final billing process to align with Medicare's methodology and that change is currently being coordinated within the Department and with the TRICARE contractors.

8. Institutional Outpatient Claims Processing. The Department will adopt this approach in the T-3 contracts.

9. Use of National Provider Identifier on Paper Claims. The Department plans on implementing the requirement for mandatory use of NPI on all claim transactions once the T-3 contracts are awarded.

10. Edit for Number of Services by Procedure Code. The Department will adopt Medicare's MUE program, thereby aligning the number of services by HCPCS/CPT codes accepted by TRICARE with that accepted by Medicare and commercial health plans. Medicare's MUE program will be incorporated into the T-3 contracts.

11. Use of Modifiers on Health Professional Shortage Area Claims. The Department will adopt Medicare's methodology for paying providers the HPSA bonus payment once the T-3 MCS Contracts have been implemented in the three TRICARE regions.

12. ASC Services Accepted on CMS 1500 Claims Form. Upon publication of the final rule migrating freestanding ASCs to the OPPS payment methodology, the Department will adopt the use of the CMS 1500 claims form for freestanding ASCs.