

# Lesson Objectives

## Welcome to Lesson 14: Claims and Appeals

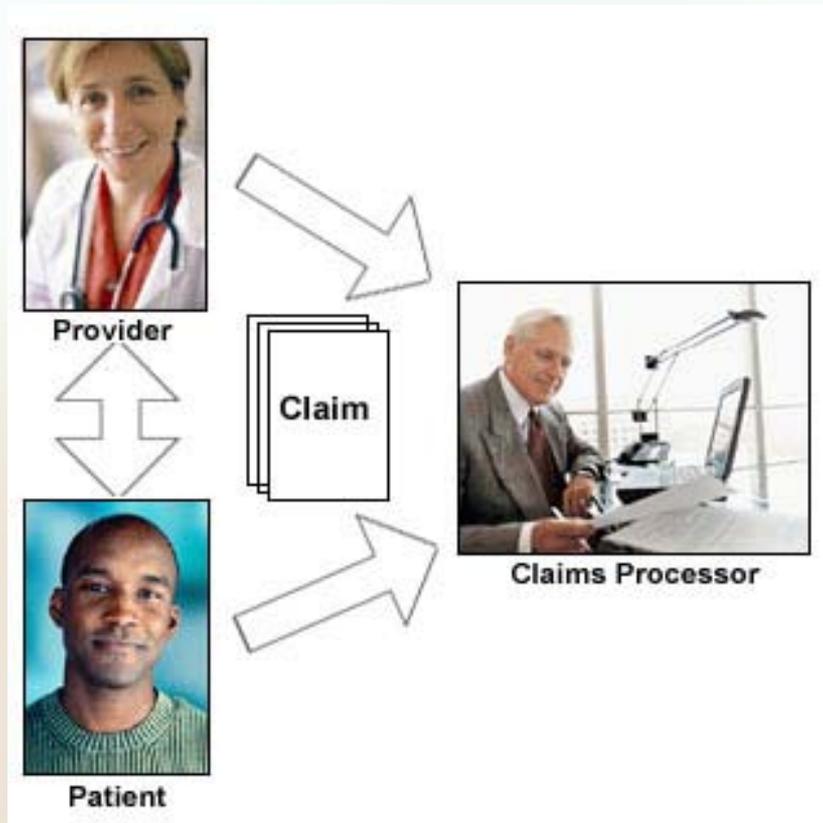
**After this lesson, you should be able to:**

- Explain who may file claims and where they submit them
- Describe how to begin to resolve a claim issue
- Identify three reasons why a claim may be denied
- Recognize what can and cannot be appealed



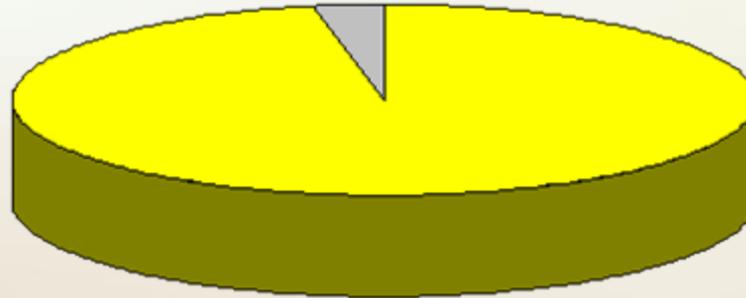
# What is a Claim?

Claims are requests filed for reimbursement for services or supplies provided by civilian providers.



# Who Files the Claim?

- The person who submits the claim is either the provider of services or supplies, or the beneficiary.
- The provider must be authorized and approved by TRICARE for services or supplies provided to a beneficiary and receives payment directly from TRICARE.

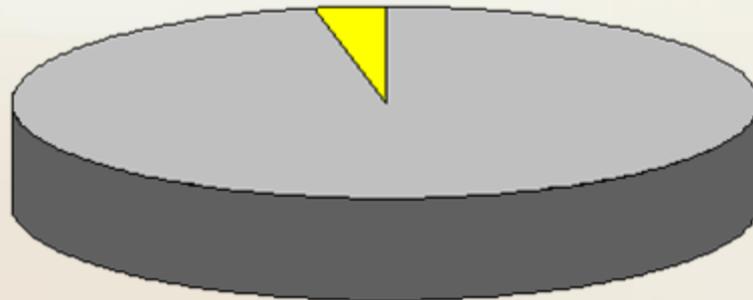


**97% of all claims are  
filed by Providers.**



# Submitting Claims

- Claims are submitted to the claims processor responsible for the region where the beneficiary lives.
- There are two major TRICARE claims processors:
  - **Palmetto Government Benefits Administration (PGBA)** - North and South region
  - **Wisconsin Physicians Service (WPS)** – West, Overseas and TRICARE for Life (TFL)



**Only 3% of all claims are filed by Beneficiaries.**



# Claims Processing Procedures

- When processing a claim, processors verify the following criteria:
  - Beneficiary eligibility
  - Was the claim filed by the beneficiary/provider within the given time limits
  - Are the provider services or supplies TRICARE authorized
  - Is the service or supply a benefit
  - Was the service or supply medically necessary and appropriate or is an approved TRICARE clinical preventive service
  - Is the beneficiary legally obligated to pay for the service or supplies, when appropriate
  - Does the claim contain sufficient information to determine the TRICARE maximum allowable charge for each service or supply



# Who is Responsible for Filing the Claim?

- Beneficiaries are ultimately responsible for ensuring the submission of claims to TRICARE for payment.
- If the beneficiary sees a network provider, the provider is responsible for filing the claim.
- If the beneficiary sees a non-network provider, the provider can choose to participate or not:
  - Participating providers may submit claims for beneficiaries.
  - Non-Participating providers are not required or may choose not to file a claim.



# Filing Deadlines

- Filing deadline: Within one (1) year of the date of service.
- Beneficiaries should file or check on a claim filing status as soon as possible.
- Beneficiaries should ask their civilian providers if the provider will file the claim.



# Other Health Insurance

- Special circumstances exist when beneficiaries have other health insurance (OHI).
- If a beneficiary has OHI, the beneficiary or the provider must file a claim with that health insurance plan before filing with TRICARE.
- After it has been processed by the OHI, a claim can then be filed with TRICARE along with a copy of:
  - The other health plan's payment determination
  - The itemized charges (bill)
- Beneficiaries should notify their Regional Contractor or their claims processor about their OHI or any changes to avoid delay in processing claims or possible denials.



# Claim Forms

- A claim form should be submitted for each individual claim; combining claims are not allowed.
- A claim should be submitted for each family member regardless if they all visited the same provider on the same day.
- A DD form 2642 “TRICARE DoD/Champus Medical Claim – Patient’s Request for Medical Payment is submitted by beneficiaries or eligible family members.
- This form can be found at:
  - [www.tricare.mil/claims/Dd2642.pdf](http://www.tricare.mil/claims/Dd2642.pdf)
  - [www.mytricare.com](http://www.mytricare.com)
  - [www.tricare4u.com](http://www.tricare4u.com)



# Claim Forms continued..

- Providers submit the CMC 1500 “Health Insurance Claim Form”.
- This form can be found at:
  - [www.tricare.mil/claims/1500-900.pdf](http://www.tricare.mil/claims/1500-900.pdf)
  - [www.mytricare.com](http://www.mytricare.com)
  - [www.tricare4u.com](http://www.tricare4u.com)
- Providers can also submit the UB-04 form used for inpatient or outpatient care from hospitals and other institutes.
- This form can be found at:
  - [www.tricare4u.com/apps/tricare2/pdfs/h1450.pdf](http://www.tricare4u.com/apps/tricare2/pdfs/h1450.pdf)
  - <http://www.cms.hhs.gov/providers/edi/h1450.pdf>



# Claim Forms continued..

- If a beneficiary receives care overseas, he/she can submit a DD Form 2642.
- Foreign providers are to submit a DD Form 2642.



# Claim Forms continued..

- The following items may be needed when submitting a claim:
  - A Non-Availability Statement (NAS) Authorization Number
  - Itemized list of charges for each service or supply provided on the provider's letterhead or standard form
  - Itemized list of charges from a pharmacy provided on the pharmacy's letterhead or standard form
  - Other health insurance claims forms
  - DD Form 2527, "Statement of Personal Injury – Possible Third-Party Liability"



# Explanation of Benefits (EOB)

- After submitting claims, the beneficiary and provider each receive an EOB from the claims processor, within six weeks, showing the services performed and the claim adjudication (or settlement of payments).
- If the beneficiary lives in the South region, they will not receive an EOB if they are not liable for charges.
- The address the beneficiary provided on his/her claim forms in the provider's office or the address the provider has on file is what is used when processing the claim.



# Explanation of Benefits (EOB) continued..

- Beneficiaries should carefully check each EOB they receive to compare their bills from the provider or service against the EOB.
- Beneficiaries should contact their claims processor if they receive charges for a service they never received.
- The regional contractor/claims processor should be the first source of assistance for any questions pertaining to the EOB, via phone, Web or at the nearest TRICARE Service Center.



# Reasons for a Delay/Denial in Processing a Claim

- Wrong address
- Claim is incomplete
- Eligibility is being questioned/DEERS information inaccurate
- Diagnosis is missing
- Third-Party Liability form is required or has not been received
- Other health insurance forms missing
- Complex claim requiring extensive review
- Government directed delay, usually because the provider is being investigated or because of fraud
- Provider delayed submitting claim
- Duplicate charges – more than one claim has been submitted for the same service
- Non-authorized service/no referral
- Medical necessity not documented
- Provider's Unique Identification Number (UIN) or National Provider Identification (NPI) is missing



# Appeals

- To appeal means to ask the TRICARE contractor or TRICARE Management Activity (TMA) for review of an authorization or claims denial.
- There are four types of appeals process:
  - **Medical necessity**
  - **Factual determination**
  - **Dual-eligible beneficiary (Medicare-TRICARE eligible beneficiaries)**
  - **Provider Sanction**



# Appeals of Medical Necessity Determinations

- “Medical Necessity” is based on whether the care is appropriate, reasonable, and adequate for the beneficiary’s condition.
- There are two kinds of medical necessity determination appeals:
  - **Expedited**
  - **Non-Expedited**
- Most appeals are non-expedited



# Expedited and Non-Expedited Appeal

- An expedited appeal should only be submitted to reconsider approval of inpatient stays or prior authorization of services by the beneficiary within three calendar days after the date of the receipt of the initial denial determination.
- A non-expedited appeal should be submitted within 90 days of the date on their EOB or initial determination by the beneficiary by sending a letter to the regional contractor at the address specified in the notice of the beneficiary's right to appeal, included on their EOB or other notification.
- Beneficiaries should send:
  - A cover letter with relevant case information
  - A copy of the denial letter
  - Any associated EOBs/claims/bills
  - Documents the beneficiary feels support overturning the denial decisions.
  - If the amount is less than \$50, the decision is final.
- If the denial is upheld, the beneficiary can appeal to TRICARE Management Activity via the National Quality Monitoring Contractor.



# National Quality Monitoring Contractor (NQMC) Reconsideration Review (Second – Level Review)

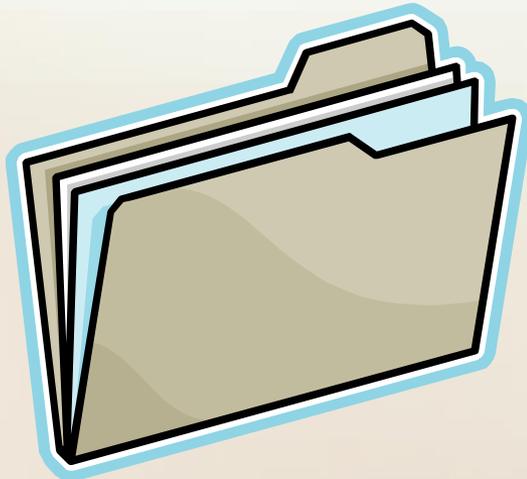
- If the regional contractor reviews the case and upholds the denial determination on second review, the next level of appeal is to NQMC.
- Beneficiaries must send a letter to NQMC postmarked or received within 90 days of the date on the contractor's reconsideration decision along with a copy of the reconsideration decision and any supporting documents.
- If the amount is less than \$300, the NQMC decision is final.
- If the beneficiary disagrees with the NQMC decision and the services are \$300 or more, the beneficiary can request TRICARE Management Activity to schedule an independent hearing by filing a request to:

**TRICARE Management Activity (TMA)  
Appeals, Hearings, and Claims Collection Divisions  
16401 E. Centretech Parkway  
Aurora, CO 80011-9066**



# Appeals of Factual Determination

- Factual determination involve issues such as coverage, provider authorization (status) requests or denial of a provider's request for approval as a TRICARE provider (just to name a few).
- To file a factual determination appeal the beneficiary submits the same kind of information he/she would for a non-expedited medical necessity appeal.

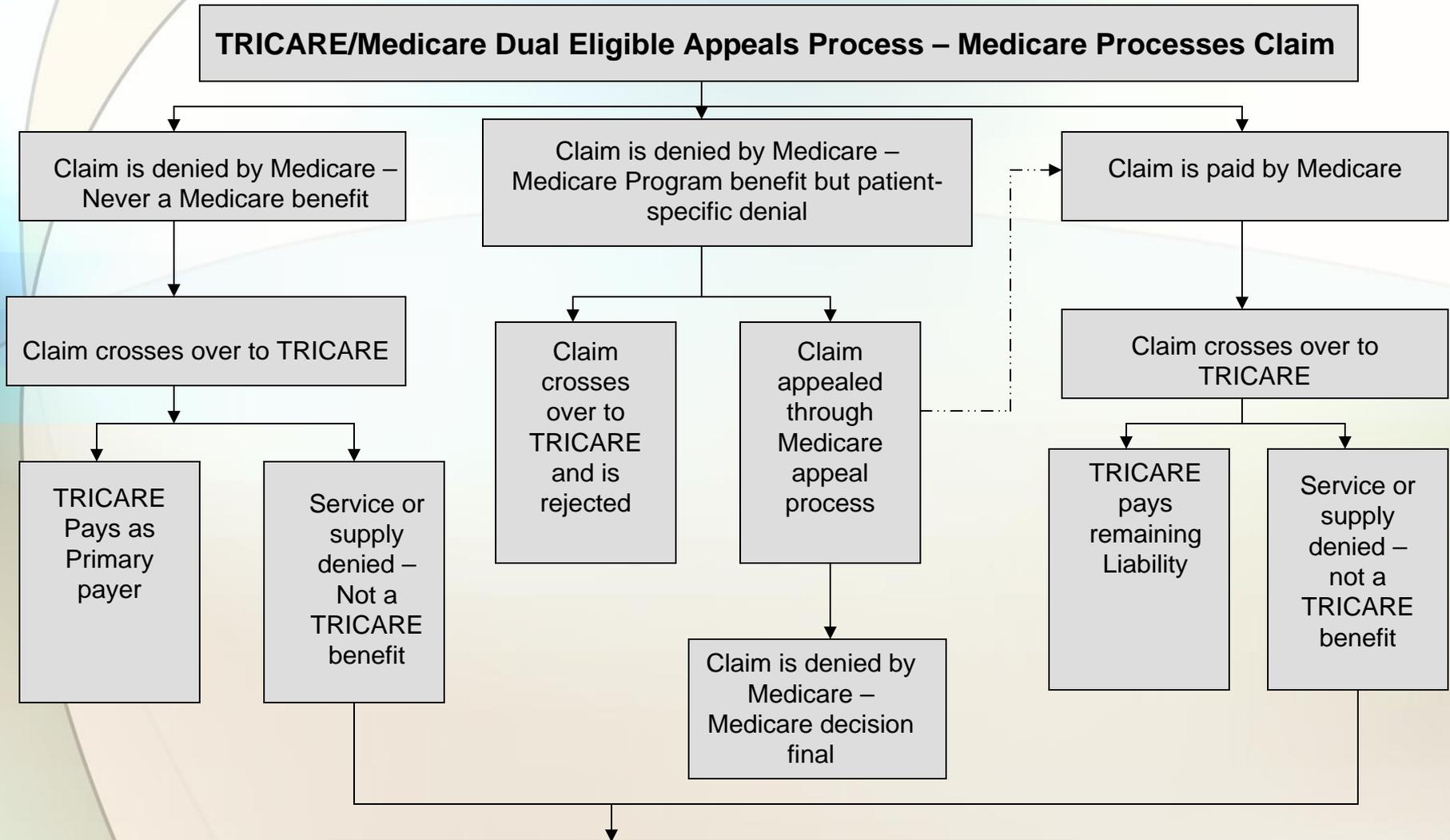


# Appeals for Dual Eligibility Determinations

- Dual eligibility are beneficiaries who are eligible for both TRICARE and Medicare.
- When Medicare and TRICARE have both denied a claim and the beneficiary has successfully appealed the Medicare claim (Medicare paid the claim), the beneficiary can appeal the TRICARE denial through the factual claim process.



# TRICARE/Medicare Appeals Process



**Source: TOM, Chapter 13, Appeal Process Applies**



# Provider Sanction Determinations

- A provider that has been denied approval as an authorized TRICARE provider or who has been terminated, excluded, suspended, or otherwise sanctioned.
- Only the provider or his/her representative can appeal.
- 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, CO.



# Who Is Able To Appeal

- The appealing party must be able to prove he/she is eligible for TRICARE benefits, this includes:
  - 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 in his or her own behalf
  - A health care provider who has been denied approval or suspended
  - Providers who participate in TRICARE and accept the allowable charge as their full fee
  - A representative appointed in writing by a beneficiary or provider
  - An officer (member of a uniformed services legal office)
  - Beneficiary Counseling and Assistance Coordinator (BCAC) or a Health Benefits Advisor (HBA)
  - Employee of the United States (employee of uniformed services legal office or an BCAC/HBA)



# What Can Be Appealed



- Diagnosis
- Necessity to be an inpatient
- Denial of preauthorization for services, including mental health
- Termination of treatments or services that have been previously authorized
- Denial of TRICARE payment for services or supplies received
- Termination of TRICARE payment for continuation of services or supplies that were previously authorized
- Denial of a provider's request for approval as a TRICARE-authorized provider or expelling a provider from TRICARE



# What Cannot Be Appealed



- The amount of the TRICARE determined costs or charges for a particular medical service.
- The decision by TRICARE, or its contractors, to ask the beneficiary for more information before taking action on the beneficiary's claim or appeal request.
- Beneficiaries cannot appeal decisions relating to the status of TRICARE providers.
- Decisions relating to eligibility as a TRICARE beneficiary.



# TRICARE Prime Remote (TPR) Appeals

- If an active duty service member (ADSM) does not receive authorization for specialty care:
  - The ADSM may appeal by first contacting the Military Medical Support Office (MMSO) or their Service Point of Contact (SPOC).
- If the request is denied on appeal, the ADSM may then appeal to his/her Surgeon General or their senior medical officer of his/her respective Service.



# Summary

## Congratulations, you've finished Lesson 14: Claims and Appeals!

### You should now be able to:

- Explain who may file claims and where they submit them
- Describe how to begin to resolve a claim issue
- Identify three reasons why a claim may be denied
- Recognize what can and cannot be appealed

