AFTER ACTION REPORT

"6 March 2012---Manila" and "7 March 2012---Cebu"

MEETING WITH TRICARE STAFF, TMA CONTRACTORS TO INCLUDE ISOS AND WPS; AND BENEFICIARIES

ON

"TRICARE PHILIPPINES RELATED ISSUES"

PURPOSE OF MEETING: The purpose of the meetings were multifold with the primary objective being centered on distributing updated information on TRICARE Philippines issues and to pass information to help smooth-out claims processing and preparation. It was also used to brief the current status of the TRICARE Area Pacific Satellite Office Philippines position and also to give updates on the upcoming Closed Network. After the meeting, time was set aside to allow WPS management to review claim specific issues that beneficiaries were experiencing.

LOCATION, DATE, and TIME:	RAO Manila:	6 Mar 12	0900-1200 hrs
	Cebu:	7 Mar 12	Unknown Time

PRESENTATION GUESTS:

Thomas W. Halliwell,	TMA, Remote Pac. Islands
John H. Pabich	Vice President, WPS TRICARE Overseas
Chip Wilcox	General Manager, TRICARE Asia Pacific ISOS
Senior Chief Galang	TAO-P—TRICARE Area Office Pacific

AFTER ACTION REPORT AUTHORS AND POC: If you have any questions concerning this report, please send to both addresses below. Also, so we can track and up channel how many people are being reach by these TRICARE Outreach Team Briefings and the subsequent information reports, please send us an email stating who exactly received this report and how many people are in the family group. Also, please send this report to any TRICARE Philippines beneficiary you have knowledge of and also please let us know who you send it to as well.

Kenneth (Ken) Fournier	kennyfour09@yahoo.com.ph
Robert (Bob) Lowe	RdLowe@Comclark.com

Other After Action Reports: Another after action report from a different meeting location (same subject) is also recommended reading and it can be obtained by sending an email request to the RAO Baguio Director ("Associate Director, RAO Baguio" raoemo@sbcglobal.net); who happens to have the most informative RAO news letter in the Philippines and if you are not signed up to get it, it is highly recommended.

BENEFICIARIES AND ORG MEMBERS PRESENT: There were about 15 beneficiaries present that represented a broad spectrum of locations throughout the Philippines and this After Action Report will be used by them to distribute information discussed to the widest possible number of beneficiaries.

INTRODUCTION: This report attempts to provide a recap, as close as possible, to information presented to the TRICARE beneficiary groups and beneficiaries.

In the past 18 months, TMA/ISOS/WPS conducted a series of similar face-to-face meetings throughout the Philippines with TRICARE beneficiaries and Service Organizations. We feel strongly feel these meeting have been crucial to ensuring the two-way communications channels are kept open, so both parties can relay critical issues and concerns to each other. Normally the meetings have been limited in size (usually no more than 20 attendees) and restricted to RAO representatives and Veteran Service Organization Representative (VSO's). Both the Manila and Cebu meetings had a mix of RAO and VSO representatives and regular beneficiaries (to include a dependent wife) who wished to hear the presentation and to have their questions answered or to have a chance to present specific claims processing issues. The Cebu meeting included a representative from a participating provider—UltimateCare.

We had members of our Philippine Yahoo Group present at the meetings in Manila and Cebu with instructions to take copious notes. The following report is based on a merging of notes from both meetings. We strived to ensure we accurately represented the presentation, as well as, the ensuing questions and answers; and have offered this report to the TMA, ISOS and WPS representatives for validation. We solicited their comments, clarification, and corrections for any statements that may need clarification or changes and we will distribute any changes as we receive them.

At times in this report, we included information, with sources, that were not specifically stated in the meetings and we have provided our own observations (clearly identified as such) and questions that we feel will require followed-up actions.

TOPICS Discussed

PRESENTED BY Mr. Halliwell

1. **TRICARE Area Office-Pacific Satellite Office-Philippines**:

   - **Background:** The satellite office was promised by TRICARE Deputy Director Maj. Gen. Elder Granger in 2008. Steps were taken to make this promise a reality and an office was leased at the old Clark AFB in Angeles City. A position solicitation was published and then withdrawn. The apparent reason for withdrawal was the U.S. Embassy did not want to place a Government position in Angeles City due to security concerns.

The office remained in flux until around the middle of 2011 when TRICARE made an agreement for office space at the new 'Veterans Administration—Out Patient Clinic' (VA OPC) in Manila. A new announcement was issued to staff the office, but has not yet been filled.

- **Information from the TRICARE Manila meeting:** Per Mr. Halliwell, the staffing of the TRICARE satellite office at the VA OPC is in flux primarily due to manpower funding issues and specifically whether or not the manpower position will be transferred from an existing funded position or if it will be a newly funded position. It boils down to current and future DOD budgets, which is causing a re-evaluation of DOD expenses to ensure funds are not squandered. Mr. Halliwell stated he believes the TRICARE Satellite Office in the Philippines is needed and will continue to voice his opinion on the matter, but at the moment he can't provide a targeted time frame for this to happen.

2. TRICARE Philippines Demonstration Project (Closed Network):

- **Background:** In August 2010, TRICARE Communication & Customer Service Division (C&CS) presented a slide show that included a description of the Closed Network (see http://db.tt/t9cyCoJ slide 17). On 28 September 2011, TMA published in the Federal Register the Demonstration Project (Closed Network). (See 60007 Federal Register/Vol. 76, No. 188/Wednesday, September 28, 2011/Notices).

- **Information from the TRICARE Manila meeting:** Mr. Halliwell briefed the status of the Closed Network. He related TMA has not yet provided the contractor—(ISOS)—with the technical requirements for the Closed Network and thus, ISOS has not started the process of establishing the Closed Network. Mr. Halliwell indicated he expects the finalization of the specific requirements to be provided by TMA in the near future.

  Based on time frames stated in the Federal Register and according to Mr. Halliwell, the clock on the Closed Network does not start until TMA provides requirements and guidance needed to establish the Closed Network to ISOS. After ISOS is given the go-ahead to start establishing the Closed Network, there will be a minimum of 240 days before the Closed Network is stood up.

  Mr. Halliwell provided a hand-out which represents the latest TMA concept of the Closed Network. A copy of that hand-out is attached to this report **(see attachment 1)**.

  Some highlights of the hand-out are:

  - ISOS will establish a list of approved providers in pre-designated locations in the Philippines who have agreed to file claims directly to WPS; agreed to accept lesser of billed charges/negotiated rate/Government directed fee schedule as full payment; and only charge beneficiaries for applicable Standard Deductibles and cost shares according to the EOB.

    - The basic intent is to relieve beneficiaries of the burden of large upfront payments for services received.

- Basic premise: In order to have TRICARE pay for care received in the demonstration area, beneficiaries must receive care from approved Demonstration area providers, unless a waiver has been granted.
    - Otherwise, TRICARE will not cost share on the claim.
- Demonstration Project will be applicable to all Standard beneficiaries (including TFL, TRR, etc.) who permanently reside in the RP and seek care in designated demonstration locations.
    - Residence determined by claim address—must be physical address, not FPO/APO.
    - Demonstration Project requirements do not apply to those who are visiting the Philippines and do not formally reside here.

Mr. Halliwell stated that as TMA has envisioned the Closed Network, the beneficiary would visit an approved demonstration provider, receive care, the provider would submit the claim, and the provider will be required to accept whatever TRICARE determines is the allowed amount for that claim. The provider will receive an EOB and a check. The EOB will indicate the deductible and co-pay the beneficiary is responsible to pay and the beneficiary will then pay that amount to the provider.

- ✓ **Our Concern:** We do not see this scenario to be workable. If the beneficiary moves; or never sees that provider again; or refuses to pay the provider the amounts that TRICARE says he owes the provider, how does the provider or TRICARE force the beneficiary to pay the amount due? This approach is very problematic.
- ✓ **Our Concern:** If, on the other hand, a provider collects the deductible (which he may not know the current deductible required because he may not have DEERS access to up-to-date deductible amounts) and collects the co-pay based on billed charges, but when the EOB arrives TRICARE had allowed a lesser amount for the claim, how will the beneficiary get a refund of the amounts overpaid to the provider? Again, this approach is problematic.

Mr. Halliwell stated that the beneficiary's physical address will be controlling as to whether the beneficiary lives in the Closed Network area and the actual determining distance for the Closed Network area has not yet been determined

This became a major discussion topic since retirees pointed out that many retirees receive mail through the FPO address through the RAO's, but do not physically reside in the RAO area, (example; a retiree with a RAO Manila address, but who lives in Mindanao). Mr. Halliwell stated that he has told TMA that the physical address will be an issue that needs to be fleshed out and resolved.

- ✓ **Our Recommendation:** We recommend TMA modify the forms the providers will be required to use for claim submission such as the CMS1500/UB4 and also the DD Form 2642 used by beneficiaries to include both a mailing address and a physical address, which should resolve the issue. Modifying a DD Form can take years to accomplish, so a supplemental form may be more the answer.

- ✓ **Our Concern:** If this change is not made, it is conceivable that a beneficiary that seeks care in the demonstration area for a major medical episode, but who lives outside of the demonstration area will then be classified by WPS as living within the demonstration area, thus causing the beneficiary claims for care in his local area for minor/moderate medical care to be denied because he did not use a demonstration approved provider.

- ✓ **Our Concern:** Also, if the beneficiary has an address listed on his DD Form 2642 or in DEERS that reflects an RAO address in the demonstration area, WPS may mistakenly determine that the beneficiary is required to use a demonstration approved provider and deny the claim.

One issue in Cebu that consumed a lot of time on the Closed Network discussion was the acknowledgement from Mr. Wilcox that TMA, in their contract with ISOS, has not contracted ISOS to educate TRICARE Standard providers on rules and regulations of the TRICARE program. Mr. Wilcox stated that, only if a Standard provider calls them and is persistent, will ISOS assist them in claims issues. He stated that the only time a TRICARE Standard provider hears directly from ISOS is when they show up at their office/facility for a Provider Certification visit.

Mr. Wilcox indicated that the interaction with the Closed Network providers will probably change to a more pro-active model similar to that which ISOS interacts with the TRICARE Prime providers for active duty personnel, but does not expect to see a change to that level of interaction with non-Closed Network Standard providers. Basically, he stated that, ISOS is not contracted to have that degree of interaction with the Standard providers.

- ✓ **Our Question:** We believe this to be a root cause of fraud issues TMA has experienced in the Philippines. If the government does not become pro-active in educating providers about what the TRICARE program entails, the rules and requirements a provider is expected to comply with, and provide assistance to the provider when they encounter claims filing or payment issues in a system that is totally foreign to them, than TMA should not complain when the providers find a way around the "system" in order to get a reasonable (or sometimes an extreme) rate of return on services provided. ***Is anything being planned to improve this situation?***

- ✓ **Our Comments:** See the attached hand-out for more details concerning waivers, demonstration areas, RP residence verses non-residence rules, etc.

PRESENTED BY: Mr. John Pabich (WPS)

The PDF copy of this Power Point Presentation can be viewed at; http://db.tt/tCEdubUV

3. Claim Submissions:

- **Professional Providers:** What information does the beneficiary need to file a claim?
  - Need provider's full name and full address. If it is a referral, WPS wants the name and address of the referring provider.
  - Professional Status—I.E. anesthesiologist, cardiologist, oncologist, etc.
  - A narrative description of each service by date. (Note, Mr. Pabich stated that WPS did not need the AMA CPT code)
    - ✓ **Added:** A narrative is critical, but the time is also critical. A 10 minute visit has a significantly lower CMAC allowed rate then a 30 minute visit.
    - ✓ **Added:** Also, if inpatient, every time a doctor visits the patient in the room, the duration of the visit must be included to get proper credit.
- **Description of the Service:** This needs to be detailed enough so that WPS can find something in the narrative that will allow them to identify the appropriate CPT code. (Mr. Pabich acknowledged that since only the Philippines and Panama are under a CMAC, and all other countries are paid billed charges, the CPT code is very important. Thus, the narrative needs to provide enough information in order to allow the claims processor to assign the proper code to the claim).
  - ✓ **Added:** This is complex, but for detailed procedures such as inpatient or surgery procedures, if at all possible, explain to the doctor that every detail is critical and to ensure the OR report is very detailed and no little details are left out.
  - ✓ **Added:** Recovery room times are often left off the reports or not completed properly, this is critical in that the payment of the Anesthesiologist will be determined based partially on these times.
  - ✓ **Added:** If a doctor visits after a surgery and performs a procedure at the bed side, such as removed stitches, insert drain tubes, changes bandages, insert IV, etc—ensure it is documented.
  - ✓ **Added:** If possible, maintain a detailed real time log of events for every single incident that occurs during an inpatient stay and if necessary, translate this to a

separate document and ask the doctor to acknowledge and sign it for submission with the claim submission.

- **Report and Records:** It is not required, but a copy of any medical reports, operating room reports, and/or doctor's orders may be included with the claim to assist the claims processor in assigning appropriate CPT codes. (nurse's notes are only needed when WPS specifically requests them)

  - At this point in the Cebu meeting, a retiree related that he submitted a claim for a Nuclear Heart Scan and he sent the scan report along with the claim. He stated the claim was paid, but the EOB listed an "x-ray" as the procedure instead of the "Nuclear Heart Scan". He stated he re-submitted the claim (the retiree did not make it clear whether the re-submission was an appeal or just a complaint made to WPS on the CPT code assignment) and the scan report; and again it was returned with the x-ray listed as the procedure.

  - Mr. Pabich stated the claims processors have basic medical terminology training, but they do not have a medical background. His solution was to tell the beneficiary that in those cases, they can appeal the 'under coding' of the claim. He also offered to review the claim after the meeting and take it back with him to WPS for review.

- **Lack of Narrative:** It was emphasized that if a claim does not have a narrative or receipts that represented each service, for each day, the beneficiary may not get fully reimbursed. An example of this would be a 10 day in-patient stay. The physician gives the patient a global bill for 'professional fees', but it is not detailed. Even though the doctor visited the patient daily in the hospital, if the itemized bill does not reflect that the physician visited the patient each day, WPS will only pay for one in-patient doctors' visit).

  - ✓ **Added:** If possible, maintain a detailed real time log of events for every single incident that occurs during an inpatient stay and if necessary, translate this to a separate document and ask the doctor to acknowledge and sign it for submission with the claim. The Doctor may also be required to identify how much of the global bill was applied to each daily visit and also any other service performed.

- **Description of Unusual or Complicating Circumstances:** Include a description of any unusual or complicating circumstances since these may allow for a higher CMAC payment.

- **ICD-9 or ICD-10 Codes:** If the patient can get an ICD-9 or ICD-10 code for the diagnosis from the provider, it will assist the claims processor in assigning the appropriate diagnosis. If the patient is unable to get the ICD codes, then ensure the narrative or the diagnosis block of the DD Form 2642 has the diagnosis described as accurately as possible. The narrative can be as simple as; '*I went to the doctor, because I was vomiting profusely*'.

- **Inpatient or Out Patient:** The claim needs to state if the care was provided on an in-patient or out-patient basis. This is indicated in "block 8b" of the DD Form 2642.

- **Staff Doctors verses Non-Staff Doctors:** At this point there was a discussion concerning hospital staff doctors' verses doctors with admitting privileges. After some confusion about the terminology, Mr. Pabich and Mr. Halliwell clarified that if the hospital provides a bill for services of hospital staff doctors (hospital paid employees) then the individual doctor does not need to be certified because they are covered under the hospital's certification. But, if the attending doctor only has admitting privileges (is not a hospital paid employee) the doctor will need to be certified.

  - ✓ **Our Question:** Herein lays a major—repeat—major problem. If the doctor is not a staff doctor, he DOES NOT have a receipt with the Hospital Address on it and subsequently, WPS, has in the past refused to pay some claims for the non-staff doctor because the receipt is not for the address for which the service was performed. A compromise must be met that if the Hospital is certified and the Doctor is certified at his office, then it stands to reason the doctor should be certified to perform a service at a certified Hospital—but that is not the case and it needs to be fixed. ***What is planned to fix this real, long-standing, and costly problem?***

- **Pharmacy Policy Change---September 2011:** Another discussion ensued surrounding the September 2011 pharmacy claims change made by TRICARE. A retiree discussed the fact that his claims for immunizations for his child were denied because the new rule requires medicine be purchased through a certified pharmacy or a certified hospital pharmacy. The problem, as explained, was that the beneficiary cannot purchase immunization medicines from the pharmacy because those purchases can only be made by the provider. However, due to the new rule, WPS cannot pay for the medicines if they were provided by the provider. This is a 'catch 22' situation and Mr. Halliwell agreed that maybe TMA did not think this through and requested to get the detailed information to take back to TMA to discuss these issues.

  - However, later in the presentation, Mr. Pabich stated that immunizations (injectable medicines) that are not normally self-administered and are administered in the provider's office (such as a pediatrician's office) should be paid by WPS.

    - ✓ **Added:** If there is a problem in this area, the beneficiary should appeal the denial decision and clearly state the type of injectable medicine given and the location of service. The beneficiary should clearly state the injectable medicine is not a self-administered injection. To preclude this from happening, suggest a note be included in the claim submission indicating this is not a self-administered injection.

- **Receipts:** It was reiterated that ***copies*** (not originals) of the receipt for payment (official receipt) need to be sent with the claim.

- One retiree asked what to do if the receipt is unable to be read once it has been copied. Another retiree explained how he had dealt with that issue with success. He stated that if you make the best copy possible, and it is still unreadable, that you can transcribe word-for-word and line-for-line the information that is contained on the receipt. He stated that it was best to do this on the same page the receipt copy is on and to note that the copy is the best copy available. Mr. Pabich agreed that this is a good way to handle the issue of receipts.

- Another option is to darken the intensity of the copied document on the copy machine and this often can bring out the faded printing on the receipt to the copy.

- Mr. Pabich also recommended the beneficiary should make at least one copy of each receipt as soon as possible since many receipts are printed on thermal paper that fades quickly—especially pharmacy receipts.

- **Hospitals:**

  - Must be certified. They may be a participating provider (file claims on behalf of beneficiary) or a non-participating provider (does not file claims on behalf of the beneficiary).

  - The claim must show each service or supply provided and must be listed for each day of the care—(Itemized billing).

  - There must be a description of each service provided. An example that was given was for physical therapy: The claim would need to state if the therapy was 'range of motion', or 'cryotherapy', etc.

    - ✓ **Added:** Some services/procedures require the amount of time in minutes that the service/procedure took in order for the correct CPT code to be applied.

      - Anesthesia is a prime example of that requirement. Anesthesia is paid by WPS in 15 minute increments from time of the start of administration of the anesthesia until the time the patient is out of the recovery room.

      - Another often overlooked example is amount of time a doctor spent with the patient during a bedside visit—a 10 min visit has a lower CMAC rate than a 30 min visit.

      - Bottom line: Document and record all start and stop times…if at all possible.

  - **Doctor Info:** Need the name and professional status of all providers rendering the care that had a dedicated Pro Fee indicated on the Bill.
  - **Diagnosis:** Diagnosis is required. If the patient can get the ICD-9 or ICD-10 code for the diagnosis, that will assist WPS in assigning the appropriate diagnosis code.

- ✓ **Added:** It is important to ensure that the ***primary diagnosis*** for the in-patient stay is noted on the hospital itemized billing and on the DD Form 2642. If there are more than one diagnosis, list them all, but list the primary diagnosis first.

- **Nurses Notes:** Nurses notes are not required unless requested by WPS.

  - ✓ **Our Comments:** However, Nurses notes are considered confidential and in many cases, the hospital will not issue these notes to the beneficiary and likely not even to WPS without special approval from the Chief of Hospital Administration.

- **Pharmacy Claims:**

  - **Item Info:** The name, strength and quantity of the medicine purchased needs to be on the purchase receipt whether it is cash register generated or on a hand written receipt with the pharmacy letterhead. (See #3--Professional Providers and under Receipts, above for information concerning poor quality copies of receipts).

    - ✓ **Added:** Suggest to always ask for a hand-written receipt (Official Receipt or Purchase Invoice). If they issue a hand-written receipt, they will not issue a machine written receipt, but the hand-written receipt has much more room for the required details and it is clearly identified with the Pharmacy Letterhead at the top of the receipt.

    - ✓ **Added:** If the item issued is a bottle with a quantity of 100 cap/pill per bottle, ask them to identify it as 100 cap/pill and give the unit price per cap/pill and not the price per bottle.

    - ✓ **Added:** Ensure they list (and you can read) the full requirements on the purchase receipt before leaving the counter----Medicine Name, Strength, QTY, Beneficiary Name, and date.

  - **Name and Address of Pharmacy:** This is needed even if they are certified as a corporation, such as Mercury Drug.

  - **Rose Pharmacy:** Mr. Pabich mentioned that he heard that Rose Pharmacy was being considered for certification at the corporate level.

    - ✓ **Added:** Frequently check the certified provider list for additions and deletions.

  - **Prescription Number on Bottles:** Mr. Pabich stated that there is a requirement to provide the prescription number on prescription bottles; however, he also stated they are aware prescription numbers are not used in the Philippines, so WPS has worked around that requirement. This was presented to illustrate that there are certain requirements that are impossible to comply with in the Philippines and they try to take these into consideration when processing claims.

However, he stated that if a claim is returned or denied due to the lack of a prescription number, the beneficiary should send it back to him. *(We took that to mean, to send it back to WPS with a statement that Mr. Pabich stated a prescription number was not required for Philippine claims).*

- **Claim Processing Metrics and Denied Codes Figures and Details:** Mr. Pabich discussed TRICARE Standard claims (including TFL, TRR etc.) and stated that for 2011 there were about 29,000 non active duty/dependent claims from the Philippines. He presented the top ten EOB explanation codes for those claims that had payment issues.

  - **No Codes: About 11,000 Claims (38%) –** These did not include explanation codes on the EOB indicating these claims were paid in full.

  - **Code 003: 5,000–6,000 claims (17% to 21%) — "If you are not satisfied with our determination, you have the right to request a review within 90 days of the process date".** This was the most common code identified on EOB's. Mr. Pabich stated that Code 003 was directly related to the fact the Philippines is under a CMAC, whereas the rest of OCONUS (except Panama) are paid according to billed charges. He explained that in the Philippines, when claims are sent in with the billed charges and the billed charges are higher than the CMAC, the payment is reduced to the CMAC (TRICARE allowed amount) and the balance is not paid by TRICARE. And subsequently, the beneficiary must absorb the difference.

    - ✓ **Added:** If you feel the allowed amount is not correct, we suggest you try to verify if the CPT code used was appropriate. CPT codes can be found at the TAO-P web site or you can Google the medical term that was used by the provider to obtain the CPT code—(example—Google: 'CPT code for urinalyses'). Once you determined the proper CPT code and determined WPS used the wrong code, you can appeal the claim decision. Please remember, you have 90 days, from the date of the EOB to appeal payment —*not the receipt date of the EOB).*

  - **Code018: About 1,800–2,000 claims (6% - 7%) – "Provider is not certified/authorized for this service".** This indicates that either the whole claim or at least one line item was completely denied for this reason. An example that Mr. Pabich gave was when a physician was dispensing pharmacy items without a Philippine pharmacy license. In that case, the claim line item associated to the pharmaceuticals would be denied with the Code 018.

    Another reason this code may be used is when ISOS was requested to certify the provider, such as Watson Drug Store, and the reason for certification was because the beneficiary had purchased a DME, (durable medical equipment—such as a

wheelchair), in which case ISOS only certified the provider for DME. That means that when WPS received another claim for a beneficiary who had used this same Watson Drug Store for prescription medicine purposes, the WPS record would reflect that the Watson Drug Store was only certified for DME purchases and not certified to dispense prescription medicines, resulting in a request to ISOS to certify the store for prescription medicine purchases.

Mr. Halliwell stated this policy was recently changed and now, ISOS will certify pharmacies and professional providers based on 'ALL' services they are licensed/qualified to provide.

- **Code 083: About 2,000 claims (7%) –"Records submitted did not meet the documentation required".** This code will usually be preceded by a letter requesting additional information. Mr. Pabich explained that at times, when providers and beneficiaries receive letters requesting additional information, they will re-send all the original documentation that had accompanied the claim; however, the requested information is not included in the documents sent. He did state in the Cebu meeting that attendees at the Manila meeting had made him aware of the fact that WPS has not been specific in the letters for request for additional information which has caused confusion on the part of providers and beneficiaries. Mr. Pabich resolved to take those comments back to WPS to attempt to resolve the issue.

  - ✓ **IMPORTANT NOTE:** Mr. Pabich stressed the importance to always send a copy of the letter requesting additional information, so the newly submitted information can be married up with existing claim data. He stated WPS did not need, nor want, the full original claim to be re-sent…as doing so can confuse the claims processors and cause payment delays.

- **Code 210: About 1,500 claims (5%) –"Services billed require a medical record report. Please submit with a copy of the original claim."** Mr. Pabich stated that this most often has to do with reconstructive surgery or geriatric services.

  - ✓ **Added:** These notices normally have a 90-day window to comply with the request; thus, the provider/beneficiary needs to respond as soon as possible or risk outright claim denial.

- **Code 028: About 1,500 claims (5%) –"Document/s requested not received".** This can be documents requested from the provider or beneficiary; and not received in the 90-day time limit.

- ✓ At this point there was a discussion concerning the 90-day time limit to respond to request for additional information. Mr. Pabich made the comment that it is possible that, due to the mail service, some providers/beneficiaries may not receive the EOB's or letters requesting additional information.

  - ✓ **Our Question:** The cases we have seen, this problem has been mostly due to the provider (that has already been paid in full) such as the Hospital, not being willing to pay for copy fees and mailing; and **the beneficiary is not notified that a request was sent to the provider for additional info**. Subsequently, since the provider has already been paid in full, they have no compelling need to provide the requested documents at their expense. ***This is a real problem that has been presented repeatedly, and to date, it appears to have been ignored by TMA, and ISOS. Is there a plan to fix this problem?***

- ➢ A beneficiary asked why WPS does not send these request via email. Mr. Pabich cited Privacy Act issues for the reason that an email is not sent by WPS requesting the additional information, however the retiree followed up with the statement that the request can be posted on the secure TRICARE-overseas.com website, and the automatic notification from that site to the beneficiary's email account would alert the beneficiary that he/she had a new message waiting for him/her on the secure web site. Mr. Pabich stated that there would be a cost associated with doing that, which WPS would have to absorb since it is not a contract requirement—(a letter is a contract requirement)—but he said it was something they could look at. Mr. Halliwell also indicated interest in this subject.

- ➢ Another option mentioned by a retiree was that WPS send an email notification that they had sent the beneficiary and/or the provider a letter requesting additional information, but without the details contained in the letter. Mr. Pabich made a note of that suggestion also.

  - ✓ **Our Comment:** Again, we do not believe this problem lies so much in the fact that the beneficiary is not notified of a letter being sent to themselves, in as much as it is, not being notified of a request letter being sent to an uncaring and unconcerned provider.

- o **Code 173: About 1,000 claims (3.5%) –"Documentation does not support the frequency of visits billed".** Mr. Pabich explained what may be the cause of this reason code, which can be easily resolved by beneficiaries. He explained that the beneficiary may file a claim that includes 4 providers who were seen in one week, the claim states that the reason for seeing the provider is "flu", but in reality the

beneficiary had seen one provider for the flu, another was a cardiologist visit, another was a visit to an EENT specialist, but the reasons for seeing the other providers is not indicated on the claim. He explained that WPS's system will see this claim as one claim for 4 providers in one week for a medical condition, flu, and will not know that it really represents 4 separate medical encounters.

- ✓ **Added:** For outpatient claims, keep the claims simple—do not bundle multiple providers in one claim. Multiple visits for a single provider, for a single diagnosis should not cause difficulty. You may add a few added diagnosis's as long as each is listed in on the DD Form 2642 and also on the Provider receipt, but keep in mind----the more complicated you make the claim, the more chance of a small glitch holding up the entire claim. Ex: Multiple receipts and dates for visits to the same doctor for recurring diabetes follow up visits over a 6 months period should not encounter road blocks. You may also submit a separate claim for each visit, but that generates more paperwork on both ends—your call.

Mr. Pabich was asked about an in-patient claim for the birth of a child where the hospital bill reflects services for the OBGYN specialist and a Pediatrician and would that cause an issue in processing the claim at WPS. Mr. Pabich stated that, even though the hospital bill included the providers under professional fees, it would be helpful if beneficiaries separated the providers for claims purposes. He suggested that submitting one claim for the OBGYN services and another claim for the Pediatrician would help to avoid confusion at WPS. "Keep it simple" was the phrase he used.

- ✓ **Added:** This has a significant added benefit. If one provider is certified and the other is not, the certified provider claim should process without delays, while the other goes through the normal certification delays.

- o **Code 327: About 800 claims 2.75% -- "Claim/service lacks information which is needed for adjudication. Missing/incomplete/invalid indication that the service was supervised or evaluated by a physician".** The above code description is taken from the TMA list of denial codes, however, when Mr. Pabich discussed this code he stated **"claim/service lacks information which is needed for adjudication, due to missing National Drug Code"**. He stated that if a beneficiary sees this on the EOB he is not responsible for it. He explained that this is specific to a pharmacy that is **"participating"** on a claim. He explained that the NDC is a requirement for pharmacies who file claims from the Philippines and Panama.

  - ✓ **Added:** Since this is only for participating Pharmacies, we can only speculate this would involve participating hospitals and 3rd party providers?

In the Cebu meeting a retiree stated that a beneficiary had been requested to provide the NDC. Mr. Pabich stated that it was a mistake and should not have happened.

- ✓ **Our Comments:** We are unsure if this code's definition has been changed to only reflect the request for NDC, but will follow-up on this.

- o **Code 033/044: About 600 claims (2%) -- "Duplicate Service".** Mr. Pabich stated that the claims are looked at on the line by line basis and if there is a line that was claimed on another claim, then the claim line item being processed will be denied as a duplicate service, (this is an automatic function of the claims processing software which will identify actual or potential duplicate claim items). Code 033 is a manual denial and 044 is an automated, perfect match denial.

  - ✓ **Added:** I have mistakenly, filed a claim with a receipt and months later filed the same receipt and the system caught it right away with code 044.

- o **Code 030: "services filed after time limit".** A frequency of use number for the code was not provided. Mr. Pabich related that previously there was a one year time limit from the date of service for filing a claim. There are waivers of this policy including administrative delays and awaiting an EOB from Other Health Insurance (OHI).A waiver must be requested by the beneficiary/provider. Mr. Pabich stated that the one year timely filing policy in the Philippines (and OCONUS) is changing and that he would discuss that later in the presentation.

- o **Code 103: "claim has been split for processing".** A frequency of use number for the code was not provided. This code is used to inform the beneficiary/provider that a claim was split, per government regulation, to separate the processing of institutional claims and professional claims—it is not a denial code.

4. Authorized Provider Certification.

- It is required that providers be licensed and qualified to provide services that are being billed for.

- Provider must have the specialty required for the services provided. Their specialties are contained in a provider record in the WPS computers.

- A provider who is a cardiologist can provide general medical care (GP), but a GP cannot provide cardiology care that requires the cardiology specialty to perform.

- An individual provider may qualify for more than one provider type.

- When a claim is received at WPS, the processor queries the database to see if the provider is in the database. If the provider is not in the database, a request is sent to ISOS to perform a certification.

  - During the Manila meeting, a discussion occurred concerning how the provider becomes listed in the database. It was explained that WPS processors will query the database for an exact match of the provider that they are making the query on. A beneficiary asked if the processor misspells the name of a provider that is in the data base, will it return a 'no record' response?

    Mr. Pabich acknowledged that it will most likely return a 'no record' response and that a new request for provider certification would be sent to ISOS, delaying the processing of the claim.

    An attempt was made to pin down whether the lack of a comma or a space in the inputting of the provider for the query action would result in a 'no record' response, but Mr. Pabich wasnot sure and was unable at the time to give a definitive response. ***This is a major concern since the Certified Provider list has many instances like this and we can only assume the WPS data base has the same issues, so we willfollow up on that question.***

- ISOS has 90 days to do the certification and if it is not completed in 90 days, the claim will be denied.

- At times, it can take ISOS longer than 90 days to get out to the area to do a certification and sometimes the provider will not 'cooperate' with ISOS in the certification process.

  - ✓ **Added:** We recommend that beneficiaries discuss the TRICARE certification with their providers if the provider is not certified at the time of service. We suggest they explain to the provider that there is no fee for certification and that they are not joining an insurance program, but that by being certified, the beneficiary can get reimbursed for care received.

  - ✓ **Our Question:** We would like to know why it appears there is not an automatic 'look-back' at claims denied for Code 018 when the denial is based on ISOS not being able to complete the certification process in the 90 days allotted. As it stands, the beneficiary is responsible for monitoring the certified provider list to determine if the provider they used finally gets certified, at which time they can re-submit the claim.

  - ✓ **Our Question:** We also would like to know why EOBs do not advise the beneficiary they can re-submit the claim once the provider has been certified. ***This is an issue that has been presented to TMA for the last 6 years, with no resolution.***

- Most certifications are done in response to WPS receiving a claim for a non-certified provider.

- ✓ **Added:** Beneficiaries doing their homework on which providers are certified in their area can eliminate a lot of this delay.

- Providers are not required to participate on claims.

- If a claim has more than one provider on it and only one provider is not certified, the whole claim must be delayed while that one provider undergoes certification. If that one provider certification does not happen in the 90 days allotted, the whole claim is denied.

  - ✓ **Added:** As stated earlier—one claim—one provider.

  - ✓ **Added:** We believe that the statement; "If that one provider certification does not happen in the 90 days allotted, the whole claim is denied" is inaccurate. From the experiences of retirees that we have talked to, (and our own experiences), we have seen the denied provider billed amounts denied, but not billed amounts not associated to the denied provider.

- 'Shoe Boxing': Mr. Pabich recommended that beneficiaries not combine numerous providers or service dates in a single claim. They call this "shoe boxing" and it can result in the claim being delayed or denied.

  - ✓ **Added:** 'Shoe boxing', means a beneficiary saves a pile of unrelated claims over time and then submits them using one claim form. This is a formula for failure.

5. **Double Proof of Payment.**

- This is a worldwide requirement.

- Claims that reach a threshold of $5,000 for professional fees or $10,000 for institutional fees will be required to provide another form of proof of payment. The official receipt from the provider will not be enough to satisfy this requirement.

- Over-utilization and beneficiaries on "pre-payment" review may be required to provide another proof of payment even though the claim did not reach the threshold listed above.

- The threshold amounts are based on the whole claim, not individual procedures within the claim. This is another reason to avoid "shoe boxing" a claim.

- Double proof of payment helps reduce fraud, but slows down payments of claims.

- Failure to provide the Double Proof of Payment may result in the claim being denied.

- Recommended that if you know, or believe, that the medical care will meet the double proof of payment thresholds, you should plan and ensure that you have additional proofs of payment.

- ✓ **Added:** Prepare for the worst and hope for the best. We recommend that if you believe a bill (or claim) will be $500 or more, that you ensure you have the additional proof of payments. One slide (slide #8) contained in the slide show presented by TMA's C&CS Division, http://db.tt/t9cyCoJ, reflects that 2,200 Philippine beneficiaries (22.3%) are on pre-payment review—mostly for potentially being victims of identity theft.

- What constitutes acceptable 'Double Proof' of Payment?

  - A cancelled check.
  - A Credit Card receipt.
  - A withdrawal receipt from your bank.

    Note: At this point a retiree objected to having to provide his account number for his checks, credit card, or bank account. Mr. Pabich stated that WPS does not need the account number and that "blacking out" the account number is appropriate. Mr. Pabich also stated if a beneficiary is requested by the contractor to provide account number information, do not provide it and contact TAO-P, so they can contact the contractor immediately to resolve the issue.

  - A loan document.
  - Copy of a certified bank draft/check.
  - An ATM receipt.
  - The additional proof does not need to be for the exact amount of the medical bill. It should be for the exact amount or more. If it is for less than the medical bill it may become an issue.

    - ✓ **Added:** Ref to the following link to TRICARE HeathMatters Newsletter, Overseas Newsletter 2012, Vol. 1 concerning the Double Receipt Issue.

      http://www.TRICARE.mil/TRICAREsmartfiles/Prod_846/HealthMatters_Newsletter_Overseas_Issue_1_2012_LoRes_022812.pdf

    - ✓ **Added:** The copy of the reference document is included as attachment 2 and, of specific note, is the note under the Japan section in the above link that states: *'If a cash gift is provided for medical care, the money should be deposited in the bank so a withdrawal receipt can be provided as proof of payment.'*

    - ✓ **Our Question:** The above note about 'Double Proof of Payment' from cash gift, sounds like it would apply worldwide, but is included under the section on Japan. **Does this apply worldwide?**

6. Timely filing.

- Under the 2012 NDAA, TRICARE was given authority to extend the timely filing requirement from 1 year to 3 years.

- Claims previously denied for timely filing from 31 December 2008 until present, will have an automatic review done by WPS. The beneficiary is not required to request a review of his claim.

- After the review of the above claims is completed, those claims that were denied because of failure to provide additional information and for which the beneficiary was unable to re-file because the claim had exceeded the timely filing limit (1 year), will have a letter sent to the beneficiary advising them to re-file the claim.

- The claims may still be denied for other reasons; however, the appeal process is available if the re-filed claim is denied.

- Do not start re-filing claims that fit the above categories until TMA or WPS advises that they are ready to accept beneficiary requests for a look-back on their claims.

7. Suggestions to improve claims results.

- Know the TRICARE program. The TRICARE Manuals, 32 CFR and 10 USC are linked on the TAO-P website. A beneficiary should try to inform himself of the contents of these resources which contain all the TRICARE rules.

- Knowing the contents of the TRICARE Manuals will help in filing an appeal or in complaining to WPS that the claim processor did not follow the rules since the beneficiary can cite the specific section that relates to his appeal or claim related issue.

- Know your provider. Know the provider's qualifications and certification status.

- Submit claims more frequently and in smaller total dollar amounts in order to not hit the double proof of payment threshold.

- File claims with one provider and multiple visits instead of, claims with multiple providers and multiple visits. It will only invite claim processing delays or denials.

- The simpler the claim the higher the likelihood that it will go through without problems.

- File your claims more often: Consider filing monthly or quarterly. You can send the claims in one envelope to save postage cost.

Attachment 1

Philippines Demonstration Project Talking Points (as of March 2012)

- 3 year demonstration to determine efficacy/acceptability of alternate approach to delivering the TRICARE benefit in Republic of the Philippines (RP)
- Int'l SOS will establish list of approved providers in designated locations of RP who will file claims to WPS, agree to accept lesser of billed charges/negotiated rate/Government directed fee schedule as payment, and only charge beneficiaries for applicable Standard deductibles and cost shares according to the resulting Explanation of Benefits (EOB)
    - Beneficiaries are to be held harmless if charges for care from approved provider is denied, unless beneficiaries are notified in writing that care is not a TRICARE-covered benefit prior to receiving care
- Basic premise: Beneficiaries must receive care from approved Demo providers in designated Demo areas, unless waiver received
    - Otherwise, TRICARE will not cost share (pay) on the care claim
- Demo will be applicable to all TRICARE Standard beneficiaries (including TRICARE for Life (TFL), TRICARE Retired Reserve (TRR), etc.) who reside in RP and seek care in designated Demo locations
    - Residence determined by claim address; must be physical address, not FPO/APO
    - Demo requirements don't apply to visiting Standard beneficiaries with address outside RP
- Aims:
  Ensure delivery of high quality, safe care
  Enhance provider understanding of TRICARE Program
  Eliminate upfront costs for beneficiaries
  Eliminate balance billing
  Drive business to trusted, approved providers
  Reduce/eliminate need for beneficiaries to file claims
  Reduce aberrant billing activities
  Control costs and preserve TRICARE benefit
- For non-RP residents and for care outside Demo areas, TRICARE payments still governed by existing RP TRICARE Standard rules, e.g., provider must be certified
- Beneficiaries may request waiver to receive care from non-approved providers within Demo area
    - Written requests to be submitted to Int'l SOS to be considered on case-by-case basis
    - Unless emergency care, beneficiaries encouraged to submit requests prior to receiving care

    - Examples of reasons: continuity of care to complete episode of care in progress with non-approved provider when Demo began, or inability to obtain appointment with approved providers within appropriate access standard
    - If denied, final determination made by Director, TAO-P
- If Int'l SOS unable to recruit sufficient number/mix of approved specialists, Int'l SOS to request applicable specialty waiver(s) so beneficiaries may receive care in Demo area from non-approved providers
    - Normal RP TRICARE Standard rules would apply for non-approved provider care
- Approved providers may be removed from list for cause or administrative reasons, e.g., failure to adhere to Demo rules
    - Removed Demo provider may appeal removal to Int'l SOS, then TAO-P
    - Appeal process not applicable to certified providers not selected by Int'l SOS for approved list in Demo area; Int'l SOS not required to offer inclusion to all certified providers in Demo area
- TMA to determine geographic areas for Demo and phased implementation approach/timeline, and communicate requirement to Int'l SOS 240 days before start of health care delivery under the Demo
    - At 180 days before, Int'l SOS to submit implementation plan to TMA
    - At 120 days before, Int'l SOS to submit list of approved providers to TMA (although may be phased in depending on number of Demo locations)
    - At 60 days before, Int'l SOS to provide beneficiaries with easy access to website (and any other means established by Int'l SOS) in order to view the approved provider list
- Likely Demo areas to be determined based on claims data; cities to be prioritized by:
    - # beneficiaries filing claims
    - # of claims
    - Total claims amount paid
- Demo area boundaries will be based on reasonable radius; not yet defined
- TMA and Int'l SOS to develop a communication plan to ensure beneficiaries and providers are informed regarding the Demo Project, including what cities will be included
    - Plan will include processes for educating beneficiaries/providers about Demo rules
    - Int'l SOS to develop/publish materials to educate beneficiaries/providers
    - Communications may include mailings to claims addresses of beneficiaries filing claims within last 2 years

Attachment 2

Providing TRICARE with Proof of Payment

http://www.TRICARE.mil/TRICAREsmartfiles/Prod_846/HealthMatters_Newsletter_Overseas_Issue_1_2012_LoRes_022812.pdf

To process your claims reimbursements quickly and efficiently, it is recommended that you submit proof of payment with all claims and the *TRICARE DoD/CHAMPUS Medical Claim Patient's Request for Medical Payment* form (*DD Form 2642*) to the TRICARE Overseas Program (TOP) claims processor, Wisconsin Physicians Service (WPS). Proof of payment is necessary for TRICARE to validate claims and safeguard benefit dollars.

When submitting your *DD Form 2642*, you should also include an itemized bill or invoice, diagnosis describing why you received medical care and/or an explanation of benefits from your other health insurance, if applicable. A cancelled check or credit card receipt showing payment for medical supplies or services often satisfies the proof-of-payment requirement. You may also provide records of electronic funds transfers or the provider's itemized billing statement and provider's matching official signed receipt. If you paid for your care or supplies in cash, TRICARE may ask for proof of cash withdrawal from your bank or credit union along with a receipt from your provider.

If you have questions regarding proof-of-payment requests, claims submissions or the status of a submitted claim, please contact your TOP Regional Call Center and press option 2 for claims assistance.

Additional Proof-of-Payment Requirements

Proof of payment is required for outpatient services exceeding $5,000 U.S. dollars (USD) and inpatient services exceeding $10,000 USD. However, in certain countries there are exceptions.

In Turkey, provider invoices are only generated when services are paid in full, so they are considered proof of payment. In Germany, the pharmacy stamp is provided only after you have paid in full, and is considered proof of payment (for prescription charges only).

In Japan, additional proof-of-payment restrictions apply—the host nation provider will stamp invoices, but a copy of the bank account transaction or ATM receipt is also required. If a cash gift is provided for medical care, the money should be deposited in the bank so a withdrawal receipt can be provided as proof of payment.