

CHAPTER 7

CLAIMS SUBMISSION, REVIEW, AND PAYMENT

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CHAPTER 7
CLAIMS SUBMISSION, REVIEW, AND PAYMENT

A. GENERAL

The Director, **OCHAMPUS**, or a designee, is responsible for ensuring that benefits under CHAMPUS are paid only to the extent described in this Regulation. Before benefits can be paid, an appropriate claim must be submitted that includes sufficient information as to beneficiary identification, the medical services and supplies provided, and double coverage information, to permit proper, accurate, and timely adjudication of the claim by the CHAMPUS fiscal intermediary or OCHAMPUS. Subject to such definitions, conditions, limitations, exclusions, and requirements as may be set forth in this Regulation, the following are the CHAMPUS claim filing requirements:

1. CHAMPUS identification card required. A patient shall present his or her applicable CHAMPUS identification card (that is, Uniformed Services **identification** card) to the authorized provider of care that identifies the patient as an eligible CHAMPUS beneficiary (refer to Chapter 3 of this Regulation).

2. Claim required. No benefit may be extended under the Basic Program or PFTH without the submission of a complete and properly executed appropriate claim form.

3. Responsibility for perfecting claim. It is the responsibility of the CHAMPUS beneficiary or sponsor or the authorized provider acting on behalf of the CHAMPUS beneficiary to perfect a claim for submission to the appropriate CHAMPUS fiscal intermediary. Neither a CHAMPUS fiscal intermediary nor **OCHAMPUS** is authorized to prepare a claim on behalf of a CHAMPUS beneficiary.

4. Obtaining appropriate claim form. CHAMPUS provides specific CHAMPUS forms appropriate for **making** a claim for benefits for various types of medical services and supplies (such as hospital, physician, or prescription drugs). Claim forms may be obtained from the appropriate CHAMPUS fiscal intermediary who processes claims for the beneficiary's state of residence, from the Director, **OCHAMPUS**, or a designee, or from CHAMPUS health benefits advisors (**HBAs**) located at all Uniformed Services medical facilities.

5. Prepayment not required. A CHAMPUS beneficiary or sponsor is not required to pay for the medical services or supplies before submitting a claim for benefits.

6. Deductible certificate. If the fiscal year outpatient deductible has been met by a **beneficiary (\$50)** or a family (\$100 aggregate) through the submission of a claim or claims to a CHAMPUS fiscal intermediary in a geographic location different from the location where a current claim is being submitted, the beneficiary or sponsor must obtain a deductible certificate from the CHAMPUS fiscal intermediary where the applicable individual or family fiscal year deductible was met. Such deductible certificate must be attached to the current claim being submitted for benefits. Failure to obtain a deductible certificate under such circumstances will result in a second individual or

family fiscal year deductible being applied. However, this second deductible may be reimbursed once appropriate documentation, as described in this subsection A.6., is supplied to the CHAMPUS fiscal intermediary applying the second deductible (refer to section F. of Chapter 4 of this Regulation).

7. Nonavailability Statement (DD Form 1251). In some geographic locations or under certain circumstances, it is necessary for a CHAMPUS beneficiary to determine whether the "required medical- care can be provided through a Uniformed Services facility. If the required medical care cannot be provided by the Uniformed Services facility, a **Nonavailability** Statement will be issued. When required (except for emergencies), this Nonavailability Statement must be issued before medical care is obtained from civilian sources. Failure to secure such a statement will waive the beneficiary's rights to benefits under CHAMPUS, subject to appeal to the appropriate hospital commander (or higher medical authority).

a. Rules applicable to issuance of Nonavailability Statement. The ASD(HA) has issued DoD Instruction 6015.19 (reference (gg)) that contains rules for the issuance of **Nonavailability** Statements. Such rules may change depending on the current situations.

b. Beneficiary responsibility. The beneficiary shall ascertain whether or not he or she resides in a geographic area that requires obtaining a Nonavailability Statement. Information concerning current rules may be obtained from the CHAMPUS fiscal intermediary concerned, a CHAMPUS HBA or the Director, OCHAMPUS, or a designee.

c. Rules in effect at time civilian care is provided apply. The applicable **rules** regarding **Nonavailability** Statements in effect at the time the civilian care is rendered apply in determining whether a **Nonavailability** Statement is required.

d. Nonavailability Statement must be filed with applicable claim. When a claim is submitted for CHAMPUS benefits that includes services for which a Nonavailability Statement is required, such statement must be submitted along with the claim form.

B. INFORMATION REQUIRED TO ADJUDICATE A CHAMPUS CLAIM

Claims received that are not completed fully and that do not provide the following minimum information may be returned. If enough space is not available on the appropriate claim form, the required information must be attached separately and include the patient's name and address, be dated, and signed.

1. Patient's identification information. The following patient identification information must be completed on every CHAMPUS claim form submitted for benefits before a claim will be adjudicated and processed:

- a. Patient's full name.
- b. Patient's residence address.
- c. Patient's date of birth.

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d. Patient's relationship to sponsor.

NOTE : If name of patient is different from sponsor, explain (for example, stepchild or illegitimate child).

e. Patient's identification number (from DD Form 1173).

f. Patient's identification card effective date and expiration date (from DD Form 1173).

g. Sponsor's full name.

h. Sponsor's service or social security number.

i. Sponsor's grade.

j. Sponsor's organization and duty station. Home port for ships; home address for retiree.

k. Sponsor's branch of service or deceased or retiree's former branch of service.

2. Sponsor's current status. Active duty, retired, or deceased.

3. Patient treatment information. The following patient treatment information routinely is required relative to the medical services and supplies for which a claim for benefits is being made before a claim will be adjudicated and processed:

a. Diagnosis. All applicable diagnoses are required: standard nomenclature is acceptable. In the absence of a diagnosis, a narrative description of the definitive set of symptoms for which the medical care was rendered must be provided.

b. Source of care. Full name of source of care (such as hospital or physician) providing the specific medical services being claimed.

c. Full address of source of care. This address must be where the care actually was provided, not a billing address.

d. Attending physician. Name of attending physician (or other authorized **individual** professional provider).

e. Referring physician. Name and address of ordering, prescribing, or referring physician.

f. Status of patient. Status of patient at the time the medical services and supplies were rendered (that is, inpatient or outpatient).

g. Dates of service. Specific and inclusive dates of service.

h. Inpatient stay. Source and dates of related inpatient stay (if applicable) .

i. Physicians or other authorized individual professional providers. For services provided by physicians (or other authorized individual professional providers), the following information also must be included:

(1) Date of each service.

(2) Procedure code or narrative description of each procedure or service for each date of service.

(3) Individual charge for each item of service or each supply for each date.

(4) Detailed description of any unusual complicating circumstances related to the medical care provided that the physician or other individual professional provider may choose to submit separately.

j. Hospitals or other authorized institutional providers. For care provided by hospitals (or other authorized institutional providers), the following information also must be provided before a claim will be adjudicated and processed:

(1) An itemized billing showing each item of service or supply provided for each day covered by the claim.

NOTE : The Director, OCHAMPUS, or a designee, may approve, in writing, an alternate billing procedure for RTCS or other special institutions, in which case the itemized billing requirement may be waived. The particular facility will be aware of such approved alternate billing procedure.

(2) Any absences from a hospital or other authorized institution during a period for which inpatient benefits are being claimed must be identified specifically as to date or dates and provide details on the purpose of the absence. Failure to provide such information will result in denial of benefits and, in an ongoing case, termination of benefits for the inpatient stay at least back to the date of the absence.

(3) For hospitals subject to the CHAMPUS DRG-based payment system (see subparagraph A.1.b. (4) of Chapter 14), the following information is also required:

(a) The principal diagnosis (the diagnosis established, after study, to be chiefly responsible for causing the patient's admission to the hospital).

(b) All secondary diagnoses.

(c) All procedures performed.

(d) The discharge status of the beneficiary.

(e) The hospital's Medicare provider number.

(f) The source of the admission.

k. Prescription drugs and medicines (and insulin). For prescription drugs and medicines (and insulin, whether or not a prescription is required) receipted bills must be attached and the following additional information provided:

(1) Name of drug.

NOTE : When the physician or pharmacist so requests, the name of the drug may be submitted to the CHAMPUS fiscal intermediary directly by the physician or pharmacist.

(2) Strength of drug.

(3) Name and address of pharmacy where drug was purchased.

(4) Prescription number of drug being claimed.

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1. Other authorized providers. For items from other authorized providers (such as medical supplies), an explanation as to the medical need must be attached to the appropriate claim form. For purchases of durable equipment under the PFTH, it is necessary also to attach a copy of the **pre-**authorization.

m. Nonparticipating providers. When the beneficiary or sponsor submits the claim to the CHAMPUS **fiscal** intermediary (that is, the provider **elects not** to participate), **an** itemized **bill** from **the** provider to the beneficiary or sponsor must be attached to the CHAMPUS claim form.

4. Double coverage information. When the CHAMPUS beneficiary is eligible for medical benefits coverage **through** another plan, insurance, or program, either private or Government, the following information must be provided:

a. Name of other coverage. Full name and address of **double** coverage plan, insurance, or program (such as Blue Cross, Medicare, commercial insurance, and state program).

b. Source of double coverage. Source of double coverage (such as employment including retirement, private purchase, membership in a group, and law) .

c. Employer information. If source of double coverage is employment, give name and address of employer.

d. Identification number. Identification number or group number of other coverage.

5. Right to additional information

a. As a condition precedent to the provision of benefits under this Regulation, **OCHAMPUS** or CHAMPUS fiscal intermediaries may request and shall be entitled to receive information from a physician or hospital or other person, institution, or organization (including a local, state, or Federal Government agency) providing services or supplies to the beneficiary for whom claims or requests for approval for benefits are submitted. Such information and records may relate to the attendance, testing, monitoring, examination, diagnosis, treatment, or' services and supplies furnished to a beneficiary and as shall be necessary for the accurate and efficient administration of CHAMPUS benefits. In addition, before a determination on a request for preauthorization or claim of benefits is made, a beneficiary, or sponsor, shall provide additional information relevant to the requested determination, when necessary. The recipient of such information shall hold such records confidential except when:

(1) Disclosure of such information is authorized specifically by the beneficiary;

(2) Disclosure is necessary to permit authorized governmental officials to investigate and prosecute criminal actions; or

(3) Disclosure is authorized or required specifically under the terms of DoD Directives 5400.7 and 5400.11, the Freedom of Information Act, and the Privacy Act (references (i), (j), and (k)) (refer to section M. of Chapter 1 of this Regulation).

b. For the purposes of determining the applicability of and implementing the provisions of Chapters 8 and 9, or any provision of similar purpose of any other medical benefits coverage or entitlement, OCHAMPUS or CHAMPUS fiscal intermediaries, without consent or notice to any beneficiary or sponsor, may release to or obtain from any insurance company or other organization, governmental agency, provider, or person, any information with respect to any beneficiary when such release constitutes a routine use duly published in the Federal Register in accordance with the Privacy Act (reference (k)). Before a beneficiary's claim of benefits will be adjudicated, the beneficiary must furnish to CHAMPUS that information which reasonably may be expected to be **in his or her** possession and which is necessary to make the benefit determination. Failure to provide the requested information may result in denial of the claim.

C. SIGNATURE ON CHAMPUS CLAIM FORM

1. Beneficiary signature. CHAMPUS claim forms must be signed by the beneficiary except under the conditions identified in paragraph C.I.e., below. The parent or guardian may sign for any beneficiary under 18 years.

a. Certification of identity. This signature certifies that the patient identification information provided is correct.

b. Certification of medical care provided. This signature certifies that the specific medical care for which benefits are being claimed actually were rendered to the beneficiary on the dates indicated.

c. Authorization to obtain or release information. Before requesting additional **information** necessary to process a claim or releasing medical information, the signature of the beneficiary who is 18 years old or older must be recorded on or obtained on the CHAMPUS claim form or on a separate release form. The signature of the **beneficiary**, parent, or guardian will be requested when the beneficiary is under 18 years.

d. Certification of accuracy and authorization to release **double coverage information.** **This signature certifies to the accuracy of the double coverage information and authorizes the release of any information related to double coverage.** (Refer to Chapter 8 of this Regulation.)

e. Exceptions to beneficiary signature requirement

(1) Except as required by paragraph C.1.c., above, the signature of a spouse, parent, or guardian will be accepted on a claim submitted for a beneficiary who is 18 years old or older.

(2) When the institutional provider obtains the signature of the beneficiary (or the signature of the parent or guardian when the beneficiary is under 18 years) on a CHAMPUS claim form at admission, the following participating claims may be submitted without the beneficiary's signature.

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(a) Claims for laboratory and diagnostic tests and test interpretations from radiologists, pathologists, neurologists, and cardiologists.

(b) Claims from anesthesiologists.

(3) Claims filed by providers using CHAMPUS-approved **signature-on-file** and claims submission procedures.

2. Provider's signature. A participating provider (see subsection A.8. of Chapter 6) is required to sign the CHAMPUS claim form.

a. Certification. A participating provider's signature on a CHAMPUS claim form:

(1) Certifies that the **specific** medical care listed on the claim form was, in fact, rendered to the specific beneficiary for which benefits are being claimed on the specific date **or** dates indicated.

(2) Certifies that the provider has agreed to participate (providing this agreement has been indicated on the claim form) and that the CHAMPUS-determined allowable charge or cost will constitute the full charge or cost for the medical care listed on the specific claim form; and further agrees to accept the amount paid by CHAMPUS or the CHAMPUS payment combined with the cost-shared amount paid by, or on **behalf** of the beneficiary, as full payment for the covered medical services or supplies.

(a) Thus, neither CHAMPUS nor the sponsor is responsible for any additional charges, whether or not the CHAMPUS-determined charge or cost is less than the billed amount.

(b) Any provider who signs and submits a CHAMPUS claim form and then violates this agreement. by billing the beneficiary or sponsor for any difference between the CHAMPUS-determined charge or cost and the amount billed is acting in bad faith and is subject to penalties including withdrawal of CHAMPUS approval as a CHAMPUS provider by administrative action of the Director, **OCHAMPUS**, or a designee, and possible legal action on the part of CHAMPUS, either directly or as a part of a beneficiary action, to recover monies improperly obtained from CHAMPUS beneficiaries or sponsors (refer to Chapter 6 of this Regulation).

b. Physician or other authorized individual professional provider. A physician or other authorized individual-professional **provider** is liable for any signature submitted on his or her behalf. Further, a facsimile signature is not acceptable unless such facsimile signature is on file with, and has been authorized specifically by, the CHAMPUS fiscal intermediary serving the state where the physician or other authorized individual professional provider practices.

c. Hospital or other authorized institutional provider. The provider signature on a **claim** form for institutional services must be that of an authorized representative of the hospital or other authorized institutional provider, whose signature is on file with and approved by the appropriate CHAMPUS fiscal intermediary.

D. CLAIMS FILING DEADLINE

To be considered for benefits, all claims submitted under CHAMPUS must be filed with the appropriate CHAMPUS fiscal intermediary no later than December 31 of the calendar year immediately following the one in which the covered service or supply was rendered. Failure to file a **claim** timely waives automatically all rights to any benefits for such services or supplies provided during the period affected by the claims filing deadline.

1. Claims returned for additional information. When a claim initially is submitted **within** the claims filing time limit, but is returned in whole or in part for **additional** information to be considered for benefits, the returned claim, along with the requested information, must be resubmitted and received by the appropriate CHAMPUS fiscal intermediary no later than the applicable December 31 deadline or 90 days from the date the claim was returned to the beneficiary, whichever is later.

2. Exception to claims filing deadline. The Director, OCHAMPUS, or a designee, may grant exceptions to the claims filing deadline requirements.

a. Types of exception

(1) Retroactive eligibility. Retroactive CHAMPUS eligibility determinations.

(2) Administrative error. Administrative error (that is, misrepresentation, **mistake**, or other accountable action) of an officer or employee of OCHAMPUS (including OCHAMPUSEUR) or a CHAMPUS fiscal intermediary, performing functions under CHAMPUS and acting within the scope of that official's authority.

(3) Mental incompetency. Mental incompetency of the beneficiary or guardian or sponsor, in the case of a minor child (which includes inability to communicate, even if it is the result of a physical disability).

(4) Provider billings. Direct billings by participating providers.

(5) Delays by other health insurance. When not attributable to the beneficiary, delays in adjudication by other health insurance companies when double coverage coordination is required before the CHAMPUS benefit determination.

b. Request for exception to claims filing deadline. Beneficiaries who wish to request an exception to the claims filing deadline may submit such a request to the CHAMPUS fiscal intermediary having jurisdiction over the location in which the service was rendered, or as otherwise designated by the Director, OCHAMPUS.

(1) Such requests for an exception must include a complete explanation of the circumstances of the late filing, together with all available documentation supporting the request, and the-specific claim denied for late filing.

(2) Each request for an-exception to the claims filing deadline is reviewed individually and considered on its own merits.

E. OTHER CLAIMS FILING REQUIREMENTS

Notwithstanding the claims filing deadline described in section D. of this chapter, to lessen any potential adverse impact on a CHAMPUS beneficiary or sponsor that could result from a retroactive denial, the following additional claims filing procedures are recommended or required.

1. Continuing care. Except for claims subject to the CHAMPUS **DRG-based** payment system, **whenever** medical services and supplies are being rendered on a continuing basis, an appropriate claim or claims should be submitted every 30 days (monthly) whether submitted directly by the beneficiary **or** sponsor or by the provider on behalf of the beneficiary. Such claims may be submitted more frequently if the beneficiary or provider so elects. The Director, **OCHAMPUS**, or a designee, also may require more frequent claims submission based on dollars. Examples of care that may be rendered on a continuing **basis are outpatient physical therapy**, private duty (special) nursing, or inpatient stays. For claims subject to the CHAMPUS **DRG-based** payment system, claims may be submitted **only** after the beneficiary has been discharged or transferred from the hospital.

2. Inpatient mental health services. Under most circumstances, the 60-day inpatient mental health limit applies to the first 60 days of care paid **in** a-calendar year. The patient-will be notified when the first 30 days of inpatient mental health benefits have been paid. The beneficiary is responsible for assuring that all claims for care are submitted sequentially and on a regular basis. Once payment has been made for care determined to be medically appropriate and a program benefit, the decision will not be reopened solely on the basis that previous inpatient mental health care had been rendered but not yet billed during the same calendar year by a different provider.

3. Claims involving the services of marriage and family counselors, pastoral counselors, and mental health counselors. CHAMPUS requires that marriage **and** family counselors, pastoral counselors, and mental health counselors make a written report to the referring physician concerning the CHAMPUS beneficiary's progress. Therefore, each claim for reimbursement for services of marriage and family counselors, pastoral counselors, and mental health counselors must include certification to the effect that a written communication has been made or will be made to the referring physician at the end of treatment, or more frequently, as required by the referring physician.

F. PREAUTHORIZATION

When specifically required in other chapters of this Regulation, pre-authorization requires the following:

1. Preauthorization must be granted before benefits can be extended. In those situations requiring preauthorization, the request for such pre-

authorization shall be submitted and approved before benefits may be extended, except as provided in Chapter 4, subsection All. If a claim for services or supplies is submitted without the required preauthorization, no benefits shall be paid, unless the Director, **OCHAMPUS**, or a designee, has granted an exception to the requirement for preauthorization.

a. Specifically preauthorized services. An approved preauthorization specifies the exact services or **supplies** for which authorization is being given. In a preauthorization situation, benefits cannot be extended for services or supplies provided beyond the specific authorization.

b. Time limit on preauthorization. Approved preauthorizations are valid for specific periods of time, usually 90 days. If the **preauthorized** services or supplies are not obtained or commenced within the specified time limit, a new preauthorization is required before benefits may be extended.

2. Treatment plan, management plan. Each **preauthorization** request shall be accompanied by a proposed medical **treatment** plan (for inpatient stays under the Basic Program) or management plan (for services under the PFTH) which shall include generally a diagnosis; a detailed summary of complete history and physical; a detailed statement of the problem; the proposed type and extent of treatment or therapy; the proposed treatment modality, including anticipated length of time the proposed modality will be required; any available test results; consultant's reports; and the prognosis. When the preauthorization request involves transfer from a hospital to another inpatient facility, medical records related to the inpatient stay also must be provided.

3. Durable equipment. Requests for preauthorization to purchase durable equipment under the PFTH must list all items of durable equipment previously authorized under the PFTH and state whether the current item of equipment is the initial purchase or a replacement. If it is a replacement item, the date the initial item was purchased also shall be provided.

4. Claims for services and supplies that have been preauthorized. **When-**ever a claim is submitted for benefits under **CHAMPUS** involving preauthorized services and supplies, the date of the approved preauthorization must be indicated on the claim form and a copy of the written preauthorization must be attached to the appropriate **CHAMPUS** claim.

G. CLAIMS REVIEW

It is the responsibility of the **CHAMPUS** fiscal intermediary (or **OCHAMPUS**, including **OCHAMPUSEUR**) to review each **CHAMPUS** claim submitted for benefit consideration to ensure compliance with all applicable definitions, conditions, limitations, or exclusions specified or enumerated in this Regulation. It is also required that before any **CHAMPUS** benefits may be extended, claims for **medical** services and supplies will be subject to utilization review and quality assurance standards, norms, and criteria issued by the Director, **OCHAMPUS**, or a designee (see paragraph **A.1.e.** of Chapter 14 for review standards for claims subject to the **CHAMPUS DRG-based** payment system).

H. BENEFIT PAYMENTS

CHAMPUS benefit payments are made either directly to the beneficiary or sponsor or to the provider, depending on the manner in which the CHAMPUS claim is submitted.

1. Benefit payments made to beneficiary or sponsor. When the CHAMPUS beneficiary or sponsor signs and submits a specific claim form directly to the appropriate CHAMPUS fiscal intermediary (or OCHAMPUS, including OCHAMPUSEUR), any CHAMPUS benefit payments due as a result of that specific claim submission will be made in the name of, and mailed to, the beneficiary or sponsor. In such circumstances, the beneficiary or sponsor is responsible to the provider for any amounts billed.

2. Benefit payments made to participating provider. When the authorized provider **elects** to participate by signing a CHAMPUS claim form, indicating participation in the appropriate space on the claim form, and submitting a specific claim on behalf of the beneficiary to the appropriate CHAMPUS fiscal intermediary, any CHAMPUS benefit payments due as a result of that claim submission will be made in the name of and mailed to the participating provider. Thus, by signing the claim form, the authorized provider agrees to abide by the CHAMPUS-determined allowable charge or cost, whether or not lower than the amount billed. Therefore, the beneficiary or sponsor is responsible only for any required deductible amount and any cost-sharing portion of the CHAMPUS-determined allowable charge or cost as may be required under the terms and conditions set forth in Chapters 4 and 5 of this Regulation.

3. CEOB. When a CHAMPUS claim is adjudicated, a CEOB is sent to the beneficiary or sponsor. A copy of the CEOB also is sent to the provider if the claim was submitted on a participating basis. The CEOB form provides, at a minimum, the following information:

- a. Name and address of beneficiary.
- b. Name and address of provider.
- c. Services or supplies covered by claim for which CEOB applies.
- d. Dates services or supplies provided.
- e. Amount billed; CHAMPUS-determined allowable charge or cost; and amount of CHAMPUS payment.
- f. To whom payment, if any, was made.
- g. Reasons for any denial.
- h. Recourse available to beneficiary for review of claim decision (refer to Chapter 10 of this Regulation).

NOTE : The Director, OCHAMPUS, or a designee, may authorize a CHAMPUS fiscal intermediary to waive a CEOB to protect the privacy of a CHAMPUS beneficiary.

4. Benefit under \$1. If the CHAMPUS benefit is determined to be under \$1, payment is waived.

I. ERRONEOUS PAYMENTS AND RECOUPMENT

1. Erroneous payments. Erroneous payments are expenditures of government funds that are not authorized by law or the Regulation. Such payments are to be recouped under the provisions of Chapter 11 of this Regulation.

2. Claims denials resulting from clarification or change in law or Regulation. In those instances where claims review results in a finding of denial of benefits previously allowed but currently denied due to a clarification or interpretation of law or this Regulation, or due to a change in this Regulation, no recoupment action need be taken to recover funds expended prior to the effective date of such clarification, interpretation, or change.

J. GENERAL ASSIGNMENT OF BENEFITS NOT RECOGNIZED

CHAMPUS does not recognize any general assignment of CHAMPUS benefits to another person. All CHAMPUS benefits are payable as described in this and other chapters of this Regulation.