

CONTRACTOR RESPONSIBILITIES AND REIMBURSEMENT

1.0. CONTRACTOR RECEIPT AND CONTROL OF CLAIMS

1.1. The contractor may establish a dedicated post office box to receive claims related to the TRICARE Prime Remote Program. This dedicated post office box, if established, may also be the one used for handling Supplemental Health Care Program claims described in [Chapter 18](#) and [19](#).

1.2. The contractor shall follow appropriate Supplemental Health Care Program requirements for claims received for medical care furnished to ADSMs not enrolled in the TRICARE Prime Remote Program.

2.0. CLAIMS PROCESSING

2.1. Jurisdiction

2.1.1. The contractor shall apply TRICARE Prime Program claims processing procedures to claims for TPR-enrollees unless otherwise specified in this chapter (refer to [Section 1](#) for some of the differences).

2.1.2. The contractor shall process inpatient and outpatient medical claims for health care services provided worldwide to the contractor's TRICARE Prime Remote enrollees.

2.1.3. The contractor shall forward claims for ADSMs enrolled in TRICARE Prime Remote in other regions to the contractors for the regions in which the members are enrolled according to provisions in [Chapter 8, Section 2](#).

2.1.4. The contractor shall process claims received for ADSMs who receive care in their regions, but who are not enrolled in TRICARE Prime Remote, according to the instructions in [Chapters 18](#) and [19](#).

2.1.5. The contractor shall forward ADSM dental (including adjunctive dental) claims and inquiries to the appropriate Service Point of Contact (SPOC) (see [Addendum A](#)). *(Adjunctive dental claims for care under the National DoD/VA shall be processed by the contractor, see [paragraph 2.4](#).)*

2.2. Claims Processing Exceptions

2.2.1. The TRICARE Prime Remote Program does not have a Point of Service (POS) option; therefore, POS claims processing provisions do not apply. Refer to [Chapter 17, Section 2, paragraph 5.3.2](#) for information on self-referred care.

2.2.2. ADSMs have no cost-share or deductible amounts, no copayments, and no out-of-pocket expenses for approved care.

2.2.3. Nonavailability Statement requirements do not apply.

2.3. Claim Authorization

Refer to [Chapter 17, Section 2, paragraph 5.0.](#) for claim authorization guidelines.

2.4. *Claims for Care Provided Under the National DoDIVA MOA for Spinal Cord Injury (SCI), Traumatic Brain Injury (TBI), and Blind Rehabilitation*

2.4.1. *Effective January 1, 2007, the contractor shall process claims for ADSM care provided by the VA for SCI, TBI, and Blind Rehabilitation. Previously, these claims were processed/paid for either by MMSO (for Army and Navy care) or by the Air Force. Claims shall be processed in accordance with this chapter and the following.*

2.4.2. *Claims received from a Veterans Affairs health care facility for ADSM care with any of the following diagnosis codes (principal or secondary) shall be processed as an MOA claim: V57.4; 049.9; 139.0; 310.2; 323.x; 324.0; 326; 344.0x; 344.1; 348.1; 367.9; 368.9; 369.01; 369.02; 369.05; 369.11; 369.15; 369.4; 430; 431; 432.x; 800.xx; 801.xx; 803.xx; 804.xx; 806.xx; 851.xx; 852.xx; 853.xx; 854.xx; 905.0; 907.0; 907.2; and 952.xx.*

2.4.3. *The contractor shall verify whether the MOA VA-provided care has been authorized by MMSO. MMSO will send authorizations to the contractor by fax. If an authorization is on file, the contractor shall process the claim to payment. The contractor shall not deny claims for lack of authorization. Rather, if a required authorization is not on file, the contractor will place the claim in a pending status and will forward appropriate documentation to MMSO for determination (following the procedures in [Chapter 19, Addendum B](#) for MMSO SPOC referral and review procedures).*

2.4.4. *MOA claims shall be reimbursed as follows:*

2.4.4.1. *Claims for inpatient care shall be paid using VA interagency rates. The interagency rate is a daily per diem to cover an inpatient stay and includes room and board, nursing, physician, and ancillary care. These rates will be provided to the contractor by TMA (including periodic updates as needed). There are three different interagency rates to be paid for rehabilitation care under the MOA. The Rehabilitation Medicine rate will apply to traumatic brain injury care. Blind rehabilitation and spinal cord injury care each have their own separate interagency rate. Additionally, it is possible that two or more separate rates may apply to one inpatient stay. If the VA-submitted claim identifies more than one rate (with the appropriate number of days identified for each separate rate), the contractor shall pay the claim using the separate rates. (For example, a stay for spinal cord injury may include days paid with the spinal cord injury rate and days paid at a surgery rate.)*

2.4.4.2. *Claims for outpatient services shall be paid at the appropriate TRICARE allowable rate (e.g., CMAC) with a 10% discount applied.*

2.4.4.3. *Claims for the following care shall be paid at the interagency rate if one exists and, if not, then at billed charges: transportation; prosthetics; orthotics; durable medical equipment; adjunctive dental care; home care; personal care attendants; and extended care (e.g., nursing home care).*

2.4.4.4. *Since this is care for ADSMs, normal TRICARE coverage limitations do not apply to services rendered for MOA care. As long as a service has been authorized by MMSO, it will be covered regardless of whether it would have ordinarily not been covered under TRICARE policy.*

2.4.5. *On January 1, 2007, contractors will begin processing claims for care provided on and after this date. Claims for care provided prior to this date, will continue to be reimbursed by either MMSO or the Air Force. After 90 days, all claims -- regardless of the date of service -- will be processed by the contractor. All TED records for this care must include Special Processing Code 17 - VA medical provider claim.*

2.4.6. *Sixty to ninety days prior to the effective date, the contractor shall meet with MMSO to discuss the transition of claims processing responsibility (this meeting can be by telephone). Items to be discussed include: points of contact (including fax numbers) for authorizations; coordination of a process to forward claims received at the wrong location during the dual processing period; establish points of contact for transition issues; other items deemed necessary to facilitate a successful transition of these claims. The contractor will not be responsible for processing adjustments for any claim previously paid by MMSO or the Services.*

3.0. CLAIM REIMBURSEMENT

3.1. For network providers, the contractor shall pay TRICARE Prime Remote medical claims at the CHAMPUS allowable charge or at a lower negotiated rate.

3.2. No deductible, cost-sharing, or copayment amounts shall be applied to ADSM claims.

3.3. If a non-participating provider requires a TPR enrollee to make an "up front" payment for health care services, in order for the enrollee to be reimbursed, the enrollee must submit a claim to the contractor with proof of payment and an explanation of the circumstances. The contractor shall process the claim according to the provisions in this chapter. If the claim is payable without SPOC review the contractor shall allow the billed amount and reimburse the enrollee for the charges on the claim. If the claim requires SPOC review the contractor shall pend the claim to the SPOC for determination. If the SPOC authorizes the care, the contractor shall allow the billed amount and reimburse the enrollee for charges on the claim.

3.4. If the contractor becomes aware that a civilian provider is trying to collect "balance billing" amounts from a TPR enrollee or has initiated collection action for emergency or authorized care, the contractor shall follow contract procedures for notifying the provider that balance billing is prohibited. If the contractor is unable to resolve the situation, the contractor shall pend the file and forward the issue to the SPOC for determination. The SPOC will issue an authorization to the contractor for payments in excess of the applicable TRICARE payment ceilings provided the SPOC has requested and has been granted a waiver from the Chief Operating Officer (COO), TRICARE Management Activity, or designee.

3.5. If required services are not available from a network or participating provider within the medically appropriate time frame, the contractor shall arrange for care with a non-participating provider subject to the normal reimbursement rules. The contractor initially shall make every effort to obtain the provider's agreement to accept, as payment in full, a rate

within the 100% of CMAC limitation. If this is not feasible, the contractor shall make every effort to obtain the provider's agreement to accept, as payment in full, a rate between 100% and 115% of CMAC. If the latter is not feasible, the contractor shall determine the lowest acceptable rate that the provider will accept. The contractor shall then request a waiver of CMAC limitation from the Regional Director, as the designee of the Chief Operating Officer (COO), TRICARE Management Activity (TMA), before patient referral is made to ensure that the patient does not bear any out-of-pocket expense. The waiver request shall include the patient name, TPR location, services requested (CPT-4 codes), CMAC rate, billed charge, and anticipated negotiated rate. The contractor must obtain approval from the Regional Director before the negotiation can be concluded. The contractors shall ensure that the approved payment is annotated in the authorization/claims processing system, and that payment is issued directly to the provider, unless there is information presented that the ADSM has personally paid the provider.

4.0. THIRD PARTY LIABILITY (TPL)

Third party liability (TPL) processing requirements ([Chapter 11](#)) apply to all claims covered by this chapter. However, the contractor shall not delay adjudication action on a claim while awaiting completion of the TPL questionnaire and compilation of documentation. Instead, the contractor shall process the claim(s) to completion. When the contractor receives a completed TPL questionnaire and/or other related documentation, the contractor shall forward the documentation as directed in [Chapter 11](#).

5.0. END OF PROCESSING

The contractor shall issue Explanations of Benefits (EOBs) and provider summary vouchers for TRICARE Prime Remote claims according to TRICARE Prime claims processing procedures.

6.0. TED VOUCHER SUBMITTAL

The contractor shall report the TRICARE Prime Remote Program claims on vouchers according to TRICARE Systems Manual, [Chapter 2, Section 2.3](#). The TED for each claim must reflect the appropriate data element values.

7.0. PAYMENT TO THE CONTRACTOR

The contractor shall be reimbursed on a non-financially underwritten basis according to the provisions of [Chapter 3](#) for the health care costs incurred for each TPR Program claim processed to completion, upon acceptance of the vouchers by TMA.

8.0. AUDITS AND INSPECTION OF THE CONTRACTOR'S RECORDS

The contractor's records and performance shall be subject to periodic inspection at the discretion of the TMA and/or any of the Service Project Officers. Such inspections shall be conducted either at TMA or at the contractor's facility in accordance with the provisions described in [Chapter 15, Section 1](#). The Service Project Officers will coordinate with TMA any audit or inspection of the contractor's records.

9.0. STANDARDS

All TRICARE Program claims processing standards apply to TRICARE Prime Remote claims see [Chapter 1, Section 3](#).

