

JURISDICTION

In the early stages of claims review, the contractor shall determine that claims received are within its contractual jurisdiction using the criteria below. Contractor jurisdictions are provided in the TRICARE Contractor Address List issued by the TRICARE Management Activity (TMA). This address list also can be found on the TMA Home Page at <http://www.tricare.mil>, then click on Claims Information.

1.0. PRIME ENROLLEES

1.1. When a beneficiary is enrolled in TRICARE Prime, contractor jurisdiction is determined by the beneficiary's regional enrollment. The contractor processes all claims for the enrollee no matter where the enrollee receives services (*except for care received overseas, see paragraph 1.2.*). For information on claims for relocating Prime enrollees, refer to [Chapter 6, Section 2](#), Enrollment Portability. When a beneficiary's enrollment changes from one region to another during a hospital stay, the contractor with jurisdiction on the date of admission shall process and pay the entire Diagnostic Related Group (DRG) claim, including cost outliers. For inpatient claims paid on a per diem basis, to include DRG transfers and short stay outliers cases, and for professional claims that are date-driven, the contractor with the jurisdiction on the date of service shall process and pay the claim.

NOTE: All dental claims for Active Duty Service Members (ADSMs) enrolled in the TRICARE Prime Remote (TPR) Program shall be forwarded to the appropriate Service Point Of Contact (SPOC) listed in [Chapter 18, Addendum B](#).

1.2. *Overseas Care for Prime Enrollees. Effective September 1, 2010, claims received for TRICARE Prime enrollees who receive Civilian Health Care (CHC) while traveling or visiting outside the 50 United States and the District of Columbia shall be processed by the TRICARE Overseas Program (TOP) contractor.*

NOTE: *This provision does not apply to beneficiaries enrolled in the Uniformed Services Family Health Plan (USFHP) or the Continued Health Care Benefit Program (CHCBP). All claims for those beneficiaries will continue to be processed as USFHP or CHCBP claims. This provision also excludes TRICARE-Medicare dual eligible beneficiaries who receive CHC in U.S. territories. All claims for these beneficiaries will continue to be processed as TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) claims.*

2.0. ALL OTHER TRICARE BENEFICIARIES

2.1. For a beneficiary who is not enrolled in TRICARE Prime, the contractor with jurisdiction for the beneficiary's claim address shall process the claim no matter where the beneficiary receives services (*except for care received overseas, see paragraph 2.2.*). This includes CHCBP claims and claims from U.S. Government medical facilities other than those of the

Uniformed Services (e.g., a claim for emergency care provided by a Veterans Administration (VA) facility or a facility under the Indian Health Service (IHS), Public Health Services (PHS)). Claims for beneficiaries residing outside the United States shall be processed in accordance with the TRICARE Policy Manual (TPM), [Chapter 12](#). For inpatient claims paid under the DRG-based payment system, the contractor with jurisdiction for the beneficiary's claim address, on the date of admission, shall process and pay the entire DRG claim including cost outliers. For inpatient claims paid on a per diem basis, to include DRG transfers and short-stay outlier cases, and for professional claims that are date-driven, the contractor with jurisdiction for the beneficiary's claim address on the date of service, shall process and pay the claim.

2.2. *Overseas Care. Effective September 1, 2010, claims received for all other TRICARE beneficiaries who receive CHC while traveling or visiting outside the 50 United States and the District of Columbia shall be processed by the TOP contractor.*

NOTE: *This provision does not apply to USFHP or CHCBP enrollees. This provision also excludes TRICARE-Medicare dual eligible beneficiaries who receive CHC in U.S. territories. All claims for these beneficiaries will continue to be processed as TDEFIC claims.*

3.0. SUPPLYING OUT-OF-AREA PROVIDER INFORMATION

For out-of-area claims the regional contractor responsible for certifying providers and developing pricing data for the region where the services were provided shall supply provider and pricing information (both institutional and non-institutional) to the contractor responsible for processing the claims. The contractor shall respond within five workdays after receipt of such requests and shall designate a **Point Of Contact (POC)** for this purpose. The contractor shall follow the procedures below in requesting and providing information. Responses to such requests shall include only that information not available in the requester's own records or in TMA-provided records. The response shall verify whether or not the provider is a TRICARE-authorized provider and whether or not the provider is a network provider. The response shall also include the appropriate pricing of the services/supplies as well as specific data needed to complete contractor records and TRICARE Encounter Data (TED) submissions to the TMA.

3.1. Procedures For Contractor Coordination On Out-Of-Jurisdiction Providers

Contractors subject to the requirements of the TRICARE Systems Manual (TSM) who are responsible for processing claims for care provided outside of their provider certification jurisdiction shall first search available provider files, including the TMA-supplied copy of the TRICARE centralized provider file (to be provided at least weekly), to determine provider certification status, obtain related provider information, and determine if the certifying contractor has submitted a TRICARE Encounter Provider Record (TEPRV) for the out-of-area provider.

3.2. File Search Unsuccessful

If the file search is unsuccessful, the following procedures apply:

3.2.1. The servicing (claims processing) contractor shall request provider information from the certifying contractor.

3.2.2. Each contractor shall designate a *POC* as specified in [paragraph 1.0](#). who shall be responsible for initiating actions related to such requests and ensuring these actions are timely and well documented.

3.2.3. The certifying contractor shall respond within five workdays of the request with either:

3.2.3.1. Complete provider information for the servicing contractor to process the claim and submit TED in situations when a TEPRV has already been accepted by TMA; or

3.2.3.2. The information that a TEPRV for the provider in question has not been submitted to or accepted by TMA and one of the following situations exist:

- The certifying contractor has sufficient documentation (including the provider's Tax Identification Number (TIN)) to complete the certification process and determine the provider's TRICARE status; or
- The certifying contractor does not have sufficient documentation to determine the provider's status and complete the certification process; or
- The certifying contractor has sufficient information to determine that the provider does not meet TRICARE certification requirements without going through the certification process; or
- The situations above apply, but the certifying contractor is not subject to the requirements of the TSM.

3.3. TEPRV Submissions

3.3.1. Since the servicing contractor will be unable to complete TED processing until a TEPRV is accepted by TMA, a coordinated effort is required between the servicing contractor and the certifying contractor in the above situations. The certifying contractor is responsible for ensuring the TEPRV is accepted by TMA before supplying the provider information indicated. Contractors shall not delay submitting TEPRVs for providers who have requested certification and such certification has been granted or denied, solely because the provider has not yet submitted a TRICARE claim. When the TEPRV is accepted, the certifying contractor shall notify the servicing contractor of this within two workdays of its acceptance and supply the provider information. Following are procedures and time frames to facilitate this coordination.

3.3.2. If the certifying contractor has completed its provider certification process but has yet to submit the TEPRV (or the TEPRV has not passed TMA edits), the certifying contractor

shall submit (or resubmit) the TEPRV within one workday of contact by the servicing contractor and notify the servicing contractor within two calendar weeks following the initial contact, of the TEPRV submission action taken and whether it was accepted.

3.3.3. If the certifying contractor does not have sufficient documentation to complete the certification process and submit a TEPRV, the certifying contractor shall initiate (or follow up on) the certification process within two workdays of the initial contact by the servicing contractor. If it is necessary to obtain documentation from the provider, the certifying contractor shall allow no longer than a two calendar week suspense from the date of its request.

3.3.4. Upon determination that the documentation is complete, the certifying contractor shall complete the certification process, submit the TEPRV, and notify the servicing contractor within one additional calendar week following completion of the certification process (i.e., within three weeks of the initial contact by the servicing contractor). The certifying contractor shall also notify the provider of the certification determination and of procedures for contacting the certifying contractor in the future regarding provider-related (non-claim) matters (e.g., address changes).

3.3.5. If the certifying contractor is unable to complete the certification process within three calendar weeks following the initial contact, it shall submit the TEPRV and notify the servicing contractor within four calendar weeks following the initial contact.

3.3.6. If the certifying contractor has substantial evidence (e.g., state licensure listing) that the provider meets TRICARE certification requirements, it shall consider the provider certified and so inform the servicing contractor one work day after acceptance.

3.3.7. If the certifying contractor does not have substantial evidence that the provider meets TRICARE certification requirements, it shall not consider the provider to be certified. The servicing contractor shall deny the claim using an appropriate Explanation of Benefits (EOB) message.

3.3.8. In either of the above cases, if the certifying contractor does not have the provider's TIN, it shall submit the TEPRV with a contractor Assigned Provider Number (APN) as described in the TSM, [Chapter 2, Section 2.10](#), Provider Taxpayer Number, and provide this number to the servicing contractor. The servicing contractor shall issue payment only to the beneficiary in this case if the claim is otherwise payable (even in the unlikely event that the provider is participating).

3.3.9. If, at the time of the servicing contractor's initial contact, the certifying contractor is able to determine that the provider does not meet the TRICARE certification requirements without going through the certification process, it shall submit the TEPRV and notify the servicing contractor within two calendar weeks of the initial contact. If the provider's TIN is not known, the certifying contractor shall assign an APN. The servicing contractor shall deny the claim using an appropriate EOB message.

3.3.10. If the certifying contractor is not subject to the requirements of the TSM, the servicing contractor will assign the provider sub-identifier (sub-ID) and create the TEPRV. The certifying contractor shall provide the servicing contractor with the minimum provider

information listed below, within two workdays of the initial contact by the servicing contractor if the certification process has been completed or if a determination can be made that the provider does not meet the certification requirements without going through the process. If it has not been completed, the servicing contractor shall be so notified within two workdays of the initial contact and the procedures and time frames above shall be followed.

3.3.11. The servicing contractor shall notify the TMA Contracting Officer's Representative (COR) if the certifying contractor does not provide the required provider information and notification of the TEPRV's acceptance by TMA within 35 calendar days from the time of the initial contact.

3.4. Provider Data

The minimum provider data to be provided by the certifying contractor is the provider's certification status including the reason a provider is not certified if such is the case, any special prepayment review status, and the following data:

3.4.1. Provider Taxpayer Number, APN, or National Provider Identifier (NPI), as appropriate.

3.4.2. Provider Sub-ID (not required for NPI). Provider Sub-Identifier may need to be assigned by the servicing contractor if the certifying contractor is not subject to the requirements of the TSM.

3.4.3. Provider Contract Affiliation Code.

3.4.4. Provider street address.

3.4.5. Provider "pay to" address.

3.4.6. Provider State or Country.

3.4.7. Provider Zip Code.

3.4.8. Provider Specialty (non-institutional providers).

3.4.9. Type of Institution (institutional providers).

3.4.10. Type of reimbursement applicable (DRG, MHPD, etc.).

3.4.11. Per diem reimbursement amount, if applicable.

3.4.12. Indirect Medical Education (IDME) factor (where applicable), Area Wage Index (DRG).

3.4.13. Provider Acceptance Date.

3.4.14. Provider Termination Date.

3.4.15. Record Effective Date.

3.4.16. The certifying contractor shall provide additional data upon request of the servicing contractor or TMA to meet internal processing, prepayment review, or file requirements or, to create a TEPRV when the certifying contractor is not under the requirements of the TSM.

3.5. Maintenance Of TEPRV With An APN

3.5.1. In all cases when an APN is assigned, the certifying contractor shall attempt to obtain the provider's actual TIN. Within ten workdays of receipt of the provider's TIN, the certifying contractor who is under the requirements of the TSM shall inactivate the APN TEPRV and add the TEPRV with the provider's TIN regardless of whether the provider meets TRICARE certification requirements.

3.5.2. All APNs must be associated with an NPI for providers who meet the Health and Human Services (HHS) definition of a covered entity and submit Health Insurance Portability and Accountability Act (HIPAA)-compliant electronic standard transactions or who otherwise obtain an NPI. Guidance for submitting the NPI on TEPRV records will be provided in a future order.

3.6. Provider Correspondence

Any provider correspondence which the servicing contractor forwards for the certifying contractor's action or information shall be sent directly to the certifying contractor's *POC* to avoid misrouting. Within one week of receipt, the servicing contractor shall forward for the certifying contractor's action any correspondence or other documentation received which indicates the need to perform a provider file transaction. This includes, but is not limited to, such transactions as address changes, adding or deleting members of clinics or group practices, or changing a provider's TIN.

3.7. Provider Certification Appeals

3.7.1. Requests for reconsideration of an contractor's adverse determination of a provider's TRICARE certification status are processed by the certifying contractor. Any such requests received by the servicing contractor are to be forwarded to the certifying contractor within five workdays of receipt and the appealing party notified of this action and the reason for the transfer. The certifying contractor shall follow standard appeal procedures including aging the appeal from the date of receipt by the certifying contractor, except that, if the reconsideration decision is favorable, the provider shall be notified to resubmit any claims denied for lack of TRICARE certification to the servicing contractor with a copy of the reconsideration response. In this case, the certifying contractor shall ensure a TEPRV for this provider is accepted by TMA within one calendar week from the date of the appeal decision.

3.7.2. The servicing contractor shall forward to the certifying contractor within five workdays of receipt any provider requests for review of claims denied because the certifying contractor was unable to complete the certification process. The servicing contractor shall notify the provider of the transfer with an explanation of the requirement to complete the certification process with the certifying contractor. Upon receipt of the provider's request, the

certifying contractor shall follow its regular TRICARE provider certification procedures. In this case, no basis for an appeal exists. If the provider is determined to meet the certification requirements, the special provider notification and TEPRV submittal requirements apply.

4.0. OUT-OF-JURISDICTION CLAIMS

The contractor shall handle all claims involving billings outside its jurisdiction (including those to be processed by TMA, and dental claims to be processed by the SPOCs listed in [Chapter 18, Addendum B](#) under the TPR Program) as follows:

4.1. Totally Out-Of-Jurisdiction

When the contractor receives a claim with no services or supplies within its jurisdiction, it shall transfer the claim to the appropriate jurisdictional contractor within 72 hours of identifying it as being out-of-jurisdiction. Paper claims shall not be converted to electronic claims. Claims received electronically shall be transferred via a HIPAA-compliant 837 transaction. For both paper and electronic claims that are transferred, the contractor shall when appropriate:

- Provide current information on the beneficiary and family deductible and catastrophic loss amounts, if any, shown on the history file.
- Notify the beneficiary claimant of the action taken and provide the address of the contractor where the claim was forwarded. For a provider claimant, the contractor shall not notify the provider of the action taken nor provide the address(es) of the contractor(s) where the claim was forwarded.
- Forward all supporting documentation and include the original date of receipt on the claim.

4.2. Partially Out-Of-Jurisdiction

When a contractor receives a claim for services or supplies both within and outside its jurisdiction before processing the services or supplies within its jurisdiction, and within 72 hours of identifying the out-of-jurisdiction items, the contractor shall:

- Draw lines through the in-jurisdiction items.
- Ensure the original date of receipt is clearly indicated on the claim.
- Send a copy of the claim and all supporting documents to the appropriate contractor(s).
- The contractor shall include current information on the beneficiary and family deductible and catastrophic loss amounts accumulated.
- If more than one other contractor is involved, the transferring contractor shall provide each the name(s) of the other(s).

- Notify a beneficiary claimant of the action taken and provide the address(es) of the contractor(s) where the claim was forwarded. For a provider claimant, the contractor shall not notify the provider of the action taken nor provide the address(es) of the contractor(s) where the claim was forwarded.

5.0. NON-TRICARE CLAIMS

The contractor shall return claims submitted on other than approved TRICARE claim forms to the sender or transfer to other lines of business, if appropriate.

5.1. Civilian Health and Medical Program of the Department of Veteran Affairs (CHAMPVA) Claims

When a claim is identified as a CHAMPVA claim, the contractor shall return the claim to the sender with a letter advising them that the CHAMPVA Program's toll-free telephone number 1-800-733-8387, and instruct them to send the claim and all future CHAMPVA claims to:

Health Administration Center
CHAMPVA Program
P.O. Box 65024
Denver, Colorado 80206-9024

5.2. Veterans Claims

If a claim is received for care of a veteran and there is evidence the care was ordered by a VA physician, the claim, with a letter of explanation, shall be sent to the VA institution from which the order came. The claimant must also be sent a copy of the letter of explanation. If there is no clear indication that the VA ordered the care, return the claim to the sender with an explanation that the veteran is not eligible under TRICARE and that the care ordered by the VA should be billed to the VA.

5.3. Claims For Parents, Parents-In-Law, Grandchildren, And Others

On occasion, a claim may be received for care of a parent or parent-in-law, a grandchild, or other ineligible relative of a TRICARE sponsor. Return the claim to the claimant with a brief explanation that such persons are not eligible for TRICARE benefits.

5.4. Pharmacy Claims

The contractor shall forward all retail pharmacy claims to the pharmacy contractor within 72 hours of identifying it as being out-of-jurisdiction.

5.5. Medicare Dual Eligibles

The contractor shall forward all claims from beneficiaries who have eligibility for both Medicare and TRICARE to the TDEFIC contractor within 72 hours of identifying it as being out-of-jurisdiction.

6.0. CONTINUED TRICARE COVERAGE FOR DUAL ELIGIBLE BENEFICIARIES UNDER AGE 65

7.0. The National Defense Authorization Act (NDAA) for FY 2005 has extended TRICARE coverage to those individuals who, because of disability or end stage renal disease, are eligible for Medicare Part A but did not obtain Part B. The new legislation provides the authority to waive collection of prior payments and to continue TRICARE coverage of benefits for these individuals for a period of July 1, 1999 and ending on December 31, 2004. In a future Centers for Medicare and Medicaid Services (CMS) Special Enrollment Period, these individuals without Part B will automatically be enrolled in Part B unless they specifically opt out. If an individual does disenroll from Medicare Part B, he or she will lose all TRICARE coverage effective with the date of disenrollment. However, individuals will be given an opportunity to change the effective date of Medicare Part B enrollment to any month in 2004. Effective January 1, 2005, any TRICARE beneficiary under the age of 65, except for dependents of active duty members, who are or become eligible for Medicare and do not purchase Part B, will lose TRICARE coverage.

8.0. On a date to be announced, Defense Manpower Data Center (DMDC) will load the most current Medicare status for all beneficiaries under age 65. The DEERS query response for Other Government Programs (OGP) will list the Medicare entitlement and reflect either Part A or both Part A and Part B effective dates. DMDC has temporarily modified the "benefits rules" within DEERS during this waiver period to show these beneficiaries with Part A or gaps in effective dates between Part A and Part B as TRICARE eligible. Treat these individuals as fully TRICARE dual eligible even if there is a gap in effective dates between Part A and Part B and accept the Health Care Delivery Plan (HCDF) returned from DEERS.

