



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
HEALTH AFFAIRS

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TRICARE  
MANAGEMENT ACTIVITY

PCPB

CHANGE 61  
6010.51-M  
MARCH 14, 2008

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL  
FOR  
TRICARE OPERATIONS MANUAL (TOM)

The TRICARE Management Activity has authorized the following addition(s)/revision(s) to 6010.51-M, reissued August 2002.

**CHANGE TITLE:** PROCESSING OF OUT-OF-JURISDICTION (OOJ)  
CLAIMS

**PAGE CHANGE(S):** See page 2.

**SUMMARY OF CHANGE(S):** This change requires electronic transfers of out-of-jurisdiction (OOJ) claims. It eliminates the requirement to notify provider claimants of the jurisdictional transfer, it continues the notice to beneficiary claimants.

**EFFECTIVE AND IMPLEMENTATION DATE:** Upon direction of the Contracting Officer.

A handwritten signature in black ink, appearing to read "Laura Sells".

Laura Sells  
Chief, Purchased Care Procurement Branch

ATTACHMENT(S): 4 PAGES  
DISTRIBUTION: 6010.51-M

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT

**CHANGE 61**  
**6010.51-M**  
**MARCH 14, 2008**

**REMOVE PAGE(S)**

**INSERT PAGE(S)**

**CHAPTER 8**

Section 2, pages 5 and 6

Section 2, pages 5 and 6

**APPENDIX A**

pages 35 and 36

pages 35 and 36

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- 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**

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.

*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 point of contact 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 an *electronic* claim with no services or supplies within its jurisdiction, *they* shall *transfer* the claim to the appropriate *jurisdictional* contractor *via a HIPAA-compliant 837 transaction* within 72 hours of identifying *the claim* as being out-of-jurisdiction. Current information on the beneficiary and family deductible and catastrophic loss amounts, if any, shown on the history file *shall be included*. The transferring contractor shall *not notify* the *provider* claimant of the action taken and *nor* provide the address of the contractor to which the claim was forwarded. *The transferring contractor shall notify the beneficiary claimant of the action taken and provide the address of the contractor to which the claim was forwarded. The contractor processing the claim may include an EOB message stating that the claim was transferred from another TRICARE contractor.*

**SUPPLEMENTAL CARE:** Medical care received by Active Duty Service Members (ADSMs) of the Uniformed Services and other designated patients pursuant to an MTF referral (MTF Referred Care). Supplemental Health Care also includes specific episodes of ADSM non-referred civilian care, both emergent and authorized non-emergent care (non-MTF Referred Care).

**SUPPLEMENTAL FUNDS:** Funds used to pay for supplemental care.

**SUPPLEMENTAL INSURANCE:** Health benefit plans that are specifically designed to supplement TRICARE Standard benefits. Unlike other health insurance (OHI) plans that are considered primary payers, TRICARE supplemental plans are always secondary payers on TRICARE claims. These plans are frequently available from military associations and other private organizations and firms.

**SUSPENSION OF CLAIMS PROCESSING:** The temporary suspension of processing (to protect the government's interests) of claims for care furnished by a specific provider (whether the claims are submitted by the provider or beneficiary) or claims submitted by or on behalf of a specific TRICARE beneficiary pending action by the Director, TMA, or a designee, in a case of suspected fraud or abuse. The action may include administrative remedies or any other Department of Defense issuance (e.g. DoD issuances implementing the Program Fraud Civil Remedies Act), case development or investigation by TMA, or referral to the Department of Defense-Inspector General or the Department of Justice for action within their cognizant jurisdictions.

**TERMINATION:** Termination is the removal of a provider as an authorized TRICARE provider based on a finding that the provider does not meet the qualifications established by [32 CFR 199.6](#) to be an authorized TRICARE provider. This includes those categories of providers who have signed specific participation agreements.

**THIRD PARTY LIABILITY (TPL) CLAIMS:** Third party liability (TPL) claims are claims in favor of the government that arise when medical care is provided to an entitled beneficiary for treatment or injury or illness caused under circumstances creating tort liability legally requiring a third person to pay damages for that care. The government pursues repayment for the care provided to the beneficiary under the provisions and authority of the Federal Medical Care Recovery Act (42 U.S.C. paragraphs 2651-2653).

**THIRD PARTY LIABILITY (TPL) RECOVERY:** The recovery by the government of expenses incurred for medical care provided to an entitled beneficiary in the treatment of injuries or illness caused by a third party who is liable in tort for damages to the beneficiary. Such recoveries can be made from the liable third party directly or from a liability insurance policy (e.g., automobile liability policy or homeowners insurance) covering the liable third party. Third party liability recoveries are made under the authority of the Medical Care Recovery Act (42 U.S.C. paragraph 2651 et sec. Other potential sources of recovery in favor of the government in third party liability situations include, but are not limited to, no fault or uninsured motorist insurance, medical payments provisions of insurance policies, and workers compensation plans. Recoveries from such other sources are made under the authority of 10. U.S.C. paragraphs 10790, 1086(g), and 1095b.)

**THIRD PARTY PAYER:** An entity that provides an insurance, medical service, or health plan by contract or agreement, including an automobile liability insurance or no fault insurance carrier and a workers compensation program or plan, and any other plan or program (e.g., homeowners insurance, etc.) that is designed to provide compensation or coverage for expenses incurred by a beneficiary for medical services or supplies.

**TIMELY FILING:** The filing of TRICARE claims within the prescribed time limits as set forth in [32 CFR 199.7](#).

**TOLL-FREE TELEPHONES:** All telephone calls are considered toll-free for the purposes of measuring the standards contained in [Chapter 1, Section 3, paragraph 3.4.](#), except for those telephone calls to a TRICARE Service Center.

**TRANSFER CLAIMS:** A claim received by a contractor which is for services received and billed from another contractor's jurisdiction. TRICARE claims and attendant documentation must be referred to the appropriate contractor for processing. Notification *shall not* be sent to the *provider* claimant explaining the action taken. *Notification shall be sent to the patient claimant explaining the action taken*, including the name and address of the correct contractor. Claims for active duty members which are sent to the appropriate Uniformed Service are not considered to be "transfer claims."

**TRANSITION:** The process of changing Contractors who serve a particular area or areas. Transition begins with the Notice of Award to the incoming contractor and is formally completed with the close out procedures of the outgoing contractor, several months after the start work date.

**TRANSITIONAL PATIENTS OR CASES:** Patients for whom active care is in progress on the date of a contractor's start work date. If the care being provided is for covered services, the Contractor is financially responsible for the portion of care delivered on or after the Contractor's start work date.

**TREATMENT ENCOUNTER:** The smallest meaningful unit of health care utilization: One provider rendering one service to one beneficiary.

**TREATMENT PLAN:** A detailed description of the medical care being rendered or expected to be rendered a TRICARE beneficiary seeking approval for inpatient benefits for which pre authorization is required as set forth in [32 CFR 199.4](#). A treatment plan must include, at a minimum, a diagnosis (either ICD-9-CM or DSM-III); detailed reports of prior treatment, medical history, family history, social history, and physical examination; diagnostic test results; consultant's reports (if any); proposed treatment by type (such as surgical, medical, and psychiatric); a description of who is or will be providing treatment (by discipline or specialty); anticipated frequency, medications, and specific goals of treatment; type of inpatient facility required and why (including length of time the related inpatient stay will be required); and prognosis. If the treatment plan involves the transfer of a TRICARE patient from a hospital or another inpatient facility, medical records related to that inpatient stay also are required as a part of the treatment plan documentation.

**TRIAGE:** A method of assessing the urgency of need for medical care using the patient's complaints and medical algorithms or other appropriate methods for analysis and then