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HEALTH AFFAIRS

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TRICARE
MANAGEMENT ACTIVITY

PCPB

CHANGE 73
6010.51-M
NOVEMBER 4, 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: CORRECTIONS TO OUT-OF-JURISDICTION CLAIMS

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change is a correction to August 2002 TRICARE
Operations Manual, Change 61, dated March 14, 2008. Change 61 erroneously
deleted previous instructions related to out-of-jurisdiction paper claims and
supporting documentation transfer. This change restores those instructions.

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

Laura Sells
Chief, Purchased Care Procurement Branch

ATTACHMENT(S): 5 PAGES
DISTRIBUTION: 6010.51-M

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

CHANGE 73
6010.51-M
November 4, 2008

REMOVE PAGE(S)

CHAPTER 8

Section 2, pages 5 through 8

INSERT PAGE(S)

Section 2, pages 5 through 9

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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 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 TRICARE Dual Eligible Fiscal Intermediary Contract (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

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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.

