Chapter 24 Section 9

Claims Processing Procedures

1.0 GENERAL

1.1 The provisions of Chapter 8, Section 1, paragraph 1.0 are applicable to the TRICARE Overseas Program (TOP).

1.2 The provisions of Chapter 8, Section 1, paragraph 2.1 are applicable to the TOP. Additionally, a designated TOP Point of Contact (POC) may submit claims in accordance with Section 12.

1.3 The provisions of Chapter 8, Section 1, paragraph 2.2 are not applicable to the TOP, except in U.S. territories where Medicaid is available.

1.4 The provisions of Chapter 8, Section 1, paragraph 2.3 are applicable the TOP; however, region or country-specific requirements regarding third party payments or payment addresses may be established by TRICARE Management Activity (TMA) at any time to prevent or reduce fraud.

Note: Benefit payment checks and Explanation Of Benefits (EOB) to Philippine providers (and other nation's providers as determined by the government) shall be mailed to the place of service identified on the claim. This policy applies even if the provider uses a Third Party Administrator (TPA). No provider payments may be sent to any other address. The government may discontinue TPA payments to other countries or specific agencies if it is determined that significant fraud is occurring on a regular basis.

1.5 The TOP contractor shall comply with the provisions of Chapter 8, Section 1, paragraph 3.1 regarding acceptable claims forms.

1.6 The provisions of Chapter 8, Section 1, paragraph 4.0 are applicable to the TOP.

1.7 The contractor's claims processing procedures shall integrate efforts to prevent and identify fraud/abuse.

2.0 JURISDICTION

2.1 In the early stages of TOP claims review, the TOP contractor shall determine whether claims received are within its contractual jurisdiction using the criteria below. TOP jurisdiction for health care and remote Active Duty Service Member (ADSM) dental care is identified in the TOP contract with TRICARE Management Activity (TMA).

2.2 Services rendered onboard a commercial ship while outside U.S. territorial waters are the responsibility of the TOP contractor. Claims for services provided on a commercial ship that is outside the territorial waters of the United States (U.S.) are to be processed as foreign claims regardless of the provider's home address. If the provider is certified within the U.S., reimbursement

for the claim is to be based on the provider's home address. If the provider is not certified within the U.S., reimbursement will follow the procedures for foreign claims. This does not include health care for enrolled ADSM on a ship at sea or on a ship at home port.

2.3 The provisions of Chapter 8, Section 2, paragraphs 1.0 and 2.0 are superseded as described in paragraphs 2.3.1 through 2.3.11

2.3.1 When a beneficiary is enrolled in TOP Prime or TOP Prime Remote, the TOP contractor shall process all health care claims for the enrollee, regardless of where the enrollee receives services. The contractor shall also process dental care claims for remote overseas ADSMs per the provisions of Section 10. Referral/authorization rules apply.

2.3.2 Claims for Active Duty Family Members (ADFMs) (including Reserve Component (RC) ADFMs whose sponsors have been activated for more than 30 days), retirees, and retiree family members whose care is normally provided under one of the three regional Managed Care Support Contracts (MCSCs) (i.e., beneficiaries enrolled or residing in the 50 United States and the District of Columbia) who receive civilian health while traveling or visiting overseas shall be processed by the TOP contractor, regardless of where the beneficiary resides or is enrolled. Referral/authorization and Point Of Service (POS) rules apply for TRICARE Prime/TRICARE Prime Remote (TPR) enrollees.

Note: This provision does not apply to beneficiaries who are enrolled to the Uniformed Services Family Health Plan (USFHP) or the Continued Health Care Benefit Program (CHCBP). Claims for these beneficiaries are processed by their respective contractor regardless of where the care is rendered.

2.3.3 Claims for ADSMs residing in the 50 United States and the District of Columbia (including RC ADSMs activated for more than 30 days) who are on Temporary Additional Duty/Temporary Duty (TAD/TDY), deployed, deployed on liberty, or in an authorized leave status in an overseas location shall be processed by the TOP contractor, regardless of where the ADSMs resides or is enrolled. Referral/authorization rules apply.

2.3.4 Claims for TOP-enrolled ADSMs (including RC ADSMs activated for more than 30 days) on a ship or with an overseas home port overseas care shall not be processed by the member's military unit. These claims shall be processed by the TOP contractor.

2.3.5 Claims for RC ADSMs on orders for 30 consecutive days or less, who are injured while traveling to or from annual training or while performing their annual training who receive civilian medical care overseas, shall have their claims processed by the TOP contractor in coordination with the Military Medical Support Office (MMSO).

2.3.6 Claims for other than remote site ADSMs in Europe shall have their claims submitted on batches and paid in accordance with Section 3, paragraph 3.3.1.

2.3.7 The TOP contractor shall process Pacific ADSM and TRICARE Latin America/Canada (TLAC) ADSM claims for self-referred care following the claims processing guidelines for TRICARE Europe ADSM claims, except that TLAC and Pacific ADSM claims shall be submitted on vouchers instead of batches, and TRICARE Pacific ADSM claims shall be processed without an authorization for urgent/emergent care.

2.3.8 Claims for Durable Medical Equipment (DME) (otherwise coverable by TRICARE) that is purchased/ordered by TOP-eligible beneficiaries in an overseas area from a stateside provider (i.e., internet, etc.) shall be processed by the TOP contractor.

2.3.9 For inpatient claims that are paid under the Diagnostic Related Group (DRG)-based payment system, the TOP contractor, 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 shall process and pay the claims.

2.3.10 When a beneficiary's enrollment changes from one TRICARE region to another during a hospital stay that will be paid under the DRG-based payment system, the contractor with jurisdiction on the date of admission shall process and pay the entire DRG claim, including cost outliers.

2.3.11 For information on portability claims for relocating TOP Prime/TOP Prime Remote enrollees, refer to Chapter 6, Section 2.

2.4 The provisions of Chapter 8, Section 2, paragraphs 6.0, 6.1, 6.2, and 6.3 are applicable to the TOP.

2.5 The provisions of Chapter 8, Section 2, paragraph 6.4 and Chapter 19, Section 4 are applicable to the TOP for U.S. citizens who are practicing outside the U.S.

2.6 The provisions of Chapter 8, Section 2, paragraphs 6.5, 6.6, 6.7, 7.1, 7.2, 8.1, 8.2, and 8.3 are applicable to the TOP.

2.7 Refer to the TRICARE Reimbursement Manual (TRM), Chapter 4, Section 4, paragraph 5.0 for jurisdictional guidance regarding health care claims for work-related illness or injury which is covered under a Worker's Compensation Program.

2.8 The provisions of Chapter 8, Section 2, paragraph 5.0 are applicable to the TOP in those locations where the TRICARE Pharmacy (TPharm) contractor has established services (the U.S. territories of Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands). The TOP contractor cannot process pharmacy claims from these locations except for pharmacy that is part of an emergency room visit or inpatient treatment. Any prescriptions from this care that are <u>not</u> provided at time of treatment for inpatient/emergency care, shall be required to be submitted through the TPharm contractor. Copays will apply.

2.9 The TOP contractor shall forward all retail pharmacy claims to the TPharm contractor within 72 hours of identifying it as being out-of-jurisdiction. In all other overseas locations, the contractor shall process claims from host nation retail pharmacies and providers.

2.10 If an enrolled Active Duty Family Member (ADFM) beneficiary in Puerto Rico, U.S. Virgin Islands, Guam, American Samoa, or Northern Mariana Islands utilizes a non-network pharmacy, POS charges including deductibles and cost-shares will apply.

2.11 Non-enrolled ADFMs (Standard), retirees or their family members residing overseas obtaining prescription from an overseas host nation pharmacy shall submit their claims to the TOP contractor. TRICARE Standard cost-share provisions will apply.

2.12 Claims for DME purchased/ordered by TOP eligible beneficiaries in an overseas area from a stateside provider shall be processed by the TOP contractor.

3.0 CLAIMS FILING DEADLINE

The provisions of Chapter 8, Section 3 are applicable to the TOP unless a specific exception to the claims filing deadline has been granted. The TOP contractor shall notify the Contracting Officer's Representative (COR) if they become aware of country-specific claims filing processes that are in conflict with normal TRICARE timely filing deadlines. See Chapter 1, Section 2, paragraph 5.0 for the timely filing waiver process.

4.0 SIGNATURE REQUIREMENTS

4.1 The provisions of Chapter 8, Section 4 are applicable to the TOP unless a different process has been directed by the TMA Contracting Officer (CO).

4.2 The TOP contractor may, at its discretion, accept a thumbprint in lieu of a signature on a claim form, unless otherwise directed by the government.

4.3 When directed by the TMA CO, the TOP contractor may not use signature on file and may not accept facsimile or thumbprint signatures on claims.

5.0 REFERRALS/PREAUTHORIZATIONS/AUTHORIZATIONS

5.1 The provisions of Chapter 8, Section 5 are superseded for the TOP by the requirements listed below.

5.2 Referral/Preauthorization/Authorization Requirements for TOP Prime and TOP Prime Remote Enrollees

5.2.1 Unless otherwise directed by the government, referrals/preauthorizations/ authorizations are not required for emergency care, clinical preventive services, ancillary services, radiological diagnostics (excluding Magnetic Resonance Imaging (MRI) and Positron Emission Tomography (PET) scans), drugs, and services provided by a TOP Partnership Provider. Additionally, TOP Prime/TOP Prime Remote ADFMs may receive the first eight outpatient mental health sessions in a fiscal year without preauthorization. All other care that is provided to a TOP Prime/TOP Prime Remote-enrolled ADSM or ADFM by anyone other than their Primary Care Manager (PCM) requires authorization, regardless of where the care is rendered.

5.2.2 Claims for ADSM care not authorized by the TOP contractor shall be pended for a review to make a determination regarding authorization. If the care is retroactively authorized, then the contractor shall enter the authorization and process the claim for payment. If the contractor determines that the care was not authorized, the contractor shall deny the claim. Refer to Section 26 for additional information.

5.2.3 TOP ADSM claims for non-emergent care obtained in the 50 United States and the District of Columbia shall only be paid when accompanied by the appropriate payment authorization forms (SF 1034 or NAVMED 6320/10) or an electronic authorization via the Electronic Non-Availability Statement (E-NAS) module.

5.2.4 Claims for ADFM care not authorized by the TOP contractor shall process with POS deductibles and cost-shares.

5.3 Referral/Preauthorization/Authorization Requirements for all other TOP beneficiaries.

5.3.1 TRICARE-eligible beneficiaries residing in an overseas location who are not enrolled in TOP Prime/TOP Prime Remote typically do not need to obtain preauthorization/authorization for care. However, preauthorization reviews shall be performed for all care and procedures listed in Chapter 7, Section 2.

5.3.2 The TOP contractor may propose additional authorization reviews for non-enrolled TOP beneficiaries to the government.

5.4 Referral/Preauthorization/Authorization Requirements for Beneficiaries Who Reside in the 50 United States and the District of Columbia.

5.4.1 TRICARE beneficiaries whose health care is normally provided under one of the three regional MCSCs who require care while traveling in an overseas location shall request any necessary preauthorizations/authorizations through the TOP contractor, regardless of where the beneficiary resides or is enrolled.

Note: This process does not apply to beneficiaries enrolled to the USFHP or the CHCBP.

5.5 Point of Service (POS) Provisions

5.5.1 Unless specifically excluded by this section, all self-referred, non-emergency care provided to TOP Prime/TOP Prime Remote-enrolled ADFMs which is not either provided/referred by the beneficiary's PCM or specifically authorized shall be reimbursed under the POS option. This provision applies regardless of where the care is rendered. POS provisions also apply to the following stateside beneficiaries when traveling overseas: ADFMs, retirees, and retiree family members who are enrolled in TRICARE Prime, and ADFMs enrolled in TPR for ADFMs.

5.5.2 POS cost-sharing only applies to TRICARE-covered services. Claims for services that are not a covered TRICARE benefit shall be denied.

5.5.3 The TOP contractor shall adjust POS deductibles and cost-shares when TOP PCMs or Health Care Finders (HCFs) do not follow established referral/authorization procedures. For example, if the contractor processes a claim under the POS option because there was no evidence of a referral and/or an authorization, and the contractor later verifies that the PCM or other appropriate provider referred the beneficiary for the care, the contractor shall adjust the claim and reverse the POS charges. The contractor need not identify past claims that may be eligible for POS adjustment; however, the contractor shall adjust these claims as they are brought to their attention.

5.5.4 On a case-by-case basis, following stabilization of the patient, the TRICARE Area Office (TAO) Director or Military Treatment Facility (MTF) Commander may require an enrolled beneficiary to transfer to a TOP network facility or an MTF. The TAO Director or MTF Commander shall provide written notice to the beneficiary (or responsible party) advising them of the impending transfer to a TOP network facility/MTF. If a beneficiary who is subject to TOP POS provisions elects to remain in the non-network facility after such notification, POS cost-sharing provisions will apply beginning 24 hours following the receipt of the written notice. Neither the TOP Director nor the MTF Commander may require a transfer until such time as the transfer is deemed medically safe.

5.5.5 The following deductible and cost-sharing amounts apply to all TOP POS claims for health care support services:

- Enrollment year deductible for outpatient claims: $300 per individual; $600 per family. No deductible applies to inpatient services.
- Beneficiary cost-share for inpatient and outpatient claims: 50% of the allowable charge after the deductible has been met (deductible only applies to outpatient claims).
- POS deductible and cost-share amounts are not creditable to the enrollment/Fiscal Year (FY) catastrophic cap and they are not limited by the cap.
- POS deductible and cost-share amounts do not apply to claims for care received by newborns and newly adopted children who are deemed enrolled in TOP Prime or TOP Prime Remote.

5.5.6 POS deductible and cost-share amounts do not apply if a TOP enrollee has Other Health Insurance (OHI) that provides primary coverage (i.e., the OHI must be primary under the provisions of the TRM, Chapter 4, Section 1). Evidence of OHI claims processing (including the exact amount paid on the claim) must be submitted with the TOP claim.

5.5.7 EOB shall clearly indicate that a claim has been processed under the POS Option.

5.5.8 POS is not applicable to ADSMs or to TOP non-enrollees.

5.6 Extended Care Health Option (ECHO) benefits in overseas locations must be authorized by the TAO Director or designee. Refer to Section 23 and the TRICARE Policy Manual (TPM), Chapter 9 for additional guidance.

5.7 Refer to Section 10 for referral/preauthorization/authorization requirements for ADSM dental care in remote overseas locations.

6.0 CLAIM DEVELOPMENT

6.1 Development of missing information shall be kept to a minimum. The TOP contractor shall use available in-house methods, contractor files, telephone, Defense Enrollment Eligibility Reporting System (DEERS), etc., to obtain incomplete or discrepant information. If this is unsuccessful, the contractor may return the claims to sender with a letter which indicates that the claims are being returned, the reason for return and requesting the required missing

documentation. The contractor's system must identify the claim as returned, not denied. The government reserves the right to audit returned claims as required, therefore the contractor shall retain sufficient information on returned claims to permit such audits. The contractor shall review all claims to ensure TOP required information is provided prior to payment.

6.2 Claims may be filed by eligible TRICARE beneficiaries, TOP host nation providers, TOP POCs, and TRICARE authorized providers in the 50 United States and the District of Columbia as allowed under TRICARE (see Chapter 8, Section 1).

6.3 Confidentiality requirements for TOP are identical to TRICARE requirements outlined in Chapter 8.

6.4 As a guideline, all overseas claims shall be sent to the microcopy area, transferred to microcopy format, and returned to the contractor's claims processing unit No Later Than (NLT) the close of business the following working day of submission.

6.5 The provisions of Chapter 8, Section 9 are applicable to TOP.

6.6 The following minimal information is required on each overseas claim prior to payment:

6.6.1 Beneficiary and host nation provider signatures.

6.6.2 Complete beneficiary and host nation provider name and address.

6.6.3 If an address is not available on the claim, obtain the address either from previously submitted claims, directly from the beneficiary/host nation provider via phone, fax or e-mail, or notify the TAO Director as appropriate.

Note: The TOP contractor shall accept APO/FPO for the beneficiary address.

6.6.4 A valid payable diagnosis. Prior to returning a claim that is missing a diagnosis, the TOP contractor shall research their history and determine whether a diagnosis from a related claim can be applied.

6.6.5 Identification of the service/supply/DME ordered, performed or prescribed, including the date ordered performed or prescribed. The TOP contractor may use the date the claim form was signed as the specific date of service, if the service/purchase date/order date is not on the bill.

6.6.6 Claims received with a narrative description of services provided shall be coded by the overseas contractor with accurate, full coding as agreed upon by the TMA CO. Claims received with ICD-10 codes shall be converted to ICD-9 codes by the TOP contractor. Refer to Chapter 8, Section 6, paragraph 4.0 regarding the use of "V" codes.

6.6.7 Care authorizations (when required).

6.6.8 Itemization of total charges. (Itemization of hospital room rates are not required on institutional claims).

6.7 The TOP contractor shall return all claims for overseas pharmacy services submitted by high volume overseas providers without National Drug Code (NDC) coding (where required), unless the provider has been granted a waiver by the TMA CO as outlined below.

6.8 Non-prescription (Over-The-Counter (OTC)) drugs are to be denied. This includes drugs that are considered OTC by U.S. standards, even when they require a prescription in a foreign country.

6.9 The TOP contractor may use Blue Book pricing identified by First DataBank as a reference source for processing drug related TRICARE overseas claims.

6.10 Claims for medications prescribed by a host-nation physician, and commonly used in the host-nation country, may be cost-shared.

6.11 The TOP contractor shall use $3,000 as the overseas pharmacy service drug tolerance. A limited waiver to the NDC coding and payment requirements (where required) may be granted for overseas claims for pharmaceuticals submitted from low volume/small overseas pharmacy providers or TRICARE eligible beneficiaries from the Philippines, Panama and Costa Rica and any other country designated by TMA, when it would create an undue hardship on a beneficiary. High volume providers who provide pharmaceuticals in the Philippines, Panama and Costa Rica (and any other country designated by TMA) would not qualify for the limited waiver. See Section 14 for specific NDC coding and payment requirements.

6.12 When an office visit is billed along with prescription drugs dispensed by a provider in the Philippines, the TOP contractor shall utilize best business practices in determining the appropriateness of the charges. The contractor shall develop internal procedures to determine whether these claims represent an office visit in conjunction with dispensing of prescription drugs (e.g., presenting symptoms or diagnosis that would be considered appropriate for the dispensing of a prescription), or whether the beneficiary only obtained a prescription refill with no accompanying provider services.

6.13 Claims for DME involving lease/purchase shall always be developed for missing information.

6.14 The TOP contractor shall use ECHO claims processing procedures outlined in TPM, Chapter 9, Section 18.1, when processing ECHO overseas claims.

6.15 The TOP contractor shall deny claims from non-certified or non-confirmed host nation providers when the TMA CO has directed contractor certification/confirmation of the host nation provider prior to payment.

6.16 Requests for missing information shall be sent on the TOP contractor's TRICARE/TOP letterhead. When development is necessary in TRICARE Europe Region, the contractor shall include a special insert in German, Italian and Spanish which indicates what missing information is required to process the claim and includes the contractor's address for returning requested information.

6.17 If the TOP contractor elects to develop for additional/missing information, and the request for additional information is not received/returned within 45 days, the contractor shall deny the claim.

6.18 If the TOP contractor has no record of referral/authorization prior to denial/payment of the claim, the contractor will follow the TOP POS rules, if the service would otherwise be covered under TOP.

6.19 The TOP contractor shall develop procedures for the identification and tracking of TOP enrollee claims submitted by either a TOP host nation designated or non-designated overseas host nation provider without preauthorization/authorization. Upon receipt of a claim for a TOP-enrolled ADFM submitted by a TOP host nation designated or non-designated overseas host nation provider without preauthorization/authorization, the contractor shall process the claims following POS payment procedures. For ADSM claims submitted by a TOP host nation provider without preauthorization/authorization, the contractor shall pend the claim for review prior to denying the claim.

6.20 The TOP contractor must have an automated data system for eligibility, deductible and claims history data and must maintain on the automated data system all the necessary TOP data elements to ensure the ability to reproduce both TRICARE Encounter Data (TED) and EOB as outlined in Chapter 8, Section 8, except for requiring overseas providers to use Health Care Procedure Coding System (HCPCS) to bill outpatient rehabilitation services, issue provider's the Form 1099 and suppression of checks/drafts for less than $1.00. The contractor is allowed to split claims to accommodate multiple invoice numbers in order to reference invoice numbers on EOB when necessary. Refer to Chapter 8, Section 6 for additional requirements related to claims splitting.

6.21 The TOP contractor shall not pay for pharmacy services obtained through the internet.

6.22 The TOP contractor shall pay all non-emergency and emergency civilian/medical surgical and dental claims for TRICARE Europe, TLAC and Pacific ADSM health care even when not a TRICARE covered benefit when the claim is:

6.22.1 Submitted by the MTF or other military command personnel, or by a designated POC; and

6.22.2 Accompanied by a completed and signed TRICARE claim form; and

6.22.3 Accompanied by either a Standard Form (SF) 1034, a Standard Form 1035 continuation sheet, a Naval Medical (NAVMED) Form 6320/10 (these forms shall be considered an authorization for payment), or electronic authorization vial the E-NAS module; and

6.22.4 DEERS verification indicates the TRICARE Europe, TLAC and Pacific ADSM was on Active Duty (AD) at the time the services were rendered.

Note: The SF 1034, SF 1035 continuation sheet or NAVMED 6320/10, or E-NAS authorization must be signed by the submitting military command. If a patient signature is not present on the claim form, the military command must submit a letter of explanation with the unsigned claim form prior to payment.

6.23 Upon payment for a TOP enrolled ADSM overseas claim, a copy of the EOB and, when applicable, the SF 1034 or SF 1035 or NAVMED 6320/10, or E-NAS authorization shall also be manually submitted to the MTF, or MTF command personnel, or a designated POC.

6.24 Emergency submitted non-remote ADSM claims for health care received overseas/stateside not meeting TPM, Chapter 2, Section 4.1 policy on emergency department services shall be denied explaining the reason of denial and advising resubmission with proper forms by the appropriate MTF, etc.

6.25 The TOP contractor shall deny non-remote TRICARE Europe, TLAC and Pacific ADSM claims for health care received overseas when any one of the administrative items are missing. Upon denial, the contractor shall instruct the non-remote TRICARE Europe, TLAC and TRICARE Pacific ADSM/host nation provider to contact the local MTF or other military command personnel, for assistance in proper claim submission and in obtaining missing documentation. Copies of EOB and claims denied as DEERS ineligible or not submitted by an MTF shall be electronically forwarded to the appropriate overseas TAO Director for further action.

6.26 The TOP contractor shall pay all TOP ADSM stateside claims as outlined in Section 26.

6.27 All claims must be submitted in a Health Insurance Portability and Accountability Act (HIPAA) compliant format. Refer to Section 28 for more information on HIPAA requirements

6.28 Electronic claims not accepted by the TOP contractor's Electronic Data Information (EDI) system/program shall be rejected.

6.29 For all overseas claims, the TOP contractor shall create and submit TEDs following current guidelines in the TRICARE Systems Manual (TSM) for TED development and submission. Claim information will be able to be accessed through the TRICARE Patient Encounter Processing and Reporting (PEPR) Purchased Care Detail Information System (PCDIS).

6.30 The TOP contractor shall establish Utilization Management (UM) high dollar/frequency thresholds in accordance with Section 6.

6.31 Claims either denied as "beneficiary not eligible" or "found to be not eligible on DEERS" may be processed as a "good faith payment" when received from the TMA Beneficiary and Provider Services (BPS). The TAO Director shall work with the TOP contractor on claims issues related to good faith payment documentation (e.g., a completed claim form and other documentation as required by Chapter 10, Sections 3 and 4).

6.32 The provisions of Chapter 8, Section 6, paragraph 10.0 shall apply to the TOP.

6.33 The Claims Auditing Software requirements outlined in the TRM, Chapter 1, Section 3 do not apply to TOP claims; however, the TOP contractor shall implement an internal process for identifying upcoding, unbundling, etc. on coded claims.

7.0 APPLICATION OF DEDUCTIBLE AND COST-SHARING

Application of TOP deductible and cost-sharing procedures shall follow the guidelines outlined in Chapter 8, Section 7.

8.0 EOB VOUCHERS

8.1 The TOP contractor shall follow the EOB voucher requirements in Chapter 8, Section 8, where applicable, with the following exceptions and additional requirements:

8.1.1 The letterhead on all TOP EOB shall also reflect "TRICARE Overseas Program" and shall be annotated Prime or Standard.

8.1.2 TOP EOB may be issued on regular stock, shall provide a message indicating the exchange rate used to determine payment and shall clearly indicate that "This is not a bill".

8.1.3 TOP EOB shall include the toll-free number for beneficiary and provider assistance.

8.1.4 TOP EOB for overseas enrolled ADSM claims shall be annotated "ACTIVE DUTY."

8.1.5 For Point of Sale or Vendor pharmacy overseas claims, TOP EOB must have the name of the provider of service on the claim.

8.1.6 For beneficiary submitted pharmacy claims, TOP EOB shall contain the name of the provider of service, if the information is available. If the information is not available, the EOB shall contain "your pharmacy" as the provider of service.

8.1.7 The TOP contractor shall insert the provider's payment invoice numbers in the patient's account field on all provider EOB, if available.

8.1.8 The following EOB message shall be used on overseas claims rendered by non-network host nation providers who are required to be certified, but have not been certified by the TOP contractor - "Your provider has not submitted documentation required to validate his/her training and/or licensure for designation as an authorized TRICARE provider".

8.1.9 When a provider's/beneficiary's EOB, EOB and check, or letter is returned as undeliverable, the check shall be voided.

9.0 DUPLICATE PAYMENT PREVENTION.

The TOP contractor shall follow the duplicate payment prevention requirements outlined in Chapter 8, Section 9.

10.0 DOUBLE COVERAGE.

10.1 TOP claims require double coverage review as outlined in the TRM, Chapter 4.

10.2 Beneficiary/provider disagreements regarding the contractor's determination shall be coordinated through the overseas TAO Director for resolution with the contractor.

10.3 Overseas insurance plans such as German Statutory Health Insurance, Japanese National Insurance (JNI), and Australian Medicare, etc., are considered OHI. When necessary, the TOP contractor may contact the appropriate TAO Director for assistance.

Note: If the Japanese insurance points are not clearly indicated on the claim/bill, the TOP contractor shall contact the submitter or the appropriate TOP POC for assistance in determining the Japanese insurance points prior to processing the claim.

11.0 THIRD PARTY LIABILITY (TPL)

The TOP contractor shall reimburse TOP claims suspected of TPL and then develop for TPL information. Upon receipt of the information, the contractor shall refer claims/documentation to the appropriate Judge Advocate General (JAG) office, as outlined in the Chapter 10.

12.0 REIMBURSEMENT/PAYMENT OF OVERSEAS CLAIMS

When processing TOP claims, the TOP contractor shall follow the reimbursement payment guidelines outlined in the TRM, Chapter 1, Section 34 and the cost-sharing and deductible policies outlined in the TRM, Chapter 2, Section 1, and shall:

12.1 Reimburse claims for host nation services/charges for care rendered to TOP eligible beneficiaries which is generally considered host nation practice and incidental to covered services, but which would not typically be covered under TRICARE. An example of such services may be, charges from host nation ambulance companies for driving host nation physicians to accidents or private residences, etc.

12.1.1 For professional services rendered in the Philippines and Panama (and any other locations where the government has established foreign fee schedules), reimbursement shall be the lower of the billed amount or the government established fee schedules (TRM, Chapter 1, Section 34), unless a different reimbursement rate has been established as described below. Government-established fee schedules are non-appealable.

12.1.2 In locations where the government has established foreign fee schedules, the contractor shall make every effort to establish host nation network provider agreements that comply with the fee schedule and provide access to care. If access to care is impaired by the fee schedules established by the government, the contractor shall identify the locations where access is impaired and shall identify the best possible reimbursement rates needed to obtain access to health care services. The contractor shall notify the CO of access issues, submit documentation of efforts to establish network(s) within the established fee schedules, and request fee schedule modification for specific services or locations. If approved, any revised rates applied to the government's fee schedule will be applicable to all beneficiary categories.

12.1.3 In locations where the government has established foreign fee schedules, the TOP contractor may negotiate the best possible rate on a case-by-case basis to obtain access to care for TOP-enrolled ADSMs and ADFMs who require urgent/emergent care or one-time specialty care. The contractor shall document the extenuating circumstances and/or efforts to obtain access to services at the fee schedule rate(s). A monthly report of payments which exceed the established fee schedule shall be submitted to the CO/COR and shall be considered during contractor performance reviews.

12.2 Not reimburse for host nation care/services specifically excluded under TRICARE.

12.3 Not reimburse for host nation care/services provided in the Philippines unless all of the certification requirements listed in Section 14 have been met.

12.4 Not reimburse for administrative charges billed separately on claims, except for individual administrative charges for Germany, and other locations as determined by the government. The contractor shall reimburse these charges only in instances when the fee is billed concurrently with the corresponding health care services. If a bill is received for these charges without a corresponding health care service, the charges should be denied.

12.5 Determine exchange rates as follow:

12.5.1 Use the exchange rate in effect on the ending date that services were received unless evidence of OHI and then the TOP contractor shall use the exchange rate of the primary insurer, not the rate based on the last date of service to determine the TOP payment amount, and/or;

12.5.2 Use the ending dates of the last service to determine exchange rates for multiple services.

12.5.3 Use the exchange rate in paragraph 12.5.1 to determine deductible and copayment amounts, if applicable, and to determine the amount to be paid in foreign currency.

12.5.4 Overseas drafts/checks and EOBs. Upon completion of processing, checks (payable in U.S. dollars) shall be created by the TOP contractor within 48 hours, after Contract Resource Management (CRM) approval. Drafts (payable in foreign currency units) shall be created by the TOP contractor within 96 hours following CRM approval, unless a different process has been authorized by TMA. Payments that need to be converted to a foreign currency shall be calculated based on the exchange rate in effect on the last date of service listed on the EOB. Drafts/checks shall be matched with the appropriate EOB, and mailed to the beneficiary/sponsor/host nation provider/POC as applicable.

12.6 The TOP contractor shall convert lump sum payments instead of line items to minimize conversion problems.

12.7 Provider claims for all overseas locations (excluding claims from Korean providers) will be paid by foreign currency/drafts. Drafts may not be changed to a U.S. dollar check after the contractor has issued a foreign draft. Claims from Korean providers will be paid in U.S. dollars.

12.8 Foreign overseas drafts (in local currency) are good for 190 days and may be cashed at any time, unless a different process has been established by TMA. U.S. dollar checks are good for 120 days unless a different process has been established by TMA. The provisions of Chapter 3, Section 4 regarding staledated, voided, or returned checks/Electronic Funds Transfers (EFTs) are applicable to the TOP.

12.9 TOP claims submitted by a beneficiary shall be paid in U.S. dollars, unless there is a beneficiary request on the claim at the time of submission for payment in a foreign currency. The payment may not be changed to U.S. dollars after the foreign draft has been issued.

12.10 Payment to Germany, Belgium, Finland, France, Greece, Ireland, Italy, Luxemburg, Netherlands, Austria, Portugal, Spain, Cyprus, and Malta shall be made in Euros. As other countries transition to Euro, the TOP contractor shall also switch to Euros.

12.11 The contractor shall issue drafts/checks for German claims which look like German drafts/checks.

Note: In order for TRICARE drafts/checks to look like German drafts/checks, a German address must be used. The TOP contractor may use a corporate address in Germany or the TAO Europe address for this purpose.

12.12 U.S. licensed Partnership providers claims for treating patients shall be paid based upon signed agreements. Refer to Section 29 for additional information related to the Partnership Program.

12.13 Pay all beneficiary-submitted claims for TRICARE covered drugs dispensed by a U.S. embassy health clinic to the beneficiary. The contractor is not to make payments directly to the embassy health clinic.

12.14 Professional services rendered by a U.S. embassy health clinic are not covered by TRICARE/TOP. These services are covered under International Cooperative Administrative Support Services (ICASS) agreements. Embassy providers (acting as PCMs) may refer TOP enrollees to host nation providers, these claims shall be processed per TOP policy and procedures.

12.15 Claims for drugs or diagnostic/ancillary services purchased overseas shall be reimbursed by the TOP contractor following applicable deductible/cost-share policies.

12.16 Not honor any draft request for currency change, except when directed by the appropriate TMA COR, once a foreign currency draft has been issued by the TOP contractor and the draft has been returned with the request.

12.17 Shall mail the drafts/checks and EOB to host nation providers unless the claim indicates payment should be made to the beneficiary. In conformity with banking requirements, the drafts/checks shall contain the contractor's address. Drafts and EOBs shall be mailed using U.S. postage. Additionally, payments/checks may be made to network providers, with an Embassy address.

12.18 Benefit payment checks and EOB to Philippine providers, and other nations' providers as directed by the TMA CO, shall be mailed to the place of service identified on the claim. No provider for Philippine providers, and other nations' providers as directed by the TMA CO may be sent to any other address.

12.19 Inpatient and outpatient claims for TRICARE overseas eligible beneficiaries, including ADSM claims, are to be processed/paid as indicated below:

12.19.1 The TPharm contractor shall allow TOP ADSM to use the TPharm retail pharmacy network under the same contract requirements as other Military Health System (MHS) eligible beneficiaries (see TPM, Chapter 8, Section 9.1).

12.19.2 The TPharm contractor shall allow TOP enrolled ADFM beneficiaries to use their stateside retail pharmacy network under the same contract requirements as other MHS eligibles (see TPM, Chapter 8, Section 9.1).

12.19.3 The TOP contractor shall process claims for overseas health care received by TRICARE beneficiaries enrolled to or residing in a stateside MCSC's region following the guidelines outlined in this chapter. Payment shall be made from applicable bank accounts and shall be based on billed charges unless a lower reimbursement rate has been established by the government or the contractor.

12.20 Provider requests for EFT payment. Upon host nation provider request, the TRICARE Overseas health care support contractor shall provide EFT payment to a U.S. or overseas bank on a weekly basis. Bank charges incurred by the provider for EFT payment shall be the responsibility of the provider. No EFT payment may be made to providers in the Philippines.

12.21 The TOP contractor shall process 85% of all retained and adjustment TOP claims to completion within 21 calendar days from the date of receipt. Claims pended per government direction are excluded from this standard. However, the number of excluded claims must be reported on the Overseas Weekly/Monthly Workload/Cycletime Aging report. 100% of all claims (both retained and excluded, including adjustments) shall be processed to completion within 90 calendar days from the date of receipt, unless the CO specifically directs the contractor to continue pending a claim or group of claims.

12.22 Correspondence pended due to stop payment orders, check tracers on foreign banks and conversion on currency. This correspondence is excluded from the routine 45 calendar day correspondence standard and the priority 10 calendar day correspondence standard. However, the number of excluded routine and priority correspondence must be reported on the Overseas Monthly Workload/Cycletime Aging report.

13.0 CLAIMS ADJUSTMENT AND RECOUPMENT

13.1 The TOP contractor shall follow the adjustment requirements in Chapter 10 except for the requirements related to financially underwritten funds.

13.2 The TOP contractor shall follow the recoupment requirements in Chapter 10 for non-financially underwritten funds, except for providers. The contractor shall use the following procedures for host nation provider recoupments. Recoupment actions shall be conducted in a manner that is considered culturally appropriate for the host nation provider's country. The contractor shall:

13.2.1 Send an initial demand letter.

13.2.2 Send a second demand letter at 90 days.

13.2.3 Send a final demand letter at 120 days.

13.2.4 Refer the case to TMA at 240 days, if the case is over $600.00, and if under $600.00 the case shall remain open for an additional four months and then shall be written off at 360 days.

13.3 Recoupment letters (i.e., the initial letter, the 90 day second request and the 120 day final demand letter) shall be modified to delete references to U.S. law. Invoice numbers shall be provided on all recoupment letters. The TOP contractor shall include language in the recoupment letter requesting that refunds be returned/provided in the exact amount requested.

13.4 Provider recoupment letters sent to Germany, Italy and Spain, shall be written in the respective language.

13.5 The TOP contractor may hand write the dollar amount and the host nation provider's name and address, on all recoupment letters.

13.6 If the recoupment action is the result of an inappropriately processed claim by the TOP contractor, recoupment is the responsibility of the contractor, not the beneficiary/provider.

13.7 The TOP contractor shall have a TOP bank account capable of receiving/accepting wire transfers from TRICARE Europe overseas for host nation provider recoupment/overpayment returns. The TOP contractor shall accept the amount received as payment against the amount owed. Any fees associated with the wire transfer will be the responsibility of the payer/provider.

14.0 DUPLICATE PAYMENT PREVENTION

The provisions of Chapter 8, Section 9 are applicable to the TOP.

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