



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
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TRICARE
MANAGEMENT ACTIVITY

OD

CHANGE 103
6010.56-M
AUGUST 22, 2013

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE OPERATIONS MANUAL (TOM), FEBRUARY 2008**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

CHANGE TITLE: COMPLIANCE DATE CHANGE FOR CONVERSION FROM INTERNATIONAL CLASSIFICATION OF DISEASES, 9TH REVISION (ICD-9) TO INTERNATIONAL CLASSIFICATION OF DISEASES, 10TH REVISION (ICD-10) CODING

CONREQ: 16287

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): The Health Insurance Portability and Accountability Act (HIPAA) Final Rule published in the Federal Register on January 16, 2009, mandated nationwide conversion from ICD-9, Clinical Modification (ICD-9-CM) coding to ICD-10, Clinical Modification (ICD-10-CM) (diagnosis) and ICD-10, Procedure Coding System (ICD-10-PCS) (procedures). On September 5, 2012, the compliance date was changed to October 1, 2014, as part of a Final Rule published by Health and Human Services (HHS), for the ICD-10-CM and ICD-10-PCS Medical Data Code Sets. Language previously published in the TRICARE Operations Manual (TOM), TRICARE Policy Manual (TPM), TRICARE Reimbursement Manual (TRM), and TRICARE Systems Manual (TSM) is revised to include the new compliance date.

EFFECTIVE DATE: October 1, 2014.

IMPLEMENTATION DATE: October 1, 2014.

This change is made in conjunction with Feb 2008 TPM, Change No. 95, Feb 2008 TRM, Change No. 85, and Feb 2008 TSM, Change No. 51.

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Director, Operations Division**

**ATTACHMENT(S): 72 PAGES
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WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT.

**CHANGE 103
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Management

1.0 GENERAL

The contractor shall establish and maintain sufficient staffing and management support services and commit all other resources and facilities necessary to achieve and maintain compliance with all quantitative and qualitative standards for claims processing timeliness, claims inventory levels, claims control, and claims accuracy. The requirements below outline minimum requirements of TRICARE Management Activity (TMA). Contractors are encouraged to develop and employ the most effective management techniques available to ensure economical and effective operation.

2.0 SYSTEM ADDITIONS OR ENHANCEMENTS

2.1 Implementation of Changes in Program Requirements

The contractor shall have the capacity, using either directly employed personnel or contracted personnel, to maintain and operate all required systems and to achieve timely implementation of changing program requirements.

2.2 Maintaining Current Status of Diagnostic and Procedural Coding Systems

Contractors are required to use the current versions of the updated American Medical Association Physicians Current Procedural Terminology, 4th Edition (CPT-4), and the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnostic coding system; and any special codes that may be directed by TMA. Beginning with dates of **service** on or **after October 1, 2014**, for outpatient facility and all non-facility services, and for inpatient facility charges with discharge dates on or after **October 1, 2014**, contractors will be required to replace the use of ICD-9-CM diagnosis codes with the current version of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) and the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) for inpatient hospital procedures. The contractor is responsible for using the most current codes correctly. That responsibility includes making any needed revisions required by periodic CPT-4 and ICD-9-CM or ICD-10-CM and ICD-10-PCS updates issued by the publishers. When updates occur, contractors will be notified of the date the TRICARE Encounter Data (TED) editing system will be accepting changes in the codes.

2.3 Zip Code File

The contractor shall update and maintain an electronic file of inpatient catchment area zip codes using the electronic zip code directory furnished by the Government. This electronic zip code directory defines Inpatient Catchment Areas that shall be used for verifying geographic Non-Availability Statement (NAS) requirements in accordance with the TRICARE Policy Manual (TPM), [Chapter 1, Section 6.1](#). The contractor shall update and maintain a second electronic file of all zip

codes using a separate Government-furnished electronic zip code directory. The contractor shall incorporate this second electronic file in its claims processing system to determine the validity of a beneficiary or provider zip code. These directories will be provided by the Government no less than four and no more than 12 times per calendar year. Updates to these electronic zip code directories for the purposes of contract modifications, directed policy actions, changes to catchment area definitions, and expansion or termination of zip codes by the U.S. Postal Service (USPS), shall be accomplished at no additional cost to the Government.

2.4 Updating And Maintaining TRICARE Reimbursement Systems

The contractor, at no additional cost to the Government and as directed by TMA shall implement all policy changes and clarifications to existing TRICARE reimbursement systems affecting both the level of payment and the basic method of reimbursement as they apply to current provider categories implemented at the time of contract award. The TRICARE Reimbursement Manual (TRM) is the source for instructions and guidance on all existing reimbursement systems for current provider categories.

3.0 MANAGEMENT CONTROLS

The contractor shall develop and employ management procedures necessary to ensure control, accuracy, and timeliness of transactions associated with operation of all TRICARE Service Center (TSC) functions, authorizations, provider referrals, claims processing, beneficiary services, provider services, reconsiderations, grievances, Automatic Data Processing (ADP), and financial functions. These procedures include such elements as:

3.1 An automated claims aging report, by status and location, for the purpose of identifying backlogs or other problem areas delaying claims processing. At a minimum, this report must be sorted to enable a count of the total number of claims pending for a specified length of time, e.g., the time periods specified in the Monthly Cycle Time/Aging Report.

3.2 An automated returned claims report counting the number of claims returned by the time periods specified in the Monthly Cycle Time/Aging Report.

3.3 Procedures to assure confidentiality of all beneficiary and provider information, to assure that the rights of the individual are protected in accordance with the provisions of the Privacy Act and the HIPAA and Health and Human Services (HHS) Privacy Regulation and prevent unauthorized use of TMA files.

3.4 A system to control adjustments to processed claims which will document the actual date the need for adjustment is identified, the reason for the adjustment and the names of both the requesting and authorizing persons. The controls shall also ensure the accurate and timely update of the beneficiary history files, the timely and accurate submission of the TED data and issuance of the proper notice to the beneficiaries and providers affected by the adjustments.

3.5 A set of processing guidelines, desk instructions/user's manuals and reference materials for internal use, at least 10 calendar days prior to the first day of delivery of health care services. These materials shall be maintained, on a current basis, for the life of the contract. Desk instructions shall be available to each employee in the immediate work area. Reference material such as procedure codes, diagnostic codes, and special processing guidelines, shall be available to each work station

with a need for frequent referral. Other reference materials shall be provided in each unit with a reasonable need and in such quantity as to ensure the ease of availability needed to facilitate work flow. Electronic versions may be used.

4.0 QUALITY CONTROL

4.1 The contractor shall develop and implement an end-of-processing quality control program which assures accurate input and correct payments for authorized services received from certified providers by eligible beneficiaries.

4.2 The contractor shall have a quality control program consisting of supervisory review on all appeals, grievances, correspondence, and telephone responses. This must begin by the end of the third month of operation and be carried out monthly thereafter. The review shall include a statistically valid sample or 30 records which ever is greater of all appeals, grievances and correspondence processed and telephonic responses completed. The criteria for review shall be accuracy and completeness of the written or telephonic response, clarity of the response, and timeliness with reference to the quantitative standards for the processing of appeals, grievances, and correspondence. Any lack of courtesy or respect in the response shall also be noted. All findings shall be documented, provided to TMA Contracting Officer's Representative (COR) staff, or authorized auditors, and used in a documented training program.

4.3 The quality review program will sample each quarter, a sufficient number of all processed claims and adjustments to ensure maintenance of quality of adjudication and processing and provide adequate management control. Claims in the sample shall include all claim types and be selected randomly, or by other acceptable statistical methods, in sufficient number to yield at least a 90% confidence level with a precision of 2%. The sample will be drawn at or near the end of each quarter from claims completed during the review period. The contractor may draw the sample up to 15 calendar days prior to the close of the quarter, but must include claims completed in the period between the date the sample is drawn and the close of the quarter in the next quarterly sample. The contractor shall reflect the inclusive processing dates of the claims in the sample in the report submitted to TMA. The sampling will begin by the end of the first quarter of processing. Documentation of the results shall be completed within 45 calendar days of the close of each contract quarter.

4.4 The contractor shall retain copies of the reviewed claims, appeals, grievances, correspondence, and related working documents, in separate files, for a period of no less than four months following submission of audit results to the Procuring Contracting Officer (PCO). TMA staff will review the results and will on a regular basis audit a selected sampling of the audited/quality review documents, either at the contractor's site or via forwarding of selected work for review at TMA.

5.0 STAFF TRAINING PROGRAM

The contractor shall develop and implement a formal initial and ongoing staff training program including training on program updates as they occur, to ensure a high quality of service to beneficiaries and providers. Such training shall include mandatory, documented training in Confidentiality of Patient Records (42 United States Code (USC) [290dd-3]) requirements (see [Section 5](#)). The contractor shall not only provide education in these requirements but must document the personnel files of the staff members who receive the training. Centralized

documentation shall also be maintained of the training session agendas, identity of attendees, actual dates and duration of training sessions, etc. The contractor is also responsible for ensuring that subcontractor staff is also trained.

6.0 INTERNAL AUDITS AND MANAGEMENT CONTROL PROGRAMS

6.1 Using its corporate internal review capability, the contractor is responsible for verifying that accounting data are correct, reliable and comply with all Government accounting standards and requirements. The contractor's corporate internal review staff must conduct regular, routine reviews to ensure proper monitoring in areas of finance, financial accounting, internal controls, special checks issued and returned, and selected history maintenance transactions for possible fraud or abuse.

6.2 Within one year of the start of health care delivery, and any time a new function is added to requirements, contractor management shall perform vulnerability assessments in accordance with the Office of Management and Budget's (OMB's) Circular A-123.

6.3 An internal control review of all functions which are rated as highly vulnerable shall be performed by the corporate audit staff within one year of the date of the vulnerability assessment. Within three years of the date of the vulnerability assessment, the internal audit staff shall make an internal control review of all functions rated as having a medium vulnerability. Internal control reviews shall be performed in accordance with the OMB's Circular A-123.

- END -

services delivery. In the event that an incumbent contractor succeeds itself, the extent of Benchmark testing may be reduced at the discretion of the TMA PCO.

3.1.2 A Benchmark Test shall consist of at least 300 but not more than 1,000 network and non-network claims, testing a multitude of claim conditions including, but not limited to, TRICARE covered/non-covered services, participating/non-participating providers, certified/non-certified providers and eligible/non-eligible beneficiaries. This Benchmark Test will require a TMA presence at the contractor's site.

3.1.3 A Benchmark Test is comprised of one or more cycles or batches of claims. When more than one cycle is used, each cycle may be submitted on consecutive days. Each cycle after the initial one will include new test claims, as well as claims not completed during preceding cycles. At the government's discretion, any or all aspects of claims processing may be tested, e.g., receiving and sending electronic transactions, provider file development and maintenance including interface with the National Provider System when implemented, screening, coding, data entry, editing, pricing, data management, data linking, record building, and access control.

3.1.4 The contractor shall demonstrate its ability to conduct enrollment, authorization and referral, and claims processing functions to include: claims control and development, accessing and updating internal and external enrollment data, accessing and updating DEERS for eligibility status, calculating cost-shares and deductibles, querying and updating internal and external family and patient deductible and cost-share files on the Catastrophic Cap and Deductible Database (CCDD), submitting and modifying provider and pricing records, issuing referrals and authorizations, applying allowable charge parameters, performing duplicate checking, applying prepayment utilization review criteria, adjusting previously processed claims, demonstrating recoupment and offset procedures and producing the required output for paper and electronic transactions (Explanation of Benefits (EOB), summary vouchers, payment records, checks, and management reports). Clerical functions will be evaluated including correctly coding diagnoses, medical and surgical procedures and accurately resolving edit exceptions. Enrollment and case management functions may also be included in the benchmark. At the government's discretion, the Benchmark Test may include testing of any or all systems (internal and external) used by the contractor to process claims. In addition to testing claims processing records, the Benchmark will test generation and acceptance of TRICARE Encounter Data (TED) records for every test claim. Contractor compliance with applicable HIPAA requirements and security requirements will be included in Benchmark tests as appropriate.

3.1.5 The Benchmark Test will be comprised of both paper and electronic claims. The contractor shall be required to create test claims, including referrals and authorizations from test scenarios provided to the incoming contractor by TMA. The contractor shall supplement these test scenarios with any internal conditions they feel appropriate for testing to ensure a minimum of 1,000 claims are tested. Under certain circumstances, however, this number may be reduced at the discretion of the PCO.

3.1.6 A Benchmark Test of a current contractor's system may be administered at any time by TMA upon instructions by the PCO. All contractor costs incurred to comply with the performance of the Benchmark Test are the responsibility of the contractor.

3.2 Conducting The Benchmark

3.2.1 At the time of the scheduled Benchmark Test a TMA Benchmark Team comprised of up to 12 people will arrive at the contractor's work site to conduct the testing and evaluate the Benchmark Test results.

3.2.2 The amount of time a contractor shall have to process the Benchmark Test claims and provide all of the output (excluding TEDs) to the Benchmark Team for evaluation will vary depending on the scope of the Benchmark and volume of claims being tested. As a guide, the following table is provided for contractor planning purposes:

NUMBER OF BENCHMARK CLAIMS/SCENARIOS	NUMBER OF DAYS TO COMPLETE PROCESSING
UP TO 100	1-2
UP TO 500	2-4
UP TO 1000	4-7

3.2.3 The contractor will be informed at the pre-benchmark meeting (see [paragraph 3.3.1](#)) of the exact number of days to be allotted for processing the benchmark claims and test scenarios and providing all of the output (excluding TEDs) to the Benchmark Team for evaluation.

3.2.4 The Benchmark Team will provide answers to all contractors written and telephonic development questions related to the test scenarios provided by TMA and will evaluate the contractor's output against the Benchmark Test conditions.

3.2.5 The Benchmark Team will require a conference room that can be locked with table(s) large enough to accommodate up to 12 people. The conference room must also be equipped with two telephones with access to internal and outside telephone lines.

3.2.6 The incoming contractor shall provide up-to-date copies of the TRICARE Operations Manual (TOM), TRICARE Policy Manual (TPM), TRICARE Reimbursement Manual (TRM), and TRICARE Systems Manual (TSM), a complete set of the current International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnostic coding manuals for dates of service **on or before September 30, 2014**, or a complete set of the current International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) diagnostic coding manual and International Classification of Diseases, 10th Revision, Procedure Classification System (ICD-10-PCS) procedure coding manual for dates of service on and after **October 1, 2014**, the currently approved HCPCS and CPT-4 procedural coding manual, in either hard copy or electronic versions. The contractor shall also provide Transaction Guides for all HIPAA transactions used by the contractor for claims adjudication, as well as any applicable supporting references to the Transaction Guides (e.g., HIPAA Health Care Provider Taxonomy, Claim Adjustment Reason Codes, etc.) explanations of the contractor's EOB message codes, edits, and denial reason codes, and any overlays required to evaluate EOB, checks, or summary vouchers.

3.2.7 The incoming contractor shall provide an appropriate printer and a minimum of three computer terminals in the conference room with on-line access to all internal and external systems used to process the Benchmark Test claims to include, but not limited to: provider files (TEPRVs), including the contracted rate files for each provider; pricing files (TEPRCs) (area prevailing and CHAMPUS Maximum Allowable Charge (CMAC) pricing) DEERS; catastrophic cap and deductible

files; and any other files used in processing claims, authorizations, referrals, and enrollments. The contractor's requirements for issuing system passwords for members of the Benchmark Team will be discussed at the pre-benchmark meeting.

3.2.8 The contractor shall provide an organizational chart and personnel directory including telephone numbers. A listing of the contractor's staff involved in performing the Benchmark Test by function (e.g., data entry, development, medical review, etc.) is also required. Claims flow/decision diagrams including authorization and referral requirements will be provided prior to the Benchmark Test.

3.3 Procedures

3.3.1 Approximately 60 calendar days following award to the contractor, representatives from TMA will meet with the incoming contractor's staff to provide an overview of the Benchmark Test process, receive an overview of the claims processing system, collect data for use in the Benchmark, and discuss the dates of the test and information regarding the administration of the Benchmark Test. At this time, TMA will provide the test scenarios to the contractor that are to be used in the development of their test claims.

Note: At TMA's discretion, the test must be completed NLT 60 days prior to the start of health care delivery to allow time to make any needed corrections. The pre-benchmark meeting will be conducted at the incoming contractor's claims processing site. Provider and beneficiary data, to include enrollment forms, physician referrals, and authorizations, will be coordinated at the pre-benchmark meeting to ensure that the contractor adequately prepares all files prior to the Benchmark. Electronic transaction requirements shall be discussed to include timing and logistics.

3.3.2 On the first day of the Benchmark Test, a brief entrance conference will be held with contractor personnel to discuss the schedule of events, expectations and administrative instructions.

3.3.3 During the Benchmark Test the contractor shall process the claims and provide TMA with all output, including EOBs, summary vouchers, suspense reports, checks, and claims histories. Paper checks and EOBs may be printed on plain paper, with EOB and check overlays. Electronic output is required for electronic transactions.

3.3.4 The contractor shall provide output for evaluation by the TMA Benchmark Team as the claims are processed to completion. The specific schedule for claims processing and the procedures for providing the output to the Benchmark Team will be discussed with the contractor at the pre-benchmark meeting.

3.3.5 TMA personnel will compare the Benchmark Test claim output against the benchmark test conditions for each claim processed during the test and provide the findings to the contractor. All appropriate contractor and Benchmark Team personnel shall be present to answer any questions raised during the Benchmark Test claims review.

3.3.6 At the conclusion of the on-site portion of the Benchmark Test, an exit conference may be held with the contractor staff to brief the contractor on all findings identified during the Benchmark. The initial test results will be provided to the contractor. The initial Benchmark Test Report will be forwarded to the contractor by TMA within 20 calendar days of the last day of the on-

site test. For any claims processing errors assessed with which the contractor disagrees, a written description of the disagreement along with any specific references must be included with the claims. The contractor's response to the Initial Benchmark Test Report shall be submitted to the TMA Contracting Officer (CO) within 20 days. Following the contractor's response, TMA shall provide the Final Benchmark Test Report to the contractor within 20 calendar days.

3.3.7 The contractor shall prepare and submit the initial TED submission to TMA for evaluation during the Benchmark Test. A TED record shall be prepared for each Benchmark claim processed to completion, whether allowed or denied, within two calendar days from the processed date. TED records will not be created for claims removed from the contractor's processing system, i.e., out of jurisdiction transfers. The contractor shall be notified of any TEDs failing the TMA edits. The contractor shall make the necessary corrections and resubmit the TEDs until 100% of the original Benchmark Test TEDs have passed the edits and are accepted by TMA. TEDs submission files related to the Benchmark Tests must be identified by transmission file and batch/voucher numbers prior to submission to TMA.

3.3.8 The contractor has 45 calendar days from the date of the initial Benchmark Test report to submit the final corrected TEDs to TMA. New TEDs need not be generated to reflect changes created from claims processing corrections, however, all TEDs originally submitted for the Benchmark Test claims which did not pass the TMA edits must continue to be corrected and resubmitted until all edit errors have been resolved and 100% of the TEDs have been accepted by TMA. TEDs submission files related to the Benchmark Tests must be identified by transmission file and batch/voucher numbers prior to submission to TMA.

3.4 Operational Aspects

3.4.1 The Benchmark Test may be conducted on the contractor's production system or an identical copy of the production system (test system). Whichever system is used for the Benchmark, it must meet all TRICARE requirements and contain all the system interconnections and features of the production system in the contractor's proposal. When the Benchmark Test is conducted on the contractor's production system, the contractor shall prevent checks and EOBs from being mailed to the beneficiaries and providers, and prevent production TEDs from being generated and sent to TMA.

3.4.2 Certain external test systems and files (e.g., DEERS) are an integral component of the Benchmark Test and the contractor is expected to perform all necessary verifications, and queries, according to TRICARE procedures and policy. The contractor shall coordinate through the TMA, Contract Operations Branch, to ensure that direct interface with any required external test systems (i.e., DEERS) is established and operational prior to the Benchmark Test.

3.4.3 TEDs shall be generated from the Benchmark Test claims and provided to TMA for processing as scheduled at the pre-benchmark meeting. The contractor shall coordinate with the TMA, O/ATIC, for TED submission procedures.

4.0 CONTRACT PHASE-OUT

4.1 Transition Specifications Meeting

The outgoing contractor shall attend a meeting with representatives of the incoming

contractor and TMA at the TMA office in Aurora, Colorado, within 15 calendar days following contract award. This meeting is for the purpose of developing a schedule of phase-out/phase-in activities. TMA will notify the contractor as to the exact date of the meeting. The outgoing contractor shall provide a proposed phase-out plan at the Transition Specifications Meeting.

4.2 Data

The outgoing contractor shall provide to TMA (or, at the option of TMA, to a successor contractor) such information as TMA shall require to facilitate transitions from the contractor's operations to operations under any successor contract. All files shall be provided in a non-proprietary format and the contractor shall include such file specifications and documentation as may be necessary for interpretation of these files. Such information may include, but is not limited to, the following:

- The data contained in the contractor's enrollment information system.
- The data contained in the contractor's claims processing systems.
- Information about the management of the contract that is not considered, under applicable Federal law, to be proprietary to the contractor.

4.3 Phase-Out of the Contractor's Claims Processing Operations

Upon notice of award to another contractor, and during the procurement process leading to a contract award, the contractor shall undertake the following phase-out activities regarding services as an outgoing contractor.

4.3.1 Transfer of Electronic File Specifications

The outgoing contractor shall transfer to the incoming contractor by express mail or similar overnight delivery service, NLT three calendar days following award announcement, electronic copies of the record layouts with specifications, formats, and definitions of fields, and data elements, access keys and sort orders, for the following:

- The TRICARE Encounter Provider Files (TEPRVs).
- The TRICARE Encounter Pricing Files (TEPRCs).
- The Enrolled Beneficiary and PCM Assignment Files.
- Mental Health Provider Files - The outgoing contractor must assure that the incoming contractor has been given accurate provider payment information on all mental health providers paid under the TRICARE inpatient mental health per diem payment system. This should include provider name; tax identification number; address including zip code; high or low volume status; if high volume, provide the date the provider became high volume; and the current per diem rate along with the two prior year's per diem amounts. The providers under the per diem payment system must be designated by Medicare, or meets exemption criteria, as exempt from the inpatient mental health unit, the unit would be identified as the provider under the TRICARE

inpatient mental health per diem payment system.

4.3.2 Transfer Of ADP Files (Electronic)

The outgoing contractor shall prepare in non-proprietary electronic format and transfer to the incoming contractor or TMA, by the 15th calendar day following the Transition Specifications Meeting unless, otherwise negotiated by the incoming and outgoing contractors, all specified ADP files, such as the Provider and Pricing files, in accordance with specifications in the official transition schedule and will continue to participate in preparation and testing of these files until they are fully readable by the incoming contractor or TMA.

4.3.3 Outgoing Contractor Weekly Shipment Of History Updates

The outgoing contractor shall transfer to the incoming contractor, in electronic format, all beneficiary history and deductible transactions (occurring from the date of preparation for shipment of the initial transfer of such history files and every week thereafter) beginning the 120th calendar day prior to the start of health care delivery (until such a time that all processing is completed by the outgoing contractor) in accordance with the specifications in the official transition schedule.

4.3.4 Transfer Of Non-ADP Files

The outgoing contractor shall transfer to the incoming contractor all non-ADP files (e.g., authorization files, clinic billing authorizations, and tapes/CDs, which identify PSAs, Congressional and TMA completed correspondence files, appeals files, TRICARE medical utilization, and administration files) in accordance with the specifications in the official transition schedule and [Chapter 2](#). The hard copies of the Beneficiary History Files are to be transferred to the incoming contractor or Federal Records Center (FRC) as required by [Chapter 2](#). The contractor shall provide samples and descriptions of these files to the incoming contractor at the Transition Specification Meeting.

4.3.5 EOB Record Data Retention And Transmittal

If the contractor elects to retain the EOB data on a computer record, it must, in the event of a transition to another contractor, provide either a full set of electronic records covering the current and two prior years, or, at the PCO's discretion, provide the data and necessary programs to reproduce the EOB in acceptable form and transfer such data and programs to the successor contractor or to TMA. TMA shall be the final authority in determining the form and/or acceptability of the data.

4.3.6 Outgoing Contractor Weekly Status Reporting

Until all inventories have been processed, the outgoing contractor shall submit a weekly status report of inventories and phase-out activities to TMA beginning the 20th calendar day following the Specifications Meeting until otherwise notified by the PCO to discontinue. This shall be done in accordance with specifications of the official transition schedule.

4.3.7 Prior Authorizations and Referrals

The outgoing contractor shall provide all prior authorizations and referrals that cover care spanning the start of health care delivery under the new contract or care that could potentially begin in the incoming contractor's health care delivery period. The outgoing and incoming contractor shall mutually agree to the date and schedule for transfer of this information.

4.3.8 Case Management and Disease Management Files

NLT 60 days prior to the start of health care delivery under the new contract, the outgoing contractor shall provide the incoming contractor with all files pertaining to beneficiaries covered under a Case Management or Disease Management program. Electronic files shall be provided under a non-proprietary format. The outgoing contractor shall cooperate with the incoming contractor to ensure seamless continuity of care and services for all such beneficiaries.

4.3.9 MTF MOUs

NLT 30 days following contract award, the outgoing contractor shall provide the incoming contractor the most recent version of all MTF MOUs in place at that time for the purpose of ensuring continuity of services to MTFs and continuity of care for TRICARE beneficiaries.

4.3.10 Program Integrity Files

NLT 30 days prior to the start of health care delivery under the new contract, the outgoing contractor shall provide the incoming contractor with all active Program Integrity case files that have been forwarded to TMA Program Integrity Office (PI). The outgoing contractor shall also provide weekly updates of Program Integrity case file, including new cases initiated through the end of the contract delivery period.

4.3.11 Provider Certification File

NLT 30 days after contract award and on a monthly basis until the start of health care delivery, the outgoing contractor shall provide the incoming contractor with copies of all provider certification files.

4.4 Final Processing Of Outgoing Contractor

The outgoing contractor shall:

- Process all claims and adjustments for care rendered prior to the start of health care delivery of the new contract that are received through the 120th day following cessation of the outgoing contractor's health care delivery. Processing of these claims shall be completed within 180 calendar days following the start of the incoming contractor's health care delivery. All claims shall meet the same standards as outlined in the current outgoing contract. Any residual claim received after 120 days shall be forwarded to the incoming contractor within 24 hours of receipt.

- Be liable, after the termination of services under this contract, for any payments to subcontractors of the contractor arising from events that took place during the period of this contract.
- Refer to [paragraph 2.10.3](#), for transitional case requirements.
- Process all correspondence, allowable charge complaints, and incoming telephonic inquiries which pertain to claims or services processed or delivered under this contract within the time frames established for response by the standards of the contract.
- Complete all appeal and grievance cases that pertain to claims or services processed or delivered under this contract within the time frames established for response by the standards of the contract.

4.4.1 Correction of Edit Rejects

The outgoing contractor shall retain sufficient resources to ensure correction (and reprocessing through TMA) of all TED record edit errors NLT 210 calendar days following the start of the incoming contractor's health care delivery.

4.4.2 Phase-Out of the Automated TRICARE DCS

The outgoing contractor shall phase-out the use of the automated TRICARE DCS in accordance with [Chapter 9](#) and transition plan requirements.

4.4.3 Phase-Out Of The Contractor's Provider Network, TSCs, And MTF Agreements

4.4.3.1 Upon notice of award to another contractor, the outgoing contractor shall provide full cooperation and support to the incoming contractor, to allow an orderly transition, without interruption, of all functions relating to the MTF interface and the establishment of a provider network by the incoming contractor. This shall include, but is not limited to, data relating to on-site service centers, resource sharing agreements, equipment, telephones and all other functions having an impact on the MTFs.

4.4.3.2 Within 15 calendar days of the Transitions Specifications Meeting the outgoing contractor shall draft and submit a revised plan for transition of the MTF interfaces. Resolution of differences identified through the coordination process must be accomplished in collaboration with the Transition Monitor appointed by TMA and according to the guidelines in the transition schedule.

4.4.3.3 The outgoing contractor shall vacate the TSCs on the 40th calendar day prior to the start of health care delivery and will establish a centralized HCF function to continue through the last date of health care delivery under the current contract, unless otherwise negotiated with the incoming contractor during the Transition Specifications Meeting.

Note: This section only applies when both the incoming and outgoing contractors have TSCs.

4.4.3.4 The outgoing contractor shall continue to issue prior authorizations for care for which it is financially responsible. However, authorization-related information shall be shared between the

Management

1.0 UTILIZATION MANAGEMENT (UM) PROGRAM PLAN

1.1 These requirements are applicable to utilization and quality review of all health care services delivered to beneficiaries living within the region, to all beneficiaries receiving care in the Region regardless of their place of residence, and to all providers delivering care within the region. Additional requirements for enrollees (such as authorizations for specialty care) and network providers (such as qualifications to be network providers) are further identified in [Chapter 5](#). All providers shall be subject to the same review standards and criteria. The contractor shall be considered a multi-function Peer Review Organization (PRO) under this contract.

1.2 The contractor shall fully describe in a written UM Plan all processes, procedures, criteria, staff and staff qualifications, and information and data collection activities and requirements the contractor shall use in conducting UM activities.

2.0 NOTIFICATION OF REVIEW REQUIREMENTS

The contractor is responsible for education and training to providers and beneficiaries on the requirements of the UM programs. The contractor shall describe fully the process for notification in a timely manner (but not less than 30 calendar days prior to commencement of review) of all providers, both network and non-network, of all review requirements such as preauthorization, concurrent review, retrospective review (including the fiscal penalties for failing to obtain review authorizations), review criteria to be used, and requirements for case management.

3.0 REVIEWER QUALIFICATIONS AND PARTICIPATION

3.1 Peer Review By Physicians

3.1.1 Except as provided in [paragraph 3.1.2](#), each person who makes an initial denial determination about services furnished or proposed to be furnished by a licensed doctor of medicine or osteopathy or by a doctor of dentistry must be respectively another licensed doctor of medicine or osteopathy or of dentistry with an active clinical practice in the PRO area, if the initial determination is based on lack of medical necessity or other reason relative to reasonableness, necessity or appropriateness.

3.1.2 If a PRO determines that peers are not available to make initial denial determinations, a doctor of medicine or osteopathy may make denial determinations for services ordered or performed by a doctor in any of the three specialties.

3.2 Peer Review By Health Care Practitioners Other Than Physicians

Health care practitioners other than physicians may review services furnished by other practitioners in the same professional field.

3.3 Diagnosis Related Group (DRG) Validation Review

Decisions about procedural and diagnostic information must be made by physicians. Technical coding issues must be reviewed by individuals with training and experience in International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) coding (for outpatient services with dates of service or inpatient services with dates of discharge provided **on or before September 30, 2014**) and in International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) coding (for outpatient services with dates of service or inpatient services with dates of discharge provided on or after **October 1, 2014**, or International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) for inpatient services with dates of discharge provided on or after **October 1, 2014**).

3.4 Persons Excluded From Review

3.4.1 A person may not review health care services or make initial denial determinations or changes as a result of DRG validations if he or she, or a member of his or her family:

- Participated in developing or executing the beneficiary's treatment plan;
- Is a member of the beneficiary's family; or
- Is a governing body member, officer, partner, 5% or more owner, or managing employee in the health care facility where the services were or are to be furnished.

3.4.2 A member of a reviewer's family is a spouse (other than a spouse who is legally separated under a decree of divorce or separate maintenance), child (including a legally adopted child), grandchild, parent, or grandparent.

3.5 Administrative Requirements

Each review shall be dated and include the signature, legibly printed name, clinical specialty, and credentials of the reviewer. Each reviewer shall include rationale for his or her decision (i.e., a complete statement of the evidence and the reasons for the decision).

4.0 WRITTEN AGREEMENTS WITH INSTITUTIONAL PROVIDERS

The contractor shall establish written agreements with each institutional provider over which the contractor has review authority. These agreements shall be in place before the start of services. Agreements must specify that:

- Institutional providers will cooperate with the contractor in the assumption and conduct of review activities.
- Institutional providers will allocate adequate space for the conduct of on site review.

- Institutional providers will photocopy and deliver to the contractor all required information within 30 calendar days of a request for off-site review.
- Institutional providers will provide all beneficiaries, in writing, their rights and responsibilities (e.g., "An Important Message from TRICARE" ([Addendum A](#)), "Hospital Issued Notice of Noncoverage" ([Addendum B](#)).
- Institutional providers will inform the contractor within three working days if they issue a notice that the beneficiary no longer requires inpatient care.
- Institutional providers will assure that each case subject to preadmission/preprocedure review has been reviewed and approved by the contractor.
- Institutional providers will agree, when they fail to obtain certification as required, they will accept full financial liability for any admission subject to preadmission review that was not reviewed and is subsequently found to be medically unnecessary or provided at an inappropriate level ([32 CFR 199.15\(g\)](#)).
- The contractor shall reimburse the provider for the costs of photocopying and postage using the same reimbursement as Medicare.
- The contractor shall provide detailed information on the review process and criteria used, including financial liability incurred by failing to obtain preauthorization.

5.0 BENEFIT POLICY DECISIONS

TRICARE Versus Local Policy. TRICARE policies have precedence over any local or internal policy of the contractor or the medical community of the region. However, the contractor shall notify TRICARE Management Activity (TMA) promptly of any conflicts between TRICARE policy and local policy. Variations from policy which expand, reduce, or adjust benefit coverage shall be referred to TMA for approval before being implemented.

6.0 CONCURRENT REVIEW REQUIREMENTS

The contractor shall conduct concurrent review for continuation of inpatient mental health services within 72 hours of emergency admissions (see [32 CFR 199.4\(b\)\(6\)\(iv\)](#)), and authorize, as appropriate, additional days.

7.0 RETROSPECTIVE REVIEWS RELATED TO DRG VALIDATION

7.1 The contractor shall conduct quarterly focused reviews of a 1% sample of medical records to assure that reimbursed services are supported by documentation in the patient's medical record. This review must determine if the diagnostic and procedural information and discharge status of the patient as reported by the hospital matches the attending physician's description of care and services documented in the patient's record. In order to accomplish this, the contractor shall conduct the following review activities:

7.2 Review of claim adjustments submitted by hospitals which result in the assignment of a higher weighted DRG (see [Addendum C](#)).

7.3 Review for physician certification as to the major diagnosis and procedures and the physician's acknowledgment of a penalty statement on file.

7.4 When the claim is submitted, the hospital must have on file a signed and dated acknowledgment from the attending physician that the physician has received the following notice:

"Notice to Physicians: TRICARE payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws."

7.5 The acknowledgment must be completed by the physician either before or at the time that the physician is granted admitting privileges at the hospital, or before, or at the time the physician admits his or her first patient. Existing acknowledgments signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital.

7.6 Outlier Review

Claims that qualify for additional payment as a cost-outlier shall be subject to review to ensure that the costs were medically necessary and appropriate and met all other requirements for payment. In addition, claims that qualify as short-stay outliers shall be reviewed to ensure that the admission was medically necessary and appropriate and that the discharge was not premature.

7.7 Procedures Regarding Certain Services Not Covered By The DRG-Based Payment System

In implementing the quality and utilization review for services not covered by the DRG-based payment system, the requirements of this section shall pertain, with the exception that ICD-9-CM (for dates of discharge **on or before September 30, 2014**) and Current Procedural Terminology, 4th Edition (CPT-4) codes will provide the basis for determining whether diagnostic and procedural information is correct and matches information contained in the medical records. The ICD-10-CM and ICD-10-PCS codes will be used to provide basis of correct information for dates of discharge beginning on or after **October 1, 2014**.

8.0 RETROSPECTIVE REVIEW REQUIREMENTS FOR OTHER THAN DRG VALIDATION

The contractor shall conduct and report quarterly focused reviews of a statistically valid sample or 30 records, whichever is greater of medical records to determine the medical necessity and quality of care provided, validate the review determinations made by review staff, and determine if the diagnostic and procedural information and/or discharge status of the patient as reported on the hospital and/or professional provider's claim matches the attending physician's description of care and services documented in the medical record. The specific types of records to be sampled shall be determined separately by each Regional Director (RD) who will provide the contractor with the sampling criteria (DRG, diagnosis, procedure, Length-Of-Stay (LOS), provider, incident or occurrence as reported on claim forms) and the time frame from which the sample is to be drawn 60 calendar days prior to each quarter. For all cases selected for retrospective review, the

following review activities shall occur:

8.1 Admission Review

The medical record must indicate that inpatient hospital care was medically necessary and provided at the appropriate level of care.

8.2 Invasive Procedure Review

The performance of unnecessary procedures may represent a quality and/or utilization problem. In addition, the presence of codes of procedures often affects DRG classification. Therefore, for every case under review, the medical record must support the medical necessity of the procedure performed. For this purpose, invasive procedures are defined as all surgical and any other procedures which affect DRG assignment.

8.3 Discharge Review

Records shall be reviewed using appropriate criteria for questionable discharges or other potential quality problems.

8.4 Mental Health Review

The contractor shall review all mental health claims in accordance with the provisions in [32 CFR 199.4\(a\)\(11\)](#) and [\(a\)\(12\)](#).

9.0 REVIEW RESULTS

9.1 Actions As A Result Of Retrospective Review Related To Individual Claims

If it is determined, based upon information obtained during reviews, that a hospital has misrepresented admission, discharge, or billing information, or is found to have quality of care defects, or has taken an action that results in the unnecessary admission of an individual entitled to benefits, unnecessary multiple admission of an individual, or other inappropriate medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries, the contractor shall, as appropriate:

- Deny payment for or recoup (in whole or in part) any amount claimed or paid for the inpatient hospital and professional services related to such determination;
- Require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice;
- Advise the provider and beneficiary of appeal rights, as required by [Chapter 12, Section 4, paragraph 2.0](#).

9.2 Findings Related To A Pattern Of Inappropriate Practices

The contractor shall notify TMA of the hospital and practice involved in all cases where a pattern of inappropriate admissions and/or billing practices, that have the effect of circumventing

the TRICARE DRG-based payment system, is identified.

9.3 Revision Of Coding Relating To DRG Validation

The contractor shall ensure the application of the following provisions in connection with the DRG validation process.

- If the diagnostic and procedural information attested to by the attending physician is found to be inconsistent with the hospital's coding or DRG assignment, the hospital's coding on the TRICARE claim shall be appropriately changed and payments recalculated on the basis of the appropriate DRG assignment.
- If the information attested to by the physician as stipulated in [paragraph 7.3](#) is found not to be correct, the contractor shall change the coding and assign the appropriate DRG on the basis of the changed coding in accordance with the paragraph above.

9.4 Notice Of Changes As A Result Of A DRG Validation

The contractor shall notify the provider of changes to procedural and diagnostic information that result in a change of DRG assignment within 30 calendar days of the contractor's decision. The notice must be understandable, written in English and shall contain:

- The corrected DRG assignment;
- The reason for the change resulting from the DRG validation;
- A statement addressing who is liable for payment of denied services (e.g., a beneficiary will be liable if the change in DRG assignment results in noncoverage of a furnished service);
- A statement informing each party (or his or her representative) of the right to request a review of a change resulting from DRG validation in accordance with the provisions in [paragraph 9.5](#);
- The locations for filing a request for review and the time period within which a request must be filed; and
- A statement concerning the duties and functions of the multi-function PRO.

9.5 Review Of DRG Coding Change

9.5.1 A provider dissatisfied with a change to the diagnostic or procedural coding information made by the contractor as a result of DRG validation is entitled to a review of that change if the change caused an assignment of a different DRG and resulted in a lower payment. A beneficiary may obtain a review of the contractor's DRG coding change only if that change results in noncoverage of a furnished service (see 42 CFR 478.15(a)(2)).

9.5.2 The contractor shall issue written notification of the results of the DRG validation review within 60 calendar days of receipt of the request for review. In the notification, the contractor shall

summarize the issue under review and discuss the additional information relevant to such issue. The notification shall state the contractor's decision and fully state the reasons that were the basis for the decision with clear and complete rationale. The notification shall include a statement that the decision is final and no further reviews are available.

10.0 PREPAYMENT REVIEW

10.1 The contractor shall establish procedures and conduct prepayment utilization review to address those cases involving diagnoses requiring prospective review, where such review was not obtained, to focus on program exclusions and limitations and to assist in the detection of and/or control of fraud and abuse. The contractor shall not be excused from claims processing cycle time standards because of this requirement.

10.2 The contractor shall perform prepayment review of all cases involving diagnoses requiring preauthorization where review was not obtained. No otherwise covered care shall be denied solely on the basis that authorization was not requested in advance, except for care provided by a network provider.

10.3 The contractor shall perform prepayment review of all DRG claim adjustments submitted by a provider which result in higher weighted DRGs.

11.0 CASE MANAGEMENT

Case management shall not be accomplished for beneficiaries eligible for Medicare Part A and Enrolled in Medicare Part B unless it is specifically contracted for inside an individual MTF or if the individual is part of the Individual Case Management Program for Persons with Extraordinary Conditions (ICMP-PEC).

12.0 CONFIDENTIALITY APPLICABLE TO ALL UM ACTIVITIES, INCLUDING RECOMMENDATIONS AND FINDINGS

12.1 The contractor shall develop and implement procedures, processes, and policies that meet the confidentiality and disclosure requirements set forth in Title 10, United States Code (USC), Chapter 55, Section 1102; the Social Security Act, Section 1160, and implementing regulations at 42 CFR 476, the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) Reorganization Act (42 USC 290dd-2), the Privacy Act (5 USC 552a), [32 CFR 199.15\(j\)](#) and [\(l\)](#). Additionally, the contractor shall display the following message on all quality assurance documents:

"Quality Assurance document under 10 USC 1102. Copies of this document, enclosures thereto, and information therefrom will not be further released under penalties of law. Unauthorized disclosure carries a possible \$3,000 fine."

12.2 Release of Information - If an inquiry is made by the beneficiary, including an eligible family member (child) regardless of age, the reply should be addressed to the beneficiary, not the beneficiary's parent or guardian. The only exceptions are when a parent writes on behalf of a minor child or a guardian writes on behalf of a physically or mentally incompetent beneficiary. The

contractor must not provide information to parents/guardians of minors or incompetents when the services are related to the following diagnoses:

- Abortion
- Alcoholism
- Substance Abuse
- Venereal Disease
- **Acquired Immune Deficiency Syndrome (AIDS)**

12.3 The term “minor” means any person who has not attained the age of 18 years. Generally, the parent of a minor beneficiary and the legally appointed guardian of an incompetent beneficiary shall be presumed to have been appointed the representative without specific designation by the beneficiary. Therefore, for beneficiaries who are under the age of 18 years or who are incompetent, a notice issued to the parent or guardian, under established TRICARE procedures, constitutes notice to the beneficiary.

12.4 If a beneficiary has been legally declared an emancipated minor, they are to be considered as an adult. If the beneficiary is under 18 years of age and is (or was) a spouse of an Active Duty Service Member (ADSM) or retiree, they are considered to be an emancipated minor.

13.0 DOCUMENTATION

The contractor shall develop and implement a program for providing beneficiaries and providers with the written results of all review activities affecting benefit determinations. All notifications to beneficiaries and providers shall be completed and mailed within the time limits established for the completion of reviews in this section. Notifications of denials shall include: patient’s name, sponsor’s name and last four digits of their Social Security Number (SSN), the clinical rationale for denial of payment for specific services (form letters are unacceptable as the clinical rationale shall provide a complete explanation, referencing any and all appropriate documentation, for the cause of the denial), all applicable appeal and grievance procedures, and the name and telephone number of an individual from whom additional information may be obtained.

- END -

Claim Development

1.0 GENERAL

1.1 Pursuant to National Defense Authorization Act for Fiscal Year 2007 (NDAA FY 2007), Section 731(b)(2) where services are covered by both Medicare and TRICARE, and medical necessity documentation is required for claims processing, the contractor shall require only the documentation as specified by the Medicare Indemnity Program, for example, the Centers for Medicare and Medicaid Services (CMS)-Certificates of Medical Necessity. No additional documentation for medical necessity is generally required if the care has been preauthorized.

1.2 The contractor shall retain all claims that contain sufficient information to allow processing to completion. The contractor shall also retain all claims that have missing information that can be obtained from in-house sources, including Defense Enrollment Eligibility Reporting System (DEERS) and contractor operated or maintained systems or files (both electronic and paper). If the claim has missing information that cannot be obtained from in-house sources, the contractor shall either return the claim to the sender or retain the claim and develop for the missing information from external sources (e.g., beneficiary or provider). If the claim is returned, the contractor will return the claim to the sender with a letter stating that the claim is being returned, stating the reason and requesting the missing or required information. The letter shall request all known missing or required documentation. The contractor's system shall identify the claim as returned, not denied. Returned claims shall not be reported on TRICARE Encounter Data (TED) records. 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.

1.3 If a claim is to be returned to a beneficiary who is under 18 years of age and involves venereal disease, substance or alcohol abuse, or abortion, the contractor shall contact the beneficiary to determine how he or she wishes to complete it. See [Section 8, paragraph 6.0](#) regarding possible contact procedures and the need for both sensitivity and use of good judgment in the protection of patient privacy. **Mail development shall not be initiated on this type of claim without consent of the beneficiary irrespective of whether it is a network or non-network claim.**

2.0 AGREEMENT TO PARTICIPATE

2.1 If the provider has agreed to participate, payment to the full extent of program liability will be paid directly to the provider, but the payment to the provider from program and beneficiary sources must not exceed the contractor determined allowable charge except as provided in payments which include other health insurance which is primary. In such a case, the provisions of [32 CFR 199.8](#) and the TRICARE Reimbursement Manual (TRM), [Chapter 4](#) will apply.

2.2 In all cases in which the contractor has documented knowledge of payment by the beneficiary or other party, the payment shall be appropriately disbursed, including, when necessary, splitting payment. (See the TRM for cases where double coverage is also involved.) If it

comes to the contractor's attention that the terms have been violated, the issue shall be resolved as outlined in [Chapter 13, Section 6, paragraph 7.0](#), under procedures for handling violation of participation agreements. If the provider returns an adjustment check to the contractor indicating that payment had been made in full, an adjustment check shall be reissued to the beneficiary/sponsor. If the non-network provider is clearly not participating or the intent cannot be determined, pay the beneficiary (parent/legal guardian).

3.0 CLAIMS FOR CERTAIN ANCILLARY SERVICES

If laboratory tests billed by a non-network provider were performed outside the office of the non-network provider, the place where the laboratory tests were performed must be provided. The contractor shall approve arrangements for laboratory work submitted by network physicians. To be covered, the services must have been ordered by an Doctor of Medicine (MD) or Doctor of Osteopathy (DO) and the laboratory must meet the requirements to provide the services as required under the 32 CFR 199, and TRICARE Management Activity (TMA) instructions.

4.0 INTERNATIONAL CLASSIFICATION OF DISEASES, 9TH REVISION, CLINICAL MODIFICATION (ICD-9-CM) "V" CODES

4.1 The ICD-9-CM codes listed in the Supplementary Classification of Factors Influencing Health Status and Contact with Health Services, otherwise known as **V** codes, deal with circumstances other than disease or injury classifiable to the ICD-9-CM categories 001-999. **V** codes are acceptable as primary diagnoses on outpatient claims (rarely on inpatient claims) to the extent that they describe the reason for a beneficiary's encountering the health care system. Claims with dates of service or dates of discharge provided **on or before September 30, 2014**, with **V** codes as the primary diagnoses are to be processed as follows without development. Claims with dates of service or dates of discharge provided **on or after October 1, 2014**, are to be processed in accordance with International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) **Z** codes.

4.2 **V** codes which provide descriptive information of the reason for the encounter based on the single code, e.g., V03.X (Prophylactic vaccination and inoculation against bacterial diseases), V20.2 (Routine infant or child health check), V22.X (Supervision of normal pregnancy), V23.X (Supervision of high risk pregnancy), V25.2 (Sterilization), are acceptable as primary diagnoses. Claims with these codes may be processed according to TRICARE benefit policy without additional diagnostic information.

4.3 **V** codes for outpatient visits/encounters involving only ancillary diagnostic or therapeutic services are acceptable as the primary diagnosis to describe the reason for the visit/encounter only if the diagnosis or problem for which the ancillary service is being performed is also provided. For example, a **V** code for radiologic exam, V72.5, followed by the code for 786.07 (wheezing) or 786.50 (chest pain) is acceptable. If the diagnosis or problem is not submitted with a claim for the **V**-coded ancillary service and the diagnosis is not on file for the physician's office services, the claim is to be denied for insufficient diagnosis.

4.4 **V** codes for preventive services due to a personal history of a medical condition or a family history of a medical condition are acceptable as primary diagnoses when medically appropriate due to the personal or family history condition. Claims with these codes may be processed

according to the TRICARE benefit policy without additional diagnostic information. Specifically, the treatment areas are as follows:

- Diagnostic and Screening Mammography, e.g., V76.11, V10.3, V15.89, and V163.0.
- Pap Smears, e.g., V72.3, V76.2, and V15.89.
- Screening for Fecal Occult Blood, e.g., V10.00, V10.05, and V10.06.

4.5 Claims with the only diagnoses being **V** codes which do not fall into one of the above of categories, e.g., codes indicating personal or family histories of conditions, are to be returned for insufficient diagnosis. This includes those **V** codes corresponding to the **V** codes for "Conditions not Attributable to a Mental Disorder" in the **Diagnostic and Statistical Manual of Mental Disorders** of the American Psychiatric Association (APA).

5.0 ICD-10-CM "Z" CODES

5.1 The codes listed in Chapter XXI of ICD-10-CM - Factors Influencing Health Status and Contact with Health Services (Z00-Z99), otherwise known as **Z** codes, will become effective on **October 1, 2014**, and replace ICD-9-CM **V** codes. These **Z** codes deal with circumstances other than disease or injury classifiable to the ICD-10-CM categories A00-Y99. **Z** codes are acceptable as primary diagnoses on outpatient claims (rarely on inpatient claims) to the extent that they describe the reason for a beneficiary encountering the health care system. Claims with **Z** codes as the primary diagnoses are to be processed as follows without development.

5.2 **Z** codes which provide descriptive information of the reason for the encounter based on the single code, e.g., Z23 (Encounter for Immunization), Z00.129 (Encounter for routine child health examination without abnormal findings), Z34.00 (Encounter for supervision of normal first pregnancy, unspecified trimester), Z30.011 (Encounter for initial prescription of contraceptive pills), are acceptable as primary diagnoses. Claims with these codes may be processed according to TRICARE benefit policy without additional diagnostic information.

5.3 **Z** codes for outpatient visits/encounters involving only ancillary diagnostic or therapeutic services are acceptable as the primary diagnosis to describe the reason for the visit/encounter only if the diagnosis or problem for which the ancillary service is being performed is also provided. For example, Z01.89, Encounter for the other specified (radiologic not associated with procedure) special examinations, followed by the code for R06.2 (wheezing) or R07.1 (chest pain on breathing) is acceptable. If the diagnosis or problem is not submitted with a claim for the **Z**-coded ancillary service and the diagnosis is not on file for the physicians office services, the claim is to be denied for insufficient diagnosis.

5.4 **Z** codes for preventive services due to a personal history of a medical condition or a family history of a medical condition are acceptable as primary diagnoses when medically appropriate due to the personal or family history condition. Claims with these codes may be processed according to the TRICARE benefit policy without additional diagnostic information. Specifically, the treatment areas are as follows:

- Diagnostic and Screening Mammography, e.g., Z12.31, Z85.3, Z86.000, Z80.3, and Z91.89.
- Pap Smears, e.g., Z12.72, Z12.4, Z11.51, Z86.001, and Z91.89.
- Screening for Fecal Occult Blood, e.g., Z85.00 (Personal history of malignant).

5.5 Claims with the only diagnoses being **Z** codes which do not fall into one of the above of categories, e.g., codes indicating personal or family histories of conditions, are to be returned for insufficient diagnosis. This includes those **Z** codes corresponding to the **Z** codes for "Conditions not Attributable to a Mental Disorder" in the **Diagnostic and Statistical Manual of Mental Disorders** of the APA.

6.0 INDIVIDUAL PROVIDER SERVICES

Claims for individual providers (including claims for ambulatory surgery) usually require materially more detailed itemization than institutional claims. The claim must show the following detail:

- Identification of the provider of care;
- Dates of services;
- Place of service, if not evident from the service description or code, e.g., office, home, hospital, Skilled Nursing Facility (SNF), etc.;
- Charge for each service;
- Description of each service and/or a clearly identifiable/acceptable procedure code; and
- The number/frequency of each service.

7.0 UNDELIVERABLE/RETURNED MAIL

When a provider's/beneficiary's Explanation of Benefits (EOB), EOB and check, or letter is returned as undeliverable, the check shall be voided.

8.0 TED DETAIL LINE ITEM - COMBINED CHARGES

Combining charges for the same procedures having the same billed charges under the contractor's "financially underwritten" operation, for TED records, is optional with the contractor if the same action is taken with all. However, for example, if the claim itemizes services and charges for daily inpatient hospital visits from March 25, 2004 to April 15, 2004 and surgery was performed on April 8, 2004, some of the visits may be denied as included in the surgical fee (post-op follow-up). The denied charges, if combined, would have to be detailed into a separate line item from those being allowed for payment. Similarly, the identical services provided between March 25th and March 31st, inclusive, would be separately coded from those rendered in April. The option to combine like services shall be applied to those services rendered the same calendar month.

9.0 CLAIMS SPLITTING

A claim shall only be split under the following conditions. Unless a claim meets one of the following conditions, all services included on the claim shall be processed together and reported on one TED record.

9.1 A claim covering services and supplies for more than one beneficiary (other than conjoint therapy, etc.) should be split into separate claims, each covering services and supplies for a specific beneficiary. This must be split under TEDs for different beneficiaries.

9.2 A claim for the lease/purchase of Durable Medical Equipment (DME) that is paid by separately submitted monthly installments will be split into one claim for each monthly installment. The

monthly installment will exclude any approved accumulation of past installments (to be reimbursed as one claim) due on the initial claim. Must be split under TEDs.

9.3 A claim that contains services, supplies or equipment covering more than one contractor's jurisdiction shall be split. See [Section 2](#), for information on transferring partially out-of-jurisdiction claims.

9.4 An inpatient maternity claim which is subject to the TRICARE Diagnosis Related Group (DRG)-based payment system and which contains charges for the mother and the newborn shall be split, only when there are no nursery/room charges for the newborn. See the TRM, [Chapter 1, Section 31](#).

9.5 Hospice claims that contain both institutional and physician services shall be split for reporting purposes. Institutional services (i.e., routine home care - 651, continuous home care - 652, inpatient respite care - 655, and general inpatient care - 656) shall be reported on an institutional claim format while hospice physician services (revenue code 657 and accompanying Current Procedural Terminology (CPT) codes) shall be reported on a non-institutional format. See the TRM, [Chapter 11, Section 4](#).

9.6 A claim for ambulatory surgery services submitted by an ambulatory surgery facility (either freestanding or hospital-based) may be split into separate claims for:

9.6.1 Charges for services which are included in the prospective group payment rate;

9.6.2 Charges for services which are not included in the prospective group payment rate and are separately allowable; and

9.6.3 Physician's fees which are allowable in addition to the facility charges. See the TRM, [Chapter 9, Section 1](#).

9.7 A claim submitted with both non-financially underwritten and financially underwritten charges shall be split.

9.8 A claim that contains both institutional and professional services may be split into separate claims for:

9.8.1 Charges for services included in the Outpatient Prospective Payment System (OPPS); and

9.8.2 Charges for professional services which are not included in the OPPS and are separately allowable.

9.9 Claims which include services covered by NDAA for FY 2008, Section 1637, Transitional Care for Service-Related Conditions (TCSRC) shall be processed in accordance with [Chapter 17, Section 3, paragraph 2.5.5](#).

9.10 Outpatient claims with dates of service that cross **October 1, 2014**, the date for ICD-10-CM coding implementation, must be split to accommodate the new coding regulations. A separate claim shall be submitted for services provided **on or before September 30, 2014**, and be coded in accordance with the ICD-9-CM, as appropriate. Claims for services provided on or after **October 1, 2014**, shall be submitted and coded with the ICD-10-CM as appropriate.

10.0 PROVIDER NUMBERS

10.1 Claims received from covered entities with the provider's National Provider Identifier (NPI) (individual and organizational) shall be processed using the NPI. Electronic claim transactions received from covered entities without the requisite NPIs in accordance with Implementation Guide for the ASC X12N 837 transaction shall be denied. See [Chapter 20](#) for further information.

10.2 Claims received (electronic, paper, or other acceptable medium) with provider's Medicare Provider Number (institutional and non-institutional) shall not be returned to the provider to obtain the TRICARE Provider Number. The contractor shall accept the claim for processing, develop the provider number internally, and report the TRICARE Provider Number as required by the TRICARE Systems Manual (TSM), [Chapter 2](#), on the TED records.

11.0 TRANSGENDERED BENEFICIARIES

If a beneficiary or provider notifies the contractor of the beneficiary's transgendered status (either prospectively or through an appeal), the contractor shall flag that patient's file and defer claims for medical review when there is a discrepancy between the patient's gender and the procedure, diagnosis*, ICD-9-CM surgical procedure code (for procedures on or before **September 30, 2014**), or ICD-10-PCS surgical procedure code (for procedures on or after **October 1, 2014**). For care that the review determines to be medically necessary and appropriate, the contractor shall override any edit identifying a discrepancy between the procedure and the patient's gender. TED record data for transgendered claims must reflect the Person Sex as downloaded from DEERS (TSM, [Chapter 2, Section 2.7](#)) and the appropriate override code.

Note: *The edition of the International Classification of Diseases, Clinical Modification reference to be used is determined by the date of service for outpatient services or date of discharge for inpatient services. Diagnoses coding for dates of service or dates of discharge prior to ICD-10 implementation should be consistent with the ICD-9-CM. Diagnoses coding for dates of service or dates of discharge on or after **October 1, 2014**, should be consistent with ICD-10-CM.

- END -

other coverage. For pregnancies in which the surrogate mother is a TRICARE beneficiary, services and supplies associated with antepartum care, postpartum care, and complications of pregnancy may be cost-shared only as a secondary payer, and only after the contractually agreed upon arrangement has been exhausted. Where contractual arrangements are silent or do not specify a reasonable amount for reimbursement for medical expenses, a reasonable amount of payment shall be assumed and deemed attributable to the medical expenses of the surrogate mother. TRICARE considers the surrogate mother responsible for the cost of providing maternity services and assumes the surrogate will seek reimbursement from the adoptive parents as first payer.

3.0 DEPARTMENT OF DEFENSE (DoD) POLICY

It is the DoD's policy that TRICARE Management Activity (TMA) establish, implement, and maintain a system to identify and enforce the government's right to recover funds expended on claims involving potential third party recovery.

4.0 RESPONSIBILITY FOR RECOVERY

Designated legal officers of the uniformed services are responsible for the recovery actions on TRICARE claims involving third-party liability under the FMCRA. [Addendum B](#), provides a complete listing of the offices in the TMA area to which TRICARE claims involving third-party liability are to be sent.

5.0 CONTRACTOR RESPONSIBILITY

5.1 Identification Of Claims Subject To Third Party Recovery (Not Applicable To Pharmacy Contract)

5.1.1 The contractor is responsible for making a preliminary investigation of all potential third party recovery claims. Any inpatient or outpatient claim with International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis code 800-999 which exceeds a TRICARE liability of \$500, shall be considered a potential third party claim and shall be developed with the questionnaire, "Statement of Personal Injury - Possible Third Party Liability," DoD Document (DD) Form 2527. (See Addendum A, Figure 10.A-2.) For inpatient claims with dates of discharge or outpatient claims with dates of service on or after **October 1, 2014**, use International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) diagnosis **S** and **T** code ranges ending in the letter "a" signifying the initial encounter. Also, use all additional encounters identifying the date of injury with the date of injury for the initial encounter. However, if the contractor can determine, based upon a specific diagnosis code (e.g., certain external cause codes), that there is little or no third party recovery potential, the claim need not be developed. Examples of cases that usually would not require development include a slip and fall incident at home, private residence, or a one-car accident in which the TRICARE beneficiary was the only occupant. Claims with the following diagnoses do not require routine development for potential TPL. References to the ICD-9-CM 800-999 diagnostic code and ICD-10-CM) **S** and **T** codes ending with the seventh character of **A** ranges category for TPL purposes excludes these codes.

- **ICD-9-CM:** 910.2 - 910.7, 911.2 - 911.7, 912.2 - 912.7, 913.2 - 913.7, 914.2 - 914.7, 915.2 - 915.7, 916.2 - 916.7, 917.2 - 917.7, 918.0, 918.2, and 919.2 - 919.7.

- **ICD-10-CM (with the exception of codes indicating abrasion and contusion):**
S00.02 - S00.97, S10.1 - S10.97, S20.1 - S20.9, S30.82 - S30.877, S40.22 - S40.879,
S50.32 - S50.879, S60.32 - S60.879, S70.22 - S70.379, S80.22 - S80.879,
S90.42 - S90.879, T15.1, and T16.

5.1.2 A system flag shall be set when the DD Form 2527 is mailed. Any claims which appear to be possible third party claims, after the contractor has reviewed the returned statement, shall be referred to a Uniformed Service Claims Office for determination and recovery action, if appropriate. These claims shall be processed to completion in the usual manner prior to referral to a claims officer. Normal processing includes appropriate Coordination of Benefits (COB) under the provisions of [paragraph 6.0](#) and the TRICARE Systems Manual (TSM), [Chapter 2](#).

5.1.3 Claims developed for TPL which require COB may either be denied or be treated as uncontrolled returns in accordance with [paragraph 5.2.1.2](#). If the contractor discovers the potential other coverage through receipt of the completed DD Form 2527, the other coverage information must be developed at that point using the normal other coverage procedures in place for the contractor. If during the course of claim adjudication, the contractor becomes aware of a potential third party recovery arising as the result of malpractice (civilian provider negligence), the contractor shall process the claim(s) under the provisions of this section regardless of the procedure codes involved.

5.2 Contractor Procedures

(For pharmacy contractor procedures, see [paragraph 5.2.8](#).)

The contractor shall have automated identification of claims with ICD-9-CM diagnoses codes 800-999. When the contractor receives a claim with ICD-9-CM diagnoses codes 800-999, the processing clerk shall follow the instructions below. Claims with dates of service or dates of discharge on or after **October 1, 2014**, will have ICD-10-CM code ranges of **S** and **T**.

5.2.1 Continue normal processing of the claim (including any required development or other insurance actions) to the point of payment, but withhold payment pending the actions that follow:

5.2.1.1 Search existing files to determine whether there is a system flag indicating that a personal injury questionnaire has been sent within the last 35 days, or an indicator that a completed DD Form 2527 has been received for the same EOC.

5.2.1.2 If there is no personal injury questionnaire attached to the claim, and none has been requested within the last 35 days or received previously for the same incident, suspend the claim payment regardless of whether the claim has been assigned, and send a request to the beneficiary asking that he/she complete the questionnaire. (See [Addendum A, Figure 10.A-3](#).) The beneficiary must be advised that if a completed questionnaire is not returned on a timely basis, the claim cannot be processed without the requested information. Every effort shall be made to request any additional information required to process the claim at the same time the questionnaire is sent. If the claim indicates that there is other insurance, or if contractor history or Defense Enrollment Eligibility Reporting System (DEERS) reflects the existence of other health insurance, the contractor may deny the claim(s) or return the claim(s) uncontrolled and simultaneously request that the DD Form 2527 be completed.

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Third Party Recovery Claims

7.4 To furnish such additional information as may be requested concerning the circumstances of the injury or disease for which care and treatment are being given and concerning any action instituted or to be instituted by or against a third person.

7.5 To notify the recovery judge advocate or such other legal officer who is representing the interests of the Government of a settlement with or an offer of settlement from a third person.

7.6 To cooperate in the prosecution of all claims and actions by the United States against such third person.

8.0 REPORTING REQUIREMENTS

The contractor shall send a report to TMA regarding claims investigated and claims referred under the FMCRA. Claims under this act shall be considered to be those which are presented with ICD-9-CM diagnoses codes which fall within the range from 800 through 999 or ICD-10-CM code ranges of **S** and **T**, for dates of service or discharge on or after **October 1, 2014**, and under which there is or could be tort liability of a third party for the patient's injury or disease.

- END -

Standards For Electronic Transactions

1.0 BACKGROUND AND PROVISIONS

The Department of Health and Human Services (HHS) published the first administrative simplification related final rule on August 17, 2000, which added subchapter C, "Administrative Data Standards and Related Requirements," to 45 CFR subtitle A. Subchapter C includes Parts 160 and 162, which will be referred to here as the Transaction and Code Sets Rule. On January 16, 2009, HHS published a Final Rule known as "Health Insurance Reform: Modifications to Health Insurance Portability and Accountability Act (HIPAA) Electronic Transaction Standards." This Final Rule (referred to here as the "Modifications to HIPAA Electronic Standards Final Rule") adopted updated versions of the standards for electronic transactions that were originally adopted under the Administrative Simplification subtitle of HIPAA.

On January 16, 2009, HHS also published a separate Final Rule adopting the International Classification of Diseases, 10th Revision (ICD-10) to replace the International Classification of Diseases, 9th Revision (ICD-9) in HIPAA transactions. This Final Rule, known as "HIPAA Administration Simplification: Modifications to Medical Data Code Set Standards to Adopt ICD-10-CM and ICD-10-PCS" (referred to here as "Modifications to Adopt ICD-10 Final Rule"), amends 45 CFR Parts 160 and 162.

On September 5, 2012, HHS published an additional Final Rule changing the compliance date for ICD-10 from October 1, 2013, to October 1, 2014. This Final Rule, known as "Administrative Simplification: Adoption of a Standard for a Unique Health Plan Identifier; Addition to the National Provider Identifier Requirements; and a Change to the Compliance Date for the ICD-10-CM and ICD-10-PCS Medical Data Code Sets" amends 45 CFR Part 162.

1.1 Compliance Date

1.1.1 Compliance with the Modifications to HIPAA Electronic Standards Final Rule is required No Later Than (NLT) January 1, 2012, and small health plans must comply by January 1, 2013. Health plans are precluded from requiring an earlier compliance date than those adopted. Use of Versions 5010 and D.0 in advance of the mandatory compliance date is permissible, based upon mutual agreement by trading partners.

1.1.2 The compliance date for ICD-10 is October 1, 2014. Health plans are precluded from requiring an earlier compliance date than those adopted by the Final Rule.

1.2 Applicability

The initial Transaction and Code Sets Rule and the subsequent Modifications to HIPAA Electronic Standards Final Rule applies to health plans, health care clearinghouses, and health care providers who transmit any health information in electronic form in connection with a transaction

covered by the rule. These Rules refer to health plans, health care clearinghouses, and health care providers as “covered entities.” The initial Transaction and Code Sets Rule specifically names the health care program for active duty military personnel under Title 10 of the United States Code (USC) and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) as defined in 10 USC 1072(4), as health plans and this designation has not changed in the Modifications to HIPAA Electronic Standards Final Rule.

1.3 Transaction Implementation Specification Standards

1.3.1 The Modifications to HIPAA Electronic Standards Final Rule adopts the ASC X12 Technical Reports Type 3 (TR3), Version 005010 and accompanying Type 1 Errata (hereinafter referred to as Version 5010) as a modification of the current X12 Version 4010 standards (hereinafter referred to as Version 4010/4010A) for the HIPAA transactions and names the following transaction implementation specifications as the new standards. In the event that additional accompanying Errata is adopted and mandated for use at a future date, TRICARE contractors, as covered entities will be required to comply with those Errata by the compliance dates specified by HHS.

- The ASC X12 Standards for Electronic Data Interchange (EDI) TR3 - Health Care Claim: Dental (837), May 2006, ASC X12N/005010X224, and Version 5010 to Health Care Claim Dental (837), ASC X12 Standards for EDI TR3, October 2007, ASC X12N/005010X224A1, as referenced in § 162.1102 and § 162.1802.
- The ASC X12 Standards for EDI TR3 - Health Care Claim: Professional (837), May 2006, ASC X12N/005010X222, as referenced in § 162.1102 and § 162.1802.
- The ASC X12 Standards for EDI TR3 - Health Care Claim: Institutional (837), May 2006, ASC X12N/005010X223, and Version 5010 to Health Care Claim: Institutional (837), ASC X12 Standards for EDI Technical Report Type 3, October 2007, ASC X12N/005010X223A1, as referenced in § 162.1102 and § 162.1802.
- The ASC X12 Standards for EDI TR3 - Health Care Eligibility Benefit Inquiry and Response (270/271), April 2008, ASC X12N/005010X279, as referenced in § 162.1202.
- The ASC X12 Standards for EDI TR3 - Health Care Services Review-Request for Review and Response (278), May 2006, ASC X12N/005010X217, and Version 5010 to Health Care Services Review-Request for Review and Response (278), ASC X12 Standards for EDI TR3, April 2008, ASC X12N/005010X217E1, as referenced in § 162.1302.
- The ASC X12 Standards for EDI TR3 - Health Care Claim Status Request and Response (276/277), August 2006, ASC X12N/005010X212, and Version 5010 to Health Care Claim Status Request and Response (276/277), ASC X12 Standards for EDI TR3, April 2008, ASC X12N/005010X212E1, as referenced in § 162.1402.
- The ASC X12 Standards for EDI TR3 - Benefit Enrollment and Maintenance (834), August 2006, ASC X12N/005010X220, as referenced in § 162.1502.
- The ASC X12 Standards for EDI TR3 - Health Care Claim Payment/Advice (835), April 2006, ASC X12N/005010X221, as referenced in § 162.1602.

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- The ASC X12 Standards for EDI TR3 - Payroll Deducted and Other Group Premium Payment for Insurance Products (820), February 2007, ASC X12N/005010X218, as referenced in § 162.1702.

1.3.2 For retail pharmacy the Modifications to HIPAA Electronic Standards Final Rule revises §§ 162.1102, 162.1202, 162.1302, and 162.1802 to adopt the National Council for Prescription Drug Programs, (NCPDP) Telecommunication Standard Implementation Guide, Version D, Release 0 (Version D.0), August 2007, the NCPDP Batch Standard Implementation Guide, Version 1, Release 2 (Version 1.2), January 2006.

1.3.2.1 Section § 162.1102 was also revised to adopt both Version D.0 and the 837 Health Care Claim: Professional ASC X12 TR3 for billing retail pharmacy supplies and professional services.

1.3.2.2 In addition, the Modifications to HIPAA Electronic Standards Final Rule adds a new subpart S to 45 CFR part 162 to adopt a standard for the subrogation of pharmacy claims paid by Medicaid. The transaction is the Medicaid pharmacy subrogation transaction and the new standards is the NCPDP Batch Standard Medicaid Subrogation Implementation Guide, Version 3 Release 0 (Version 3.0), July 2007, as referenced in § 162.1902. This standard would be applicable to Medicaid agencies in their role as health plans, as well as to other health plans that are covered entities under HIPAA, but not to providers because this transaction is not utilized by them.

1.3.3 Section 1104 of the Administrative Simplification provisions of the Patient Protection and Affordable Care Act (PPACA) (hereafter referred to as the Affordable Care Act) establishes new requirements for administrative transactions that will improve the utility of the existing HIPAA transactions and reduce administrative costs. On July 8, 2011, HHS published the first of several expected regulations to adopt Operating Rules for HIPAA Transactions. This Interim Final Rule (IFR) known as "Administrative Simplification: Adoption of Operating Rules for Eligibility for a Health Plan and Health Care Claim Status Transactions" adopts operating rules for two HIPAA transactions: eligibility for a health plan (ASC X12N 270/271 electronic transaction) and health care claim status (ASC X12N 276/277 electronic transaction). The adopted Operating Rules are as follows:

- Phase I Committee on Operating Rules for Information Exchange (CORE) 152: Eligibility and Benefit Real Time Companion Guide Rule, version 1.1.0, March 2011, and CORE Version 5010 Master Companion Guide Template, 005010, 1.2, March 2011.
- Phase I CORE 153: Eligibility and Benefits Connectivity Rule, version 1.1.0, March 2011.
- Phase I CORE 154: Eligibility and Benefits 270/271 Data Content Rule, version 1.1.0, March 2011.
- Phase I CORE 155: Eligibility and Benefits Batch Response Time Rule, version 1.1.0, March 2011.
- Phase I CORE 156: Eligibility and Benefits Real Time Response Time Rule, version 1.1.0, March 2011.
- Phase I CORE 157: Eligibility and Benefits System Availability Rule, version 1.1.0, March 2011.

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- Phase II CORE 250: Claim Status Rule, version 2.1.0, March 2011, and CORE Version 5010 Master Companion Guide Template, 005010, 1.2, March 2011.
- Phase II CORE 258: Eligibility and Benefits 270/271 Normalizing Patient Last Name Rule, version 2.1.0, March 2011.
- Phase II CORE 259: Eligibility and Benefits 270/271 AAA Error Code Reporting Rule, version 2.1.0, March 2011.
- Phase II CORE 260: Eligibility & Benefits Data Content (270/271) Rule, version 2.1.0, March 2011.
- Phase II CORE 270: Connectivity Rule, version 2.2.0, March 2011.

TRICARE contractors are required to comply with these Operating Rules and the provisions of the above referenced IFR (and any revisions to that IFR) by the mandated compliance date of January 1, 2013. Sections 162.1203 and 162.1403 of the Eligibility and Health Care Claim Status Operating Rules excludes from adoption, “where the Council for Affordable Quality Health (CAQH) CORE rules reference and pertain to acknowledgments and CORE certification”; this exclusion is also applied herein.

1.3.4 On August 10, 2012, HHS published an Interim Final Rule with comment (IFC) known as “Administrative Simplification: Adoption of Operating Rules for Health Care Electronic Funds Transfers (EFT) and Remittance Advice (RA) Transactions”. The adopted Operating Rules, to include the applicable version number and date created, are as follows:

- Phase III CORE 380 EFT Enrollment Data Rule, version 3.0.0, June 2012.
- Phase III CORE 382 Electronic Remittance Advice (ERA) Enrollment Data Rule, version 3.0.0, June 2012.
- Phase III 360 CORE Uniform Use of Claim Adjustment Reason Codes (CARCs) and Remittance Advice Remark Codes (RARCs) (835) Rule, version 3.0.0, June 2012.
- CORE-Required Code Combinations for CORE-defined Business Scenarios for the Phase III CORE 360 Uniform Use of CARCs and RARCs (835) Rule, version 3.0.0, June 2012.
- Phase III CORE 370 EFT & ERA Reassociation (Corporate Credit or Debit (CCD+)/835) Rule, version 3.0.0, June 2012.
- Phase III CORE 350 Health Care Claim Payment/Advice (835) Infrastructure Rule, version 3.0.0, June 2012.
- ACME Health Plan, CORE v5010 Master Companion Guide Template, 005010, 1.2, March 2011 (incorporated by reference in § 162.920), as required by the Phase III CORE 350 Health Care Claim Payment/Advice (835).

TRICARE contractors are required to comply with these Operating Rules and the provisions of the above referenced IFC (and any revisions to that IFC) by the mandated compliance date of January 1, 2014. Sections 162.920 and 162.1603 of the EFT and RA Operating Rules exclude from adoption, "Requirement 4.2 titled 'Health Care Claim Payment/Advice Batch Acknowledgment Requirements'"; this exclusion is also applied herein.

1.4 Transition from X12 Version 4010A1/NCPDP 5.1 to X12 Version 5010 and NCPDP Version D.0

1.4.1 During the transition from X12 Version 4010 to X12 version 5010 and from NCPDP version 1.5 to D.0, the Secretary, HHS has adopted Level 1 and Level 2 testing periods where either version of the standards may be used in production mode - Version 4010/4010A and/or Version 5010, as well as Version 5.1 and/or Version D.0—as agreed to by trading partners. As covered entities, TRICARE contractors should be prepared to meet Level 1 compliance by December 31, 2010, and Level 2 compliance by December 31, 2011. After December 31, 2011, covered entities may not use Versions 4010/4010A and 5.1. On January 1, 2012, Level 2 compliance must be reached, and TRICARE contractors must be fully compliant in using Versions 5010 and D.0 exclusively.

1.4.2 The Level 1 testing period is the period during which covered entities perform all of their internal readiness activities in preparation for testing the new versions of the standards with their trading partners. Compliance with Level 1, means that a covered entity can demonstrably create and receive compliant transactions, resulting from the completion of all design/build activities and internal testing. When a covered entity has attained Level 1 compliance, it has completed all internal readiness activities and is fully prepared to initiate testing of the new versions in a test or production environment, pursuant to its standard protocols for testing and implementing new software or data exchanges.

1.4.3 The Level 2 testing period is the period during which covered entities are preparing to reach full production readiness with all trading partners. When a covered entity is in compliance with Level 2, it has completed end-to-end testing with each of its trading partners, and is able to operate in production mode with the new versions of the standards by the end of that period. "Production mode," means that covered entities can successfully exchange (accept and/or send) standard transactions, and as appropriate, be able to process them successfully.

1.5 Code Set General Requirements

The initial Transactions and Code Sets Rule stipulates that when conducting a transaction, a covered entity must:

1.5.1 Use the applicable medical data code sets described in § 162.1002 as specified in the adopted implementation specifications that are valid at the time the health care is furnished.

1.5.2 Use the nonmedical data code sets as specified in the adopted implementation specifications that are valid at the time the transaction is initiated.

1.6 Medical Code Set Standards

On January 16, 2009, the Secretary, HHS, adopted modifications to the standard medical data code sets for coding diagnoses and inpatient hospital procedures. Beginning on **October 1, 2014**, the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Volumes 1 and 2, including the Official ICD-9-CM Guidelines for Coding and Reporting, hereinafter referred to as ICD-9-CM Volumes 1 and 2, and the ICD-9-CM, Volume 3, including the Official ICD-9-CM Guidelines for Coding and Reporting, hereinafter referred to as ICD-9-CM Volume 3, for diagnosis and procedure codes, respectively will be replaced as follows:

1.6.1 International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM) (including the Official ICD-10-CM Guidelines for Coding and Reporting), as maintained and distributed by HHS, for the following conditions:

- Diseases.
- Injuries.
- Impairments.
- Other health problems and their manifestations.
- Causes of injury, disease, impairment, or other health problems.

1.6.2 International Classification of Diseases, 10th Edition, Procedure Coding System (ICD-10-PCS) (including the Official ICD-10-PCS Guidelines for Coding and Reporting), as maintained and distributed by HHS, for the following procedures or other actions taken for diseases, injuries, and impairments on hospital inpatients by hospitals:

- Prevention.
- Diagnosis.
- Treatment.
- Management.

1.6.3 ICD-9-CM Volumes 1, 2, and 3, are the code sets in effect to be used for coding medical diagnoses with dates of service or discharge and inpatient procedures with dates of discharge occurring **on or before September 30, 2014**.

1.6.4 For retail pharmacy transactions only, National Drug Codes (NDCs), as maintained and distributed by HHS, in collaboration with drug manufacturers, for reporting the following in retail pharmacy transactions for which standards have been adopted:

- Drugs.
- Biologics.

Note: For transactions involving institutional (supplies, equipment) and professional providers (non-retail pharmacy transactions), Healthcare Common Procedure Coding System (HCPCS) codes, may be used (e.g., HCPCS J-codes). See [paragraph 1.6.7](#).

1.6.5 Code on Dental Procedures and Nomenclature, as maintained and distributed by the American Dental Association (ADA), for dental services. The Current Dental Terminology (CDT) Manual contains the ADA's codes for dental procedures and nomenclature and is the nationally accepted set of numeric codes and descriptive terms for reporting dental treatments.

1.6.6 The combination of HCPCS, as maintained and distributed by HHS, and Current Procedural Terminology, Fourth Edition (CPT-4), as maintained and distributed by the American Medical Association (AMA), for physician services and other health care services. These services include, but are not limited to, the following:

- Physician services (or other health care professional services).
- Physical, occupational, speech, nutritional, and therapy services.
- Radiologic procedures.
- Clinical laboratory tests.
- Other medical diagnostic procedures.
- Hearing and vision services.
- Transportation services including ambulance.

1.6.7 The HCPCS, as maintained and distributed by HHS, for all other substances, equipment, supplies, or other items used in health care services except patient administered drugs and biologics. These items include, but are not limited to, the following:

- Medical supplies.
- Orthotic and prosthetic devices.
- Durable medical equipment.

Note: The Rule does not name the HCPCS Level III, local codes, as a standard medical data code set. HCPCS Level III local codes shall not be used in standard transactions after compliance with the Rule is required.

1.7 General Requirements For Covered Entities

The Modifications to HIPAA Electronic Standards Final Rule also revised some of the general requirements of the initial Transactions and Code Sets Rule for covered entities. It requires the following of all covered entities.

1.7.1 "General rule. § 162.923 paragraph (a) was revised to read as follows: Except as otherwise provided in this part, if a covered entity conducts business with another covered entity that is required to comply with a transaction standard adopted under this part (or within the same covered entity), using electronic media, a transaction for which the Secretary (HHS) has adopted a standard under this part, the covered entity must conduct the transaction as a standard transaction."

1.7.2 "Exception for direct data entry transactions. A health care provider electing to use direct data entry offered by a health plan to conduct a transaction for which a standard has been adopted under this part must use the applicable data content and data condition requirements of the standard when conducting the transaction. The health care provider is not required to use the format requirement of the standard."

1.7.3 "Use of a business associate. A covered entity may use a business associate, including a health care clearinghouse, to conduct a transaction covered by this part. If a covered entity chooses to use a business associate to conduct all or part of a transaction on behalf of the covered entity, the covered entity must require the business associate to do the following:

- Comply with all applicable requirements of this part.
- Require any agent or subcontractor to comply with all applicable requirements of this part." See [Appendix B](#) for the definition of "business associate."

1.8 General Requirements For Health Plans

1.8.1 The initial Transactions and Code Sets Rule requires the following of health plans as general rules.

- "If an entity requests a health plan to conduct a transaction as a standard transaction, the health plan must do so."
- "A health plan may not delay or reject a transaction, or attempt to adversely affect the other entity or the transaction, because the transaction is a standard transaction."
- "A health plan may not reject a standard transaction on the basis that it contains data elements not needed or used by the health plan (for example, coordination of benefits information)."
- "A health plan may not offer an incentive for a health care provider to conduct a transaction covered by this part as a transaction described under the exception provided for in § 162.923(b)." (Exception for direct data entry transactions.)
- "A health plan that operates as a health care clearinghouse, or requires an entity to use a health care clearinghouse to receive, process, or transmit a standard transaction may not charge fees or costs in excess of the fees or costs for normal telecommunications that the entity incurs when it directly transmits, or receives, a standard transaction to, or from, a health plan."

1.8.2 The Modifications to HIPAA Electronic Standards Final Rule amended section § 162.925 by adding a new paragraph (a)(6) as follows:

- Additional requirements for health plans: "(a) * * * (6) During the period from March 17, 2009 through December 31, 2011, a health plan may not delay or reject a standard transaction, or attempt to adversely affect the other entity or the transaction, on the basis that it does not comply with another adopted standard for the same period."

1.8.3 The initial Transactions and Code Sets Rule requires the following of health plans regarding coordination of benefits.

- “If a health plan receives a standard transaction and coordinates benefits with another health plan (or another payer), it must store the coordination of benefits data it needs to forward the standard transaction to the other health plan (or other payer).”

1.8.4 The initial Transactions and Code Sets Rule requires the following of health plans regarding Code Sets.

1.8.5 A health plan must meet each of the following requirements:

- Accept and promptly process any standard transaction that contains codes that are valid, as provided in subpart J of this part. (Code Sets)
- Keep code sets for the current billing period and appeals periods still open to processing under the terms of the health plan’s coverage.

2.0 TRICARE OBJECTIVES

2.1 The TRICARE program shall be in full compliance with the Transaction and Code Sets Rule and the Modifications of HIPAA Electronic Standards Final Rule.

2.2 Purchased Care Systems shall be able to receive, process, and send compliant standard transactions where required.

3.0 CONTRACTOR RELATIONSHIPS TO THE TRICARE HEALTH PLAN

3.1 The Transaction and Code Sets Rule specifically names the health care program for active duty military personnel under Title 10 of the USC and the CHAMPUS as defined in 10 USC 1072(4), as health plans. For the purposes of implementing the Transaction and Code Sets Rule, the term “TRICARE” will be used in this chapter to mean a combination of both the Direct Care (DC) and Purchased Care Systems. TRICARE is therefore a health plan.

3.2 The relationships of the entities that comprise TRICARE determine, in part, where standard transactions must be used. Determinations as to when and where the transaction standards apply are not based on whether a transaction occurs within or outside of a “corporate entity” but rather are based on the answers to the two following questions. (1) Is the transaction initiated by a covered entity or its business associate? If the answer is “yes,” then the standard applies and question (2) must be answered. If “no,” then the standard does not apply and need not be used. (2) Is the transaction one for which the Secretary has adopted a standard? If “yes,” the standard must be used. If “no,” the standard need not be used. To decide if a transaction is one for which a standard has been adopted, the definition of the transaction, as provided in the rule, must be used. It is also critical to know who is a business associate of the TRICARE health plan and who is not in determining where standard transactions must be used within TRICARE. See [Appendix B](#) for the definition of “business associate.”

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3.3 The following table defines the TRICARE entities and their relationships to the TRICARE health plan.

ENTITY	COVERED ENTITIES			NON-COVERED ENTITY	BUSINESS ASSOCIATE OF THE TRICARE HEALTH PLAN?
	HEALTH PLAN?	PROVIDER?	CLEARING-HOUSE?	EMPLOYER?	
Department of Defense (DoD) (Army, Navy, Air Force, Marines, Coast Guard*) *In time of war	N	N	N	Y	N
TRICARE Health Plan (Represents both the Health Care Program for Active Duty Military Personnel under Title 10 of the USC and the CHAMPUS as defined in 10 USC 1072(4).)	Y	N	N	N	N
Military Treatment Facilities (MTFs) (Supporting Systems: Composite Health Care System (CHCS), Enterprise Wide Referral and Authorization System (EWRAS), Armed Forces Health Longitudinal Technology Application (AHLTA), Third Party Outpatient Collections System (TPOCS), and others)	N	Y	N	N	N
Defense Manpower Data Center (DMDC) (DEERS)	N	N	N	N	Y
Managed Care Support Contractors (MCSCs)	N	N	N	N	Y
TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC)	N	N	N	N	Y
Defense Finance and Accounting Service (DFAS)	N	N	N	Y	N
TRICARE Dental Program (TDP) Contractor	Y	N	N	N	Y (for foreign claims processing only)
Active Duty Dental Program (ADDP) Contractor	Y	N	N	N	N
TRICARE Retiree Dental Program (TRDP) Contractor	Y	N	N	N	N
Pharmacy Data Transaction System (PDTs) Contractor	N	N	N	N	Y
Designated Provider (DP) Contractors	Y	Y	N	N	N
Military Medical Support Office (MMSO)	N	N	N	N	Y
Continued Health Care Benefit Program (CHCBP) Contractor	N	N	N	N	Y
TRICARE Quality Monitoring Contractor (TQMC)	N	N	N	N	Y
Contractor for Data Analysis for the DP Contracts	N	N	N	N	Y
TRICARE Overseas Program (TOP) Contractor	N	N	N	N	Y
TRICARE Management Activity (TMA) (Supporting Systems: DEERS Catastrophic Cap and Deductible (CCDD), payment record databases (TRICARE Encounter Data (TED) records, TED Provider (TEPRV) records, and TED Pricing (TEPRC) records), management databases (Military Health System (MHS)) Data Repository and its associated data marts)	N	N	N	N	Y
TRICARE Pharmacy (TPharm) Contractor	N	Y	N	N	Y
TRICARE Regional Offices (TROs)	N	N	N	N	Y
TRICARE Area Offices (TAOs)	N	N	N	N	Y

4.0 TRANSACTION REQUIREMENTS FOR TRICARE CONTRACTORS

4.1 General

4.1.1 Transactions shall be implemented in accordance with the transaction implementation specifications and any addenda, named by the Secretary, HHS, as standards (see [paragraphs 1.3](#) and [1.4](#)).

4.1.2 Standard transactions received by contractors from trading partners that are correct at the interchange control structure level (envelope) and that are syntactically correct at the standard level and at the implementation guide level and are semantically correct at the implementation guide level must be accepted. Front-end business or application level edits for transaction content, such as an edit for a recognized provider number, shall not be the cause of rejecting an otherwise syntactically correct transaction. Front-end business or application level edits shall be applied after the transaction has been accepted. Claims failing front-end business or application edits, after passing syntax and semantic edits, shall be rejected, developed or denied in accordance with established procedures for such actions.

4.2 Transactions Exchanged Between Contractors And Providers (Network And Non-Network Providers, MTFs (CHCS and EWRAS))

4.2.1 Transactions exchanged between contractors and providers must be in standard format.

4.2.2 The contractors must be able to receive, process, and send the following transactions from and to providers:

4.2.2.1 Claims Transactions

[Receive 837 Transactions]

- The ASC X12N 837 - Health Care Claim: Professional, Version 5010.
- The ASC X12N 837 - Health Care Claim: Institutional, Version 5010.
- The ASC X12N 837 - Health Care Claim: Dental, Version 5010.
- **The NCPDP Telecommunication Standard, Version D.0 and equivalent NCPDP Batch Standard Version 1.2** including claims for retail pharmacy supplies and professional services.

4.2.2.2 Coordination Of Benefits Transactions

[Receive 837 Coordination of Benefits Transactions]

- The ASC X12N 837 - Health Care Claim: Professional, Version 5010.
- The ASC X12N 837 - Health Care Claim: Institutional, Version 5010.
- The ASC X12N 837 - Health Care Claim: Dental, Version 5010.

4.2.2.3 Eligibility Inquiry And Response Transactions

[Receive 270 Transactions and Send 271 Transactions]

- The ASC X12N 270/271 - Health Care Eligibility Benefit Inquiry and Response, Version 5010.

4.2.2.4 Referral Certification And Authorization Transactions

[Receive 278 Requests and Send 278 Responses]

- The ASC X12N 278 - Health Care Services Review - Request for Review and Response, Version 5010.

4.2.2.5 Claim Status Request And Response Transactions

[Receive 276 Transactions and Send 277 Transactions]

- The ASC X12N 276/277 - Health Care Claim Status Request and Response, Version 5010.

4.2.2.6 Payment And Remittance Advice (RA) Transactions

[Send 835 Transactions]

- The ASC X12N 835 - Health Care Claim Payment/Advice, Version 5010.

4.2.2.7 Electronic Funds Transfer (EFT) and Remittance Advice (RA)

The contractors shall be able to send the following transmissions by January 1, 2014:

[Stage 1 Payment Initiation, transmission of health care payment/processing information]

The National Automated Clearing House Association (NACHA) Corporate Credit or Deposit Entry with Addenda Record (CCD+) implementation specifications as contained in the 2011 NACHA Operating Rules & Guidelines, A Complete Guide to the Rules Governing the Automated Clearing House (ACH) Network as follows (incorporated by reference in § 162.920).

- 2011 NACHA Operating Rules & Guidelines, A Complete Guide to the Rules Governing the ACH Network, NACHA Operating Rules, Appendix One: ACH File Exchange Specifications.
- 2011 NACHA Operating Rules & Guidelines, A Complete Guide to the Rules Governing the ACH Network, NACHA Operating Rules Appendix Three: ACH Record Format Specifications, Part 3.1, Subpart 3.1.8 Sequence of Records for CCD Entries.

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 19, Section 2

Standards For Electronic Transactions

- For the CCD Addenda Record ("7"), field 3, the ASC X12 Standards for EDI Technical Report Type 3, "Health Care Claim Payment/Advice (835)," April 2006: Section 2.4: 835 Segment Detail: "TRN Reassociation Trace Number," Washington Publishing Company, 005010X221.

[Stage 1 Payment Initiation, transmission of health care RA]

- The ASC X12N 835 - Health Care Claim Payment/Advice, Version 5010.

4.3 Transactions Exchanged Between Contractors And Other Health Plans (And Employers, Where Applicable)

4.3.1 Transactions exchanged between contractors and other health plans (including TRICARE supplemental plans) must be in standard format.

4.3.2 The contractors must be able to receive, process, and send the following transactions from and to other health plans:

4.3.2.1 Coordination Of Benefits Transactions

[Send and Receive all 837 Transactions]

- The ASC X12N 837 - Health Care Claim: Professional, Version 5010.
- The ASC X12N 837 - Health Care Claim: Institutional, Version 5010.
- The ASC X12N 837 - Health Care Claim: Dental, Version 5010.

4.3.2.2 Eligibility Inquiry And Response Transactions

[Send and Receive 270 Transactions; Send and Receive 271 Transactions]

- The ASC X12N 270/271 - Health Care Eligibility Benefit Inquiry and Response, Version 5010.

4.3.2.3 Referral Certification And Authorization Transactions

[Send and Receive 278 Requests; Send and Receive 278 Responses]

- The ASC X12N 278 - Health Care Services Review - Request for Review and Response, Version 5010.

4.3.2.4 Payment And Remittance Advice (RA) Transactions

[Send 835 Transactions]

- The ASC X12N 835 - Health Care Claim Payment/Advice, Version 5010.

4.3.2.5 Claim Status Request And Response Transactions

[Receive 276 Transactions and Send 277 Transactions]

- The ASC X12N 276/277 - Health Care Claim Status Request and Response, Version 5010.

4.3.2.6 Health Plan Premium Payment Transactions

[Receive 820 Transactions]

- The ASC X12N820 - Payroll Deducted and Other Group Premium Payment for Insurance Products, Version 5010.

4.3.2.7 Request to More Primary Payer for Payment Already Made by Subordinate Payer (Medicaid)

[Receive Medicaid Pharmacy Subrogation Transactions]

- NCPDP Batch Standard Medicaid Subrogation, Version 3.0. The Modifications to HIPAA Electronic Standards Final Rule adopted a standard for the subrogation of pharmacy claims paid by Medicaid. This transaction is the Medicaid Pharmacy Subrogation Transaction. The standard for that transaction is the NCPDP Batch Standard Medicaid Subrogation Implementation guide, Version 3, Release 0 (Version 3.0) July 2007 (hereinafter referred to as Version 3.0). A Medicaid Pharmacy subrogation transaction is defined as the transmission of a claim from a Medicaid agency to a payer for the purpose of seeking reimbursement from the responsible health plan for a pharmacy claim the State has paid on behalf of a Medicaid recipient. This standard is applicable to Medicaid agencies in their role as health plans, but not to providers or health care clearinghouses because this transaction is not utilized by them. To the extent that Pharmacy Benefit Managers and claims processors are required by contract or otherwise to process claims on behalf of TRICARE, they will need to be able to receive the Medicaid Pharmacy Subrogation Transaction in the standard format.

4.4 Transactions Exchanged Between Contractors And DMDC (DEERS)

4.4.1 Eligibility Inquiries And Response Transactions

Based on the “two-question rule” for determining when a transaction must be in standard format (see [paragraph 3.2](#)), and the definition of the Eligibility for a Health Plan Transaction in the Rule, eligibility inquiry and response transactions occurring between business associates of the same health plan need not be in standard format. Only when the inquiries and responses are between providers and health plans or between health plans and health plans must these transactions be in standard format. Because the contractors and DMDC (DEERS) are business associates of the same health plan, eligibility inquiry and response transactions between them may be performed in non-standard format.

4.4.1.1 Real-time eligibility inquiries and responses, associated with enrollment processing, between the contractors and DMDC (DEERS) shall be performed using the DEERS Online Enrollment System (DOES).

4.4.1.2 Real-time and batch eligibility inquiries and responses between the contractors and DMDC (DEERS) for claims processing and other administrative purposes will be in DEERS specified format.

4.4.2 Enrollment And Disenrollment Transactions

TRICARE Prime enrollment and disenrollment transactions between the contractors and DMDC (DEERS) may be performed using the DEERS Online Enrollment System (DOES). The Government will provide a HIPAA standard data and condition compliant version of DOES for contractor use. Note: Transactions generated by DMDC (DEERS) that validate that enrollments have been established and that are used by contractors to update their system files, are not considered covered transactions and may be sent in proprietary format.

4.5 Transactions Exchanged Between Contractors And Providers (Network And Non-Network Providers, MTFs (CHCS and EWRAS)) Through Direct Data Entry Systems

4.5.1 Direct Data Entry Systems

4.5.1.1 All transactions covered under the Transaction and Code Sets Rule occurring between contractors and network/non-network providers and MTFs must be in standard format, unless subject to the exception in [paragraph 1.7.2](#). Contractors may offer a direct data entry system for use by providers, however, a direct data entry system does not replace the requirement to support the standard transactions. Direct data entry systems must be compliant with standard transaction data content and conditions.

4.5.1.2 A direct data entry system may not add to or delete from the standard data elements and code values. Direct data entry systems may take the form of web applications. Non-standard data elements and code values may be included in the direct data entry system if the non-standard data is obtained or sent through a separate mechanism such as a web page that is separate from the web page containing the standard data content, and the resolution of the standard transaction does not depend on the additional information.

4.5.2 Web Server Technology

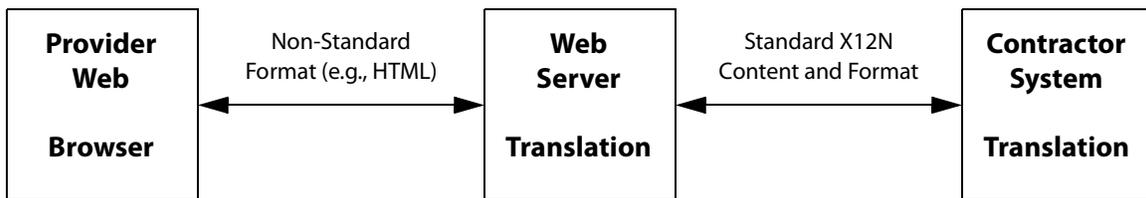
Note: This section discusses web server technology and, as a courtesy, provides guidance as to HIPAA requirements for the use of web applications. It is not an instruction from TMA to develop, operate, modify, or maintain contractor web applications. This section provides the HIPAA rules for operating web applications within the context of the Transaction and Code Sets Rule and provides TMA compliance expectations for any applicable web application that has been deployed by a contractor. Development, operation, modification and maintenance costs of contractor web applications are at contractor expense.

4.5.2.1 Web server technology may be used. The browser provides a template for use in uploading and downloading data. The browser data structure will be non-standard HyperText Markup Language (HTML). Data content in the HTML transmission must meet the X12N standard or

conversion to the standard is required. The provider's web server application can perform the translation and transmit a compliant transaction. The contractor will need to translate (convert) the compliant transaction to the contractor's system format (if it is a non-standard format). Translation of data content depends on whether the contractor accepts and uses standard data, or accepts and translates to non-standard data.¹

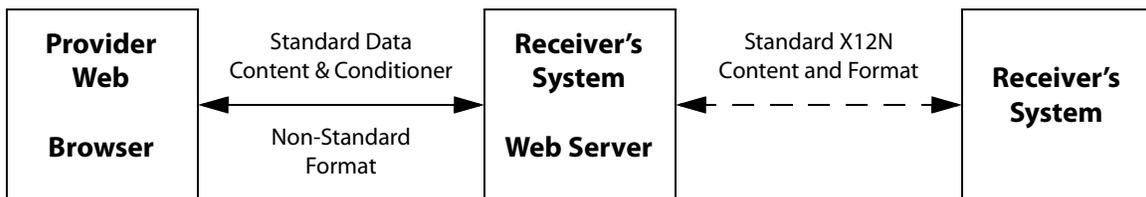
4.5.2.2 Browser-To-Web Server Data Exchange (not part of the receiver's system):

When data is being entered onto a server that is not part of the receiver's system and is being repackaged for transmission to the receiver's system, the transaction between the server and the receiver's system must be in Standard X12 format.



4.5.2.3 Browser-To-Web Server Data Exchange (part of the receiver's system)

If a server is using a browser to directly enter data onto a server that is part of the receiver's system, such a transaction is considered a direct data entry transaction that need only meet the standard data content and condition requirements.



4.6 Transactions Involving Foreign Entities

4.6.1 Electronic transactions from overseas MTFs and from U.S. territories will be sent directly to the contractor in standard format or routed through a U.S. based clearinghouse for translation into standard format prior to being sent to the contractor.

4.6.2 Electronic transactions submitted by foreign entities, such as claims transactions from foreign providers, may be accepted directly by the contractor or they may be routed through a clearinghouse to the contractor for processing. Transactions submitted by foreign entities, except for those originating from U.S. territories or overseas MTFs, are not covered transactions and may be accepted by the contractor in non-standard format.

¹ This information was drawn from the Health Care Financing Administration (HCFA) paper, **The Role of Translators: Do We Need Them? What Can They Do for Us? What Are the Installation Alternatives? How Do We Choose the Right Ones?** Note: The HCFA is now doing business as the Centers for Medicare and Medicaid Services (CMS).

4.6.2.1 Except for transactions originating from U.S. territories or overseas MTFs (which must be in standard format), the contractor may define the format or formats they will accept from foreign entities, either directly or through a clearinghouse.

4.6.2.2 Where the TRICARE Global Remote Overseas (TGRO) health care contractor pays foreign claims and subsequently bills the contractor for reimbursement, claim data submitted to the contractor in support of the invoice shall be sent in standard format.

4.7 Transactions Exchanged Between Contractors And TMA

Payment Record Submissions, TED records, TEPRV records, and TEPRC records -

Payment records are considered reports and are not covered transactions. Payment records shall be submitted in accordance with contract requirements.

4.8 Clearinghouse Use By Contractors

4.8.1 Contractors may use contracted clearinghouses for the purposes of receiving, translating, and routing electronic transactions on their behalf. Contractor-contracted clearinghouses may receive standard transactions, convert them into the contractors' system formats and route them to the contractors' systems for processing. Contractors may send non-standard formatted transactions to their contracted clearinghouses for the purposes of translating them into standard format and routing them to the intended recipients.

4.8.2 Transactions between health care clearinghouses must be conducted in standard format.

4.8.3 Where a contractor has contracted with the same clearinghouse as the entity that is submitting or receiving the transaction, the clearinghouse is required to convert the nonstandard transaction into the standard prior to converting it again to the intended recipient's format and sending it.

5.0 TRADING PARTNER AGREEMENTS

5.1 Contractors shall have trading partner agreements with all entities with which electronic transactions are exchanged. Where a provider uses a billing service or clearinghouse to exchange transactions, the contractor shall have a trading partner agreement with both the provider and billing service/clearinghouse. Trading partner agreements with providers shall contain a "provider signature on file" provision that will allow the contractor to process the electronic transaction if the provider signature on file requirement is not being met through another vehicle (e.g., provider certification). Contractors are required to develop and execute trading partner agreements that comply with all DoD and TMA privacy and security requirements (see [paragraphs 3.0](#) and [4.0](#) for additional information regarding privacy and security). See [Appendix B](#) for the definition of "trading partner agreement." All trading partner agreements, including all existing and active trading partner agreements previously executed, shall be updated, and kept updated, to reflect current requirements.

5.2 Implementation Guide Requirements

5.2.1 Contractor trading partner agreements shall include, as recommended in the ANSI ASC X12N transaction implementation guides, any information regarding the processing, or

adjudication of the transactions that will be helpful to the trading partners and that will simplify implementation.

5.2.2 Trading partner agreements shall **NOT**:

- Modify the definition, condition, or use of a data element or segment in a standard Implementation Guide.
- Add any additional data elements or segments to a standard Implementation Guide.
- Utilize any code or data values, which are not valid to a standard Implementation Guide.
- Change the meaning or intent of a standard Implementation Guide.

6.0 ADDITIONAL NON-HIPAA TRANSACTIONS REQUIRED

Contractors shall implement the following non-HIPAA mandated transactions as appropriate.

6.1 Acknowledgments

The following are required for a transaction to be HIPAA-compliant:

- The interchange or “envelope” must be correct;
- The transaction must be syntactically correct at the standard level;
- The transaction must be syntactically correct at the implementation guide level; and
- The transaction must be semantically correct at the implementation guide level.

Syntax relates to the structure of the data. Semantics relates to the meaning of the data. Any transaction that meets these four requirements is HIPAA-compliant and must be accepted.

Note: In the case of a claim transaction, “accepted” does not mean that it must be paid. A transaction that is accepted may then be subjected to business or application level edits. “Accepted” transactions, i.e., those that are HIPAA-compliant, that subsequently fail business or application level edits shall be rejected, developed, or denied in accordance with established procedures for such actions.

6.1.1 Interchange Acknowledgment

The Interchange or TA1 Acknowledgment is a means of replying to an interchange or transmission that has been sent. The TA1 verifies the envelopes only. Contractors shall develop and implement the capability to generate and send the following transaction. Reference the ASC X12C/005010X231 Implementation Acknowledgement for Health Care Insurance (999) TR3, Appendix C.1, to address implementation use of this transaction.

- The ANSI ASC X12N TA1 - Interchange Acknowledgment Segment.

6.1.2 Implementation Acknowledgment

The implementation acknowledgment transaction is used to report the results of the syntactical analysis of the functional groups of transaction sets. It is generally the first response to a transaction. (Exception: The TA1 will be the first response if there are errors at the interchange or "envelope" level.) Implementation acknowledgment transactions report the extent to which the syntax complies with the standards for transaction sets and functional groups. They report on syntax errors that prevented the transaction from being accepted. Version 5010 of the implementation acknowledgment transaction does not cover the semantic meaning of the information encoded in the transaction sets. The implementation acknowledgment transaction may be used to convey both positive and negative acknowledgments. Positive acknowledgments indicate that the transaction was received and is compliant with standard syntax. Negative acknowledgments indicate that the transaction did not comply with standard syntax. Contractors shall develop and implement the capability to generate, send, and receive the following transaction (both positive and negative).

- The ASC X12N 999 - Implementation Acknowledgment, Version 5010.

6.1.3 Implementation Guide Syntax And Semantic And Business Edit Acknowledgments

Contractors may use a proprietary acknowledgment to convey implementation guide syntax errors, implementation guide semantic errors, and business edit errors. Alternatively, for claim transactions (ANSI ASC X12N 837 Professional, Institutional, or Dental), the Health Care Claim Acknowledgment Transaction Set (ANSI ASC X12N 277CA) may be used to indicate which claims in an 837 batch were accepted into the adjudication system (i.e., which claims passed the front-end edits) and which claims were rejected before entering the adjudication system.

Note: In the future, the standards may mandate transactions for acknowledgments to convey standard syntax, implementation guide syntax, implementation guide semantic, and business/application level edit errors. Contractors shall develop and implement the capability to generate and send the following transaction(s).

6.1.3.1 A proprietary acknowledgment containing syntax and semantic errors at the implementation guide level, as well as business/application level edit errors.

6.1.3.2 For 837 claim transactions, contractors may use the Health Care Claim Acknowledgment Transaction Set (ANSI ASC X12N 277CA, Version 5010) in place of a proprietary acknowledgment.

6.2 Medicaid Non-Pharmacy Subrogation Claims

6.2.1 When a beneficiary is eligible for both TRICARE and Medicaid, [32 CFR 199.8](#) establishes TRICARE as the primary payer. Existing TRICARE policy requires contractors to arrange coordination of benefits procedures with the various states to facilitate the flow of claims and to try to achieve a reduction in the amount of effort required to reimburse the states for the funds they erroneously disbursed on behalf of the TRICARE-eligible beneficiary. TRICARE Policy requires that the contractors make disbursements directly to the billing state agency.

6.2.2 Currently, a subrogation non-pharmacy claim from a Medicaid State Agency is not a HIPAA covered transaction since the Transaction and Code Sets Rule defines a health care claim or

equivalent encounter information transaction as occurring between a provider and a health plan. Since Medicaid State Agencies are not providers, their claims to TRICARE are not covered transactions and need not be in standard format; however, Version 5010 ASC X12 claim standards used for processing institutional, professional and dental claims include the ability to perform Medicaid subrogation. While they are not currently mandated for use under HIPAA, covered entities are not prohibited from using Version 5010 transactions for non-pharmacy Medicaid subrogation transactions between willing trading partners.

- In accordance with existing TRICARE policy, contractors shall coordinate with the Medicaid State Agencies submitting non-pharmacy claims and define the acceptable forms and formats of the claims that are to be used by the Medicaid State Agencies when billing TRICARE. State Agency Billing Agreements shall be modified to reflect the acceptable forms and formats.

Note: It is expected that the Secretary, HHS will modify the standard to incorporate Medicaid subrogation claims as HIPAA covered transactions sometime in the future. If this occurs, this section will be modified to reflect the change.]

7.0 ONGOING TRANSACTION TESTING

In the absence of the inclusion of testing requirements in updated HIPAA legislation, contractors shall comply with testing requirements in accordance with the Contracting Officer (CO) direction. At a minimum, testing shall include the following:

7.1 Contractors shall test their capability to create, send, and receive compliant transactions. Contractors shall provide written evidence (e.g., certification from a transaction testing service) of successful testing of their capabilities to create, send, and receive compliant transactions to the contracting offices no later than 60 days prior to the start of services.

- Where failures occur during testing, the contractor shall make necessary corrections and re-test until a successful outcome is achieved.

7.2 Contractors shall test their capability to process standard transactions. This testing shall be "cradle-to-grave" testing from receipt of the transactions, through processing, and completion of all associated functions including creating and transmitting associated response transactions. Testing involving the receipt and processing of claims transactions shall also include the submission to and acceptance by the TMA of TED records and the creation of contract compliant paper Explanation Of Benefits (EOB). It is expected that the contractors shall complete "cradle-to-grave" testing no later than 30 days prior to the start of services.

8.0 MISCELLANEOUS REQUIREMENTS

8.1 Paper Transactions

8.1.1 Contractors shall continue to accept and process paper-based transactions.

8.1.2 Contractors may pay claims via electronic funds transfer or by paper check. The ASC X12N 835 Health Care Claim Payment/Advice transaction contains two parts, a mechanism for the transfer of dollars and one for the transfer of information about the claim payment. These two parts

may be sent separately. The 835 Implementation Guide allows payment to be sent in a number of different ways, including by check and electronic funds transfer. Contractors must be able to send the RA portion electronically but may continue to send payment via check.

8.1.3 Current applicable requirements for the processing of paper-based and electronic media transactions, such as claims splitting, forwarding out-of-jurisdiction claims, generating and sending EOBs to beneficiaries and providers, etc., apply to the processing of electronic transactions.

8.2 Attendance At Designated Standards Maintenance Organization (DSMO) Meetings

8.2.1 Contractors shall regularly send representatives to the following separate DSMO meetings: the ANSI X12 Trimester Meetings, and the Health Level Seven (HL7) Trimester Meetings. Each MCSC shall send one representative to each DSMO Trimester meeting. A contractor may elect to send representatives from their claims processing subcontractor(s) in place of a contractor representative. Every effort should be made to have the same representatives attend each meeting for continuity purposes. The team lead will be the TMA representative in attendance.

8.2.2 Representatives shall be knowledgeable of TRICARE program requirements, and of their own administrative and claims processing systems. Prior to attending a DSMO meeting, the representatives shall identify from within their own organizations any issues that need to be addressed at the DSMO meeting. The representatives shall inform the TMA representative (team lead) of the issues at least one week prior to the meetings.

8.2.3 Contractor representatives shall attend the DSMO meetings as exclusive advocates for TRICARE business needs and should not divide their participation and attention with any commercial business needs and concerns. Contractor representatives shall attend and participate in workgroup and full committee meetings. They shall work within the DSMOs to incorporate into the standards and implementation guides any data elements, code values, etc., that may be required to conduct current and future TRICARE business. The representatives shall also work to prevent removal of any existing data elements, code values, etc., from the standards and implementation guides that are necessary to conduct current and future TRICARE business.

8.2.4 When attending the DSMO meetings, contractor representatives shall work as a team and collaborate with other government and DoD/TRICARE representatives. Contractor representatives shall register under the DoD/Health Affairs (HA) DSMO memberships. Contractor representatives are responsible for taking proposed changes through the processes necessary for adoption within the DSMOs. They are responsible for tracking and reporting on the status of each proposed change as it progresses through the process.

8.2.5 Contractor representatives shall keep TMA apprised of any additions to the standards that must be made to accommodate TRICARE business needs and of any proposed changes to existing standards and implementation guides. Following a DSMO meeting, each representative attendee shall prepare a summary report that includes, at a minimum; the workgroup and full committee meetings attended, a brief description of the content of the meetings, the status of any changes in progress, and any problems or information of which the Government/TMA should be aware. Each representative shall submit their reports to the TMA team lead within 10 work days following the DSMO meetings.

8.3 Provider Marketing

8.3.1 Contractors shall encourage providers to utilize electronic transactions only through marketing and provider education vehicles permitted within existing contract limitations and requirements. No additional or special marketing or provider education campaigns are required. Marketing efforts shall educate providers as to the cost and efficiency benefits that can be realized through adoption and utilization of electronic transactions.

8.3.2 Contractors shall assist and work with providers, who wish to exchange electronic transactions, to establish trading partner agreements and connectivity with their systems and to implement the transactions in a timely manner. Contractors are not required by the government to perfect transactions on behalf of trading partners.

8.4 Data Retention And Audit Requirements

8.4.1 All HIPAA-covered electronic transaction data, including eligibility and claims status transaction data, shall be stored until the end of the calendar year in which it was received plus an additional six years. Where a contractor is directed by TMA to freeze records, electronic transaction data shall be included and shall be retained until otherwise directed by TMA.

8.4.2 Contractors shall generate transaction histories covering a period of up to seven years upon request by TMA in a text format (delimited text format for table reports) that is able to be imported, read, edited, and printed by Microsoft® Word (Microsoft® Excel for table reports). Contractors shall have the ability to generate transaction histories on paper. Transaction histories shall include at a minimum, the transaction name or type, the dates the transaction was sent or received and the identity of the sender and receiver. Transaction histories must be able to be read and understood by a person.

8.4.3 Transaction data is subject to audit by TMA, DoD, HHS, and other authorized government personnel. Contractors shall have the ability to retrieve and produce all electronic transaction data upon request from TMA (for up to seven years, or longer if the data is being retained pursuant to a records freeze), to include reasons for transaction rejections.

- END -

and producing the required output for paper and electronic transactions [Explanations of Benefits (EOBs), summary vouchers, payment records, checks, and management reports]. Clerical functions will be evaluated including correctly coding diagnoses, medical and surgical procedures and accurately resolving edit exceptions. The benchmark test may include testing of any and all systems (internal and external) used by the contractor to process claims. In addition to testing claims processing records, the benchmark will test generation and acceptance of TRICARE Encounter Data (TED) records for every test claim. Contractor compliance with applicable **Health Insurance Portability and Accountability Act (HIPAA)** of 1996 requirements and all applicable security requirements will be included in benchmark tests as appropriate.

3.1.5 The contractor shall be required to create test claims, including referrals and authorizations from test scenarios provided to the incoming contractor by TMA. The contractor shall supplement these test scenarios with any internal conditions they feel appropriate for testing to ensure a minimum of 1,000 claims are tested. Under certain circumstances, however, this number may be reduced at the discretion of the PCO.

3.1.6 A benchmark test of a current contractor's system may be administered at any time by TMA upon instructions by the PCO. All contractor costs incurred to comply with the performance of the Benchmark test are the responsibility of the contractor.

3.2 Conducting The Benchmark

3.2.1 At the time of the scheduled benchmark test a TMA Benchmark Team comprised of up to 12 people will arrive at the contractor's work site to monitor the testing and assist the contractor in the evaluation of the benchmark test results.

3.2.2 The amount of time a contractor shall have to process the benchmark test claims and provide all of the output (excluding TED) to the benchmark team for evaluation will vary depending on the scope of the benchmark and volume of claims being tested. As a guide, the following table is provided for contractor planning purposes.

NUMBER OF BENCHMARK CLAIMS/SCENARIOS	NUMBER OF DAYS TO COMPLETE PROCESSING
UP TO 100	1-2
UP TO 500	2-4
UP TO 1000	4-7

3.2.3 The contractor will be informed at the pre-benchmark meeting (see [paragraph 3.3.1](#)) of the exact number of days to be allotted for processing the benchmark claims and test scenarios and providing all of the output (excluding TED) to the Benchmark Team for evaluation.

3.2.4 The benchmark team will provide answers to all contractors written and telephonic development questions related to the test scenarios provided by TMA and will evaluate the contractor's output against the benchmark test conditions.

3.2.5 The benchmark team will require a conference room that can be locked with table(s) large enough to accommodate up to 12 people. The conference room must also be equipped with two telephones with access to internal and outside telephone lines.

3.2.6 The contractor shall provide up-to-date copies of the TRICARE Operations Manual (TOM), TRICARE Systems Manual (TSM), TRICARE Policy Manual (TPM), and TRICARE Reimbursement Manual (TRM), a complete set of current International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnostic coding manuals for dates of service **on or before September 30, 2014**, or a complete set of the current International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) diagnostic coding manual and International Classification of Diseases, 10th Revision, Procedure Classification System (ICD-10-PCS) procedure coding manual for dates of service on or after **October 1, 2014**, the currently approved Healthcare Common Procedure Coding System (HCPCS) and Current Procedural Terminology, 4th Edition (CPT-4) procedural coding manual, in either hard copy or electronic versions. The contractor shall also provide Transaction Guides for all HIPAA transactions used by the contractor for claims adjudication, as well as any applicable supporting references to the Transaction Guides (e.g., HIPAA Health Care Provider Taxonomy, Claims Adjustment Reason Codes, etc.) explanations of the contractor's EOB message codes, edits, and denial reason codes, and any overlays required to evaluate EOBs, checks, or summary vouchers.

3.2.7 The contractor shall provide an appropriate printer and a minimum of three computer terminals in the conference room with on-line access to all internal and external systems used to process the benchmark test claims to include, but not limited to: TRICARE Encounter Provider (TEPRVs) files, contractor pricing files; DEERS; CCDD files; and any other files used in processing claims. The contractor's requirements for issuing system passwords for members of the Benchmark Team will be discussed at the pre-benchmark meeting.

3.2.8 The contractor shall provide an organizational chart and personnel directory including telephone numbers. A listing of the contractor's staff involved in performing the benchmark by function (e.g., data entry, development, medical review, etc.) is also required. Claims flow/decision diagrams will be provided to the COR prior to the benchmark test.

3.3 Procedures

3.3.1 Approximately 60 calendar days following award to the contractor, representatives from TMA will meet with the contractor's staff to provide an overview of the benchmark test process, receive an overview of the claims processing system, collect data for use in the benchmark, and discuss the dates of the test and information regarding the administration of the benchmark test. At this time, TMA shall provide the test scenarios to the contractor that are to be used in the development of their test claims.

Note: At TMA's discretion, the test must be completed NLT 120 calendar days prior to the start of services delivery to allow time to make any needed corrections. The pre-benchmark meeting will be conducted at the contractor's claims processing site. Data requirements will be coordinated at the pre-benchmark meeting to ensure that the contractor adequately prepares all files prior to the benchmark. Electronic transaction requirements shall be discussed to include timing and logistics.

3.3.2 On the first day of the benchmark test, a brief entrance conference will be held with contractor personnel to discuss the schedule of events, expectations and administrative instructions.

3.3.3 During the Benchmark Test the contractor shall process the claims and provide TMA with all input documentation, including hardcopy printouts of electronic crossover files and all output,

including EOBs, summary vouchers, suspense reports, checks, claims histories, etc. Paper checks and EOBs may be printed on plain paper, with EOB and check overlays. Electronic output is required for electronic transactions.

3.3.4 The contractor shall provide output for evaluation by TMA and contractor personnel as the claims are processed to completion. The specific schedule for claims processing and the procedures for providing the output to the benchmark team will be discussed with the contractor at the pre-benchmark meeting.

3.3.5 TMA and contractor personnel will jointly compare the benchmark test claim output against the benchmark test conditions for each claim processed during the test and provide the findings to contractor personnel. All appropriate contractor and benchmark team personnel shall be present to answer any questions raised.

3.3.6 At the conclusion of the benchmark test, an exit conference may be held with the contractor staff to brief the contractor on all findings identified during the benchmark. The contractor shall correct all findings identified in the benchmark NLT 45 days from the date of the initial report. A draft report of the initial test results will be left with the contractor for review. The initial Benchmark Test Report will be forwarded to the contractor by TMA within 45 calendar days of the last day of the test. For any claims processing errors assessed with which the contractor disagrees; a written description of the disagreement along with any specific references must be included with the claims.

3.3.7 The contractor shall prepare and submit the initial TED submission to the TMA for evaluation. The TED for each benchmark claim shall be prepared and submitted within two calendar days from the processed date. The contractor shall be notified of any TED failing the TMA edits. The contractor shall make the necessary corrections and resubmit the TED until 100% of the original benchmark test TED have passed the edits and are accepted by TMA.

3.3.8 The contractor has 45 calendar days from the date of the initial benchmark test report to submit the final corrected TED to TMA. New TED need not be generated to reflect changes created from claims processing corrections, however, all TED originally submitted for the benchmark test claims which did not pass the TMA edits must continue to be corrected and resubmitted until all edit errors have been resolved and 100% of the TED have been accepted by TMA.

3.4 Operational Aspects

3.4.1 The benchmark test may be conducted on the contractor's production system or an identical copy of the production system (test system). Whichever system is used for the benchmark, it must meet all TRICARE requirements and contain all the system interconnections and features proposed for the production system in the contractor's proposal. When the benchmark test is conducted on the contractor's production system, the contractor shall prevent checks and EOBs from being mailed to the beneficiaries and providers, and prevent production TED from being generated and sent to TMA.

3.4.2 Certain external test systems and files (e.g., DEERS) are an integral component of the benchmark test and the contractor is expected to perform all necessary verifications, queries, etc., according to TRICARE procedures and policy. The contractor shall coordinate through the TMA, Contract Operations Division, and the TMA ADP contractor to ensure that direct interface with any

required external test systems (i.e., DEERS) is established and operational prior to the benchmark test.

4.0 CONTRACT TRANSITION-OUT

4.1 Transitions Specifications Meeting

The outgoing contractor shall attend a meeting with representatives of the incoming contractor and TMA at the TMA office in Aurora, Colorado, within 15 calendar days following contract award. This meeting is for the purpose of developing a schedule of phase-out/phase-in activities. TMA will notify the contractor as to the exact date of the meeting. Contractor representatives attending this meeting shall have the experience, expertise, and authority to provide approvals and establish project commitments on behalf of their organization.

4.2 Data

The outgoing contractor shall provide to TMA (or, at the option of TMA, to a successor contractor) such information as TMA shall require to facilitate transitions from the contractor's operations to operations under any successor contract. Such information may include, but is not limited to, the following:

- The data contained in the contractor's claims processing systems.
- Information about the management of the contract that is not considered, under applicable Federal law, to be proprietary to the contractor.

4.3 Phase-Out Of The Contractor's Claims Processing Operations

Upon notice of award to another contractor, and during the procurement process leading to a contract award, the contractor shall undertake the following phase-out activities regarding services as an outgoing contractor.

4.3.1 Provide Information

The contractor shall, upon receipt of written request from TMA, provide to potential offerors such items and data as required by TMA. This shall include non-proprietary information, such as record formats and specifications, field descriptions and data elements, claims and correspondence volumes, etc.

4.3.2 Transfer Of Electronic File Specifications

- The outgoing contractor shall transfer to the incoming contractor by express mail or similar overnight delivery service, NLT three calendar days following award announcement, electronic copies of the record layouts with specifications, formats, and definitions of fields, and data elements, access keys and sort orders, for the following:
- The TEPRV Files

- The Beneficiary History and Deductible Files (including eligibility files, if applicable)
- Mental Health Provider Files - The outgoing contractor must assure that the incoming contractor has been given accurate provider payment information on all mental health providers paid under the TRICARE inpatient mental health per diem payment system. This should include provider name; Tax Identification Number (TIN); address including zip code; high or low volume status; if high volume, provide the date the provider became high volume; and the current per diem rate along with the two prior year's per diem amounts. The providers under the per diem payment system must be designated by Medicare, or meet exemption criteria, as exempt from the inpatient mental health unit, the unit would be identified as the provider under the TRICARE inpatient mental health per diem payment system.

4.3.3 Transfer Of ADP Files (Electronic)

The outgoing contractor shall prepare in electronic format and transfer to the incoming contractor or TMA, by the 15th calendar day following the Transition Specifications meeting unless, otherwise negotiated by the incoming and outgoing contractors, all specified ADP files (e.g., provider and any pricing files, check copies, release of information documents, TPL files, etc.), in accordance with specifications in the official transition schedule and will continue to participate in preparation and testing of these files until they are fully readable by the incoming contractor or TMA.

4.3.4 Outgoing Contractor Weekly Shipment Of History Updates

The outgoing contractor shall transfer to the incoming contractor, in electronic format, all beneficiary history and deductible transactions (occurring from the date of preparation for shipment of the initial transfer of such history files and every week thereafter) beginning the 120th calendar day prior to the start of services delivery (until such a time that all processing is completed by the outgoing contractor) in accordance with the specifications in the official transition schedule. See dual operations in [paragraph 2.3.2](#).

4.3.5 Transfer Of Non-ADP Files

The outgoing contractor shall transfer to the incoming contractor all non-ADP files (e.g., Congressional and TMA completed correspondence files, appeals files, TRICARE medical utilization, and administration files) in accordance with the specifications in the official transition schedule and [Chapter 2](#). The hard copies files are to be transferred to the incoming contractor or Federal Records Center (FRC) as required by [Chapter 2](#). The contractor shall provide samples, formats and descriptions of these files to the incoming contractor at the Transition Specification Meeting.

4.3.6 EOB Record Data Retention And Transmittal

If the contractor elects to retain the EOB data on a computer record, it must, in the event of a transition to another contractor, provide either a full set of electronic records covering the current and two prior years, or, at the CO's discretion, provide the data and necessary programs to reproduce the EOB in acceptable form and transfer such data and programs to the successor contractor or to TMA. TMA shall be the final authority in determining the form and/or acceptability of the data and/or microcopies.

4.3.7 Outgoing Contractor Weekly Status Reporting

Until all inventories have been processed, the outgoing contractor shall submit a weekly status report of inventories and phase-out activities to TMA beginning the 20th calendar day following the Transitions Specifications Meeting until otherwise notified by the PCO to discontinue. This shall be done in accordance with specifications of the official transition schedule.

4.4 Final Processing Of Outgoing Contractor

The outgoing contractor shall:

- Process to completion all claims, to include adjustments, received during its period of services delivery. Processing of these claims shall be completed within 180 calendar days following the start of the incoming contractor's services delivery. All claims shall meet the same standards as outlined in the current contract.
- Be liable, after the termination of services under this contract, for any payments to subcontractors of the contractor arising from events that took place during the period of this contract.
- Process all correspondence, allowable charge complaints, and incoming telephonic inquiries which pertain to claims or services processed or delivered under this contract within the time frames established for response by the standards of the contract.
- Complete all appeal/grievance cases that pertain to claims or services processed or delivered under this contract within the time frames established for response by the standards of the contract.

4.4.1 Correction Of Edit Rejects

The outgoing contractor shall retain sufficient resources to ensure correction (and reprocessing through TMA) of all TED record edit errors NLT 210 calendar days following the start of the incoming contractor's services delivery.

4.4.2 Cost Accounting

If the outgoing contractor succeeds itself, costs related to each contract shall be kept separate for purposes of contract accountability.

4.4.3 Records Disposition

The outgoing contractor shall comply with the provisions of [Chapter 2](#), in final disposition of all files and documentation. The contractor shall include a records disposition plan as part of the phase-out plan submitted to TMA at the Transition Specifications Meeting.

- END -

5.6 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. **For the Philippines, claims requiring development of missing or discrepant information, or those being developed for medical documentation, shall be pended for 90 days and are excluded from the claims processing standard.**

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](#)). Providers may submit claims by fax if the TOP contractor provides a secure fax for claims receipt by the contractor.

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 Signatures

Beneficiary and host nation provider signatures.

6.6.2 Name and Address

6.6.2.1 Complete beneficiary and host nation provider name and address.

6.6.2.2 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, DEERS per [paragraph 6.11](#), or notify the TAO Director as appropriate.

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

6.6.3 Diagnosis(es)

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

6.6.3.2 Claims received for dates of service for outpatient services or dates of discharge for inpatient services **on or before September 30, 2014**, with **International Classification of Diseases, 10th Revision (ICD-10)** codes shall be converted to International Classification of Diseases, 9th Revision, Clinical Modifications (ICD-9-CM) codes by the TOP contractor. Claims received for dates of service for outpatient services or dates of discharge for inpatient services **on or after October 1, 2014**, with International Classification of Diseases, 9th Revision (ICD-9) or ICD-9-CM codes shall be converted to International Classification of Diseases, 10th Revision, Clinical Modifications (ICD-10-CM) codes by the TOP contractor. Refer to **Chapter 8, Section 6, paragraphs 4.0** and **5.0** regarding the use of ICD-9-CM **V** codes (factors influencing health status and contact with health services) and ICD-10-CM **Z** codes (factors influencing health status and contact with health services).

6.6.4 Procedures/Services/Supply/DME

Identification of the procedure/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.

6.6.5 Claims received with a narrative description of services provided shall be coded by the TOP contractor with as accurate-coding as possible based upon the level of detail provided in the narrative description or as directed by the TMA CO. The provisions of **paragraph 6.1** apply for narrative claims that cannot be accurately coded due to insufficient or vague information. Claims received for dates of service for outpatient services or dates of discharge for inpatient services **on or before September 30, 2014**, with ICD-10 codes shall be converted to ICD-9 codes by the TOP contractor. Claims received for dates of discharge for inpatient services **on or after October 1, 2014**, with ICD-9 codes shall be converted to ICD-10 codes by the TOP contractor. Refer to **Chapter 8, Section 6, paragraph 4.0** regarding the use of **V** and **Z** codes.

6.6.5.1 Inpatient Institutional Procedures

Inpatient institutional (i.e., hospital) claims received for claims received for dates of discharge for inpatient services **on or before September 30, 2014**, shall have the procedure narratives coded by the TOP contractor using ICD-9-CM, Volume 3 procedure codes. Inpatient institutional (i.e., hospital) claims received for dates of discharge for inpatient services **on or after October 1, 2014**, shall have the procedure narratives coded by the TOP contractor using ICD-10-Procedure Classification System (ICD-10-PCS) procedure codes.

6.6.5.2 Outpatient Institutional Procedures and Professional Services

Claims received for outpatient institutional (e.g., ambulance services, laboratory, Ambulatory Surgery Centers (ASCs), partial hospitalizations, outpatient hospital services) services and professional services shall be coded using Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT).

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- 6.6.6** Care authorizations (when required).
- 6.6.7** Itemization of total charges. (Itemization of hospital room rates are not required on institutional claims).
- 6.6.8** Proof of payment is required for all beneficiary submitted claims if the claim indicates that the beneficiary made payment to the provider or facility. The overseas claims processor shall use best business practices when determining if the documentation provided is acceptable for the country where the services were rendered.
- 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 shall use a schedule of allowable charges based on the Average Wholesale Price (AWP) 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** For the Philippines, prescription drugs may only be cost-shared when dispensed by a certified retail pharmacy or hospital-based pharmacy. The TOP contractor shall deny claims for prescription drugs dispensed by a physician's office. Certification requirements outlined in [Section 14](#) apply.
- Note:** This does not apply to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).
- 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.

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6.16 Requests for missing information shall be sent on the TOP contractor's TRICARE/TOP letterhead. When development is necessary in TRICARE Eurasia-Africa 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 Eurasia-Africa, 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 a referral from the ADSM's PCM or designee; and

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

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Note: The SF 1034, SF 1035 continuation sheet or NAVMED 6320/10 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 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 Eurasia-Africa, 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 Eurasia-Africa, 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 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 Education and Support Division (BE&SD). 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 11.0](#) 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 EOBs, 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.

9.1 The TOP contractor shall follow the duplicate payment prevention requirements outlined in [Chapter 8, Section 9](#).

9.2 The TOP contractor shall ensure that business processes are established which require appropriate system and/or supervisory controls to prevent erroneous manual overrides when reviewing potential duplicate payments.

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. National Health Insurance (NHI) plans do not always provide EOBs to assist in the adjudication of TRICARE claims. If a beneficiary has attempted unsuccessfully to obtain an EOB from their NHI plan, they may submit a beneficiary attestation and an itemized claim checklist (approved by TMA) with their claim. The TOP contractor shall waive the requirement for an EOB from the NHI plan when accompanied by the TMA-approved document.

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, or the manner in which services are rendered and considered the standard of care in a host nation country, such as rehabilitation services received in an inpatient setting.

12.2 Reimburse claims at the lesser of the billed amount, the negotiated reimbursement rate, or the government established fee schedules (TRM, [Chapter 1, Sections 34 and 35](#)), unless a different reimbursement rate has been established as described in TPM, [Chapter 12, Section 1.3](#).

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

12.4 Not reimburse for host nation care/services provided in the Philippines unless all of the certification requirements listed in [Section 14](#) have been met.

12.5 Not reimburse for administrative charges billed separately on claims, except for individual administrative charges as determined by the government. The contractor shall reimburse these

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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.

12.6 Determine exchange rates as follow:

12.6.1 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;

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

12.6.3 Use the exchange rate in [paragraph 12.6.1](#) to determine deductible and copayment amounts, if applicable, and to determine the amount to be paid in foreign currency.

12.6.4 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.

Note: Drafts for certain foreign currency units may require purchase from a bank location other than the one normally used by the TOP contractor (out of state or out of country). Currency units that must be purchased from an alternate bank (out of state or out of country) may take up to 10 business days for the draft to be returned and matched up with the EOB.

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

12.8 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.

12.9 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.

12.10 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 TOP contractor may reissue the payment in U.S. dollars if a request is subsequently received from the beneficiary and the foreign draft is included in the request or the payment has staledated.

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 24, Section 9

Claims Processing Procedures

12.11 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.

12.12 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 Eurasia-Africa address for this purpose.

12.13 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.

12.14 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.

12.15 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.

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

12.17 Not honor any draft request for currency change, except as outlined in [paragraph 12.10](#) or when directed by the appropriate TMA COR, once a foreign currency draft has been issued by the TOP contractor.

12.18 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.

12.19 Benefit payment checks and EOBs 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 checks or EOBs for Philippine providers, and other nations' providers as directed by the TMA CO may be sent to any other address.

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

12.20.1 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](#)).

12.20.2 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](#)).

12.20.3 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.

12.21 EFT payments. 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. Upon beneficiary request, EFT payments to a U.S. bank may be provided. Bank charges associated with beneficiary EFT payments shall be the responsibility of the beneficiary.

12.22 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.

12.23 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.

12.24 The TOP contractor is authorized to pay Value Added Tax (VAT) included on German health care claims for all beneficiary categories.

12.25 Fees for transplant donor searches in Germany may be reimbursed on a global flat fee basis since the German government does not permit health care facilities to itemize such charges.

12.26 Itemized fees for supplies that are related or incidental to inpatient treatment (e.g., hospital gowns) may be reimbursed if similar supplies would be covered under reimbursement methodologies used within the U.S. The TOP contractor shall implement internal management controls to ensure that payments are reasonable and customary for the location.

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 Eurasia-Africa 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.

- END -

Health Information (HIPAA/Privacy Definition)

Any information, whether oral or recorded in any form or medium, that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

Health Insurance Issuer (HIPAA/Privacy Definition)

An insurance company, insurance service, or insurance organization (including an HMO) that is licensed to engage in the business of insurance in a State and is subject to State Law that regulates insurance. Such term does not include a group health plan.

Health Maintenance Organization (HMO) (HIPAA/Privacy Definition)

A federally qualified HMO, an organization recognized as an HMO under State law, or a similar organization regulated for solvency under State law in the same manner and to the same extent as such an HMO.

Health Oversight Agency (HIPAA/Privacy Definition)

An agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is authorized by law to oversee the health care system (whether public or private) or government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which health information is relevant. The term "health oversight agency" includes any DoD Component authorized under applicable DoD Regulation to oversee the MHS, including with respect to matters of quality of care, risk management, program integrity, financial management, standards of conduct, or the effectiveness of the Military Health System (MHS) in carrying out its mission.

Health Plan (HIPAA/Privacy Definition)

Any DoD program that provides or pays the cost of health care. For full details, see the DoD Health Information Privacy Regulation.

HHS Regulation (HIPAA/Privacy Definition)

45 CFR Parts 160-164.

Homebound (Respite Care Definition)

A beneficiary's condition is such that there exists a normal inability to leave home and, consequently, leaving home would require considerable and taxing effort. Any absence of an individual from the home attributable to the need to receive health care treatment—including regular absences for the purpose of participating in rehabilitative, therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a state, or accredited to furnish adult day-care services in the state shall not disqualify an individual from being considered to be confined to home. Any other absence of an individual from the home shall not disqualify an individual if the absence is infrequent or of relatively short duration. Any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. Also, absences from the home for non-medical purposes, such as an occasional trip to the barber, a walk around the block or a drive, would not necessarily negate the beneficiary's homebound status if the absences are undertaken on an infrequent basis and are of relatively short duration. Absences, whether regular or infrequent, from the beneficiary's primary home for the purpose of attending an educational program in a public or private school that is licensed and/or certified by a state, shall not negate the beneficiary's homebound status.

Hospital Day

An overnight stay at a hospital. Normally if the patient is discharged in less than 24 hours it would not be considered an inpatient stay; however, if the patient was admitted and assigned to a bed and the intent of the hospital was to keep the patient overnight, regardless of the actual Length-Of-Stay (LOS), the stay will be considered an inpatient stay and, therefore, a hospital day. For hospital stays exceeding 24 hours, the day of admission is considered a hospital day; the day of discharge is not.

ICD-9-CM

A technical reference, **International Classification of Diseases, 9th Edition, Clinical Modification**. Volumes 1 and 2 are a required reference and coding system for diagnoses and Volume 3 is required as a coding system for procedures in processing TRICARE claims for medical care with dates of service for outpatient services or dates of discharge for inpatient services **on or before September 30, 2014**.

ICD-10-CM

A technical reference, **International Classification of Diseases, 10th Edition, Clinical Modification**. It is a required reference and coding system for diagnoses in processing TRICARE claims for medical care with dates of service for outpatient services or dates of discharge for inpatient services **on or after October 1, 2014**.

ICD-10-PCS

A technical reference, **International Classification of Diseases, 10th Edition, Procedure Coding System**. It is a required reference and coding system for procedures in processing TRICARE claims for medical care with dates of discharge for inpatient services **on or after October 1, 2014**.

Treatment (HIPAA/Privacy Definition)

The provision, coordination, or management of health care and related services by one or more HCPs, including the coordination or management of health care by a HCP with a third party; consultation between HCPs relating to a patient; or the referral of a patient for health care from one HCP to another.

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 preauthorization is required as set forth in [32 CFR 199.4](#). A treatment plan must include, at a minimum, a diagnosis (either ICD-9-CM, ICD-10-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.

Note: *The edition of the **International Classification of Diseases, Clinical Modification**, reference to be used is determined by the date of service for outpatient services or date of discharge for inpatient services of the care provided. Diagnoses coding for dates of service for outpatient services or date of discharge for inpatient services **on or before September 30, 2014**, should be consistent with ICD-9-CM. Diagnoses coding for dates of service for outpatient services or date of discharge for inpatient services **on or after October 1, 2014** should be consistent with ICD-10-CM.

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 arranging for care. Medically qualified contractor personnel on 24 hour telephone coverage will perform the function.

TRICARE

The DoD's managed health care program for ADSMs, service families, retirees and their families, survivors, and other TRICARE-eligible beneficiaries. TRICARE is a blend of the military's DC system of hospitals and clinics and civilian providers. TRICARE offers three options: TRICARE Standard Plan, TRICARE Extra Plan, and TRICARE Prime Plan (see definitions).

TRICARE Beneficiary

An individual who has been determined to be eligible for TRICARE benefits, as set forth in [32 CFR 199.3](#).

TRICARE Contractor

An organization with which TMA has entered into a contract for delivery of and/or processing of payment for health care services through contracted providers and for processing of claims for health care received from non-network providers and for performance of related support activities.

TRICARE DRG-Based Payment System

A reimbursement system for hospitals which assigns prospectively-determined payment levels to each DRG based on the average cost of treating all TRICARE patients in a given DRG.

TRICARE Encounter Data (TED)

A data set of information required for all care received/delivered under the contract and provided by the contractor in a government-specified format and submitted to TMA via a telecommunication network. The information in the data set can be described in the following broad categories:

1. Beneficiary identification.
2. Provider identification.
3. Health information:
 - Place and type of service
 - Diagnosis and treatment-related data
 - Units of service (admissions, days, visits, etc.)
4. Related financial information.

TRICARE Encounter Data (TED) Record Transmittal Summary

A single record which identifies the submitting contractor and summarizes, for transmittal purposes, the number of records and the financial information contained within the associated "batch" of TED records.

TRICARE Extra

A PPO-like option, provided as part of the TRICARE program under [32 CFR 199.17](#), where MHS beneficiaries may choose to receive care in facilities of the uniformed services, or from special civilian network providers (with reduced cost-sharing), or from any other TRICARE-authorized provider (with standard cost-sharing).