



DEFENSE  
HEALTH AGENCY

HPOS

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
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CHANGE 129  
6010.56-M  
SEPTEMBER 22, 2014

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:** UPDATE INTERNATIONAL CLASSIFICATION OF DISEASES-10 COMPLIANCE  
DATE

**CONREQ:** 16287

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

**SUMMARY OF CHANGE(S):** This change updates current ICD-10 language to comply with the Protecting Access to Medicare Act of 2014 (H.R. 4302), which precludes International Classification of Diseases, 10th Revision (ICD-10) code sets from being adopted by the Department of Health and Human Services (HHS) prior to 1 October 2015.

**EFFECTIVE DATE:** September 3, 2014.

**IMPLEMENTATION DATE:** October 1, 2015.

This change is made in conjunction with Feb 2008 TPM, Change No. 117, Feb 2008 TRM, Change No. 103, and Feb 2008 TSM, Change No. 67.

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**ATTACHMENT(S):** 53 PAGES  
**DISTRIBUTION:** 6010.56-M

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

**CHANGE 129  
6010.56-M  
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**REMOVE PAGE(S)**

**CHAPTER 1**

Section 4, pages 1 through 4

**CHAPTER 7**

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**CHAPTER 8**

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**CHAPTER 10**

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**CHAPTER 18**

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**CHAPTER 24**

Section 9, pages 7 through 17

**APPENDIX B**

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**INSERT PAGE(S)**

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## Management

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### 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 **the mandated date, as directed by Health and Human Services (HHS), for International Classification of Diseases, 10th Revision (ICD-10) implementation**, for outpatient facility and all non-facility services, and for inpatient facility charges with discharge dates on or after **the mandated date, as directed by HHS, for ICD-10 implementation**, contractors will be required to replace the use of ICD-9-CM diagnosis codes with the current version of the 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 their call center, TRICARE Service Center (TSC) functions (TRICARE overseas contract only), 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 -

## Management

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### **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 before **the mandated date, as directed by Health and Human Services (HHS), for International Classification of Diseases, 10th Revision (ICD-10) implementation**) and in ICD-10-CM coding (for outpatient services with dates of service or inpatient services with dates of discharge provided on or after **the mandated date, as directed by HHS, for ICD-10 implementation**, or International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) for inpatient services with dates of discharge provided on or after **the mandated date, as directed by HHS, for ICD-10 implementation**).

### **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 before **the mandated date, as directed by HHS, for ICD-10 implementation**) 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 **the mandated date, as directed by HHS, for ICD-10 implementation**.

#### **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.

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## Claim Development

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### 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

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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 before **the mandated date, as directed by Health and Human Services (HHS), for International Classification of Diseases, 10th Revision (ICD-10) implementation**, 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 **the mandated date, as directed by HHS, for ICD-10 implementation**, are to be processed in accordance with 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

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 non-institutional financially underwritten claim where Begin Date of Care (TRICARE Systems Manual (TSM) Data Element 2-150) crosses contract option periods shall be split. See the TSM, [Chapter 2, Section 1.1, paragraph 6.0](#).

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

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

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

**9.10** 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](#).

**9.11** Outpatient claims with dates of service that cross **the mandated date, as directed by HHS, for ICD-10 implementation**, 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 before **the mandated date, as directed by HHS, for ICD-10 implementation**, and be coded in accordance with the ICD-9-CM, as appropriate. Claims for services provided on or after **the mandated date, as directed by HHS, for ICD-10 implementation**, 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 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 before **the mandated date, as directed by HHS, for ICD-10 implementation**), or ICD-10-PCS surgical procedure code (for procedures on or after **the mandated date, as directed by HHS, for ICD-10 implementation**). 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 **the mandated date, as directed by HHS, for ICD-10 implementation**, should be consistent with ICD-10-CM.

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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 **the mandated date, as directed by Health and Human Services (HHS), for International Classification of Diseases, 10th Revision (ICD-10) implementation**, use 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 **the mandated date, as directed by HHS, for ICD-10 implementation**, 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

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**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 **the mandated date, as directed by HHS, for ICD-10 implementation**, and under which there is or could be tort liability of a third party for the patient's injury or disease.

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## Department Of Defense (DoD) Enhanced Access To Autism Services Demonstration

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### 1.0 PURPOSE

The Enhanced Access to Autism Services Demonstration (“Autism Demonstration”) provides TRICARE reimbursement for Applied Behavior Analysis (ABA) for Active Duty Family Members (ADFM) with Autism Spectrum Disorders (ASDs). This Autism Demonstration will enable the DoD to determine whether:

- There is increased access to these services;
- The services are reaching those most likely to benefit from them;
- The quality of those services is meeting a standard of care currently accepted by the professional community of providers, including the Behavior Analyst Certification Board (BACB); and
- Requirements are met for State licensure and certification where such exists.

### 2.0 BACKGROUND

**2.1** The Military Health System (MHS) includes 59 military hospitals, over 350 military health clinics, and an extensive network of private sector health care partners, that provides medical care for more than nine million beneficiaries, including Active Duty Service Members (ADSMs) and ADFMs.

**2.2** Autistic Spectrum Disorders affect essential human behaviors such as social interaction, the ability to communicate ideas and feelings, imagination, and the establishment of relationships with others.

**2.3** ABA is the only service accepted within the MHS as having been shown to possibly reduce or eliminate specific problem behaviors and teach new skills to individuals with ASD. ABA reinforcement is rendered by TRICARE-authorized providers as an Other Service benefit under the Extended Care Health Option (ECHO). Only those individuals who are licensed or certified by a State or certified by the BACB (<http://www.bacb.com>) as a Board Certified Behavior Analyst (BCBA) or a Board Certified Assistant Behavior Analyst (BCaBA) are eligible to be TRICARE-authorized providers of ABA.

**2.4** The Autism Demonstration allows TRICARE reimbursement for ABA services, referred to as Intensive Behavioral Interventions in the Federal Register Demonstration Notice (72 FR 68130,

December 4, 2007), delivered by paraprofessional providers under a modified Corporate Services Provider (CSP) model.

### 3.0 DEFINITIONS

#### 3.1 Applied Behavior Analysis (ABA)

A well-developed discipline with a mature body of scientific knowledge, established standards for evidence-based practice, distinct methods of service, recognized experience and educational requirements for practice, and identified sources of requisite education. Information regarding the content of ABA is contained in the BACB Behavior Analysis Task List, available at <http://www.bacb.com/Downloadfiles/AutismTaskList/708AutismTaskListF.pdf>.

#### 3.2 Autism Spectrum Disorders (ASD)

**3.2.1** The covered ASD diagnoses are described under the Neurodevelopmental Disorders category of the most current edition of the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V). The DSM-V was released in May 2013. The DSM-V diagnostic code for ASD (299.00) is equivalent to the corresponding codes for Autistic Disorder (299.0) in the currently used edition of the International Classification of Diseases, Clinical Modification manual (currently ICD-9-CM) used for claims processing under TRICARE for services provided on or before September 30, 2014.

- The Military Health System (MHS) and mental health community has transitioned to the DSM-5 (released May 2013). This transition resulted in the five covered diagnoses for an ASD (ASD, Rett's Disorder, Childhood Disintegrative Disorder (CDD), Asperger's Disorder, and Pervasive Developmental Disorder (PDDNOS)) under the DSM, Fourth Edition, Text Revision (DSM-IV-TR) falling under the one diagnosis of ASD (299.00) in the DSM-V. The corresponding ICD-9-CM code is Autistic Disorder (299.0) and the corresponding ICD-10-CM code is Autistic Disorder (F84.0).

**Note:** The DSM-IV-TR and the ICD-9-CM use the same numeric diagnosis codes for three of the five ASD Diagnoses found in the DSM-IV-TR (Autistic Disorder (299.00 & 299.0), CDD (299.10 & 299.1), and Asperger's (299.80 & 299.8)). The DSM-IV-TR uses one code 299.80 to refer to Rett's Disorder, PDD, and Asperger's Disorder whereas the ICD-9-CM designates a unique code for each diagnosis.

**3.2.2** Significant symptoms associated with ASD include communication and social behavior deficits, and behaviors concerning objects and routine.

**3.2.2.1** Communication deficits include a lack of speech, especially when associated with the lack of desire to communicate and lack of nonverbal compensatory efforts such as gestures.

**3.2.2.2** Social Skills Deficits. Children with ASD demonstrate a decreased drive to interact with others and share complementary feeling states. Children with ASD often appear to be content being alone, ignore their parents' and others' bids for attention with gestures or vocalizations and seldom make eye contact.

**3.2.2.3** Restricted, Repetitive, and Stereotyped Patterns of Behavior, Interests, and Activities. Children with ASD can demonstrate atypical behaviors in a variety of areas including peculiar mannerisms, unusual attachments to objects, obsessions, compulsions, self-injurious behaviors, and stereotypes. Stereotypes are repetitive, nonfunctional, atypical behaviors such as hand flapping, finger movements, rocking, or twirling.

### **3.3 Behavior Plan (BP)**

Also referred to as an ABA treatment plan, a written assessment of the objectives and goals of behavior modification and the specific evidence-based practices and techniques to be utilized. Requirements for the BP are specified in [paragraph 7.0](#).

### **3.4 Interventions For ASDs**

Individualized interventions, as specified in the BP, to systematically increase adaptive behaviors and modify maladaptive or inappropriate behaviors. Under the Demonstration, only ABA, as defined by the BACB, is authorized and reimbursable.

### **3.5 Progress Report (PR) And Updated BP**

A report of the individual's progress towards achieving the behavioral goals and objectives specified in the BP. The report also revises the BP to reflect new or modified goals, objectives and strategies. Requirements for the EPR and the updated BP are specified in [paragraphs 7.2](#) and [7.3](#), respectively.

### **3.6 Functional Behavioral Assessment And Analysis**

The process of identifying the variables that reliably predict and maintain problem behaviors. The functional behavioral assessment and analysis process typically involves:

- Identifying the problem behavior(s);
- Developing hypotheses about the antecedents and consequences likely to trigger or support the problem behavior; and
- Performing an analysis of the function of the behavior by testing the hypotheses.

### **3.7 Individuals With Disabilities Education Act (IDEA)**

Public Law 108-446, December 3, 2004 (20 U.S.C. 1400 et seq.): The United States law that entitles all children, including those with a disability, to a Free Appropriate Public Education (FAPE).

### **3.8 Individualized Family Service Plan (IFSP)**

A multidisciplinary assessment and plan that specifies the unique strengths, services and resources needed by an infant or toddler (age zero to three years) with a developmental disability or who is at risk for such, and his/her family.

### **3.9 Individualized Education Program (IEP)**

A multidisciplinary assessment and plan that specifies the objectives, goals and related services associated with providing a FAPE to a child with a disability.

### **3.10 Special Education**

Specially designed instruction to meet the unique FAPE needs, as specified in the IEP, of a child with a disability.

## **4.0 PROVIDERS**

### **4.1 Primary Care Provider (PCP)**

A collective reference within the Autism Demonstration to:

**4.1.1** A Primary Care Manager (PCM) under the TRICARE Prime or TRICARE Prime Remote for Active Duty Family Member (TPRADFM) programs; and

**4.1.2** TRICARE-authorized family practice, general medicine, internal medicine, and pediatric physicians under the TRICARE Standard program; and

**4.1.3** A Military Treatment Facility (MTF) provider or team of providers or a network provider to whom a beneficiary is assigned for primary care services at the time of enrollment in TRICARE Prime.

### **4.2 Autism Demonstration Corporate Services Provider (ACSP)**

An individual, corporation, foundation, or public entity that meets the TRICARE definition of a CSP under [32 CFR 199.6\(e\)\(2\)\(ii\)\(B\)](#) that predominantly renders services of a type uniquely allowable under the ECHO and which meets the requirements specified in [paragraph 5.1](#).

### **4.3 ABA Supervisor**

An individual TRICARE authorized provider meeting the requirements specified in [paragraph 5.2](#) who provides supervisory oversight of ABA Tutors.

### **4.4 ABA Tutor**

An individual who meets the requirements specified in [paragraph 5.3](#) and delivers ABA services to TRICARE beneficiaries under the supervision of an ABA Supervisor. ABA Tutors work one-on-one with children in accordance with the BP and gather behavioral data necessary for the ABA Supervisor to evaluate the effectiveness of the BP. An ABA Tutor may not conduct behavioral evaluations, establish a child's BP, or submit claims for services provided to TRICARE beneficiaries.

#### **4.5 Specialized ASD Provider**

A TRICARE authorized provider who is a:

- Physician board-certified or board-eligible in behavioral developmental pediatrics, neurodevelopmental pediatrics, pediatric neurology or child psychiatry; or
- Ph.D. clinical psychologist working primarily with children.

#### **5.0 ABA PROVIDER REQUIREMENTS**

**5.1** ACSPs shall:

**5.1.1** Submit evidence to the appropriate Managed Care Support Contractor (MCSC) that professional liability insurance in the amounts of one million dollars per claim and three million dollars in aggregate, unless State requirements specify greater amounts, is maintained in the ACSP's name.

**5.1.2** Submit claims to the appropriate MCSC using the assigned Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes specified in [paragraph 9.0](#).

**5.1.3** Submit to the MCSC all documents necessary to support an application for designation as a TRICARE ACSP;

**5.1.4** Enter into a Participation Agreement ([Addendum A](#)) approved by the Director, TRICARE Management Activity (TMA) or designee;

**5.1.5** Employ directly or contract with ABA Supervisors and/or ABA Tutors;

**5.1.6** Certify that all ABA Supervisors and ABA Tutors employed by or contracted with the ACSP meet the education, training, experience, competency, supervision and Autism Demonstration requirements specified herein;

**5.1.7** Comply with all applicable organizational and individual licensing or certification requirements that are extant in the State, county, municipality, or other political jurisdiction in which ABA services are provided under the Autism Demonstration;

**5.1.8** Maintain employment or contractual documentation in accordance with applicable Federal, State, and local requirements and corporate policies regarding ABA Supervisors and ABA Tutors;

**5.1.9** Comply with all applicable requirements of the Government designated utilization and clinical quality management organization for the geographic area in which the ACSP provides ABA services; and

**5.1.10** Comply with all other requirements applicable to TRICARE-authorized providers.

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**5.2** ABA Supervisor shall:

**5.2.1** Have a current, unrestricted State-issued license to provide ABA services; or

**5.2.2** Have a current, unrestricted State-issued certificate as a provider of ABA services; or

**5.2.3** Have a current certification from BACB (<http://www.bacb.com>) as either a BCBA or a BCaBA where such state-issued license or certification is not available; and

**5.2.4** Enter into a Participation Agreement ([Addendum A](#)) approved by the Director, TMA or designee; and

**5.2.5** Employ directly or contract with ABA Tutors; and

**5.2.6** Report to the MCSC within 30 days of notification of a BACB sanction issued to the ABA Supervisor for violation of BACB disciplinary standards (<http://www.bacb.com/index.php?page=85>) or notification of loss of BACB certification. Loss of BACB certification shall result in termination of the Participation Agreement with the ABA Supervisor with an effective date of such notification. Termination of the Participation Agreement by the MCSC may be appealed to the TMA in accordance with the requirements of [Chapter 13](#); and

**5.2.7** Ensure that the quality of the ABA services provided by ABA Tutors meet the minimum evidence-based standards as indicated by the current BACB Task List, the BACB Professional Disciplinary Standards, the BACB Guidelines for Responsible Conduct for Behavior Analysts, the BACB Guidelines: Health Plan Coverage of Applied Behavior Analysis Treatment for **ASD**, and current BACB rules and regulations; and

**5.2.8** Maintain all applicable business licenses and employment or contractual documentation in accordance with Federal, State, and local requirements and the ABA Supervisor's business policies regarding ABA Tutors; and

**5.2.9** Meet all applicable requirements of the states in which they provide ABA services, including those of states in which they provide remote supervision of ABA Tutors and oversee ABA services provided where the beneficiary resides; and

**5.2.10** Cooperate fully with a designated utilization and clinical quality management organization which has a contract with the DoD for the geographic area in which the provider does business; and

**5.2.11** Comply with all other applicable TRICARE-authorized provider requirements.

**5.3** ABA Tutor:

**5.3.1** Prior to providing ABA services under the Autism Demonstration, shall have completed 40 hours of documented classroom training in ABA techniques in accordance with the BACB Guidelines for Responsible Conduct for Behavior Analysts (<http://www.bacb.com>), undergone a criminal background check as specified in [paragraph 5.4.3](#); and

- Completed a minimum of 12 semester hours of college coursework in psychology,

education, social work, behavioral sciences, human development or related fields and be currently enrolled in a course of study leading to an associate's or bachelor's degree by an accredited college or university; or

- Completed a minimum of 48 semester hours of college courses in an accredited college or university; or
- A High School diploma or GED equivalent and have completed 500 hours of employment providing ABA services as verified by the ACSP.

**5.3.2** Shall receive no less than two hours direct supervision per month from the ABA Supervisor with each beneficiary the ABA Tutor provides services to and in accordance with the BACB Guidelines for Responsible Conduct for Behavior Analysts. Remote supervision through the use of real time methods is authorized. For the purpose of this paragraph, "real-time" is defined as the simultaneous "live" audio and video interaction between the ABA Supervisor and the ABA Tutor by electronic means such that the occurrence is the same as if the individuals were in the physical presence of each other. Such is usually done by electronic transmission over the internet.

#### **5.4 Provider Background Review**

**5.4.1** The MCSC shall obtain a Criminal History Review, as specified in [Chapter 4, Section 1, paragraph 9.0](#), for ACSPs who are individual providers with whom the MCSC enters into a Participation Agreement.

**5.4.2** ACSPs, other than those specified in [paragraph 5.4.1](#), shall:

**5.4.2.1** Obtain a Criminal History Review of ABA Supervisors whom the ACSP employs directly or with whom the ACSP enters into a contract.

**5.4.2.2** Obtain a Criminal Background Check of ABA Tutors whom the ACSP employs directly or with whom the ACSP enters into a contract.

**5.4.3** The ABA Supervisor shall obtain a Criminal Background Check of ABA Tutors the ABA Supervisor employs directly or with whom the ABA Supervisor enters into a contract to supervise the ABA Tutor. The Criminal Background Check of ABA Tutors shall:

**5.4.3.1** Include current Federal, State, and County Criminal and Sex Offender reports for all locations the ABA Tutor has resided or worked during the previous 10 years; and

**5.4.3.2** Be completed prior to the ABA Tutor providing ABA services to TRICARE beneficiaries.

#### **6.0 BENEFICIARY ELIGIBILITY REQUIREMENTS**

**6.1** TRICARE beneficiaries who request participation in the Autism Demonstration shall:

**6.1.1** Be at least 18 months of age; and

**6.1.2** Be registered in the ECHO; and

**6.1.3** Have been diagnosed with an ASD specified in [paragraph 3.2](#) by a TRICARE-authorized PCP or Specialized ASD Provider; and

**6.1.4** Provide the MCSC with the beneficiary's IFSP or the IEP documenting that the beneficiary is receiving Early Intervention Services or Special Education and that adequate ABA services are not available through the IDEA.

**Note:** If the child is home schooled or enrolled in a private school and not required by State law to have an IEP, the child's PCP or Specialized ASD Provider must certify to the MCSC that the child requires participation in the Autism Demonstration.

**6.2** Eligibility for benefits under the Autism Demonstration ceases as of 12:01 a.m. of the day after:

- The Autism Demonstration ends, or
- Eligibility for the ECHO program ends.

**6.3** Absence of eligibility for the Autism Demonstration does not preclude beneficiaries from receiving otherwise allowable services under ECHO or the TRICARE Basic program.

## **7.0 BP REQUIREMENTS**

The initial BP, the PR, and updated BP shall be developed by the ACSP directing the delivery of ABA services and shall include the name/title/address of the preparer and the elements specified in [paragraphs 7.1](#) through [7.3](#) to the extent applicable.

**7.1** The initial BP shall include:

**7.1.1** The beneficiary's name, date of birth, date the Functional Behavioral Assessment and Analysis was completed, sponsor's Social Security Number (SSN) or DoD benefits number, name of the referring provider, background and history, goals and objectives, parental training, summary and recommendations.

**7.1.2** Background and history shall include:

**7.1.2.1** Information that clearly demonstrates the beneficiary's condition, diagnosis, and family history;

**7.1.2.2** How long the beneficiary has been receiving ABA services;

**7.1.2.3** Identification of any services or therapies being received through community resources (e.g., state waiver programs, Medicaid, services available through a Regional or Community Center); and

**7.1.2.4** How the ACSP will coordinate ABA services with available community services.

**7.1.3** Goals and objectives of the ABA services shall include:

**7.1.3.1** A detailed description of the targeted skills and behaviors that will be addressed through the ABA sessions and the objectives that will be measured, which may include:

- Communication skills
- Mental health issues
- Vocational skills
- Adaptive skills
- Motor skills
- Academic skills
- Cognitive skills
- Developmental skills
- Behavior skills
- Social skills
- Medical and quasi-medical issues

**7.1.3.2** Administration of any diagnostic tests that will assess skill acquisition or behavior modification; and

**7.1.3.3** The frequency and method of assessing the beneficiary's progress towards achieving the goals and objectives.

**7.1.4** Parental training shall be included in the BP. Parental training shall be provided while billable ABA services are being provided to the beneficiary. The BP shall include a detailed plan that specifies how parents will be trained to:

**7.1.4.1** Implement and reinforce skills and behaviors; and

**7.1.4.2** Receive support to implement strategies within a specified setting.

**7.1.5** Summary and recommendations of the BP shall include the extent of parent/caregiver involvement that will be expected to support the plan.

**7.1.6** The initial BP shall be reviewed and updated by the ACSP at six-month intervals and submitted to the MCSC for review and authorization of ABA services.

**7.2** The PR shall include:

**7.2.1** Beneficiary's name, date of birth, inclusive dates of the evaluation period, sponsor's SSN, or DoD benefits number, name of the referring provider;

**7.2.2** A summary of the child's progress;

**7.2.3** A summary of the child's challenges to meet the goals and objectives; and

**7.2.4** A summary of parent/caregiver participation in implementing the BP during the evaluation period.

**7.2.5** Recommendations for continued ABA services.

**7.3** The updated BP shall include:

**7.3.1** The data elements specified in [paragraph 7.1](#);

**7.3.2** The dates of the plan being updated; and

**7.3.3** The number of ABA hours of services to be provided each month by the ABA Supervisor and the ABA Tutor.

**7.4** The ACSP shall provide an information copy of the BP, the PR, and the updated BP to the beneficiary's PCP or ASD Specialized provider, within 10 calendar days of completion.

## **8.0 POLICY**

**8.1** Under the Autism Demonstration, TRICARE will reimburse ACSP's only for ABA services that meet the minimum standards established by the current BACB Task List, the BACB Professional Disciplinary Standards, the BACB Guidelines for Responsible Conduct for Behavior Analysts, and current BACB rules and regulations when rendered by providers who meet all applicable requirements specified herein.

**8.2** All ABA services under this Autism Demonstration require prior written authorization by the Director, TMA or designee.

**8.3** The following are eligible for reimbursement under the Autism Demonstration:

**8.3.1** Evaluation of a beneficiary using the Functional Behavioral Assessment and Analysis.

**8.3.2** Development of the initial BP, the PR, and the updated BP.

**8.3.3** ABA rendered directly to a TRICARE beneficiary on a one-on-one basis. Group ABA sessions are not a TRICARE benefit.

**8.3.4** ABA services rendered jointly, in-person, or during directly supervised fieldwork of the ABA Tutor by the ABA Supervisor. Only the services provided by the Supervisor will be reimbursed as specified in [paragraph 9.1](#).

**8.3.5** Quarterly, in-person meetings between the ABA Supervisor and the beneficiary's primary caregivers.

**8.4** The allowed cost of services provided by this Autism Demonstration on or after October 14, 2008, accrue to the Government's maximum fiscal year share of providing benefits in accordance with the TRICARE Policy Manual (TPM), [Chapter 9](#), (except ECHO Home Health Care (EHHC)), of \$36,000.

## 9.0 REIMBURSEMENT

**9.1** Claims for Autism Demonstration services will be submitted by the ACSP on a Centers for Medicare and Medicaid (CMS) 1500 Claim Form as follows:

**9.1.1** Functional Behavioral Assessment and Analysis.

**9.1.1.1** During the first month the beneficiary is enrolled in the Autism Demonstration, the ACSP will be authorized and reimbursed by the MCSC for not more than four hours for conducting the initial Functional Behavioral Assessment and Analysis and establishing the initial BP.

**9.1.1.2** The Functional Behavioral Assessment and Analysis and initial BP will be invoiced using HCPCS code "S5108, Home care training to home care client, per 15 minutes."

**9.1.1.3** Reimbursement for the Functional Behavioral Assessment and Analysis includes the intellectual work and diagnostic evaluation required to establish the initial BP.

**9.1.1.4** Reassessment of established Autism Demonstration participants will be conducted as part of the ACSP's routine supervision services and is not separately reimbursable.

**9.1.2** ABA services rendered jointly by an ABA Supervisor and an ABA Tutor, in-person, during directly supervised fieldwork of the ABA Tutor by the ABA Supervisor, will be invoiced using HCPCS code "S5108, Home care training to home care client, per 15 minutes."

**9.1.3** ABA services provided directly by an ABA Tutor will be invoiced using HCPCS code "H2019, Therapeutic behavioral services, per 15 minutes."

**9.1.4** Development of the required PR and updated BP will be invoiced using CPT<sup>1</sup> code 99080, "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form."

**9.1.5** Conducting the required quarterly progress meetings with the beneficiary's caregivers will be invoiced using CPT1 code 90887, "Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible person, or advising them how to assist patient."

**9.2** Reimbursement of claims in accordance with [paragraph 9.1.1](#) and will be the lesser of:

- The CHAMPUS Maximum Allowable Charge (CMAC); or
- \$125 per hour for services provided by the ABA Supervisor and \$50 per hour for services provided by the ABA Tutor; or
- The negotiated rate; or
- The billed charge.

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<sup>1</sup> CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

## 10.0 ADDITIONAL MCSC RESPONSIBILITIES

The MCSC shall:

**10.1** Consider and advise beneficiaries of the availability of community based or funded programs and services, when authorizing Autism Demonstration benefits.

**10.2** Maintain all documents related to the Autism Demonstration in accordance with [Chapter 2](#).

**10.3** Forward to the "gaining" MCSC all Autism Demonstration related documents within 10 calendar days of being notified that a beneficiary is transferring to a location under the jurisdiction of another MCSC.

**10.4** Review the beneficiary's BP prior to authorizing Autism Demonstration services.

**Note:** The Functional Behavioral Assessment and Analysis specified in [paragraph 9.1.1](#) will be authorized by the MCSC prior to development of the BP.

**10.5** Conduct annual audits on at least 20% of each ACSP's ABA Tutors for compliance with the requirements specified in [paragraph 5.3](#). Upon determining non-compliance with one or more ABA Tutor qualification requirements, the MCSC will immediately initiate a compliance audit of all ABA Tutors employed by or contracted with that ACSP.

**10.6** Complete and submit the monthly, quarterly, and semi-annual reports as described in the Contract Data Requirements List (CDRL), DD Form 1423.

## 11.0 APPLICABILITY

**11.1** This Autism Demonstration is limited to TRICARE beneficiaries who meet the requirements specified in [paragraph 6.0](#).

**11.2** This Autism Demonstration is limited to the 50 United States and the District of Columbia.

**11.3** All provisions of the ECHO program apply to the Autism Demonstration unless specifically modified by the Federal Register Demonstration Notice (72 FR 68130, December 4, 2007) or by this Section.

## 12.0 EXCLUSIONS

TRICARE will not cost-share:

**12.1** Training of ABA Tutors as specified in [paragraph 5.3.1](#).

**12.2** Charges for program development, administrative services, and the assessment required for developing the PR and updating the BP.

**12.3** More than one Autism Demonstration service provided to the same beneficiary during the same time period, such as the case of the supervision of the ABA Tutor specified in [paragraph 5.3.2](#).

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**12.4** Training of parents specified in [paragraph 7.1.4](#).

**13.0 EFFECTIVE DATE**

This Autism Demonstration is effective for claims for services provided in accordance with this Section during the period March 15, 2008 through March 14, 2015.

- END -



## Standards For Electronic Transactions

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### 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.

On April 1, 2014, President Obama signed and enacted "Protecting Access to Medicare Act of 2014" (H.R. 4302), which precludes ICD-10 codes from being adopted by HHS as the industry standard prior to October 1, 2015.

On August 4, 2014, HHS published a Final Rule setting October 1, 2015, as the new compliance date for ICD-10 implementation. This Final Rule, known as "Administrative Simplification: Change to the Compliance Date for International Classification of Diseases, 10th (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 **use of ICD-10 code sets is as directed by HHS.**

## **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.

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- 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.
- 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.

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- 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.
- 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 **the mandated date, as directed by HHS, for ICD-10 implementation**, 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** 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 before **the mandated date, as directed by HHS, for ICD-10 implementation**.

**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.

**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 before **the mandated date, as directed by Health and Human Services (HHS), for International Classification of Diseases, 10th Revision (ICD-10) implementation**, with 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 **the mandated date, as directed by HHS, for ICD-10 implementation**, with ICD-9 or ICD-9-CM codes shall be converted to 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 before **the mandated date, as directed by HHS, for ICD-10 implementation**, 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 **the mandated date, as directed by HHS, for ICD-10 implementation**, 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).

**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.

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

**6.16** Requests for missing information shall be sent on the TOP contractor's TRICARE/TOP letterhead. When development is necessary in TRICARE 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

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**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.

**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.

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**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 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

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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.

**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.

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**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 pending 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 pending 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 before **the mandated date, as directed by HHS, for ICD-10 implementation**.

### **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 **the mandated date, as directed by HHS, for ICD-10 implementation**.

### **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 **the mandated date, as directed by HHS, for ICD-10 implementation**.

### **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 before **the mandated date, as directed by HHS, for ICD-10 implementation**, 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 **the mandated date, as directed by HHS, for ICD-10 implementation** 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).