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CHANGE 134  
6010.56-M  
OCTOBER 28, 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 ICD-10 COMPLIANCE DATE

**CONREQ:** 16287

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

**SUMMARY OF CHANGE(S):** This changes adds updates that were inadvertently omitted from the original change published as Change No. 129 on September 22, 2014.

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

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

This change is made in conjunction with Feb 2008 TPM, Change No. 120.

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Date: 2014.10.27 07:42:30 -06'00'

**ATTACHMENT(S):** 10 PAGES  
**DISTRIBUTION:** 6010.56-M

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

**CHANGE 134  
6010.56-M  
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**REMOVE PAGE(S)**

**CHAPTER 8**

Section 6, pages 3 and 4

**CHAPTER 18**

Section 8, pages 1 and 2

**CHAPTER 19**

Section 2, pages 1 and 2

**CHAPTER 24**

Section 9, pages 7 through 10

**INSERT PAGE(S)**

Section 6, pages 3 and 4

Section 8, pages 1 and 2

Section 2, pages 1 and 2

Section 9, pages 7 through 10

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

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

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

## 5.0 ICD-10-CM "Z" CODES

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

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

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

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

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

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

## **6.0 INDIVIDUAL PROVIDER SERVICES**

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

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

## **7.0 UNDELIVERABLE/RETURNED MAIL**

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

## **8.0 TED DETAIL LINE ITEM - COMBINED CHARGES**

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

## **9.0 CLAIMS SPLITTING**

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

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

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

## 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 **International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)**) used for claims processing under TRICARE for services provided before **the mandated date, as directed by Health and Human Services (HHS), for International Classification of Diseases, 10th Revision (ICD-10) implementation.**

- 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.

## 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 **Revision** (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.

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

## TRICARE Operations Manual 6010.56-M, February 1, 2008

### Chapter 24, Section 9

#### Claims Processing Procedures

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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.

## TRICARE Operations Manual 6010.56-M, February 1, 2008

### Chapter 24, Section 9

#### Claims Processing Procedures

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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