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**REMOVE PAGE(S)**

**CHAPTER 20**

Table of Contents, page 1  
Section 1, pages 1 and 2  
Section 2, page 1  
Section 3, pages 1 through 4  
Section 4, pages 1 and 2  
Section 5, pages 1 through 7  
Section 6, pages 1 through 4

**INDEX**

pages 1 through 4

**INSERT PAGE(S)**

Table of Contents, page 1  
Section 1, pages 1 and 2  
Section 2, page 1  
Section 3, pages 1 through 3  
Section 4, pages 1 and 2  
Section 5, pages 1 through 6  
★ ★ ★ ★ ★ ★

pages 1 through 4

## Chapter 20

### TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC)

Section/Addendum	Subject/Addendum Title
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- |   |                                      |
|---|--------------------------------------|
| 1 | General                              |
| 2 | Jurisdiction                         |
| 3 | Claims Processing For Dual Eligibles |
| 4 | Other Contract Requirements          |
| 5 | Transition                           |

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## General

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### 1.0 GENERAL

The TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) encompasses the processing of all TRICARE claims for services rendered within the 50 United States and the District of Columbia, as well as Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands, to individuals who have dual eligibility under both TRICARE and Medicare.

### 2.0 DUAL ELIGIBLES

There are six general categories of beneficiaries who have dual eligibility under both TRICARE and Medicare and whose claims will be processed under TDEFIC:

**2.1** TRICARE beneficiaries, who are 65 or older and who are entitled to premium-free Medicare Part A and who have Medicare Part B;

**2.2** TRICARE beneficiaries who are 65 or older and who are not entitled to premium-free Medicare Part A on their own record or the record of their current, former, or deceased spouse but have Medicare Part B;

**2.3** Active Duty Family Members (ADFM) who are 65 or older and who are entitled to premium-free Medicare Part A only;

**2.4** TRICARE beneficiaries who are entitled to premium-free Medicare Part A because of a disability or End Stage Renal Disease (ESRD) and who have Medicare Part B;

**2.5** ADFMs who have a disability or ESRD and are entitled to premium-free Medicare Part A only (While those with Medicare based on disability get a special enrollment period and therefore are not subject to the Part B premium surcharge, the special enrollment period does not apply to those with ESRD. ESRD patients who do not keep Medicare Part B when first eligible may have to pay a surcharge of 10% for each 12 month period that they could have enrolled in Part B but did not.); and

**2.6** TRICARE beneficiaries, who are entitled to premium-free Medicare Part A because of a disability, where Social Security Disability Insurance (SSDI) is awarded on appeal. These beneficiaries will have a Medicare Part B effective date of October 1, 2009, or later and a six-month minimum gap between their Medicare Part A and Medicare Part B effective dates and will remain TRICARE eligible for the period where only Part A was effective. If a beneficiary declines Part B coverage, he/she will be ineligible for TRICARE from the original Part B effective date until Part B coverage is established.

**3.0 APPLICABILITY OF TRICARE REQUIREMENTS**

Unless specifically waived or superseded by the provisions of this chapter, all normal TRICARE requirements set forth in the TRICARE Operations Manual (TOM), TRICARE Policy Manual (TPM), TRICARE Reimbursement Manual (TRM), and TRICARE Systems Manual (TSM) apply to claims processed under TDEFIC.

- END -

## Jurisdiction

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### 1.0 REGIONAL BOUNDARIES

**1.1** For claims processing jurisdiction purposes, TRICARE regional boundaries do not apply under the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC). The TDEFIC contractor is responsible for processing all medical claims for services, except retail pharmaceuticals, rendered to TRICARE/Medicare dual eligible individuals within the 50 United States and the District of Columbia, as well as Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands.

**1.2** Medicare claims processing jurisdiction is based on place of service. The TDEFIC contractor shall contract with the Medicare Coordination of Benefits Contractor (COBC) to ensure that Medicare claims for all dual eligible beneficiaries receiving care within the respective carrier's/FI's state(s) are electronically forwarded to the TDEFIC contractor. The cross-over claims agreement shall include all dual-eligible beneficiaries regardless of the beneficiary's status (Active Duty Dependent (ADD), retiree, survivor, etc.).

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## Claims Processing For Dual Eligibles

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### 1.0 GENERAL

Claims under the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) will be adjudicated under the rules set forth below. In general, TRICARE pays secondary to Medicare and any other coverage.

### 2.0 DETERMINING PAYMENTS DUE AFTER COORDINATION WITH MEDICARE

**2.1** Special double coverage procedures are to be used for all claims for beneficiaries who are eligible for Medicare, including active duty dependents who are age 65 and over as well as those beneficiaries under age 65 who are eligible for Medicare for any reason. For specific instructions, refer to the TRICARE Reimbursement Manual (TRM), [Chapter 4, Section 4](#).

### 2.2 Claims Auditing Software

The contractor is not required to have the claims auditing software described in the TRM, [Chapter 1, Section 3](#).

### 3.0 EXCEPTIONS TO TIMELY CLAIMS FILING

#### 3.1 Medicare

The contractor may grant exceptions to the claims filing deadline if Medicare accepted the claim as timely. If submitted by the beneficiary, the claim must be submitted within 90 calendar days from the date of Medicare's adjudication to be considered for a waiver.

#### 3.2 Other Health Insurance (OHI)

Reference [Chapter 8, Section 3, paragraph 2.4](#).

### 4.0 CLAIMS DEVELOPMENT REQUIREMENTS

#### 4.1 Medicare Providers

**4.1.1** The contractor shall accept the Medicare certification of individual professional providers who have a like class of individual professional providers under TRICARE without further authorization. An exception to this general rule occurs if there is information indicating Medicare, TRICARE or other federal health care program integrity violations by the physician or other health care practitioner. In such cases the contractor shall seek guidance from [Defense Health Agency \(DHA\)](#) Program Integrity (PI) prior to accepting the Medicare certification as valid for TRICARE

purposes. Individual professional providers without a like class (e.g., chiropractors) under TRICARE shall be denied.

**4.1.2** TRICARE claims which TRICARE processes after Medicare, do not need to be developed to the individual provider level for home health or group practice claims.

**4.1.3** Electronic "cross over" claims received from Medicare after Medicare completes its claims processing do not need a beneficiary or provider signature. For paper claims, when TRICARE is second pay to Medicare and a Medicare EOB is attached, the contractor does not need to develop for provider or beneficiary signature. Signature on file requirements of [Chapter 8, Section 4](#) apply.

## **4.2 Civilian Services Rendered To Military Treatment Facility (MTF) Inpatients**

Civilian claims for TRICARE dual eligible beneficiaries shall be processed by Medicare first without consideration of the Supplemental Health Care Program (SHCP).

## **4.3 Preauthorization Requirements**

Special authorization/preauthorization services outlined in [Chapter 7, Section 2](#) and in the TRICARE Policy Manual (TPM), [Chapter 1, Section 7.1](#) require preauthorization, and if necessary, review of waivers of the day limits for dual eligible beneficiaries when TRICARE is the primary payer. As secondary payer, TRICARE will rely on and not replicate Medicare's determination of medical necessity and appropriateness in all circumstances where Medicare is primary payer (see the TRM, [Chapter 4, Section 4](#)). In the event that TRICARE is primary payer for these services and preauthorization was not obtained, the contractor shall obtain the necessary information and perform a retrospective review. **Skilled Nursing Facility (SNF) preauthorizations shall be tracked separately from the required preauthorizations noted in [Chapter 7, Section 2](#) and TPM, [Chapter 1, Section 7.1](#).**

## **4.4 Provider Locator Assistance/Referral Requirements**

**4.4.1** Dual eligible beneficiaries can contact a regional Managed Care Support Contractor (MCSC) for assistance in locating a network provider. The MCSC shall provide the TDEFIC beneficiary with the name, telephone number, and address of network providers of the appropriate clinical specialty located within the beneficiary's geographic area. The MCSC is not required to make appointments with network providers.

**4.4.2** The TDEFIC contractor is not responsible for obtaining or verifying that a Prime-enrolled dual eligible beneficiary has a referral for care not provided by their Primary Care Manager (PCM). Dual eligible beneficiaries who are enrolled in Prime are not subject to Point of Service (POS) cost-sharing.

## **4.5 Resource Sharing Or Clinical Support**

The contractor shall not process a claim from any civilian provider practicing in an MTF under the Resource Sharing or Clinical Support Agreement (CSA) programs.

## 5.0 UTILIZATION MANAGEMENT (UM)

Any UM provisions applied under the TRICARE Managed Care Support Contracts (MCSCs), except for those specifically required by the TPM, TRM, or TRICARE Operations Manual (TOM), shall not apply under TDEFIC. Region-specific requirements shall not apply.

## 6.0 END OF PROCESSING

### 6.1 Beneficiary Cost-Shares

End Of Processing. Beneficiary cost-shares shall be based on the following when TRICARE is the primary payer. If the services were received by a TRICARE Prime enrollee (as indicated in DEERS), the contractor shall apply the Prime copayments. For a TRICARE Standard beneficiary, if a provider is known to be a network provider (e.g., Veteran Affairs Medical Center (VAMC)), the Extra cost-shares shall be applied. In all other cases, the TRICARE Standard cost-shares shall be applied.

### 6.2 Application Of Catastrophic Cap

Only the actual beneficiary out-of-pocket liability remaining after TRICARE payments will be counted for purposes of the annual catastrophic loss protection.

### 6.3 Appeals

Initial Determinations. Services and supplies denied payment by Medicare will not be considered for coverage by TRICARE if the Medicare denial of payment is appealable under the Medicare appeal process. If, however, a Medicare appeal results in some payment by Medicare, the services and supplies covered by Medicare will be considered for coverage by TRICARE. Services and supplies denied payment by Medicare will be considered for coverage by TRICARE, if the Medicare denial of payment is not appealable under the Medicare appeal process. The appeal procedures set forth in Chapter 12 are applicable to initial denial determinations by TRICARE under TDEFIC. Appeals of SNF preauthorizations follow concurrent review procedures.

## 7.0 TED SUBMISSION

For every claim processed to completion, the TDEFIC contractor shall submit a TRICARE Encounter Data (TED) record to DHA in accordance with the requirements of the TRICARE Systems Manual (TSM).

## 8.0 TRICARE PROCESSING STANDARDS

All TRICARE Processing Standards in Chapter 1, Section 3 apply except for Chapter 1, Section 3, paragraphs 1.2, 1.3, 1.4, and 4.1.

- END -



## Other Contract Requirements

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### 1.0 CUSTOMER SERVICE

#### 1.1 Telephone Inquiries

The contractor shall provide nationwide (to include Hawaii, Alaska, and Puerto Rico) toll-free telephone service that is fully staffed and provides continuous service during normal business hours. During normal business hours for the caller's time zone, callers must be offered the option of speaking with a customer service representative. Telephone access outside of normal business hours for the caller's time zone may be by automated means, such as a provision for leaving messages and/or for obtaining information via an automated response mechanism. Responses must be furnished within the time frames mandated under TDEFIC.

#### 1.2 Written Inquiries

The contractor shall respond promptly and meaningfully to all written inquiries, including inquiries received via e-mail. Responses must be furnished within the time frames mandated under TDEFIC.

#### 1.3 Education Requirements

**1.3.1** The education of TRICARE beneficiaries and providers will be accomplished through a collaborative effort with Defense Health Agency (DHA) Communications. This collaboration will ensure information and education about the TRICARE for Life (TFL) Program changes and/or additions to benefits are effectively provided. Educational activities include targeted beneficiary and provider education related to specific issues. Issues may be identified by the Government or the contractor.

**1.3.2** The contractor shall submit an education plan that outlines how TRICARE beneficiaries and providers will be informed and educated on all aspects of the TFL Program. DHA and DHA Communications will review the plan and provide appropriate feedback for recommended changes.

##### 1.3.3 Required Educational Materials

**1.3.3.1** The Government will furnish all beneficiary educational materials which may include printed and electronic media. Materials developed by the Government and distributed in support of the TFL Program will be selected on the basis of recommendations by the contractor, the Program Manager, DHA leadership and others with interests and concerns about the information being provided to TRICARE/Medicare dual eligible beneficiaries, and other stakeholders. DHA Communications and the DHA Program Office will review all recommendations and will prioritize

the educational products to be developed. The contractor will be responsible for the distribution of Government-furnished materials to TFL beneficiaries.

**1.3.3.2** The contractor shall furnish claim forms, claim completion instructions, the TFL Handbook, Defense Enrollment Eligibility Reporting System (DEERS) information and other TFL educational materials upon request to beneficiaries, providers, and congressional offices. The contractor shall establish and maintain effective communications with all TRICARE/Medicare dual eligible beneficiaries.

## **2.0 MEDICARE CROSSOVER FEES**

Medicare crossover fees are paid to Medicare contractors by the DHA contractors. These fees cover the transmission of data on paid claims from the Medicare contractor to DHA contractors in order to facilitate DHA processing as second payer on the TFL claims. The contractor shall submit non-TRICARE Encounter Data (TED) vouchers covering these expenses to DHA on an as needed basis, generally once or twice a month.

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## Transition

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### 1.0 CONTRACT TRANSITION-IN

#### 1.1 Transition-In (Phase-In) Plan

This comprehensive plan shall be submitted electronically, in Microsoft® (MS) Project files, to the Procuring Contracting Officer (PCO) and the Contracting Officer's Representative (COR) No Later Than (NLT) 10 calendar days following contract award. The plans shall address all events and milestones that need to occur for each functional area described in the contract to enable the start of service performance under this contract. Within 15 calendar days following the interface meetings, the incoming contractor shall submit to the **Defense Health Agency (DHA)** a revised **transition-in** plan for approval which incorporates the results of the Transition Specifications and Interface meetings. The final **transition-in** plan **may** be incorporated into the contract at no cost to the Government.

#### 1.2 Transitions Specifications Meetings

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

#### 1.3 Interface Meetings

Within 30 calendar days from contract award, the contractor shall arrange meetings with Government and external agencies to establish all systems interfaces necessary to meet the requirements of this contract, including, but not limited to, the Defense Enrollment **Eligibility Reporting** System (DEERS), the Medicare Coordination of Benefits Contractor (COBC), Military Health System (MHS) Information Assurance (IA) Certification and Accreditation Team, and **DHA Communications**. **DHA** representatives shall be included in these meetings and all plans developed shall be submitted to the **DHA** PCO and the COR within 10 calendar days after the meeting.

### 2.0 START-UP REQUIREMENTS

#### 2.1 Systems Development

Approximately 60 calendar days prior to the initiation of services delivery under this contract, the non-claims processing systems and the telecommunications interconnections between these systems shall be reviewed by the **DHA** or its designees, to include a demonstration by the contractor of the system(s) capabilities, to determine whether the systems satisfy the requirements

of TRICARE as otherwise provided in the contract. This includes the telecommunications links with DHA and DEERS. The review will also confirm access for operating the automated TRICARE Duplicate Claims System (DCS). The contractor shall effect any modifications required by DHA prior to the initiation of services delivery under this contract.

## 2.2 Medicare Crossover Claims

NLT 60 calendar days prior to the start of the service delivery, the contractor shall have an established contract with the COBC for receipt of TRICARE crossover claims for all dual eligible beneficiaries for implementation when the outgoing contractor terminates claims processing. NLT 60 days prior to the start of services delivery, the contractor shall demonstrate to DHA successful receipt and testing of electronic claims batches from the COBC for accurate processing of dual eligible claims, including claims for services covered by TRICARE but not covered by Medicare.

**2.2.1** Sixty (60) calendar days prior to the start of services delivery, the contractor shall have executed a Memorandum of Understanding (MOU) with all TRICARE MCSCs. The MOU shall include, but not be limited to, provider file update coordination, beneficiary history transfers, customer service coordination and marketing/education coordination.

**2.2.2** Within 60 calendar days of contract award, the contractor shall meet with and establish an MOU with DHA Communications. The MOU shall include, but not be limited to, the review and approval process for educational materials, the identification of desired educational materials required by either DHA or the contractor, the process for requesting additional educational materials, and the ordering and bulk shipment of materials. The MOU shall be effective within 30 days of the meeting. The content of the MOU will be coordinated with the Contracting Officer (CO) and the COR.

## 2.3 Claims Processing System And Operations

During the period between the date of award and the start of services delivery, contractor shall, pursuant to an implementation schedule approved by DHA, meet the following requirements:

### 2.3.1 Contractor File Conversions And Testing

**2.3.1.1** The contractor shall perform initial conversion and testing of all Automated Data Processing (ADP) files (e.g., provider files, pricing files, and beneficiary history and deductible files) no later than (NLT) 45 calendar days following receipt of the files from the outgoing contractor(s). Integration testing will be conducted to validate the contractor's internal interfaces to each of the TRICARE MHS Systems. This testing will verify the contractor's system integration, functionality, and implementation process.

**2.3.1.2** DHA Test Managers will work with the contractor to plan, execute and evaluate the Integration Testing efforts. The contractor shall identify a primary and a back-up Testing Coordinator to work with the DHA Test Managers. The Testing Coordinator is responsible for contractor testing preparations, coordination of tests, identification of issues and their resolution, and verification of test results. A web application will be available for use by contractor Test Coordinators to report and track issues and problems identified during integration testing.

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### **2.3.2 Receipt Of Outgoing MCSC's Weekly Shipment Of History Updates And Dual Operations**

**2.3.2.1** Beginning with the 120th calendar day prior to the start of services delivery and continuing after the start of services delivery until all pertinent claims received by the outgoing contractor have been processed, the contractor shall convert the weekly shipments of the beneficiary history and deductible file updates from the outgoing contractor(s) within two work days following receipt. These files shall be validated by the incoming contractor before use. Tests for claims, update of catastrophic cap, and duplicate claims shall be performed within two workdays following conversion. Any issues identified by the incoming contractor shall be resolved with the outgoing contractor and the DHA COR shall be kept informed of all issues identified within two work days and the problem resolution. Following the start of services delivery, these files shall be loaded to history and used for claims processing on the first processing cycle following the check for duplicate claims.

**2.3.2.2** During the period after the start of services delivery when the incoming contractor and the outgoing contractor are processing claims, both contractors shall maintain close interface on history update exchanges and provider file maintenance. During the first 60 calendar days of dual operations, the contractors shall exchange beneficiary history updates with each contractor's claims processing cycle run. Thereafter, the exchange shall not be less than twice per week until the end of dual processing.

### **2.3.3 DCS**

Approximately 30-45 days prior to service delivery, DHA will provide training for users of the DCS in accordance with Chapter 9. Following the start of services delivery, the DCS will begin displaying identified potential duplicate claim sets for which the contractor has responsibility. The contractor shall begin using the DCS to resolve potential duplicate claim sets in accordance with Chapter 9 and the transition plan requirements.

### **2.4 Transition-In (Phase-In) Status Report**

The contractor shall submit a weekly status report of phase-in and operational activities and inventories to DHA beginning the 20th calendar day following "Notice of Award" by DHA through the 180th calendar day after the start of services delivery (or as directed by the PCO based on the status of the transition and other operational factors). The status report will address only those items identified as being key to the success of the transition as identified in the Transition Specifications Meeting or in the contractor's start-up plan.

### **2.5 Public Notification Program - Provider And Congressional Mailing**

The contractor shall prepare a mailing to all Congressional offices within the region being transitioned by the 45th calendar day prior to the start of services delivery according to the specifications of the official transition schedule. The proposed mailing shall be submitted to the PCO and the COR for review, and the DHA Communications for approval NLT 90 calendar days prior to the start of services. The mailing shall discuss any unique processing requirements of the contractor and any other needed information dictated by the official transition schedule.

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### 3.0 CONTRACT TRANSITION-OUT

#### 3.1 Transitions Specifications Meeting

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

#### 3.2 Data

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

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

#### 3.3 Phase-Out Of The Contractor's Claims Processing Operations

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

##### 3.3.1 Provide Information

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

##### 3.3.2 Transfer Of Electronic File Specifications

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

- The TRICARE Encounter Provider (TEPRV) Files.
- The Beneficiary History and Deductible Files (including eligibility files, if applicable).

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

### 3.3.3 Transfer Of ADP Files (Electronic)

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

### 3.3.4 Outgoing Contractor Weekly Shipment Of History Updates

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

### 3.3.5 Transfer Of Non-ADP Files

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

### 3.3.6 EOB Record Data Retention And Transmittal

If the contractor elects to retain the EOB data on a computer record, it must, in the event of a transition to another contractor, provide either a full set of electronic records covering the current and two prior years, or, at the CO's discretion, provide the data and necessary programs to reproduce the EOB in acceptable form and transfer such data and programs to the successor contractor or to **DHA**. **DHA** shall be the final authority in determining the form and/or acceptability of the data and/or microcopies. See [Chapter 1, Section 7 \(Transitions\)](#) and [Chapter 2 \(Records Management\)](#) for additional information on transitioning electronic EOBs.

### **3.3.7 Transition-Out (Phase-Out) Status Report**

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

### **3.4 Final Processing Of Outgoing Contractor**

The outgoing contractor shall:

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

#### **3.4.1 Correction Of Edit Rejects**

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

#### **3.4.2 Cost Accounting**

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

#### **3.4.3 Records Disposition**

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

- END -

# Index

<b>A</b>	<b>Chap</b>	<b>Sec/Add</b>	<b>C</b>	<b>Chap</b>	<b>Sec/Add</b>
Acronyms And Abbreviations		Appendix A	Case Development And Action	13	2
Active Duty Dental Care In Remote Overseas Locations	24	10	Civilian Health Care (CHC) Of Uniformed Service Members	24	26
Additional Supporting Information Pertaining To The Transaction And Code Sets Final Rule	19	A	Claim Development	8	6
Administration			Claim Refund And Collection Procedures	3	3
Figures	1	A	Claims Adjustments And Recoupments		
Management	1	4	Figures	10	A
Transitions	1	7	General	10	1
Allowable Charge Reviews	11	7	Claims Filing Deadline	8	3
Ambulance/Aeromedical Evacuation Services	24	7	Claims Processing For Dual Eligibles	20	3
Appeal Of Factual (Non-Medical Necessity) Determinations	12	5	Claims Processing Procedures		
Appeals And Hearings			Figures	8	A
Figures	12	A	General	8	1
General	12	1	TRICARE Overseas Program (TOP)	24	9
TRICARE Overseas Program (TOP)	24	13	Clinical Preventive Services (Prime/Standard)	24	8
Appeals Of Medical Necessity Determinations	12	4	Clinical Quality Management Program (CQMP)	7	4
Application Of Deductible And Cost-Sharing	8	7	Clinical Support Agreement (CSA) Program	15	3
Applied Behavior Analysis (ABA) Pilot For Non-Active Duty Family Member (NADFM)	18	15	Collection Actions Against Beneficiaries	11	9
Audits And Inspections	14	1	Compliance With Federal Statutes	1	5
Reports And Plans	14	2	Comprehensive Autism Care		
Special Reports	14	3	Demonstration	18	18
Audits, Inspections, Reports, And Plans	24	15	Participation Agreement	18	B
TRICARE Overseas Program (TOP)	24	15	Continued Health Care Benefit Program (CHCBP)		
Autism Demonstration Corporate Services Provider (ACSP) Participation Agreement	18	A	Eligibility And Coverage	26	1
			TRICARE Overseas Program (TOP)	24	25
			Contract Administration And Instructions	1	2
			Contractor Relationship With The Military Health System (MHS) TRICARE Quality Monitoring Contractor (TQMC)	7	3
			Contractor Responsibilities - SHCP	17	3
			Contractor Responsibilities And Reimbursement - TPR	16	4
			Correspondence Control, Processing, And Appraisal	11	5
			Critical Access Hospital (CAH) Payment Rates	18	7
			Customer Service Functions	24	11

  

<b>B</b>	<b>Chap</b>	<b>Sec/Add</b>
Beneficiary Education And Support Division (BE&SD)	24	11
Beneficiary, Congressional, Media, BCAC, DCAO, And HBA Relations	11	3

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

Index

<b>D</b>	<b>Chap</b>	<b>Sec/Add</b>	<b>D (CONTINUED)</b>	<b>Chap</b>	<b>Sec/Add</b>
Definitions		Appendix B	Destruction Of Records	2	6
Demonstrations			Digital Imaging (Scanned) And Electronic (Born-Digital) Records Process And Formats	2	3
DoD Applied Behavior Analysis (ABA) Pilot For Non-Active Duty Family Member (NADFMs)	18	15	Director of TRICARE Regional Offices (TROs)/Military Treatment Facility (MTF) Commanders and Enhanced Multi-Service Market (eMSM) Interface	15	1
DoD Comprehensive Autism Care Demonstration	18	18	Duplicate Payment Prevention	8	9
DoD Enhanced Access To Autism Services	18	8			
DoD Enhanced Access to Patient Centered Medical Home (PCMH)			<b>E</b>	<b>Chap</b>	<b>Sec/Add</b>
Demonstration Project for Participation in the Maryland Multi-Payer Patient-Centered Medical Home Program (MMPCMHP)	18	14	Education Requirements	11	1
DoD TRICARE Demonstration Project for the Philippines	18	12	Electronic Record Transfer Procedures	2	B
EXPIRED - Critical Access Hospital (CAH) Payment Rates	18	7	Electronic Records Disposition, Storage, And Transfer	2	4
EXPIRED - DoD Alcohol Abuse Prevention And Education	18	6	Enhanced Access To Autism Services Demonstration	18	8
EXPIRED - DoD Cancer Prevention And Treatment Clinical Trials	18	2	Participation Agreement	18	A
EXPIRED - DoD In-Utero Fetal Surgical Repair Of Myelomeningocele Clinical Trial	18	3	Enrollment Portability	6	2
EXPIRED - DoD Tobacco Cessation	18	5	Enrollment Processing	6	1
EXPIRED - DoD Weight Management	18	4	Enrollment, Beneficiary Education, And Support Services	16	3
EXPIRED - Operation Noble Eagle/ Operation Enduring Freedom Reservist And National Guard (NG) Benefits	18	9	Explanation Of Benefits (EOB)	8	8
EXPIRED - Web-Based TRICARE Assistance Program (TRIAP)	18	10	Extended Care Health Option (ECHO)	24	23
<b>EXPIRED As Of September 30, 2015 - Pilot Program for Refills of Maintenance Medications for TRICARE For Life (TFL) Beneficiaries through the TRICARE Mail Order Program (TMOP)</b>	<b>18</b>	<b>16</b>	<b>F</b>	<b>Chap</b>	<b>Sec/Add</b>
General	18	1	Financial Administration		
TRICARE Evaluation Of Centers For Medicare And Medicaid Services (CMS) Approved Laboratory Developed Tests (LDTs)	18	13	General	3	1
TRICARE Management Activity (TMA) Evaluation Of Non-United States Food and Drug Administration (FDA) Approved Laboratory Developed Tests (LDTs)	18	17	TRICARE Overseas Program (TOP)	24	3
TRICARE Overseas Program (TOP)	24	27	<b>G</b>	<b>Chap</b>	<b>Sec/Add</b>
TRICARE South Region USCG ATC For TRICARE Prime/TPR Beneficiaries	18	11	Governing Principles	12	2
			Government Staff And Beneficiary Education	11	2
			Grievances And Grievance Processing	11	8
			<b>H</b>	<b>Chap</b>	<b>Sec/Add</b>
			Health Care Providers And Review Requirements	16	2
			Health Insurance Portability and Accountability Act (HIPAA) of 1996		
			General	19	1
			TRICARE Overseas Program (TOP)	24	28
			Health Insurance Portability And Accountability Act (HIPAA) Standard Unique Health Identifier For Health Care Providers Final Rule	19	4
			Hospital Adjustments	7	C
			Hospital Issued Notices Of Noncoverage	7	B
			Host Nation Providers	24	4



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

Index

<b>T</b>	<b>Chap</b>	<b>Sec/Add</b>	<b>T (CONTINUED)</b>	<b>Chap</b>	<b>Sec/Add</b>
Telephone Inquiries	11	6	Prime Program	24	17
Third Party Recovery Claims	10	5	Prime Remote Program	24	18
Threats Against Contractors	13	8	Standard	24	19
Transferring Records (Federal Records Centers (FRCs) And Transitions)	2	5	TRICARE For Life (TFL)	24	20
Transitional Assistance Management Program (TAMP)	24	24	TRICARE Plus	24	22
TRICARE Alaska	21	1	TRICARE Reserve Select (TRS)	24	21
TRICARE Area Office (TAO) Director/MTF And Contractor Interfaces	24	16	TRICARE Pharmacy (TPharm)		
TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC)			Claims Processing	23	3
Claims Processing For Dual Eligibles	20	3	General	23	1
General	20	1	Other Contract Requirements	23	4
Jurisdiction	20	2	Out-Of-Jurisdiction Claims	23	2
Other Contract Requirements	20	4	Transition	23	5
Transition	20	5	TRICARE Plus	6	4
TRICARE Duplicate Claims System - TED Version			TRICARE Prime Remote (TPR) Program		
Claim Sets And The Claim Set Life Cycle	9	4	General	16	1
Contractor To Contractor Transition Guide	9	C	Points Of Contacts	16	A
Download Files	9	E	Reports	16	5
Duplicate Claims Data	9	3	TRICARE Prime Remote For Active Duty Family Member (TPRADFM) Program	16	6
Duplicate Claims System (DCS)			TRICARE Processing Standards	1	3
Displayed Data Fields	9	A	TRICARE Reserve Select (TRS)		
Mass Change Function For Contract Transitions	9	7	Figures	22	A
Multi-Contractor Claim Sets	9	6	TRICARE Reserve Select (TRS)	22	1
Overview	9	1	TRICARE Retired Reserve (TRR)	22	2
Quick Start Instructions	9	2	TRICARE Service Center (TSC)	24	11
Reason Codes	9	B	TRICARE Young Adult (TYA)	25	1
Report Descriptions And Examples	9	D			
Reports	9	8	<b>U</b>	<b>Chap</b>	<b>Sec/Add</b>
System Implementation And Operational Requirements	9	9	Underpayments	10	2
User's Guide	9	5	Utilization And Quality Management	7	1
TRICARE Logo	11	A			
TRICARE Management Activity (TMA) Appeals	12	6	- END -		
TRICARE Overseas Program (TOP)					
Administration	24	1			
Continued Health Care Benefit Program (CHCBP)	24	25			
Eligibility And Enrollment	24	5			
Figures	24	30			
Partnership Program	24	29			
Point Of Contact (POC) Program	24	12			
TRICARE Overseas Program (TOP) (Continued)					