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**CHANGE 155
6010.56-M
NOVEMBER 20, 2015**

**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: CLARIFICATION ON DURABLE EQUIPMENT/DURABLE MEDICAL EQUIPMENT,
ORDERING DURABLE EQUIPMENT/DURABLE MEDICAL EQUIPMENT, AND
ASSISTIVE TECHNOLOGY DEVICES**

CONREQ: 17374

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change provides clarifying instructions for processing of claims for DME, which is a subset of "DE" for purposes of the TRICARE Basic Program. Claims related to DME (including exclusion of luxury features and pricing methods) apply to DE. This change also clarifies that physicians, dentists, or any TRICARE-authorized allied health care professionals, as described in 32 CFR 199.6(c)(3)(ii), may order or prescribe DE.

EFFECTIVE DATE: January 30, 2015.

IMPLEMENTATION DATE: December 21, 2015.

This change is made in conjunction with Feb 2008 TPM, Change No. 145 and Feb 2008 TRM, Change No. 118.

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**ATTACHMENT(S): 48 PAGES
DISTRIBUTION: 6010.56-M**

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

**CHANGE 155
6010.56-M
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REMOVE PAGE(S)

CHAPTER 8

Section 4, pages 1 through 4

Section 6, pages 1 through 6

CHAPTER 17

Section 2, pages 1 through 5

CHAPTER 19

Section 2, pages 7 through 10 and 15 through 22

CHAPTER 24

Section 9, pages 1 through 4 and 7 through 17

APPENDIX A

pages 3 through 8

INSERT PAGE(S)

Section 4, pages 1 through 4

Section 6, pages 1 through 6

Section 2, pages 1 through 5

Section 2, pages 7 through 10 and 15 through 22

Section 9, pages 1 through 4 and 7 through 17

pages 3 through 8

Signature Requirements

1.0 SIGNATURE REQUIREMENTS

1.1 In establishing signature requirements for financially underwritten TRICARE claims, the contractor shall comply with state laws and with corporate policy for requiring signatures on their private business claims. However, when the private or state signature requirements conflict with Federal Privacy Act, Health Insurance Portability and Accountability Act (HIPAA), or Freedom of Information Act (FOIA) requirements, the latter shall prevail.

1.2 The contractor shall comply with the following requirements in processing non-network TRICARE claims for which the signature of the beneficiary, spouse, or parent or guardian of a beneficiary is required unless qualifying for an exception. If additional personal information or release of medical information is required to complete claim processing, the claim shall be returned to the beneficiary for his/her signature, unless the beneficiary is not competent.

2.0 PRIVACY ACT REQUIREMENTS CUSTODIAL/NONCUSTODIAL PARENT

Any relaxation of signature requirements does not, in any way, relax the confidentiality requirement imposed by the Privacy Act. Checks, Explanations of Benefits (EOBs), responses to inquiries, etc., shall be addressed to the beneficiary or parent or guardian of a beneficiary who is incompetent or under 18 years of age. Under the provisions of the Privacy Act of 1974, neither **Defense Health Agency (DHA)** nor a claims processor shall provide the non-custodial parent with any information concerning the processing of TRICARE claims for the minor children without the written consent of the custodial parent. In the case of divorce or legal separation only the custodial parent shall have access to the medical record(s), unless the divorce or legal separation decree gives rights to the records to the non-custodial parent. Questions regarding custodial parent issues should be addressed to the **DHA** Office of General Counsel (OGC).

3.0 BENEFICIARY IS UNDER 18 YEARS OF AGE

3.1 Non-Participating Provider Claims

Normally, the claim should be signed by the parent or legal guardian if the beneficiary is under 18 years of age. However, if the beneficiary signs the claim form legibly, the claim should be processed unless there is other reason to return the claim form, or doing so conflicts with state law or contractor policy. Request the parent/legal guardian signature, if the claim form is returned except for the two exceptions listed below. In the following situations, a beneficiary under 18 years of age may always sign the claim form in his or her own behalf in accordance with state laws related to the age of consent and the Federal Privacy Act.

3.1.1 Exceptions

- He or she is (or was) a spouse of an Active Duty Service Member (ADSM) or retiree; or
- The services are related to venereal disease, substance or alcohol abuse, or abortion.

3.2 Participating Provider Claims

If a claim is signed by a beneficiary who is under 18 years of age but the provider agrees to participate, it is not necessary to obtain the signature of the parent/legal guardian.

4.0 BENEFICIARY IS 18 YEARS OF AGE OR OLDER (INCOMPETENT OR INCAPABLE)

4.1 When the beneficiary is mentally incompetent or physically incapable, the person signing should be either the legal guardian, or in the absence of a legal guardian, a spouse or parent of the patient. The person signing should:

- Write the beneficiary's name in the appropriate space on the claim form, followed with the word "by" and his or her own signature;
- Include a statement that a legal guardian has not been appointed, if such is the case; and
- Include documentation of appointment if a legal guardian has been appointed or if a power of attorney has been issued. Attach a statement giving his or her full name and address, relationship to the patient, and the reason the patient is unable to sign. Beneficiaries who have no legal guardian or family member available to sign claims, can provide documentation (i.e., a report from a physician describing the physical and or mental incapacitating illness). For those conditions/illnesses which are temporary, the signature waiver needs to specify the inclusive dates of the condition/illness.

4.2 A beneficiary who is physically incapable of signing their signature can have a general or limited power of attorney issued by having their "mark" (e.g., an "X") witnessed and notarized.

5.0 BENEFICIARY DECEASED

5.1 If the provider of care has an approved signature on file agreement and the beneficiary expires, the authorization for payment will satisfy the signature requirements and the contractor shall process the claim.

5.2 If the beneficiary is deceased, the claim form must be signed by the legal representative of the estate. Documentation must accompany the claim form to show that the person signing is the legally appointed representative. If no legal representative has been appointed, the claim form may be signed by the parent, the spouse, or the next of kin. The signer must provide a statement that no legal representative has been appointed. The statement should contain the date of the beneficiary's death and the signer's relationship to the beneficiary to enable the contractor to update the history file.

5.3 In the event that there is no spouse, parent or guardian to sign the claim form for a deceased beneficiary, the claim must be signed by the surviving next of kin or a legally appointed representative (indicate relationship to beneficiary).

5.4 When there is no spouse, parent or guardian to sign the claim form for a deceased beneficiary, no next of kin, and no legal representative, the contractor shall arrange to pay the provider whether network or non-network for services rendered in accord with state law and corporate policy.

6.0 BENEFICIARY SIGNATURE ON FILE

Use of the signature on file procedure is the provider's indication that he or she agrees to the following requirements: Verification of the beneficiary's TRICARE eligibility at the time of admission or at the time care or services are provided. Incorporation of the language below, or comparable language acceptable to the TRICARE contracts, into the provider's permanent records.

6.1 Institutional Providers

"I request payment of authorized benefits to me or on my behalf for any services furnished me by **(Name of Provider)**, including physician services. I authorize any holder of medical or other information about me to release to **(Contractor's Name)** any information needed to determine these benefits or benefits for related services." Professional providers who submit claims on the basis of an institution's signature on file should include the name of the institutional provider that maintains the signature on file. The Centers for Medicaid and Medicare Services (CMS) 1450 UB-04 instructions shall be followed for certifying signature on file except that the permanent hospital record containing a release statement will be recognized. Institutional includes all claims related to an institution."

6.2 Professional Providers

"I request that payment of authorized benefits be made either to me or on my behalf to Dr. _____, for any services furnished me by that physician. I authorize any holder of medical information about me to release to **(Contractor's Name)** any information needed to determine these benefits or the benefits payable for related services."

6.2.1 If a claim is submitted by a nonparticipating provider and payment will not be made to the patient, the provider must indicate the name, address, and relationship of the person to whom payment will be made. This will be the sponsor, other parent or a legal guardian for minor children or incompetent beneficiaries, except for claims involving abortion, venereal disease or substance/ alcohol abuse.

6.2.2 Cooperate with the contractor postpayment audits by supplying copies of the requested signature(s) on file within 21 days of the date of the request and/or allow the contractor access to the signature files for purposes of verification. See [Chapter 1, Section 4, paragraph 4.1](#) and [Chapter 11, Section 5, paragraph 6.3](#) for audit requirements.

6.2.3 Correct any deficiencies found by the contractor audit within 60 days of notification of the deficiency of participation in the signature relaxation program will be terminated.

6.3 Institutional Claims

Outpatient hospital, professional inpatient and outpatient hospital services for release of information purposes, the provider must obtain the beneficiary or other authorized signature on a permanent hospital admission record for each separate inpatient admission. A professional provider submitting a claim related to an inpatient admission must indicate the name of the facility maintaining the signature on file. Claim forms must indicate that the signature is on file.

6.4 Professional Provider Claims

Outpatient professional providers such as physician's office and suppliers such as Durable Equipment (DE) and Durable Medical Equipment (DME). Authorized individual providers have the option to retain on their own forms appropriate beneficiary release of information statements for each visit or obtain and retain in his or her files a one-time payment authorization applicable to any current and future treatment that the authorized individual provider may furnish him or her. Claim forms must indicate that the signature is on file.

6.5 Outpatient Ancillary Claims

Such as claims that are submitted from an independent laboratory where, ordinarily, no patient contact occurs. A provider submitting a claim for diagnostic tests or test interpretations, or other similar services, is not required to obtain the patient's signature. These providers must indicate on the claim form: "patient not present." For services when there is patient contact, such as services furnished in a medical facility which is visited by the beneficiary, the same procedure used for professional claims for outpatient services is required, except that the provider will indicate along with "signature on file" information, the name of the supplier or other entity rather than a physician maintaining the signature on file.

6.6 Verification Of Provider's Compliance With The Beneficiary Signature On File Requirement

The contractor shall verify beneficiary signature on file compliance using the postpayment audit requirement in paragraph 6.2.2, and Chapter 1, Section 4, paragraph 4.1, and the audit procedures in Chapter 11, Section 5, paragraph 6.3.

7.0 UNACCEPTABLE SIGNATURES

A provider or an employee of an institution providing care to the patient may not sign the claim form on behalf of the beneficiary under any circumstances. Nor can an employee of a contractor execute a claim on behalf of a beneficiary (unless such employee is the beneficiary's parent, legal guardian, or spouse). Beneficiaries, who have no legal guardian or family member available to sign claims, can provide documentation (i.e., a report from a physician describing the physical and/or mental incapacitating illness). For those conditions/illnesses, which are temporary, the signature waiver needs to specify the inclusive dates of the condition/illness. If the beneficiary is unable to sign due to an incapacitating condition/illness, the provider can annotate in the Signature Box on the TRICARE claim form "Unable to sign." A letter from the provider shall be attached to the claim form describing the physical and or mental incapacitating illness. For those illnesses, which are temporary, the letter needs to specify the inclusive dates of the illness.

Claim Development

1.0 GENERAL

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

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

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

2.0 AGREEMENT TO PARTICIPATE

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

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

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

3.0 CLAIMS FOR CERTAIN ANCILLARY SERVICES

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

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 Equipment (DE) and Durable Medical Equipment (DME)** that is paid by separately submitted monthly installments will be split into one claim for each

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

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

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

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

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

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

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

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

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

9.8 A 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.

- END -

Providers Of Care

1.0 GENERAL

1.1 The Supplemental Health Care Program (SHCP) payment structure applies to inpatient and outpatient medical claims submitted by civilian institutions, individual professional providers, suppliers, pharmacies, and other TRICARE authorized providers for Civilian Health Care (CHC) rendered to Uniformed Service members and other SHCP-eligible individuals. For Military Treatment Facility (MTF)-referred care, the Managed Care Support Contractor (MCSC) will make referrals to network providers as required by contract.

1.2 For care that is not MTF referred (including care for MTF enrollees), most patients covered by this chapter will have undergone medical care prior to any contact with the Specified Authorization Staff (SAS) ([Addendum A](#)) or the MCSC. However, when the patient initiates contact prior to treatment and the SAS has authorized the care being sought, the MCSC will issue authorizations and assist in finding network providers; if a network provider is not available, the referral will be made to a TRICARE authorized provider.

1.3 For service determined eligible patients other than active duty (e.g., Reserve Officer Training Corps (ROTC), Reserve Component (RC), foreign military, etc.), the contractor, upon receiving an authorization from the SAS, will record and enter the authorization to enable appropriate claims processing, and, if necessary, will assist the patient with a network provider or TRICARE-authorized provider (if available).

1.4 Claims for active duty dental services in the 50 United States, the District of Columbia, and U.S. territories and commonwealths will be processed and paid by a single, separate active duty dental program contractor. Claims for adjunctive dental care will be processed and paid by the MCSC (or the TOP contractor for overseas care).

2.0 UNIFORMED SERVICES FAMILY HEALTH PLAN (USFHP)

2.1 In addition to receiving claims from civilian providers, the contractor may also receive SHCP claims from certain USFHP Designated Providers (DPs). The provisions of the SHCP will not apply to services furnished by a USFHP DP if the services are included as covered services under the current negotiated agreement between the USFHP DP and the **Defense Health Agency (DHA)** (this includes care for a USFHP enrollee). However, any services not included in the USFHP DP agreement shall be paid by the contractor in accordance with the requirements in this chapter.

2.2 The USFHP, administered by the DPs listed below currently have negotiated agreements which provide the Prime benefit (inpatient and outpatient care). Since these facilities have the

capability for inpatient services, they can submit claims which will be paid in accordance with applicable TRICARE reimbursement rules under the SHCP:

- CHRISTUS Health, Houston, TX (which also includes):
 - St. Mary's Hospital, Port Arthur, TX
 - St. John Hospital, Nassau Bay, TX
 - St. Joseph Hospital, Houston, TX
- Martin's Point Health Care, Portland, ME
- Johns Hopkins Health Care Corporation, Baltimore, MD
- Brighton Marine Health Center, Boston, MA
- St. Vincent's Catholic Medical Centers of New York, New York City, NY
- Pacific Medical Clinics, Seattle, WA

3.0 DEPARTMENT OF VETERANS AFFAIRS (DVA)

In addition to receiving claims from civilian providers, the contractor may also receive SHCP claims from the DVA. The provisions of the SHCP will not apply to services provided under any Memorandum of Agreement (MOA) for sharing between the Department of Defense (DoD) (including the Army, Air Force, Navy/Marine Corps, and Coast Guard facilities) and the DVA. Claims for these services will continue to be processed by the Services. However, any services not included in any MOA described below shall be paid by the contractor in accordance with the TRICARE Reimbursement Manual (TRM) to include claims referred for beneficiaries on the Temporary Disability Retirement List (TDRL).

3.1 Claims for Care Provided Under the National DoD/DVA MOA for Spinal Cord Injury (SCI), Traumatic Brain Injury (TBI), Blind Rehabilitation, and Polytrauma

3.1.1 Effective August 4, 2009, the contractor shall process DVA submitted claims for Service members' treated under the MOA in accordance with this chapter and the following (SCI, TBI MOA; see [Addendum D](#) for a full text copy of the MOA for references purposes only).

3.1.2 Claims received from a DVA health care facility for Service member care shall be processed as an MOA claim based upon the DHA/Defense Health Agency-Great Lakes (DHA-GL) authorization number. As determined by DHA/DHA-GL, all medical conditions shall be authorized and paid under this MOA if a condition of TBI, SCI, Blindness, or Polytrauma exists for the patient. The authorization shall clearly indicate that the care has been authorized under the SCI, TBI, Blindness, and Polytrauma MOA. The authorization shall specify type of care (inpatient, outpatient, etc.) to be given under the referenced MOA and limits of the authorization (inpatient days, outpatient visits, expiration date, etc.). Suggested authorization language to possibly include all care authorized under the SCI, TBI, Blindness, and Polytrauma MOA for inpatient, outpatient and rehabilitative care. DHA/DHA-GL shall send authorizations to the contractor either by fax or by other mutually agreed upon modality.

3.1.3 The contractor shall verify whether the DVA-provided care has been authorized by the DHA/DHA-GL. If an authorization is on file, the contractor shall process the claim to payment. The contractor shall not deny claims for lack of authorization. If a required authorization is not on file, the contractor shall place the claim in a pending status and forward the appropriate documentation to the DHA/DHA-GL identifying the claim as a possible MOA claim for determination (following the procedures in Addendum B for the DHA/DHA-GL SAS referral and review procedures). Additionally, any DVA submitted claim for a Service member with a TBI, SCI, blindness, or polytrauma condition that does not have a matching authorization number shall be pending to the DHA/DHA-GL for payment determination.

3.1.4 MOA claims shall be reimbursed as follows:

3.1.4.1 Claims for inpatient care shall be paid using DVA interagency rates, published in the Federal Register. The interagency rate is a daily per diem to cover an inpatient stay and includes room and board, nursing, physician, and ancillary care. These rates will be provided to the contractor by the DHA (including periodic updates as needed). There are three different interagency rates to be paid for rehabilitation care under the MOA. The Rehabilitation Medicine rate will apply to TBI care. Blind rehabilitation and SCI care each have their own separate interagency rate. Additionally, it is possible that two or more separate rates will apply to one inpatient stay. All interagency rates except the outpatient interagency rate in the Office of Management and Budget (OMB) Federal Register Notice provided by DHA will be applicable. If the DVA-submitted claim identifies more than one rate (with the appropriate number of days identified for each separate rate), the contractor shall pay the claim using the separate rate. (For example, a stay for SCI may include days paid with the SCI rate and days billed at a surgery rate.) MCSCs shall verify the DVA billed rate on inpatient claims matches one of the interagency rates provided by DHA. DVA claims for inpatient care submitted with an applicable interagency rate shall not be developed any further (i.e., for revenue codes, diagnosis, etc.) if care has been approved by the DHA/DHA-GL. Claims without an applicable interagency rate shall be denied and an Explanation of Benefits (EOB) shall be issued to the DVA, but not the beneficiary. The claim will need to be resubmitted for payment.

3.1.4.2 Claims for outpatient and ambulatory surgery professional services shall be paid at the appropriate TRICARE allowable rate (e.g., CHAMPUS Maximum Allowable Charge (CMAC)) with a 10% discount applied. For those services without a TRICARE allowable rate, DVA shall be reimbursed at billed charges.

3.1.4.3 The following care services, irrespective of health care delivery setting require authorization from DHA-GL and are reimbursed at billed charges (actual DVA cost) separately from DVA inpatient interagency rates, if one exists:

- Transportation
- Prosthetics
- Non-medical rehabilitative items
- Durable Equipment (DE) and Durable Medical Equipment (DME)
- Orthotics (including cognitive devices)
- Routine and adjunctive dental services
- Optometry
- Lens prescriptions
- Inpatient/outpatient TBI evaluations

- Special diagnostic procedures
- Inpatient/outpatient polytrauma transitional rehabilitation program
- Home care
- Personal care attendants
- Conjoint family therapy
- Ambulatory surgeries
- Cognitive rehabilitation
- Extended care/nursing home care

3.1.4.4 On August 4, 2009, the contractor shall process all claims received on or after this date using the guidelines established under the updated MOA regardless of the date of service. All TRICARE Encounter Data (TED) records for this care shall include Special Processing Code 17 - DVA medical provider claim.

3.1.4.5 If paid at per diem rates, the provisions of [Chapter 8, Section 2, paragraph 7.2](#), apply when enrollment changes in the middle of an inpatient stay. If enrollment changes retroactively, prior payments will not be recouped.

3.2 Claims for Care Provided Under the National DoD/DVA MOA for Payment for Processing Disability Compensation and Pension Examinations (DCPE) in the Integrated Disability Evaluation System (IDES)

The contractor shall reimburse the DVA for services provided under the current national DoD/DVA MOA for "Processing Payment for Disability Compensation and Pension Examinations in the Integrated Disability Evaluation System" (IDES MOA; see [Addendum C](#) for a full text copy of the MOA for reference purposes only). The contractor shall begin processing these claims with dates of care January 1, 2011 and forward. Claims under the IDES MOA shall be processed in accordance with this chapter and the following:

3.2.1 Claims submitted by the DVA on a Centers for Medicare and Medicaid Services (CMS) 1500 Claim Form for a Service member's care with the Current Procedural Terminology (CPT¹) code of 99456 (principal or secondary) shall be processed as a IDES MOA claim.

3.2.2 The contractor shall verify whether services provided under the IDES MOA have been referred and authorized by the MTF. The MTF will generate a single referral request in the Armed Forces Health Longitudinal Technology Application (AHLTA) and submit the referral to the contractor. The referral will specify the total number of Compensation and Pension (C&P) examinations authorized for payment by the contractor. It is not necessary for the referral to identify the various specialists who will render the different C&P examinations. The reason for referral will be entered by the MTF as "**DVA only: Disability Evaluation System (DES) C&P exams for fitness for duty determination - total ___**." The MTF will complete the referral as described in [Chapter 8, Section 5, paragraph 6.1](#) including Note 4.

3.2.3 The DVA will list one C&P examination (CPT¹ code 99456) per the appropriate field of the CMS 1500 Claim Form and indicate one unit such that there is a separate line item for each C&P examination. The DVA can list related ancillary services separately in the appropriate field of the CMS 1500 Claim Form using the appropriate CPT codes.

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TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 17, Section 2

Providers Of Care

3.2.4 If an authorization is on file, the contractor shall process the claim to payment (see [Section 2, paragraph 2.2](#)). One C&P examination fee will be paid for each referred and authorized C&P examination up to the total number of C&P examinations authorized. If no authorization is on file, the contractor shall place the claim in a pending status and shall forward appropriate documentation to the MTF for determination (following the procedures in [Section 3, paragraph 1.2.1](#)).

3.2.5 Claims for C&P exams shall be paid SHCP using the pricing provisions agreed upon in the IDES MOA. CPT² procedure code 99456 shall be used and will be considered to include all parts of each C&P examination, except ancillary services. Claims for related ancillary services shall be paid at the appropriate TRICARE allowable rate (e.g., CMAC) with a 10% discount applied.

FIGURE 17.2-1 DISABILITY PAY SCHEDULE

EFFECTIVE DATE	C& P DISABILITY EXAM (99456 ²)	ANCILLARY SERVICES
01/01/2011	\$515.00	CMAC - 10%

3.2.6 All TED records for this care shall include Special Processing Code **DC** - Compensation and Pension Examinations-DVA, Special Processing Code **17** - VA Medical Provider Claim, and Enrollment Health Plan Code **SR** - SHCP-Referred Care.

3.2.7 Claims for care provided prior to January 1, 2011 will be paid by **DHA**. The contractor shall pay all claims with dates of care from that date forward. The contractor shall NOT be responsible for processing adjustments for any claims previously paid by **DHA**.

- END -

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

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

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

- Medical supplies.
- Orthotic and prosthetic devices.
- **Durable Equipment (DE) and Durable Medical Equipment (DME).**

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

1.7 General Requirements For Covered Entities

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

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

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

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

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

1.8 General Requirements For Health Plans

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

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

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

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

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

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

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

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

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

2.0 TRICARE OBJECTIVES

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

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

3.0 CONTRACTOR RELATIONSHIPS TO THE TRICARE HEALTH PLAN

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

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

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 19, Section 2

Standards For Electronic Transactions

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

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

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

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

4.4.2 Enrollment And Disenrollment Transactions

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

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

4.5.1 Direct Data Entry Systems

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

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

4.5.2 Web Server Technology

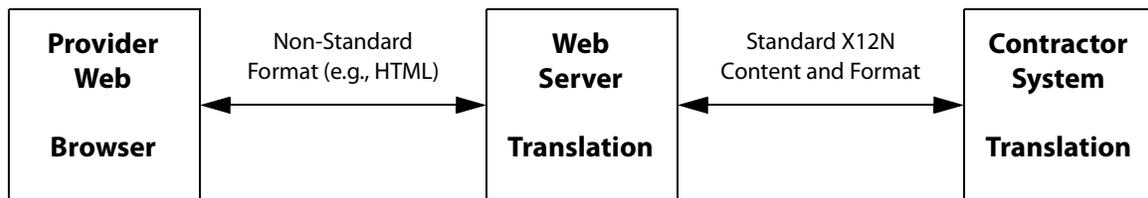
Note: This section discusses web server technology and, as a courtesy, provides guidance as to HIPAA requirements for the use of web applications. It is not an instruction from DHA to develop, operate, modify, or maintain contractor web applications. This section provides the HIPAA rules for operating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

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

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

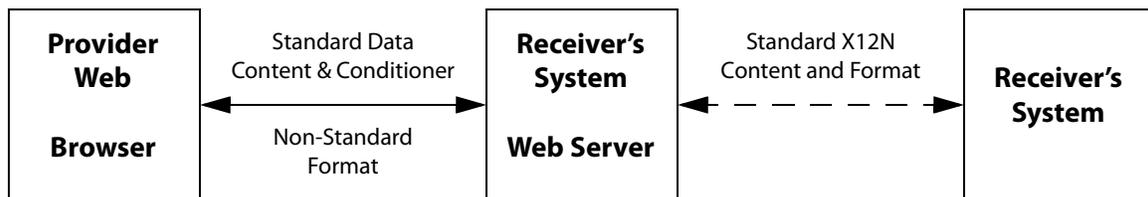
4.5.2.2 Browser-To-Web Server Data Exchange (not part of the receiver's system):

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



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

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



4.6 Transactions Involving Foreign Entities

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

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

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

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

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

4.7 Transactions Exchanged Between Contractors And DHA

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

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

4.8 Clearinghouse Use By Contractors

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

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

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

5.0 TRADING PARTNER AGREEMENTS

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

5.2 Implementation Guide Requirements

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

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

5.2.2 Trading partner agreements shall **NOT**:

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

6.0 ADDITIONAL NON-HIPAA TRANSACTIONS REQUIRED

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

6.1 Acknowledgments

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

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

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

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

6.1.1 Interchange Acknowledgment

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

- The ANSI ASC X12N TA1 - Interchange Acknowledgment Segment.

6.1.2 Implementation Acknowledgment

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

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

6.1.3 Implementation Guide Syntax And Semantic And Business Edit Acknowledgments

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

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

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

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

6.2 Medicaid Non-Pharmacy Subrogation Claims

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

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

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

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

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

7.0 ONGOING TRANSACTION TESTING

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

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

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

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

8.0 MISCELLANEOUS REQUIREMENTS

8.1 Paper Transactions

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

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

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

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

8.2 Attendance At Designated Standards Maintenance Organization (DSMO) Meetings

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

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

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

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

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

8.3 Provider Marketing

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

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

8.4 Data Retention And Audit Requirements

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

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

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

- END -

Claims Processing Procedures

1.0 GENERAL

1.1 All TRICARE requirements regarding claims processing shall apply to the TRICARE Overseas Program (TOP) unless specifically changed, waived, or superseded by this section; the TRICARE Policy Manual (TPM), [Chapter 12](#); or the TRICARE contract for health care support services outside the 50 United States and the District of Columbia (hereinafter referred to as the "TOP Contract"). See [Chapter 8](#) for additional instructions.

1.2 The provisions of [Chapter 8, Section 1, paragraph 1.0](#) are applicable to the TOP.

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

1.4 The provisions of [Chapter 8, Section 1, paragraph 2.2](#) are not applicable to the TOP, except in U.S. territories where Medicaid is available.

1.5 The provisions of [Chapter 8, Section 1, paragraph 2.3](#) are applicable the TOP; however, region or country-specific requirements regarding third party payments or payment addresses may be established by [Defense Health Agency \(DHA\)](#) at any time to prevent or reduce fraud.

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

1.6 The TOP contractor shall comply with the provisions of [Chapter 8, Section 1, paragraph 3.1](#) regarding acceptable claims forms, unless a different process has been authorized by the [DHA Contracting Officer \(CO\)](#).

1.7 The provisions of [Chapter 8, Section 1, paragraph 4.0](#) are applicable to the TOP.

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

2.0 JURISDICTION

2.1 In the early stages of TOP claims review, the TOP contractor shall determine whether claims received are within its contractual jurisdiction using the criteria below. TOP jurisdiction for health

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 24, Section 9

Claims Processing Procedures

care and remote Active Duty Service Member (ADSM) dental care is identified in the TOP contract with **DHA**.

2.2 Services rendered onboard a commercial ship while outside U.S. territorial waters are the responsibility of the TOP contractor. Claims for services provided on a commercial ship that is outside the territorial waters of the United States (U.S.) are to be processed as foreign claims regardless of the provider's home address. If the provider is certified within the U.S., reimbursement for the claim is to be based on the provider's home address. If the provider is not certified within the U.S., reimbursement will follow the procedures for foreign claims. This does not include health care for enrolled ADSM on a ship at sea or on a ship at home port.

2.3 The provisions of [Chapter 8, Section 2, paragraphs 1.0](#) and [2.0](#) are superseded as described in [paragraphs 2.3.1](#) through [2.3.9](#).

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

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

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

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

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

2.3.5 Initial and follow-on Line Of Duty (LOD) claims for RC ADSMs on orders for 30 consecutive days or less, who are injured while traveling to or from annual training or while performing their annual training who receive civilian medical care overseas, shall have their claims processed by the TOP contractor in coordination with the Military Medical Support Office (MMSO) or the TRICARE Area Office (TAO) Medical Director. MMSO will Coordinate LOD care in the U.S. Virgin Islands.

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 24, Section 9

Claims Processing Procedures

2.3.6 The TOP contractor shall process claims for Durable Equipment (DE) and Durable Medical Equipment (DME) (otherwise coverable by TRICARE) that is purchased/ordered by TOP-eligible beneficiaries in an overseas area from a stateside provider (i.e., internet, etc.).

2.3.7 For inpatient claims that are paid under the Diagnosis Related Group (DRG)-based payment system, the TOP contractor, on the date of admission, shall process and pay the entire DRG claim, including cost outliers. For inpatient claims paid on a per diem basis, to include DRG transfers and short stay outlier cases, and for professional claims that are date-driven, the contractor shall process and pay the claims.

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

2.3.9 For information on portability claims for relocating TOP Prime/TOP Prime Remote enrollees, refer to [Chapter 6, Section 2](#).

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

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

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

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

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

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

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

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

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

3.0 CLAIMS FILING DEADLINE

The provisions of [Chapter 8, Section 3](#) are applicable to the TOP except that claims for services provided outside the 50 United States or the District of Columbia, the Commonwealth of Puerto Rico, or the possessions of the United States are considered to be filed in a timely manner if they are filed No Later Than (NLT) three years after the date the services were provided or three years from the date of discharge for an inpatient admission. The TOP contractor shall search their claims system and reprocess any such claims that denied for lack of timely filing, retroactive to December 30, 2008. The TOP contractor shall notify the Contracting Officer's Representative (COR) if they become aware of country-specific claims filing processes that are in conflict with this timely filing deadlines. All other claims must be filed within one year according to the requirements listed in [Chapter 8, Section 3](#), unless an exception to the filing deadline has been granted. See [Chapter 1, Section 2, paragraph 5.0](#) for the timely filing waiver process.

4.0 SIGNATURE REQUIREMENTS

4.1 The provisions of [Chapter 8, Section 4](#) are applicable to the TOP unless a different process has been directed by the DHA CO.

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

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

5.0 REFERRALS/PREAUTHORIZATIONS/AUTHORIZATIONS

The provisions of [Chapter 8, Section 5](#) are altered for the TOP by the requirements listed below.

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

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

5.6 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 **DHA** 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

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 **DHA** 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 **DHA**, 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 **DHA**) 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

6.15 The TOP contractor shall deny claims from non-certified or non-confirmed host nation providers when the DHA 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

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 24, Section 9

Claims Processing Procedures

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 DHA 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 DHA) with their claim. The TOP contractor shall waive the requirement for an EOB from the NHI plan when accompanied by the DHA-approved document.

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

11.0 THIRD PARTY LIABILITY (TPL)

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

12.0 REIMBURSEMENT/PAYMENT OF OVERSEAS CLAIMS

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

12.1 Reimburse claims for host nation services/charges for care rendered to TOP eligible beneficiaries which is generally considered host nation practice and incidental to covered services, but which would not typically be covered under TRICARE. An example of such services may be, charges from host nation ambulance companies for driving host nation physicians to accidents or private residences, or the manner in which services are rendered and considered the standard of care in a host nation country, such as rehabilitation services received in an inpatient setting.

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

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

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

12.5 Not reimburse for administrative charges billed separately on claims, except for individual administrative charges as determined by the government. The contractor shall reimburse these 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 **DHA**. 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 **DHA**. U.S. dollar checks are good for 120 days unless a different process has been established by **DHA**. 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

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 24, Section 9

Claims Processing Procedures

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 **DHA** 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 **DHA** 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 **DHA** CO may be sent to any other address.

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 24, Section 9

Claims Processing Procedures

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

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

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

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

13.0 CLAIMS ADJUSTMENT AND RECOUPMENT

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

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

13.2.1 Send an initial demand letter.

13.2.2 Send a second demand letter at 90 days.

13.2.3 Send a final demand letter at 120 days.

13.2.4 Refer the case to [DHA](#) 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 -

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

ANCC	American Nurses Credentialing Center
ANSI	American National Standards Institute
AOA	American Osteopathic Association
APA	American Psychiatric Association American Podiatry Association
APC	Adenomatous Polyposis Coli Ambulatory Payment Classification
API	Application Program Interface
APN	Assigned Provider Number
APO	Army Post Office
ARB	Angiotensin Receptor Blocker
ARCIS	Archives and Records Centers Information System
ART	Assisted Reproductive Technology
ARU	Automated Response Unit
ARVC	Arrhythmogenic Right Ventricular Cardiomyopathy
ASA	Adjusted Standardized Amount American Society of Anesthesiologists
ASAP	Automated Standard Application for Payment
ASC	Accredited Standards Committee Ambulatory Surgical Center
ASCA	Administrative Simplification Compliance Act
ASCUS	Atypical Squamous Cells of Undetermined Significance
ASD	Assistant Secretary of Defense Atrial Septal Defect Autism Spectrum Disorder
ASD(C3I)	Assistant Secretary of Defense for Command, Control, Communications, and Intelligence
ASD(HA)	Assistant Secretary of Defense (Health Affairs)
ASD (MRA&L)	Assistant Secretary of Defense for Manpower, Reserve Affairs, and Logistics
ASP	Average Sale Price
ASRM	American Society for Reproductive Medicine
AT	Assistive Technology
ATA	American Telemedicine Association
ATB	All Trunks Busy
ATO	Approval to Operate
AVM	Arteriovenous Malformation
AWOL	Absent Without Leave
AWP	Average Wholesale Price
B&PS	Benefits and Provider Services
B2B	Business to Business
BAA	Business Associate Agreement
BACB	Behavior Analyst Certification Board
BART	BRAC Analysis Large Rearrangement Test

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

BBA	Balanced Budget Act
BBP	Bloodborne Pathogen
BBRA	Balanced Budget Refinement Act
BC	Birth Center
BCaBA	Board Certified Assistant Behavior Analyst
BCAC	Beneficiary Counseling and Assistance Coordinator
BCBA	Board Certified Behavior Analyst
BCBA-D	Board Certified Behavior Analyst - Doctoral
BCBS	Blue Cross [and] Blue Shield
BCBSA	Blue Cross [and] Blue Shield Association
BCC	Biostatistics Center
BE&SD	Beneficiary Education and Support Division
BH	Behavioral Health
BI	Background Investigation
BIA	Bureau of Indian Affairs
BIPA	Benefits Improvement Protection Act
BL	Black Lung
BLS	Basic Life Support
BMI	Body Mass Index
BMT	Bone Marrow Transplantation
BNAF	Budget Neutrality Adjustment Factor
BOS	Bronchiolitis Obliterans Syndrome
BP	Behavioral Plan
BPC	Beneficiary Publication Committee
BPPV	Benign Paroxysmal Positional Vertigo
BRAC	Base Realignment and Closure
BRCA	BReast CAncer (genetic testing)
BRCA1/2	BReast CAncer Gene 1/2
BS	Bachelor of Science
BSGI	Breast-Specific Gamma Imaging
BSID	Bayley Scales of Infant Development
BSR	Beneficiary Service Representative
BT	Behavior Technician
BWE	Beneficiary Web Enrollment
C&A	Certification and Accreditation
C&P	Compensation and Pension
C/S	Client/Server
CA	Care Authorization
CA/NAS	Care Authorization/Non-Availability Statement
CABG	Coronary Artery Bypass Graft
CAC	Common Access Card
CACREP	Council for Accreditation of Counseling and Related Educational Programs

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

CAD	Coronary Artery Disease
CAF	Central Adjudication Facility
CAH	Critical Access Hospital
CAMBHC	Comprehensive Accreditation Manual for Behavioral Health Care
CAP	Competitive Acquisition Program
CAP/DME	Capital and Direct Medical Education
CAPD	Continuous Ambulatory Peritoneal Dialysis
CAPP	Controlled Access Protection Profile
CAQH	Council for Affordable Quality Health
CARC	Claim Adjustment Reason Code
CAS	Carotid Artery Stenosis
CAT	Computerized Axial Tomography
CB	Consolidated Billing
CBC	Cypher Block Chaining
CBE	Clinical Breast Examination
CBHCO	Community-Based Health Care Organizations
CBL	Commercial Bill of Lading
CBP	Competitive Bidding Program
CBSA	Core Based Statistical Area
CC	Common Criteria Convenience Clinic Criminal Control (Act)
CC&D	Catastrophic Cap and Deductible
CCCT	Clomiphene Citrate Challenge Test
CCD	Corporate Credit or Debit
CCDD	Catastrophic Cap and Deductible Data
CCEP	Comprehensive Clinical Evaluation Program
CCN	Case Control Number
CCPD	Continuous Cycling Peritoneal Dialysis
CCR	Cost-To-Charge Ratio
CCTP	Custodial Care Transitional Policy
CD	Compact Disc
CDC	Centers for Disease Control and Prevention
CDCF	Central Deductible and Catastrophic Cap File
CDD	Childhood Disintegrative Disorder
CDH	Congenital Diaphragmatic Hernia
CD-I	Compact Disc - Interactive
CDR	Clinical Data Repository
CDRL	Contract Data Requirements List
CD-ROM	Compact Disc - Read Only Memory
CDT	Current Dental Terminology
CEA	Carotid Endarterectomy

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

CEIS	Corporate Executive Information System
CEO	Chief Executive Officer
CEOB	CHAMPUS Explanation of Benefits
CES	Cranial Electrotherapy Stimulation
CF	Conversion Factor Cystic Fibrosis
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CFRD	Cystic Fibrosis-Related Diabetes
CFS	Chronic Fatigue Syndrome
CGMS	Continuous Glucose Monitoring System
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHAMPVA	Civilian Health and Medical Program of the Department of Veteran Affairs
CHBC	Criminal History Background Check
CHBR	Criminal History Background Review
CHC	Civilian Health Care
CHCBP	Continued Health Care Benefits Program
CHCS	Composite Health Care System
CHEA	Council on Higher Education Accreditation
CHKT	Combined Heart-Kidney Transplant
CHOP	Children's Hospital of Philadelphia
CI	Counterintelligence
CIA	Central Intelligence Agency
CID	Central Institute for the Deaf
CIF	Central Issuing Facility Common Intermediate Format
CIO	Chief Information Officer
CIPA	Classified Information Procedures Act
CJCSM	Chairman of the Joint Chiefs of Staff Manual
CL	Confidentiality Level (Classified, Public, Sensitive)
CLIA	Clinical Laboratory Improvement Amendment
CLIN	Contract Line Item Number
CLKT	Combined Liver-Kidney Transplant
CLL	Chronic Lymphocytic Leukemia
CMAC	CHAMPUS Maximum Allowable Charge
CMHC	Community Mental Health Center
CML	Chronic Myelogenous Leukemia
CMN	Certificate(s) of Medical Necessity
CMO	Chief Medical Officer
CMP	Civil Money Penalty
CMR	Cardiovascular Magnetic Resonance
CMS	Centers for Medicare and Medicaid Services

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

CMVP	Cryptographic Module Validation Program
CNM	Certified Nurse Midwife
CNS	Central Nervous System Clinical Nurse Specialist
CO	Contracting Officer
COB	Close of Business Coordination of Benefits
COBC	Coordination of Benefits Contractor
COBRA	Consolidated Omnibus Budget Reconciliation Act
COCO	Contractor Owned-Contractor Operated
COE	Common Operating Environment
CONUS	Continental United States
COO	Chief Operating Officer
COOP	Continuity of Operations Plan
COPA	Council on Postsecondary Accreditation
COPD	Chronic Obstructive Pulmonary Disease
COR	Contracting Officer's Representative
CORE	Committee on Operating Rules for Information Exchange
CORF	Comprehensive Outpatient Rehabilitation Facility
CORPA	Commission on Recognition of Postsecondary Accreditation
COTS	Commercial-off-the-shelf
CP	Cerebral Palsy
CPA	Certified Public Accountant
CPE	Contract Performance Evaluation
CPI	Consumer Price Index
CPI-U	Consumer Price Index - Urban (Wage Earner)
CPNS	Certified Psychiatric Nurse Specialists
CPR	CAC PIN Reset
CPT	Chest Physiotherapy Current Procedural Terminology
CPT-4	Current Procedural Terminology, 4th Edition
CQM	Clinical Quality Management
CQMP	Clinical Quality Management Program
CQMP AR	Clinical Quality Management Program Annual Report
CQS	Clinical Quality Studies
CRM	Contract Resource Management (Directorate)
CRNA	Certified Registered Nurse Anesthetist
CRP	Canalith Repositioning Procedure
CRS	Cytoreductive Surgery
CRSC	Combat-Related Special Compensation
CRT	Computer Remote Terminal
CSA	Clinical Support Agreement
CSE	Communications Security Establishment (of the Government of Canada)

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

CSP	Corporate Service Provider Critical Security Parameter
CST	Central Standard Time
CSU	Channel Sending Unit
CSV	Comma-Separated Value
CSW	Clinical Social Worker
CT	Central Time Computerized Tomography
CTA	Composite Tissue Allotransplantation Computerized Tomography Angiography
CTC	Computed Tomographic Colonography
CTCL	Cutaneous T-Cell Lymphoma
CTEP	Cancer Therapy Evaluation Program
CTLN1	Citrullinemia Type 1
CTX	Corporate Trade Exchange
CUI	Controlled Unclassified Information
CUC	Chronic Ulcerative Colitis
CVAC	CHAMPVA Center
CVS	Contractor Verification System
CY	Calendar Year
DAA	Designated Approving Authority
DAO	Defense Attache Offices
DBA	Doing Business As
DBN	DoD Benefits Number
DC	Direct Care
DCAA	Defense Contract Audit Agency
DCAO	Debt Collection Assistance Officer
DCID	Director of Central Intelligence Directive
DCII	Defense Clearance and Investigation Index
DCIS	Defense Criminal Investigative Service Ductal Carcinoma In Situ
DCN	Document Control Number
DCP	Data Collection Period
DCPE	Disability Compensation and Pension Examination
DCR	Developed Character Reference
DCS	Duplicate Claims System
DCSI	Defense Central Security Index
DCWS	DEERS Claims Web Service
DD (Form)	Department of Defense (Form)
DDAS	DCII Disclosure Accounting System
DDD	Degenerative Disc Disease
DDP	Dependent Dental Plan
DDS	DEERS Dependent Suffix