



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
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TRICARE
MANAGEMENT ACTIVITY

PCPB

CHANGE 3
6010.56-M
JUNE 10, 2008

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

The TRICARE Management Activity has authorized the following addition(s)/revision(s) to 6010.56-M, issued February 2008.

CHANGE TITLE: CONSOLIDATED PACKAGE

PAGE CHANGE(S): See pages 2 through 4.

SUMMARY OF CHANGE(S): This change includes the following revisions: In Chapter 3, the requirements for payments to beneficiaries/providers (Section 2) and claim refund and collection procedures (Section 3) are clarified and expanded on; adds information on management reports provided to the contractors to assist in identifying enrollment fee discrepancies (Chapter 6, Section 1) and to assist in determining if Catastrophic Cap and Deductible Data (CCDD) adjustments/corrections are required (Chapter 8, Section 7); clarifies the transfer of out-of-jurisdiction claim requirements for both electronic and paper claims; and clarifies responsibility for processing/reimbursement of Active Duty Service Member (ADSM) dental claims (Chapters 16 and 17). This change also includes several other minor corrections and/or clarifications to existing requirements.

EFFECTIVE AND IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Feb 2008 TPM, Change No. 3, Feb 2008 TRM, Change No. 3, and Feb 2008 TSM, Change No. 3.

Laura Sells
Chief, Purchased Care Procurement Branch

ATTACHMENT(S): 158 PAGES
DISTRIBUTION: 6010.56-M

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Contract Administration And Instructions

1.0 TRICARE MANUALS

These include the TRICARE Operations Manual (TOM), TRICARE Policy Manual (TPM), TRICARE Reimbursement Manual (TRM), and TRICARE Systems Manual (TSM). The TRICARE Manuals are the principal vehicles for general operating instructions to all health care delivery contractors and may be accessed at <http://manuals.tricare.osd.mil/>. The official archive copies of these documents are maintained at TRICARE Management Activity (TMA). The documents and all official changes to them will be maintained at TMA in an electronic medium using the PDF (Portable Document Format) format, and are available at the above web site. Distribution of paper copies will be on an exception basis. Regardless of publication medium, their printed and displayed appearance will be identical. The principal means of distribution will be via an electronic notification of publication and the contractor's subsequent download of the manual or change from the above web site. All proposed changes to these documents will be distributed for review and comment in an electronic medium, using PDF as the document format, and comments must be returned to TMA in an acceptable electronic format. Contractors shall furnish the TMA Procuring Contracting Officer (PCO) with designated point(s) of contact and e-mail address(es) for review and comment on proposed manual changes, and notification of final publication of manual changes.

2.0 IMPLEMENTATION OF MANUAL CHANGES

The contractor shall implement changes in requirements as specified by the PCO. If a contractor is unable to comply by the effective date, the PCO shall be notified in writing. The notification shall include the reasons for the noncompliance and a plan for reaching compliance. The proposal shall include milestones, if appropriate, and a firm date for completion.

3.0 COMMUNICATIONS WITH TMA

The contractor shall:

3.1 Provide complete replies to TMA requests for Rough Order Of Magnitude (ROM) estimates, comments, and/or cost estimates on proposed changes to the manuals **no later than 30 days from the date of the request**. In addition, in the event of an urgent need imposed by law or a program requirement under which significant loss to the Government would result from delay, a period of less than 30 days will be imposed, whether it is a major or minor change.

3.2 Provide timely responses to all requests for information directed to them by TMA.

3.3 Use assigned Contracting Officer's Representative (COR) at TMA as the initial POC for program interpretation or other forms of **operational** guidance.

4.0 TMA-REQUIRED MEETINGS

Generally, a 14 calendar day notice will be provided for all meetings hosted by TMA. The Managed Care Support Contractor (MCSC) shall provide representation at two regional MCSC/ TRICARE Regional Office (TRO), and two regional provider conferences. The MCSC shall provide up to four contractor representatives at up to four additional meetings at the direction of the PCO per contract year.

5.0 TMA DELEGATION OF RESPONSIBILITY

Responsibility has been delegated to TMA, Beneficiary and Provider Services (BPS) to perform the following:

- Grant exceptions to the claims filing deadline;
- Grant "good faith payments";
- Waive the signature requirements on TRICARE claims;
- Adjudicate and process unique claims requiring special handling, and claims for emergency care provided by a Department of Veterans Affairs (DVA) facility or a facility under the Bureau of Indian Affairs;
- Authorize benefits for which the authority has not otherwise been delegated to other TRICARE officials or MCSCs;
- Authorize an "override" of information contained on Defense Enrollment Eligibility Reporting System (DEERS), pending a system update, based on appropriate documentation regarding eligibility under the law, regulation and policy.

- END -

Note: Nothing in this definition prohibits a contractor from retaining a claim for external development.

1.5.2 Retained and Excluded Claims

One hundred percent (100%) of all claims (both retained and excluded, including adjustments), shall be processed to completion within 90 calendar days unless the Government specifically directs the contractor to continue pending a claim or group of claims.

“Excluded Claims” are defined as:

- Claims retained at the discretion of the contractor for the external development of information necessary to process the claim to completion;
- Claims requiring development for possible third-party liability;
- Claims requiring intervention by another Prime contractor; and
- Claims requiring government intervention (i.e., claims held for CHAMPUS Maximum Allowable Charge (CMAC) updates, claims held pending the issuance of a policy change, etc.).

1.6 Claims Processing Cycle

The contractor shall generate an initial submission claims processing cycle and transmit related TRICARE Encounter Data (TED) and required documents to TMA not less than three times every seven calendar days. The contractor shall have an updated beneficiary processed claims history and deductible file available and accessible within one workday following each processing cycle. The contractor shall ensure only one processed claims history and deductible file is maintained for each beneficiary.

1.7 Claims Processing Accuracy

1.7.1 Claim Payment Errors

The absolute value of the payment errors shall not exceed 2% of the total billed charges for the first two option periods. In all remaining option periods, the absolute value of the payment errors shall not exceed 1.75% of the total billed charges.

1.7.2 Claim Occurrence Errors

The TED occurrence error rate shall not exceed 3% for all types of TEDs.

1.8 TEDs - Timeliness

- One hundred percent (100%) of initial submission vouchers/batches shall be transmitted to TMA within five calendar days of the date of the batch/voucher create date.

- Eighty-five percent (85%) of all unprocessable vouchers/batches, including but not limited to, out-of-balance conditions and invalid header record information shall be corrected by the contractor and returned for receipt at TMA within 20 calendar days of the date the invalid data was transmitted to the contractor by TMA.
- One hundred percent (100%) of unprocessable vouchers/batches shall be corrected and returned for receipt at TMA within 30 calendar days of the date the invalid data was transmitted to the contractor by TMA.
- Ninety-nine and one-half percent (99.5%) of all vouchers/batches having TEDs (initial submissions, resubmissions, and adjustment/cancellation submissions) failing the edit system shall be corrected and resubmitted to TMA within 30 calendar days after the errors and rejected TEDs were transmitted to the contractor by TMA. The resubmission data shall contain all TEDs rejected on the voucher/batch in question.
- One hundred percent (100%) of all remaining vouchers/batches having TEDs failing the edit system shall be corrected and resubmitted to TMA within 45 calendar days after the errors and rejected TEDs were transmitted to the contractor by TMA. The resubmission data shall contain all TEDs rejected in the voucher/batch.

1.9 TEDs - Accuracy

1.9.1 Following the start of health care delivery, the contractor shall have the following percentages of TEDs (initial submissions, resubmissions and adjustment/cancellation submissions) passing the TMA edit system at the following time lines:

- One through three months - 80%
- Four through six months - 85%
- Seven through nine months - 90%
- Ten through 11 months - 95%
- Twelve through 23 months - 96%
- Month 24 through contract close - 97%

1.9.2 Vouchers/Batches

Three months following the start work date of the contract, the contractor shall have no more than 2% of the vouchers/batches being unprocessable due to, but not limited to, such problems as:

- Out-of-balance;
- Invalid header conditions;
- Invalid record type;
- Invalid contractor number;
- Invalid voucher/batch identifier;
- Invalid voucher/batch date;
- Invalid sequence number;
- Invalid resubmission number;
- Invalid period begin date;
- Invalid period end date;

Management

1.0 GENERAL

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

2.0 SYSTEM ADDITIONS OR ENHANCEMENTS

2.1 Implementation of Changes in Program Requirements

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

2.2 Maintaining Current Status of Diagnostic and Procedural Coding Systems

Contractors are required to use the current versions of the updated American Medical Association Physicians Current Procedural Terminology, 4th Edition (CPT-4), and the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnostic coding system; and any special codes that may be directed by TMA. The contractor is responsible for using the most current codes correctly. That responsibility includes making any needed revisions required by periodic CPT-4 and ICD-9-CM updates issued by the publishers. When updates occur, contractors will be notified of the date the TRICARE Encounter Data (TED) editing system will be accepting changes in the codes.

2.3 Zip Code File

The contractor shall update and maintain an electronic file of inpatient catchment area zip codes using the electronic zip code directory furnished by the Government. This electronic zip code directory defines Inpatient Catchment Areas that shall be used for verifying geographic Non-Availability Statement (NAS) requirements in accordance with the TRICARE Policy Manual (TPM), [Chapter 1, Section 6.1](#). The contractor shall update and maintain a second electronic file of all zip codes using a separate Government-furnished electronic zip code directory. The contractor shall incorporate this second electronic file in its claims processing system to determine the validity of a beneficiary or provider zip code. These directories will be provided by the Government no less than four and no more than 12 times per calendar year. Updates to these electronic zip code directories for the purposes of contract modifications, directed policy actions, changes to catchment area

definitions, and expansion or termination of zip codes by the U.S. Postal Service, shall be accomplished at no additional cost to the Government.

2.4 Updating And Maintaining TRICARE Reimbursement Systems

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

3.0 MANAGEMENT CONTROLS

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

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

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

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

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

3.5 A set of processing guidelines, desk instructions/user's manuals and reference materials for internal use, at least 10 calendar days prior to the first day of delivery of health care services. These materials shall be maintained, on a current basis, for the life of the contract. Desk instructions shall be available to each employee in the immediate work area. Reference material such as procedure codes, diagnostic codes, and special processing guidelines, shall be available to each work station with a need for frequent referral. Other reference materials shall be provided in each unit with a reasonable need and in such quantity as to ensure the ease of availability needed to facilitate work flow. Electronic versions may be used.

Legal Matters

1.0 LITIGATION

1.1 The TRICARE Management Activity (TMA) Office of General Counsel (OGC) shall be notified by telephone immediately upon receipt of any summons, writ, or other legal process which develops as a result of performance under a TRICARE contract. In no event, shall the telephonic notice to TMA OGC be more than three workdays following receipt of any such legal process which could involve TRICARE. Such notice shall include the nature of the legal process, the name of the court of jurisdiction, the parties named in the suit, the type of TRICARE issue or claim involved, the amount involved and any other relevant information. Additionally, copies of all documentation shall be transmitted to TMA by facsimile as soon as possible and followed up with hardcopy mailed to TMA OGC on the same workday as telephone notice is given.

1.2 The United States reserves the right to render a determination concerning whether the Government should be a party to the legal process. Additionally, TMA will determine if the contractor is to be indemnified against judgments, settlements and costs in favor of an individual, or his or her assignee, in accordance with any applicable indemnification clauses in the TRICARE contract.

1.3 In some cases, TMA OGC may determine that the Government is the real party in interest to an action which challenges a TRICARE determination. In such a case, the suit may be removed from a State court to the appropriate United States District Court, however, such action must be taken immediately. Therefore, it becomes imperative that the contractor fully cooperates with TMA counsel assigned to direct the case. TMA counsel may request the appropriate United States Attorney to the district court of the United States for the district and division embracing the place wherein the action is pending, dismiss the contractor, and substitute the United States of America as defendant in its place. In other cases, TMA OGC may determine the issue is a private matter between the plaintiff and the defendant contractor or subcontractor. Additionally, the court may decline to substitute parties. Nevertheless, in some cases, the contractor may remain fully responsible for defending the case.

1.4 Acts of fraud, theft, embezzlement, or sabotage involving TRICARE funds or materials, may constitute violations of the United States Criminal Code and ensuing investigations may be matters within the jurisdiction of the Federal Government. In such cases, as stated above, immediate notice shall be given to TMA OGC. When the act clearly involves only contractor funds, action should be instituted by the contractor under the laws of the state with jurisdiction.

2.0 SUBPOENAS

Department of Defense (DoD) regulations restrict contractor disclosure of information obtained in carrying out its TRICARE functions. When a contractor is served with a subpoena in connection with its TRICARE responsibilities, TMA OGC shall be notified in a timely manner to

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safeguard against the unauthorized disclosure of information. This procedure will be followed whether the subpoena is for reproduction of records which are, or may be protected, or for the personal appearance of a representative of the contractor. If a contractor is served a summons by the U.S. Internal Revenue Service (IRS) to produce and disclose any file, record, report or other paper, or information in connection with TRICARE and federal tax laws, the summons must be honored. The assistance of TMA shall be requested immediately if the contractor encounters any problems in complying with the IRS request (e.g., machine capability, cost).

3.0 ASSIGNMENTS OF PROVIDERS' RIGHTS TO PAYMENT

A provider of services in need of funds might arrange for a commercial loan from a bank or other lending institution and, as collateral on the loan, attempt to assign its TRICARE payments to the creditor. Such TRICARE benefit payments shall be made only to providers of services which are eligible to file for such payment. The authorization given by Congress to expend TRICARE funds does not permit compliance with a commercial assignment, even though such arrangement may otherwise be in full compliance with the law of the appropriate state.

4.0 BANKRUPTCY

When any TRICARE debtor files a petition in bankruptcy, contractors will follow the instructions in [Chapter 10, Section 3, paragraph 22.0](#). When a TRICARE provider files a petition in bankruptcy, regardless of whether there is an outstanding recoupment action against that provider, contractors will follow the applicable laws of the state in which the bankruptcy was filed.

- END -

2.10.1 Contractor File Conversions and Testing

The incoming contractor shall perform initial conversion and testing of all Automated Data Processing (ADP) files (e.g., provider files, pricing files, and beneficiary history) NLT 30 calendar days following receipt of the files from the outgoing contractor(s). All ADP file conversions shall be fully tested and operational for the Benchmark (see [paragraph 3.0](#)). Integration testing will be conducted to validate the contractor's internal interfaces to each of the TRICARE Military Health Systems (MHSs). This testing will verify the contractor's system integration, functionality, and implementation process. The incoming contractor shall be responsible for the preparation and completion of Integration Testing prior to the start of Benchmark Testing.

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

2.10.2 Receipt of Outgoing Contractor's Weekly Shipment of History Updates and Dual Operations

2.10.2.1 Beginning with the 120th calendar day prior to the start of health care delivery and continuing for 180 calendar days after the start of health care delivery, the incoming contractor shall convert the weekly shipments of the beneficiary history updates from the outgoing contractor(s) within two working days following receipt. These files shall be validated by the incoming contractor before use. Tests for claims and duplicate claims shall be performed within two workdays following conversion. Following the start of health care delivery, these files shall be loaded to history and used for claims processing.

2.10.2.2 During the 180 calendar days after the start of health care delivery when both the incoming and outgoing contractors are processing claims, both contractors shall maintain close interface on history update exchanges and provider file information. During the first 60 calendar days of dual operations, the contractors shall exchange beneficiary history updates with each contractor's claims processing cycle run. Thereafter, the exchange shall not be less than twice per week until the end of dual processing. The incoming contractor shall assume total responsibility for the maintenance of the TRICARE Encounter Provider Record (TEPRV) beginning with the start of health care delivery. The incoming contractor will coordinate and cooperate with the outgoing contractor to ensure that the outgoing contractor can continue to process claims accurately; conversely, the outgoing contractor has responsibility to notify the incoming contractor of any changes in provider status that they become aware of through their operations.

2.10.3 Phase-In Requirements Related To Transitional Cases

In notifying beneficiaries of the transition to another contractor, both the incoming and outgoing contractors shall include instructions on how the beneficiary may obtain assistance with transitional care. If the outgoing contractor succeeds itself, costs related to each contract will be kept separate for purposes of contract accountability.

2.10.3.1 Non-Network Inpatient Transitional Cases

These are beneficiaries who are inpatients (occupying an inpatient bed) at 0001 hours on the first day of any health care contract period in which the incoming contractor begins health care delivery. In the case of Diagnostic Related Group (DRG) reimbursement, the outgoing contractor shall pay through the first month of health care delivery or the date of discharge, whichever ever occurs first. If the facility is reimbursed on a per diem basis, the outgoing contractor is responsible for payment of all the institutional charges accrued prior to 0001 hours on the first day of health care delivery, under the incoming contractor. The incoming contractor thereafter is responsible for payment.

2.10.3.2 Non-Network Outpatient/Professional Transitional Cases

These are cases, such as obstetric care, that are billed and payable under "Global" billing provisions of Current Procedural Terminology, 4th edition (CPT-4), HCFA Common Procedure Coding System (HCPCS), or local coding in use at the time of contract transition, and where an Episode Of Care (EOC) shall have commenced during the period of health care delivery of the outgoing contractor and continues, uninterrupted, after the start of health care delivery by the incoming contractor. Outpatient/professional services related to transitional cases are the responsibility of the outgoing contractor for services delivered prior to 0001 hours on the first day of health care delivery and of the incoming contractor thereafter.

2.10.3.3 Network Inpatient Care During Contract Transition

The status of network provider changes (provider's network agreement with the outgoing contractor is terminated resulting in the provider's loss of network status) with the start of health care delivery of the new contract. As a result, claims for inpatient care shall be reimbursed in accordance with [paragraph 2.10.3.1](#) for non-network transitional cases. Beneficiary copay is based on the date of admission; therefore, Prime beneficiaries who are inpatients as described in [paragraph 2.10.3.1](#), shall continue to be subject to Prime network copayments and shall not be subject to Point Of Service (POS) copayments.

2.10.3.4 Home Health Care (HHC) During Contract Transition

HHC, for a 60-day episode of care, initiated during the outgoing contractor's health care delivery period and extending, uninterrupted, into the health care delivery period of the incoming contractor are considered to be transitional cases. Reimbursement for both the Request for Anticipated Payment (RAP) and the final claim shall be the responsibility of the outgoing contractor for the entire 60-day episodes covering the transition period from the outgoing to the incoming contractor.

2.10.4 Prior Authorizations and Referrals

The incoming contractor shall honor outstanding prior authorizations and referrals issued by the outgoing contractor, covering care through 60 days after the start of health care delivery under the incoming contract, in accordance with the outgoing contractors existing practices and protocols, within the scope of the TRICARE program and applicable regulations or statutes. In the case of Residential Treatment Care (RTC) care, both the incoming and outgoing contractors are responsible for authorizing that part of the stay falling within their areas of

responsibility; however, the incoming contractor may utilize the authorization issued by the outgoing contractor as the basis for continued stay.

2.10.5 Case Management and Disease Management

The incoming contractor shall receive case files and documentation regarding all beneficiaries under case management or disease management programs. The incoming contractor shall ensure seamless continuity of services to those beneficiaries.

2.10.6 Program Integrity

The incoming contractor shall receive case files and documentation regarding all open program integrity cases from the outgoing contractor NLT 30 days from the start of health care delivery. The incoming contractor shall work with the TMA Program Integrity Office (PI) to ensure seamless continuity of oversight of these cases.

2.10.7 Health Insurance Portability And Accountability Act of 1996 (HIPAA)

The incoming contractor, as a covered entity under HIPAA, may honor an authorization or other express legal document obtained from an individual permitting the use and disclosure of protected health information prior to the compliance date (HHS Privacy Regulation, §164.532).

2.10.8 Installation And Operation Of The Duplicate Claims System (DCS)

The incoming contractor shall have purchased, installed, configured, and connected the personal computers and printers required to operate the DCS NLT 60 days prior to the start of the health care delivery. See [Chapter 9](#), for hardware, software, printer, configuration and communications requirements and contractor installation responsibilities. Approximately 30-45 days prior to health care delivery, TMA will provide and install the DCS application software on the incoming contractor designated personal computers and provide on-site training for users of the DCS in accordance with [Chapter 9](#). Following the start of health care delivery, the DCS will begin displaying identified potential duplicate claim sets for which the incoming contractor has responsibility for resolving. The incoming contractor shall begin using the DCS to resolve potential duplicate claim sets in accordance with [Chapter 9](#) and the transition plan requirements.

2.10.9 Processing of Residual Claims

2.10.9.1 After 120 days following the start of health care delivery for all claims, the incoming contractor shall process claims received for care that occurred during the outgoing contractor's health care delivery period. (Prior to these dates, any claims received for care that occurred during the outgoing contractor's period, shall be transferred to the outgoing contractor for processing.) In the case of network claims, the incoming contractor shall attempt to obtain any negotiated rate or discount information for reimbursement purposes. If the incoming contractor is unable to obtain this information, the claim shall be reimbursed using standard TRICARE reimbursement methodologies as if no negotiated or discount rates were in effect.

2.10.9.2 Processing of Overseas Residual Claims

Residual claims for overseas care shall be processed by the TRICARE Overseas Program (TOP) contractor. One hundred twenty days following the end of any Managed Care Support Contractor's (MCSC's) health care delivery period, the TOP contractor shall process all claims, **including adjustments**, received for care in a foreign country that occurred during the outgoing MCSC's health care delivery period.

2.11 Contractor Weekly Status Reporting

The incoming contractor shall submit a weekly status report of phase-in and operational activities and inventories.

2.12 Public Notification Program-Provider And Congressional Mailing

The contractor shall prepare a mailing to all non-network TRICARE providers and Congressional offices within the region by the 45th calendar day prior to the start of health care delivery according to the specifications of the official transition schedule. The proposed mailing shall be submitted to the PCO and the COR, and the TMA Marketing and Education Committee (MEC) for approval NLT 90 calendar days prior to the start of each health care delivery period. The mailing shall discuss any unique processing requirements of the contractor and any other needed information dictated by the official transition schedule.

2.13 Web-Based Services And Applications

NLT 15 days prior to the start of health care delivery, the incoming contractor shall demonstrate to TMA successful implementation of all web-based capabilities as described in the contract.

2.14 TRICARE Handbook Mailing

NLT 30 days prior to the start of health care delivery, the MCSC shall mail one TRICARE Handbook to every residence in the region based on DEERS data.

3.0 INSTRUCTIONS FOR BENCHMARK TESTING

3.1 General

3.1.1 Prior to the start of health care delivery, the incoming contractor shall demonstrate the ability of its staff and its automated enrollment, authorization and referral, and claims processing systems to accurately process TRICARE claims in accordance with current requirements. This will be accomplished through a comprehensive Benchmark Test. The Benchmark Test is administered by the contractor under the oversight of TMA and must be completed NLT 60 days prior to the start of services delivery. In the event that an incumbent contractor succeeds itself, the extent of Benchmark testing may be reduced at the discretion of the TMA PCO.

3.1.2 A Benchmark Test shall consist of at least 300 but not more than 1,000 network and non-network claims, testing a multitude of claim conditions including, but not limited to, TRICARE covered/non-covered services, participating/non-participating providers, certified/non-certified

incoming contractor the most recent version of all MTF MOUs in place at that time for the purpose of ensuring continuity of services to MTFs and continuity of care for TRICARE beneficiaries.

4.3.10 Program Integrity Files

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

4.3.11 Provider Certification File

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

4.4 Final Processing Of Outgoing Contractor

The outgoing contractor shall:

- Process all claims and adjustments for care rendered prior to the start of health care delivery of the new contract that are received through the 120th day following cessation of the outgoing contractor's health care delivery. Processing of these claims shall be completed within 180 calendar days following the start of the incoming contractor's health care delivery. All claims shall meet the same standards as outlined in the current **outgoing** contract. **Any residual claim received after 120 days shall be forwarded to the incoming contractor within 24 hours of receipt.**
- Be liable, after the termination of services under this contract, for any payments to subcontractors of the contractor arising from events that took place during the period of this contract.
- Refer to [paragraph 2.10.3](#), for transitional case requirements.
- Process all correspondence, allowable charge complaints, and incoming telephonic inquiries which pertain to claims or services processed or delivered under this contract within the time frames established for response by the standards of the contract.
- Complete all appeal **and** grievance cases that pertain to claims or services processed or delivered under this contract within the time frames established for response by the standards of the contract.

4.4.1 Correction of Edit Rejects

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

4.4.2 Phase-Out of the Automated TRICARE DCS

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

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

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

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

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

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

4.4.3.4 The outgoing contractor shall continue to issue prior authorizations for care for which it is financially responsible. However, authorization-related information shall be shared between the incoming and the outgoing contractors to preclude requiring a provider or beneficiary to duplicate the paperwork and other effort related to establishing prior authorizations. The outgoing contractor may issue prior authorizations as late as midnight on the day prior to the end of its health care delivery for inpatient stays that will continue as transitional cases. The two contractors shall interface on the clinical issues of a case where both contractors will, or can reasonably expect to have periods of liability for the same EOC.

4.4.3.5 The outgoing contractor shall maintain toll-free lines and web-based customer service capabilities, accessible to the public during the first 90 calendar days of dual operations in order to properly respond to inquiries related to claims processed for services incurred during the period of their respective liability. Beneficiary inquiry lines will continue to be staffed as defined in the contract. In general, the outgoing contractor shall maintain adequate toll-free line coverage to ensure that the blockage rate does not exceed the blockage rate on the contractor's most critical private or other government business access line.

4.5 Phase-Out of Enrollment Activities

4.5.1 Prior to the start of health care delivery under the successor contract, for all enrollment renewals or payments in which the new enrollment period or period covered by the premium payment will begin under the new contract, the outgoing contractor shall amend renewal notices

Payments To Beneficiaries/Providers

1.0 CHECKS

When issuing checks for payments to beneficiaries and providers, the contractor shall use the following formats/statements:

- For non-underwritten funds, the check shall be dated the same date as the Initial Transmission Date (derived by the TRICARE Management Activity (TMA) and equal to the calendar date the Batch/Voucher is transmitted to TMA). For underwritten funds, the check shall be dated on the date the contractor makes payment.
- The words "TRICARE Payment" shall be printed in at least 18-point font at the top of the check.
- The TRICARE logo and the contractor's name and address shall be on the check.
- The following endorsement statement shall be printed using four or five point type in the 1.5 inches allotted on the reverse side of the check. This will comply with Federal Reserve Bank Regulation CC (Availability of Funds and Collection of Checks) regarding check endorsements. The endorsement shall read as follows:
 - "This payment is made with Federal funds. Fraud in procuring, forging of signature or endorsement, or materially altering this check is punishable under the U.S. Criminal Code. IF PAYABLE TO A PARTICIPATING PROVIDER OF SERVICES - By endorsing this check, the undersigned payee agrees that he/she is subject to the terms of the participating agreement (assignment) as set forth in the TRICARE regulation."
- A statement that the check must be negotiated within 120 calendar days.

2.0 ELECTRONIC FUNDS TRANSFER (EFT)

2.1 Payments may be made by EFT to beneficiaries and providers. Underwritten EFTs shall be done prior to submission of the related TED record to TMA. Non-underwritten EFTs shall be done within two federal workdays after receiving payment approval from TMA. Rejected EFTs may be paid as checks. If payment cannot be accomplished as a check or EFT, an adjustment/cancellation TED record shall be submitted within five work days of rejection of an EFT.

2.2 The contractor may require providers who submit claims electronically to also accept an electronic remittance advice and to receive payment by EFT.

3.0 INTEREST PAYMENTS

3.1 The contractor shall pay interest to providers or beneficiaries on claims that have not been processed to timely completion. For claims with addresses within the United States (US), simple interest shall be paid on the payment amount based upon the Prompt Payment Act Interest Rate in effect on the "processed to completion" date, on all retained claims beginning with the 31st day following the date of receipt until processed to completion. No interest shall be paid on claims with addresses outside the US.

3.2 The contractor shall include interest in the benefit check/EFT regardless of who is fiscally responsible for the interest payment. Interest shall be paid to the nearest penny. The maximum interest penalty period shall be one year. All interest shall be paid to the recipient of the benefit check/EFT; however, if a payment is split as a result of a beneficiary overpaying a provider, the interest payment shall be made, in total, to the provider. No interest shall be paid on any claim pending for recoupment or future offset.

3.3 Interest penalty payments and reasons for interest penalty shall be reported on the TRICARE Encounter Data (TED) submission in a separate field as specified in the TRICARE Systems Manual (TSM), [Chapter 2, Section 2.3](#). Total interest paid shall not be included in the "Total Government Dollars Paid" field. The "Total Amount Paid" report on the voucher header record shall equal the dollar amount of payments (which will be a combination of "Total Government Dollars Paid" and "Interest Payment").

3.4 On a daily basis, TMA/[Contract Resource Management \(CRM\)](#) will reconcile the TED record submissions (by voucher header) to determine the total interest payment amounts reported and the total interest amounts owed by the responsible party (based on the code used in the Interest Reason field). Based upon the results of the reconciliation, the TMA/CRM will either pay the contractor, or deduct the interest payment amount owed to or due from the contractor. Any amounts owed to or due from the contractor will be settled by the payment office at the same time the benefits payments are made for underwritten claims or within seven calendar days of receipt for claims paid from non-underwritten accounts.

3.5 The fiscal responsibility for the interest payment shall be determined based on the following hierarchy. The first cause for the delay in processing the claim shall remain with the claim for the purpose of determining who is responsible for interest payments.

- Claims pending at government direction that the government has specifically directed the contractor to hold for an extended period of time. These will primarily be claims pending a Program Integrity (PI) investigation. (The government is fiscally responsible for any interest).
- Claims requiring government intervention (the government is fiscally responsible for any interest).
- Claims requiring development for potential third-party liability (the government is fiscally responsible for any interest).
- Claims requiring an action/interface with another prime contractor (the contractor is fiscally responsible for any interest).

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- Claims retained by the contractor that do not fall into one of the above categories (the contractor is fiscally responsible for any interest).

- END -

Claim Refund And Collection Procedures

1.0 GENERAL

This section outlines **requirements** for claim refunds and installment repayments from providers and beneficiaries. Examples include ineligible beneficiaries, third party insurance, overpayments, duplicate payments, payments to wrong providers or beneficiaries, **and any unallowable costs under the terms of the contract.**

2.0 COLLECTION AND DEPOSIT PROCEDURES

Recoupment procedures shall follow the requirements listed in [Chapter 10](#).

2.1 Non-Underwritten Refunds, Collections, Etc.

The contractor shall make deposits to the applicable non-underwritten bank account as soon as possible but No Later Than (NLT) the close of the next business day from the time the contractor collects the funds from a beneficiary/provider. **Upon collection of monies from providers, beneficiaries, or other parties; the contractor shall immediately submit a credit TRICARE Encounter Data (TED) record citing the appropriate current fiscal year non-underwritten Contract Line Item Number (CLIN)/Automated Standard Application for Payment (ASAP) Account Number assigned to them by the TRICARE Management Activity (TMA), Contract Resource Management (CRM) (see the TRICARE Systems Manual (TSM), [Chapter 2, Section 1.1](#)).**

2.2 Underwritten Refunds, Collections, Etc.

2.2.1 Collections Occurring Before Administrative Closeout of the Underwritten CLIN

When a contractor has been reimbursed by the TRICARE Management Activity (TMA), a credit TED record is required immediately when an overpayment or otherwise unallowable cost is identified. Credit TED records for voluntary refunds and other unexpected collections will be submitted immediately upon receipt of funds. Credit TED records for overpayments that have not been collected and are related to a good faith payment may be done upon collection of funds rather than identification of overpayment (see [Chapter 10, Section 3, paragraph 7.0](#)). For "active" underwritten CLINs, all overpayments or unallowable costs shall be credited back to the CLIN the contractor originally billed. The contractor shall cite the current fiscal year underwritten CLIN/ASAP Account Number assigned by TMA, CRM that is associated with the CLIN billed originally (see the TSM, [Chapter 2, Section 1.1](#)). After the Government has been made whole by the contractor via the credit TED record for the contractor's reimbursement of the unallowable costs by the Government, any refunds, collections, or recoveries by the contractor is retained by the contractor. Any collection activity by the contractor shall be in accordance with [Chapter 10, Section 3](#).

2.2.2 Collections Occurring After Administrative Closeout of the Underwritten CLIN

After an underwritten CLIN has been administratively closed-out, the Government is unable to recover overpayments or unallowable costs (such as unallowable costs determined by audit) via TED records; as such, the contractor shall follow the instructions of the contracting officer or designee. After the administrative close-out of an underwritten CLIN, the contractor retains any collection of overpayments. Any collection activity by the contractor shall be in accordance with the [Chapter 10, Section 3](#). In order to maintain accurate records, the contractor shall submit a credit TED record upon identification of any overpayment amounts. For "in-active" CLINs, all credit TED records shall be submitted to TMA citing the Batch type CLIN/ASAP Account Number (see the TSM, [Chapter 2, Section 1.1](#)) TED records for voluntary refunds, unexpected collections, and collections relating to good faith payments will be submitted upon receipt of funds.

- END -

Staledated, Voided, Or Returned Checks

1.0 CANCELLATIONS AND STALEDATED CHECKS

Checks will staledate at 120 calendar days following the date on the check. **Related TRICARE Encounter Data (TED) record adjustments/cancellations shall be submitted 15 to 20 calendar days after the 120 calendar day staledate. (This is to allow for checks that have been presented by the 120th day to clear the banking system.)**

2.0 REPLACEMENT CHECKS

2.1 If a payee, or the estate or guardian of the payee, requests in writing reissuance of a staledated check or claims non-receipt of a check, the contractor will honor the request.

3.0 REISSUANCE OF CHECKS WHEN ORIGINAL PAYEE IS DECEASED

Checks/Electronic Funds Transfers (EFTs) issued by the contractor shall be made payable to the legal representative of the estate of the person concerned with an additional line stating "For the estate of ____." Checks shall not be payable to the "estate of" a decedent, nor to a deceased person. Checks shall be delivered to the named payee or mailed to the payee's address of record.

- END -

General

1.0 PROVIDER CERTIFICATION CRITERIA

Refer to the [32 CFR 199.6](#) and the TRICARE Policy Manual (TPM), [Chapters 1 and 11](#). All providers shall be TRICARE certified in accordance with the TPM. Network providers shall be credentialed in accordance with nationally accepted credentialing standards adopted by a national accrediting body. "Authorized Provider" is any provider who meets the requirements set forth in [32 CFR 199.6](#) and in the TPM, [Chapter 11](#). If a beneficiary submits a claim for services provided by a non-participating individual professional provider who is known to be legally practicing and is eligible for TRICARE-authorization, the provider shall be certified and payment shall be made to the beneficiary. In no case shall a provider who refuses to provide proper Social Security Number (SSN)/ Employer Identification Number (EIN) identification be paid directly.

2.0 PROVIDER APPROVALS

2.1 The contractor shall accurately certify all providers of care (except for the providers certified by the TRICARE Quality Monitoring Contractor (TQMC)) using a single, centralized certification process. The contractors shall ensure that all providers of care for whom a billing is made or claim submitted under TRICARE meet all conditions, limitations or exclusions specified or enumerated in 32 CFR 199, the TPM, and the TRICARE Operations Manual (TOM). The contractor shall maintain separate institutional and non-institutional provider files. Additions, deletions, and changes to these files, shall be reported to TRICARE Management Activity (TMA) as specified in the TRICARE Systems Manual (TSM).

2.2 Upon receipt of a claim or request for provider certification information involving a provider practicing in the contractor's jurisdiction but not on the TRICARE Encounter Provider (TEPRV) file, the contractor shall contact the provider, the state licensing board, the appropriate national or professional association, or other sources to determine that the provider meets certification requirements. The contractor may establish eligibility for certification by any of these means. Documentation may be a copy of the page from the most recent state licenser listings; screen print from on-line access to state board licensing files, or other methods that show proof that the provider meets the certification requirements.

2.3 If certification cannot be accomplished, all pending and subsequent claims for services from that provider shall be denied. Claims denied for this reason may be reopened and processed if requested by the provider or beneficiary, if the provider is determined to be authorized upon receipt of the required documentation.

2.4 Services delivered by any provider must be within the scope of the license or other legal authorization. The contractor shall maintain a current computer listing of all certified providers, including at a minimum the data required by the TSM, [Chapter 2, Section 2.10](#). If the provider was initially certified by the contractor, the certification shall be supported by a documented and

readily accessible hardcopy or microcopy file documenting each provider's qualifications. A hardcopy or electronic file documenting the provider's existence on the TEPRV shall be maintained for all other providers.

2.5 Any provider who has not submitted a claim or whose services have not been submitted on a claim within the past two years may be removed from the active file to the inactive file. **However, even if the provider remains on the active file, if a claim is received from a provider who has not submitted a claim or whose services have not been submitted on a claim within the past two years, the provider must be fully recertified.** Providers who have been terminated or suspended shall not be deleted. Suspended or terminated, or excluded providers shall remain on the file as flagged providers indefinitely or until the flag is dropped because the suspended provider has been reinstated. The contractor shall review all provider flags and ensure they are working at a minimum of once each year. To do this, the contractor shall maintain records of all suspended and terminated providers and audit the provider file flags and, as necessary, test to ensure they are operational.

2.6 The contractor shall accept the Medicare certification of individual professional providers who have a like class of individual professional providers under TRICARE without further authorization unless there is information indicating Medicare, TRICARE or other federal health care program integrity violations by the physician or other health care practitioner. Certification of individual professional providers without a like class (e.g., chiropractors) under TRICARE shall be denied.

3.0 PART-TIME PHYSICIAN EMPLOYEES OF THE DEPARTMENT OF VETERANS AFFAIRS (DVA)

3.1 The Director, TMA, has authorized an exception, on a case-by-case basis, to the TRICARE policy which excludes any civilian employee of the DVA from certification as a TRICARE provider. This exception is for part-time physician (MD) employees only who file claims for service furnished in their private, non-DVA employment practice.

3.2 In order to be considered as a certified provider, the DVA facility administrator must send a request for an exception to the appropriate contractor ([Addendum A, Figure 4.A-1](#)) along with a signed Part-Time Physician Employee Provider Certification Form ([Addendum A, Figure 4.A-2](#)) signed by the physician. Upon receipt of these two documents, the contractor shall approve the physician as a TRICARE provider for services furnished by this provider in his private practice effective with the date the contractor approves the waiver. The contractor shall notify the physician and requesting DVA facility by letter of the approval and the effective date. No retroactive approval dates shall be allowed. All claims from these providers shall be annotated on the signature block of the claim form, "additional certification on file".

4.0 VENDORS OF MEDICAL SUPPLIES, DURABLE MEDICAL EQUIPMENT, OR DURABLE EQUIPMENT

Medical supplies, durable medical equipment, or durable equipment otherwise allowable as a Basic Program or authorized Extended Care Health Option (ECHO) benefit purchased from an approved vendor (TPM, [Chapter 11, Section 9.1](#)), may be cost-shared (currently or retroactively) when payment is made directly to the beneficiary.

5.0 PROVIDERS APPROVED BY THE TRICARE QUALITY MONITORING CONTRACT (TQMC)

The TQMC is the TRICARE certifying authority for Psychiatric Residential Treatment Centers (RTCs) serving children and adolescents; Substance Use Disorder Rehabilitation Facilities (SUDRFs); and Psychiatric Partial Hospitalization Programs (PHPs). The TQMC will notify the Managed Care Support Contractor (MCSC) by letter of approvals and changes in status (withdrawals, closure, terminations, etc.) for the above facilities. In addition, the TQMC will provide a listing of all TRICARE approved RTCs, SUDRFs, and PHPs to the MCSCs on a monthly basis.

6.0 TMA PROVIDER FILE

6.1 The TMA provider file is created from contractor submissions of TEPRVs as required in the TSM, [Chapter 2, Section 1.2](#) and is a singular database which is added to or changed through contractors' reporting activity. This file provides critical provider data which supplements that reported on the TEPRVs. The concept of the TMA centralized provider file is based on the agency's commitment to a singular database which operates on the premise of accountability. The contractor having contractual authority for provider certification in a given region has accountability for the TEPRVs for providers in that region and is responsible for ensuring these TEPRVs pass the TMA edits and for performing all maintenance transactions. This responsibility extends to those TEPRVs submitted in support of the claims processing by another contractor, except the Pharmacy contractor.

6.2 Due to the various methods in use for defining contractor claims processing jurisdictions, a contractor having claims processing responsibility may not be the contractor having accountability for the TEPRV (i.e., having provider certification responsibility) for the provider rendering the service(s) on a claim. In this case, the servicing contractor (i.e., the claims processor) may have to obtain provider data from the certifying contractor. See [Chapter 8, Section 2, paragraph 6.0](#) for instructions regarding development of out-of-jurisdiction provider certification information.

7.0 PROVIDER FILE AUDITS

Each year, the contractor shall conduct an audit, which must include either 5% or 50, whichever is less, of all prime contractors' and subcontractors' individual network provider credentialing and privileging files to ensure that information is appropriately verified. The audit shall be completed prior to the start of each option period. Thirty calendar days prior to each audit, the contractor shall invite the Regional Director (RD), or for the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) the Contracting Officer's Representative (COR), to monitor and/or participate in the audit. Not less than 85% of the audited files shall be in full compliance with all provider file requirements. Within five business days of the completion of the audit's provider file review, the contractor shall submit to the Procuring Contracting Officer (PCO) and the RD, or for the TDEFIC the COR, a written corrective action plan which addresses all credentialing and privileging files not in full compliance. Within 30 calendar days after completion of the audit's provider file review, the incomplete or incorrect files shall be corrected to full compliance.

8.0 CRIMINAL HISTORY BACKGROUND CHECKS

8.1 Contractors shall perform criminal history background checks in accordance with Department of Defense Instruction (DoDI) 1402.5 ("Criminal History Background Checks on Individuals in Child Care Services"; see <http://www.dtic.mil/whs/directives/corres/html/14025.htm>)

for clinical support agreement personnel working in a Military Treatment Facility (MTF) involved on a frequent and regular basis in the provision of care and services to children under the age 18. The background checks are required by Criminal Control (CC) Act, Public Law (PL) 101-647, Section 231 (CC Act 1990, 42 United States Code (USC) Section 13041). The contractor shall assemble all necessary documentation required by DoDI 1402.5 (<http://www.dtic.mil/whs/directives/corres/html/14025.htm>) for the background checks and forward the documentation to the office designated by the PCO or to the office designated in the Memorandum of Understanding (MOU) (see [Chapter 15, Addendum A](#)).

8.2 For health care practitioners requiring MTF clinical privileges, the contractor shall furnish completed background check documentation to the MTF commander prior to the award of privileges.

8.3 For individuals who require background checks but not clinical privileges, the contractor shall furnish the completed documentation to the MTF commander prior to employment at, or assignment to, the MTF.

8.4 While waiting the 30 day minimum period for a background check to be completed, the contractor shall follow the Criminal History Background Check Procedures outlined in DoDI 1402.5 (<http://www.dtic.mil/whs/directives/corres/html/14025.htm>).

Note: A criminal history background check is not required during the recredentialing process. The contractor shall complete the criminal history background check at the time of initial credentialing and shall continue to follow the DoDI 1402.5 (<http://www.dtic.mil/whs/directives/corres/html/14025.htm>) which calls for a re-check after five years.

9.0 CRIMINAL HISTORY REVIEWS

9.1 Contractors shall perform criminal history reviews on certain physician (see [paragraph 9.2](#)) and non-physician (see [paragraph 9.3](#)) network providers. Contractors may search federal, state, and county public records in performing criminal history checks. Contractors may subcontract for these services; for example, MEDI-NET, Inc., provides physician screening services, and ADREM Profiles, Inc., performs criminal history checks. The contractor shall document, in a form of the contractors' choosing, the American Medical Association (AMA) screen and the results of all criminal history checks.

9.2 Contractors shall screen their TRICARE network physicians' licensure and discipline histories using the AMA's master file. Contractors shall check the criminal histories of physicians with anomalies in their licensure history [i.e., who have four or more active and/or expired licenses] or who have been disciplined.

9.3 Contractors also shall perform criminal history reviews on all non-physician providers who practice independently and who are not supervised by a physician (refer to [32 CFR 199.6\(c\)\(3\)](#), for types of providers).

9.4 The contractor shall maintain a copy of all background check documentation with the provider certification files.

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9.5 The contractor is financially responsible for all credentialing requirements, including background reviews.

Note: A criminal history review is not required during the recredentialing process. A criminal history review shall be completed by the contractor at the time of initial credentialing for those providers for whom criminal history reviews are required.

- END -

4.1.3.2 The contractor shall be responsible for verifying the information necessary to initiate monthly allotments and EFTs.

4.1.3.3 The contractor shall direct bill the beneficiary only when a problem occurs in initially setting up the allotment or EFT.

4.2 Member Category

The sponsor's member category on the effective date of the initial enrollment, as displayed in DOES, shall determine the requirement for an enrollment fee.

4.3 Unremarried Former Spouses (URFs) and Children Residing with Them

4.3.1 URFs became sponsors in their own right as of October 1, 2003. As such, they are enrolled under their own SSNs and pay an individual enrollment fee. URFs may not "sponsor" other family members and their fees may not be factored into any family fees associated with the former spouse/sponsor.

4.3.2 Children residing with the URF and whose eligibility for benefits is based on the ex-spouse/former sponsor are identified under the ex-spouse/former sponsor's SSN on DEERS. Likewise, they are enrolled under the ex-spouse/former sponsor and fees for these children shall be combined with other fees paid under the ex-spouse/former sponsor.

Example: A contractor would collect the individual enrollment fee for an URF's enrollment under the URF's own SSN. The contractor would also collect a family enrollment fee for any two or more eligible family members enrolled under the SSN of the ex-spouse/former sponsor. These enrollees might include the sponsor, any current spouse, and all eligible children, including those living with the URF.

4.4 Medicare Part B Fee Waiver

Each Prime enrolled beneficiary under age 65, who maintains enrollment in Medicare Part B, is entitled to a waiver of an amount equivalent to the individual TRICARE Prime enrollment fee. Hence, individual enrollments for such beneficiaries will have the enrollment fee waived. A family enrollment in TRICARE Prime, where one family member is under age 65 and maintains enrollment in Medicare Part B, shall have one-half of the family enrollment fee waived; the remaining half must be paid. For a family enrollment where two or more family members are under age 65 and maintain enrollment in Medicare Part B, the family enrollment fee is waived regardless of the number of family members who are enrolled in addition to those entitled to Medicare Part B.

4.5 Mid-Month Enrollees

The contractor shall collect any applicable enrollment fee from mid-month enrollees at the time of enrollment. However, there will be no enrollment fee collected for the days between the effective enrollment date and the determined enrollment date.

4.5.1 The effective enrollment date shall be the actual start date of the enrollment.

4.5.2 The determined enrollment date shall be established using the 20th of the month rule, as it is for initial enrollments.

Example: If the retirement date is May 27, the effective enrollment date will be May 27 and the determined enrollment date will be July 1. Fees will be charged for the period from July 1 forward; no fees will be assessed for the period from May 27 through June 30. Reference the TPM, [Chapter 10, Section 3.1](#).

4.6 Overpayment Of Enrollment Fees

If enrollment fees are overpaid at any point during an enrollment year, the contractor may credit the overpayment to any outstanding payments due. Such credits shall be reported on DEERS. If the overpayment of enrollment fees is not applied to outstanding payments due, the contractor shall refund any overpayments of \$1 or more to the enrollee. When TRICARE Prime enrollment changes from an individual to a family prior to annual renewal, the unused portion of the enrollment fee shall be prorated on a monthly basis and shall be applied toward a new enrollment period.

4.7 The following reports will be provided to the contractor to assist with identifying and correcting enrollment fee discrepancies. The contractor shall correct all accounts identified as discrepant. The contractor who is responsible for a beneficiary's current enrollment is responsible for resolving any over/under payments. For split enrollments, the reports will use the billing hierarchy to determine the responsible contractor.

4.7.1 Monthly Under Report

Enrollment fees are considered delinquent and will show up on the Monthly Under Report when the paid through date associated with a policy is greater than 60 days in the past. The Under Report will be provided on the first of each month. The contractor is required to analyze and correct all reported delinquencies within 30 days of the report's availability. The corrections may include synchronizing the fee data between the contractor's system and DEERS, correcting data discrepancies, and potentially terminating enrollments for failure to pay fees.

4.7.2 Monthly Over Report

The Monthly Over Report will identify those policies where the paid amount is over the amount owed. Amount owed is based on the enrollment begin date, the paid through date, and any existing fee waivers. The Over Report will be provided on the first of each month. The contractor is required to analyze and correct all reported accounts within 30 days of the report's availability. The contractor is responsible for correcting any data inaccuracies within the enrollment fee reporting system to include the refunding of any enrollment fees in excess of what is due if necessary.

4.7.3 Quarterly Under Report

The Quarterly Under Report will identify all terminated policies since the inception of the contract that have an associated paid through date prior to the termination date. The Quarterly Report will be provided on the first day of the first month of the fiscal quarter (i.e., October 1, January 1, April 1, and July 1). The contractor shall correct all data discrepancies within 60 days of

the report's availability.

5.0 ENROLLMENT OF FAMILY MEMBERS OF E-1 THROUGH E-4

5.1 When family members of E-1 through E-4 reside in a Prime Service Area (PSA) of an MTF offering TRICARE Prime, the family members will be encouraged to enroll in TRICARE Prime. Upon enrollment, they will choose or be assigned a PCM located in the MTF. Such family members may, however, specifically decline such enrollment without adverse consequences. The choice of whether to enroll in TRICARE Prime, or to decline enrollment is completely voluntary. Family members of E-1 through E-4 who decline enrollment or who enroll in Prime and subsequently disenroll may re-enroll at any time. The completion of an enrollment application is a prerequisite for enrollment of such family members.

5.2 Enrollment processing and allowance of civilian PCM assignments will be in accordance with the Memorandum of Understanding between the contractor and the MTF.

5.3 The primary means of identification and subsequent referral for enrollment will occur during in-processing. These non-enrolled families may also be referred to the local TSC by the MTF, Commanders, First Sergeants/Sergeants Major, supervisors, Family Support Centers, and others.

5.4 The local TSC will provide enrollment information and support the family member in making an enrollment decision (i.e., to enroll in TRICARE Prime or to decline enrollment). The education of such potential enrollees shall specifically address the advantages of TRICARE Prime enrollment, including guaranteed access, the support of a PCM, etc. The contractor shall reinforce that enrollment is at no cost for family members of E-1 through E-4 and will give them the opportunity to select or be assigned an MTF PCM, to select a civilian PCM if permitted by applicable MOU, or to decline enrollment in TRICARE Prime.

5.5 The contractor shall also discuss the potential effective date of the enrollment, explaining that the actual effective date will depend upon the date the enrollment application is received, consistent with current TRICARE rules (i.e., the "20th of the month" rule). The effective date of enrollment shall be determined by the date the enrollment application is received by the MCSC. These enrollments and enrollment refusals should not be tracked, nor the enrollees identified differently than enrollments initiated through any other process, such as the MCSC's own marketing efforts.

5.6 Enrollment may be terminated at any time upon request of the enrollee, sponsor or other party as appropriate under existing enrollment/disenrollment procedures. Beneficiaries in this group may re-enroll at any time without restriction or penalty. However, such re-enrollments are subject to the 20th of the month rule.

5.7 Contractors are not required to screen TRICARE claims to determine whether it may be for treatment of a non-enrolled ADFM of E-1 through E-4 living in a PSA. Rather, they are to support the prompt and informed enrollment of such individuals when they have been identified by DoD in the course of such a person's interaction with the military health care system or personnel community and have been referred to the contractor for enrollment.

6.0 TRICARE ELIGIBILITY CHANGES/REFUNDS OF FEES

6.1 Refer to the TPM, [Chapter 10, Section 3.1](#), for information on changes in eligibility.

6.2 The contractor shall allow a TRICARE-eligible beneficiary who has less than 12 months of eligibility remaining to enroll in TRICARE Prime until such time as the enrollee loses his/her TRICARE eligibility. The enrollment transaction to DEERS shall reflect the end date of enrollment to be the same as the end date of eligibility on DEERS. The beneficiary shall have the choice of paying the entire enrollment fee or paying the fees on a more frequent basis (e.g., monthly or quarterly). If the enrollee chooses to pay by installments, the contractor shall collect only those installments required to cover the period of eligibility.

6.3 Contractors shall reimburse the unused portion of the TRICARE Prime enrollment fee to retired TRICARE Prime enrollees and their families who have been recalled to active duty. Contractors shall calculate the reimbursement using monthly pro-rating, and shall report such reimbursements to DEERS. If the reactivated member's family chooses continued enrollment in TRICARE Prime, the family shall begin a new enrollment period and shall be offered the opportunity to keep its PCM, if possible. Any enrollment/fiscal year catastrophic cap accumulations shall be applied to the new enrollment period.

6.4 The contractor shall reimburse enrollment fees for deceased enrollees upon receiving a written request from the remaining enrollee or the executor of the decedent's estate. The request must include a copy of the death certificate. Reimbursements shall be prorated on a monthly basis and apply both to individual plans where the sole enrollee is deceased and to the conversion of a family enrollment to an individual plan upon the death of one or more family members. For individual enrollments, the contractor shall refund remaining enrollment fees to the executor of the estate. For family enrollments that convert to individual plans, the contractor shall either credit the excess fees to the individual plan or refund them either to the remaining enrollee or to the executor of the decedent's estate, as appropriate. Enrollment fees for family enrollments of three or more members are not affected by the death of only one enrollee and no refunds shall be issued. The contractor shall record all reimbursements of fees in DEERS.

6.5 The MCSCs shall refund the unused portion of the TRICARE Prime enrollment fee to TRICARE Prime enrollees who become eligible for Medicare Part A based upon disability, End Stage Renal Disease (ESRD) or upon attaining age 65, provided the beneficiary' has Medicare Part B coverage. The contractor shall calculate the refund using monthly prorating.

6.5.1 For Prime enrollees who become Medicare eligible upon attaining age 65 and who maintain Medicare Part B coverage, refunds are required for overpayments occurring on and after the start of health care delivery of all MCS contracts. The contractor shall utilize its files to substantiate any claim of overpayment.

6.5.2 For Prime enrollees who are under 65 years of age and become Medicare eligible due to disability or ESRD and who maintain Medicare Part B coverage, refunds are required for overpayments starting on the date the enrollee has Medicare Part B coverage. Beneficiaries must provide sufficient documentation to support the overpayment for a refund. The contractor shall supplement the beneficiary's documentation using DEERS and any available internal files, from the current and any prior contracts.

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6.5.3 The contractors are not required to research their files to identify these individuals. If the contractor receives a refund request, then the contractor shall refund the unused portion of the enrollment fee determined to be an overpayment in accordance with policy.

6.5.4 Medicare eligibles age 65 and over are not eligible to either enroll or remain in TRICARE Prime. Beneficiaries age 65 and over who are not entitled to premium free Medicare Part A remain eligible for TRICARE Prime.

6.6 The contractor shall include full and complete information about the effects of changes in eligibility and rank in beneficiary education materials and briefings.

- END -

Contractor Relationship With The Military Health System (MHS) TRICARE Quality Monitoring Contractor (TQMC)

1.0 The TRICARE Quality Monitoring Contractor (TQMC) conducts reviews to validate the appropriateness of the contractor's quality of care and utilization review decisions. The Managed Care Support Contractor (MCSC) and Designated Provider (DP) shall transmit copies of the medical record and all case documentation to the TQMC for each case or category of case requested by the TQMC. The estimated number of cases (including inpatient and outpatient care) to be selected on a monthly basis will vary depending upon the health care region involved and the case selection criteria. The estimated quantities per region could range from 300 to 630 cases per month for the MCSC. The DPs' estimated quantity could range from 10 to 30 cases per month.

2.0 The MCSC and DP shall transmit **95% of the requested** records to the TQMC within 45 calendar days **and 98% within 60 calendar days** from the date the MCSC and DP receives the request for records from the TQMC. Records to be transmitted shall include the complete medical record, the MCSC's and DP's utilization review decision, rationale for that decision, and quality of care determinations. The MCSC and DP shall incur all costs for obtaining and transmitting the records.

3.0 The TQMC conducts focused studies of the purchased care sector. At the direction of the government, the MCSC shall use the findings and address, as appropriate, each recommendation made in the focused studies to update the Clinical Quality Management **Program (CQMP)** Plan and Utilization Management (**UM**) Plan. **Any updates directed by the Procuring Contracting Officer (PCO) to the CQMP Plan and UM Plan as a result of the findings of the focused studies, will be made by the MCSC at no additional cost to the government.**

4.0 **Annually, the TQMC evaluates each MCSC's and DP's CQMP Annual Report (AR) to identify patterns and trends and assist the Government in determining best practices.**

- END -

Clinical Quality Management Program (CQMP)

1.0 CLINICAL QUALITY MANAGEMENT PROGRAM (CQMP) PLAN

1.1 The contractor shall operate a CQMP which results in demonstrable quality improvement of the quality of health care provided beneficiaries and of the process and services delivered by the contractor.

1.2 The contractor shall fully describe in a written CQMP plan the structural and function components of the program. **The CQMP is defined as the integrated processes, both clinical and administrative, that provide a framework for goals and objectives, leadership, structured and operational components, designed to achieve the efficient and effective provision of access to and quality of care. The contractor shall have a written CQMP Plan as described in Exhibit B, Contract Data Requirements List (CDRL), DD Form 1423, P040.**

1.3 Clinical Quality Management Program Annual Report (CQMP AR)

Annually, on the date specified by the contract, the contractor shall provide the CQMP AR. As specified in the contract, at the end of the last option year of the contract, the contractor shall submit a final CQMP AR. The report shall link to the annual plan and reflect the status of active Quality Improvement Initiatives (QIIs) and studies. See for the structure and content of the CQMP AR.

2.0 CQMP STRUCTURAL AND FUNCTIONAL REQUIREMENTS

The contractor shall participate in monthly, or at a frequency determined by the Regional Director (RD), in region level quality management committees. The contractor shall develop and implement written policies and procedures to identify Potential Quality Issues (PQIs), steps to resolve identified problems, suggest interventions to resolve problems, and provide ongoing monitoring of all components of the contractor's operations and the care and treatment of TRICARE beneficiaries.

At a minimum, the contractor shall assess every medical record reviewed for any purpose and any care managed/observed/monitored on an ongoing basis for PQIs in accordance with the following table.

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Clinical Quality Management Program (CQMP)

Using the most current National Quality Forum (NQF) Serious Reportable Events (SREs), the contractor shall identify, track, trend, and report interventions to resolve the PQIs and Quality Issues (QIs) using the below minimum indicators/criteria:

EVENT	ADDITIONAL SPECIFICATIONS
Medical, Surgical, Mental Health: Inpatient, Outpatient, and all levels of care throughout the continuum. Events 1 through 6 are NQF SREs.	
1. Surgical Events	
<p>a. Surgery performed on the wrong body part</p>	<p>Defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient.</p> <p>Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent.</p> <p>Surgery includes endoscopies and other invasive procedures.</p>
<p>b. Surgery performed on the wrong patient</p>	<p>Defined as any surgery on a patient that is not consistent with the documented informed consent for that patient.</p> <p>Surgery includes endoscopies and other invasive procedures.</p>
<p>c. Wrong surgical procedure performed on a patient</p>	<p>Defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient.</p> <p>Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent.</p> <p>Surgery includes endoscopies and other invasive procedures.</p>
<p>d. Retention of a foreign object in a patient after surgery or other procedure</p>	<p>Excludes objects intentionally implanted as part of a planned intervention and objects present prior to surgery that were intentionally retained.</p>
<p>e. Intraoperative or immediately post-operative death in an ASA Class I patient</p>	<p>Includes all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out.</p> <p>Immediately post-operative means within 24 hours after induction of anesthesia (if surgery not completed), surgery, or other invasive procedure was completed.</p>
2. Product Or Device Events	
<p>a. Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the health care facility</p>	<p>Includes generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination and/or product.</p>
<p>b. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended</p>	<p>Includes, but is not limited to, catheters, drains, and other specialized tubes, infusion pumps, and ventilators.</p>
<p>c. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a health care facility</p>	<p>Excludes deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.</p>

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EVENT	ADDITIONAL SPECIFICATIONS
EVENT 9 is for use at contractor's discretion	
9. Other	

Additionally, the contractor shall report potential SREs to the TRICARE Regional Office (TRO) within two working days from when the contractor becomes aware of the event including the beneficiary's name, sponsor's Social Security Number (SSN), beneficiary date of birth, enrollment status, brief summary of the event, location of event, and any contractor actions taken to date. The contractor shall report closure of the reported SRE to include closure date and summary of actions taken.

3.0 PATIENT SAFETY OR QI IDENTIFICATION

The contractor shall apply medical judgment, evidence based medicine, best medical practice and follow the TRICARE criteria as set forth in [paragraph 2.0](#) for the identification, evaluation and reporting of all PQIs and confirmed QIs.

3.1 Quality Intervention

The contractor shall implement appropriate quality interventions using evidence based medicine/guidelines and best medical practices to reduce the number of QIs and improve patient safety. When the contractor confirms a QI, the determination shall include assignment of an appropriate severity level and/or sentinel event, and describe the actions taken to resolve the quality problem.

3.2 Definitions

- **PQI** - A clinical or system variance warranting further review and investigation for determination of the presence of an Actual QI.
- **No QI** - Following investigation there is NO QI finding.
- **QI** - A verified deviation from acceptable standard of practice or standard of care as a result of some process, individual, or institutional component of the health care system.
 - **Severity Level 1** - QI is present with minimal potential for significant adverse effects on the patient.
 - **Severity Level 2** - QI is present with the potential for significant adverse effects on the patient.
 - **Severity Level 3** - QI is present with significant adverse effects on the patient.
 - **Severity Level 4** - QI with the most severe adverse effect and warrants exhaustive review.
 - **Sentinel Event** - A sentinel event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase "or the risk thereof" includes any process

variation for which a recurrence would carry a significant chance of a serious adverse outcome.

4.0 AGENCY FOR HEALTHCARE RESEARCH AND QUALITY (AHRQ) PATIENT SAFETY INDICATORS

Annually, the contractor will utilize the current patient safety indicator software, provider level, available from the AHRQ, to evaluate the safety of care delivered in the network. The software is designed for use with administrative data sets and will not require manual chart abstraction. The contractor shall run the appropriate data for all of the patient safety indicators and use the analysis of the results to identify PQIs and patient safety issues for individual providers, groups or facilities. Analysis will also be used to provide focus for specific patient safety interventions and/or study activity that will be implemented at the direction of the contractor.

- END -

Jurisdiction

The contractor shall determine that claims received are within its contractual jurisdiction using the criteria below.

1.0 PRIME ENROLLEES

When a beneficiary is enrolled in TRICARE Prime, contractor jurisdiction is determined by the beneficiary's regional enrollment. (Contractors shall use Defense Enrollment Eligibility Reporting System (DEERS) as the method to determine a beneficiary's enrollment status.) The contractor processes all claims for the enrollee no matter where the enrollee receives services (except for care received overseas, see below). For information on claims for relocating Prime enrollees, refer to [Chapter 6, Section 2](#). When a beneficiary's enrollment changes from one region to another during a hospital stay, the contractor with jurisdiction on the date of admission shall process and pay the entire Diagnostic Related Group (DRG) claim, including cost outliers. For inpatient claims paid on a per diem basis, to include DRG transfers and short stay outliers cases, and for professional claims that are date-driven, the contractor with the jurisdiction on the date of service shall process and pay the claim.

2.0 ALL OTHER TRICARE BENEFICIARIES

For a beneficiary who is not enrolled in TRICARE Prime, the contractor with jurisdiction for the beneficiary's claim address shall process the claim no matter where the beneficiary receives services (except for **Continued Health Care Benefits Program (CHCBP) claims and for** care received overseas). For inpatient claims paid under the DRG-based payment system, the contractor with jurisdiction for the beneficiary's claim address, 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 with jurisdiction for the beneficiary's claim address on the date of service, shall process and pay the claim.

3.0 CARE RECEIVED OVERSEAS

Claims for beneficiaries who reside overseas or who are enrolled in the TRICARE Overseas Program (TOP) shall be processed by the TOP contractor regardless of where the enrollee receives the services. Claims for CONUS-based beneficiaries who receive civilian health care while traveling or visiting abroad shall be processed by the TOP contractor, regardless of where the beneficiary resides or where they are enrolled. See [Chapter 24, Section 9](#), for additional information.

4.0 TRICARE/MEDICARE DUAL ELIGIBLES

Claims for services rendered to TRICARE/Medicare dual eligibles within the 50 United States, the District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands, American Samoa, and the Northern

Mariana Islands are the responsibility of the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) contractor.

5.0 PHARMACY CLAIMS

All claims for pharmaceuticals dispensed at a retail pharmacy or a mail order pharmacy are the responsibility of the TRICARE Pharmacy (TPharm) contractor. Claims for pharmaceuticals (e.g., injectibles) ordered by and administered in a physicians office or other place of practice such as a clinic, are the responsibility of the MCSCs for enrollees and residents of their Region. Claims for pharmaceuticals dispensed by a provider who does not have a National Council of Prescription Drug Plans (NCPDP) number are also the responsibility of the appropriate MCSC.

6.0 SUPPLYING OUT-OF-AREA PROVIDER INFORMATION

For out of area claims the regional contractor responsible for certifying providers and developing pricing data for the region where the services were provided shall supply provider and pricing information (both institutional and non-institutional) to the contractor responsible for processing the claims. The contractor shall respond within five workdays after receipt of such requests and shall designate a Point Of Contact (POC) for this purpose. The contractor shall follow the procedures below in requesting and providing information. Responses to such requests shall include only that information not available in the requester's own records or in TMA-provided records. The response shall verify whether or not the provider is a TRICARE-authorized provider and whether or not the provider is a network provider. The response shall also include the appropriate pricing of the services/supplies as well as specific data needed to complete contractor records and TRICARE Encounter Data (TED) submissions to the TMA.

6.1 Procedures For Contractor Coordination On Out-Of-Jurisdiction Providers

Contractors subject to the requirements of the TRICARE Systems Manual (TSM) who are responsible for processing claims for care provided outside of their provider certification jurisdiction shall first search available provider files, including the TMA-supplied copy of the TRICARE centralized provider file (to be provided at least weekly), to determine provider certification status, obtain related provider information, and determine if the certifying contractor has submitted a TRICARE Encounter Provider (TEPRV) record for the out-of-area provider.

6.2 File Search Unsuccessful

If the file search is unsuccessful, the following procedures apply:

6.2.1 The servicing (claims processing) contractor shall request provider information from the certifying contractor.

6.2.2 Each contractor shall designate a POC as specified in [paragraph 6.0](#) who shall be responsible for initiating actions related to such requests and ensuring these actions are timely and well documented.

- 6.4.2** Provider Sub-ID (not required for NPI). Provider Sub-ID may need to be assigned by the servicing contractor if the certifying contractor is not subject to the requirements of the TSM.
- 6.4.3** Provider Contract Affiliation Code.
- 6.4.4** Provider Street Address.
- 6.4.5** Provider “pay to” address.
- 6.4.6** Provider State or Country.
- 6.4.7** Provider Zip Code.
- 6.4.8** Provider Specialty (non-institutional providers).
- 6.4.9** Type of Institution (institutional providers).
- 6.4.10** Type of reimbursement applicable (DRG, MHPD, etc.).
- 6.4.11** Per diem reimbursement amount, if applicable.
- 6.4.12** Indirect Medical Education (IDME) factor (where applicable), Area Wage Index (DRG).
- 6.4.13** Provider Acceptance Date.
- 6.4.14** Provider Termination Date.
- 6.4.15** Record Effective Date.
- 6.4.16** The certifying contractor shall provide additional data upon request of the servicing contractor or TMA to meet internal processing, prepayment review, or file requirements or, to create a TEPRV when the certifying contractor is not under the requirements of the TSM.

6.5 Maintenance Of TEPRV With An APN

In all cases when an APN is assigned, the certifying contractor shall attempt to obtain the provider’s actual TIN. Within 10 workdays of receipt of the provider’s TIN, the certifying contractor who is under the requirements of the TSM shall inactivate the APN TEPRV and add the TEPRV with the provider’s TIN regardless of whether the provider meets TRICARE certification requirements.

All APNs must be associated with an NPI for providers who meet the Health and Human Services (HHS) definition of a covered entity and submit Health Insurance Portability and Accountability Act (HIPAA)-compliant electronic standard transactions or who otherwise obtain an NPI. Guidance for submitting the NPI on TEPRV records will be provided in a future order.

6.6 Provider Correspondence

Any provider correspondence which the servicing contractor forwards for the certifying contractor’s action or information shall be sent directly to the certifying contractor’s POC to avoid

misrouting. Within one week of receipt, the servicing contractor shall forward for the certifying contractor's action any correspondence or other documentation received which indicates the need to perform a provider file transaction. This includes, but is not limited to, such transactions as address changes, adding or deleting members of clinics or group practices, or changing a provider's TIN.

6.7 Provider Certification Appeals

6.7.1 Requests for reconsideration of an contractor's adverse determination of a provider's TRICARE certification status are processed by the certifying contractor. Any such requests received by the servicing contractor are to be forwarded to the certifying contractor within five workdays of receipt and the appealing party notified of this action and the reason for the transfer. The certifying contractor shall follow standard appeal procedures including aging the appeal from the date of receipt by the certifying contractor, except that, if the reconsideration decision is favorable, the provider shall be notified to resubmit any claims denied for lack of TRICARE certification to the servicing contractor with a copy of the reconsideration response. In this case, the certifying contractor shall ensure a TEPRV for this provider is accepted by TMA within one calendar week from the date of the appeal decision.

6.7.2 The servicing contractor shall forward to the certifying contractor within five workdays of receipt any provider requests for review of claims denied because the certifying contractor was unable to complete the certification process. The servicing contractor shall notify the provider of the transfer with an explanation of the requirement to complete the certification process with the certifying contractor. Upon receipt of the provider's request, the certifying contractor shall follow its regular TRICARE provider certification procedures. In this case, no basis for an appeal exists. If the provider is determined to meet the certification requirements, the special provider notification and TEPRV submittal requirements apply.

7.0 OUT-OF-JURISDICTION TRICARE CLAIMS

Contractors shall transfer out-of-jurisdiction claims to the appropriate contractor (including the retail pharmacy (TPharm) contractor and the TRICARE/Medicare dual eligibles (TDEFIC) contractor) within 72 hours of identifying out-of-jurisdiction services on a claim. The transferring contractor shall not notify the provider claimant of the transfer. The transferring contractor needs to notify the beneficiary claimant of the action taken and provide the address of the contractor to which the claim was forwarded. The processing contractor may include an EOB message indicating that the claim was transferred from another TRICARE contractor.

7.1 Totally Out-Of-Jurisdiction

When the contractor receives an electronic claim with no services or supplies within its jurisdiction, they shall transfer the claim to the appropriate jurisdictional contractor via a HIPAA-compliant 837 transaction. When the contractor receives a paper claim that is totally out of its jurisdiction, the paper claim (and any attachments) shall be transferred to the appropriate contractor.

7.2 Partially Out-Of-Jurisdiction

When a contractor receives a claim for services or supplies both within and outside its jurisdiction before processing the services or supplies within its jurisdiction, and within 72 hours of identifying the out-of-jurisdiction items, the contractor shall:

- Draw lines through the in-jurisdiction items.
- Ensure the original date of receipt is clearly indicated on the claim.
- Send a copy of the claim and all supporting documents to the appropriate contractor(s).

8.0 NON-TRICARE CLAIMS

The contractor shall return claims submitted on other than approved TRICARE claim forms to the sender or transfer to other lines of business, if appropriate.

8.1 Civilian Health and Medical Program of the Department of Veteran Affairs (CHAMPVA) Claims

When a claim is identified as a CHAMPVA claim, the contractor shall return the claim to the sender with a letter advising them that the CHAMPVA Program's toll-free telephone number 1-800-733-8387, and instruct them to send the claim and all future CHAMPVA claims to:

Health Administration Center
CHAMPVA Program
P.O. Box 65024
Denver, Colorado 80206-9024

8.2 Veterans Claims

If a claim is received for care of a veteran not eligible for TRICARE and there is evidence the care was ordered by a **Department of Veterans Affairs (DVA)** physician, the claim, with a letter of explanation, shall be sent to the DVA institution from which the order came. The claimant must also be sent a copy of the letter of explanation. If there is no clear indication that the DVA ordered the care, return the claim to the sender with an explanation that the veteran is not eligible under TRICARE and that the care ordered by the DVA should be billed to the DVA.

8.3 Claims For Parents, Parents-In-Law, Grandchildren, And Others

On occasion, a claim may be received for care of a parent or parent-in-law, a grandchild, or other ineligible relative of a TRICARE sponsor. Return the claim to the claimant with a brief explanation that such persons are not eligible for TRICARE benefits.

- END -

- 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.

5.0 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.

6.0 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.

7.0 TRICARE ENCOUNTER DATA 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.

8.0 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.

8.1 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.

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Claim Development

8.2 A claim for the lease/purchase of durable medical equipment 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.

8.3 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.

8.4 An inpatient maternity claim which is subject to the TRICARE Diagnostic 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](#).

8.5 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](#).

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

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

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

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

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

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

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

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

9.0 PROVIDER NUMBERS

9.1 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.

Application Of Deductible And Cost-Sharing

1.0 DEFENSE ENROLLMENT ELIGIBILITY REPORTING SYSTEM (DEERS) CATASTROPHIC CAP AND DEDUCTIBLE DATA (CCDD)

1.1 For non-network TRICARE claims, cost-share and deductible amounts shall be applied toward the catastrophic cap as the claims are processed for each fiscal year.

1.2 For TRICARE Prime and TRICARE Extra claims, all beneficiary cost-shares and deductibles specified in the contract shall be applied toward the cap, including nominal copayments for outpatient care. The amount applied toward the cap on the current claim and the family's cumulative total must be reflected on the Explanation of Benefits (EOB), except on complete denials.

1.3 Once the contractor determines that the maximum individual/family liability is met for the fiscal year, cost-shares and deductibles will no longer apply, and the TRICARE-determined allowable amount shall be paid in full for all covered services and supplies under the Basic Program through the end of that fiscal year.

1.4 To assist the contractor with determining if changes to the CCDD need to be made, a monthly Claims Reprocessing Alert Report will be made available to facilitate adjustments of cost share amounts and enrollment fee payments. This report will identify beneficiaries that may need claim and/or fee payment adjustments based on catastrophic cap activity. When a total amount exceeds the fiscal year limit, a review of recent activity is required to ensure proper processing has occurred. The report will identify policies where the catastrophic cap limit (\$3,000) has been exceeded as a result of applying claim and/or enrollment fee amounts. The contractor shall correct all accounts identified as exceeding the catastrophic cap limit. These policies will be reported on an aging basis of 30, 60, 90, and 180 days. The report will also identify policies where the catastrophic cap limit is reduced for any reason, resulting in the total going under the annual limit. The contractor shall determine if any previously waived/reduced cost shares or enrollment fee payments are now due from the beneficiary.

2.0 CLAIM ORDER FOR APPLYING DEDUCTIBLE

The outpatient deductible amounts shall be applied as the claims are processed. When claims are adjusted, the contractor shall apply the deductible based upon the date the claim was initially processed, not the date the claim was subsequently adjusted. See the TRICARE Reimbursement Manual (TRM), [Chapter 2, Section 1](#).

3.0 DEDUCTIBLE DOCUMENTATION

3.1 Contractors shall furnish a deductible certificate or show the status of the deductible on the EOB except on complete denials. For complete denials the contractor does not query any internal

or external catastrophic cap and deductible files and is not required to send deductible information or catastrophic cap information on the denial notice.

3.2 For claims processed for fiscal years included in CCDD, the contractor shall obtain the amount met toward the deductible from the CCDD.

3.3 When a claim is adjusted, the contractor shall query CCDD and apply deductible and cap as directed by the CCDD query response. The contractor shall not review any intervening claims processed between the initial claim and the adjustment for the purpose of adjusting deductible or cap amounts.

3.4 For services in prior years, the beneficiary may request in writing the application of deductibles and cost-shares taken by other contractors or paid by Other Health Insurance (OHI). The contractor shall determine from their deductible record, and/or EOBs from other contractors submitted by the beneficiary, the amount the contractor has to apply to the CCDD. When a beneficiary subsequently documents an excess deductible, the claim shall be adjusted by the contractor that took the excess, based on the order in which claims were processed. The beneficiary must provide the EOB to the contractor for credit to be given for fiscal years not maintained on the CCDD. The contractor must determine which services are creditable toward the catastrophic cap by reference to the TRM, [Chapter 2, Section 2](#).

3.5 For purposes of catastrophic loss protection, a TRICARE claim must be submitted along with an EOB from other health insurance in order for the beneficiary to receive credit for any amount paid by other health insurance, even if the OHI paid the bill in total. Normal double coverage rules remain in effect after the cap has been reached; the beneficiary must submit a claim to the other health insurance before submitting a claim to the TRICARE contractor.

4.0 AUDIT TRAIL AND HISTORY FILE

The contractor shall ensure that the history file accurately reflects all transactions pertaining to care received, cost-shares, deductible, copayments, and adjustments. The contractor shall maintain the integrity of the audit trail and protect the confidentiality and integrity of the files.

5.0 ADJUSTMENTS AND RECOUPMENTS

If the contractor is required to recoup a benefit payment any deductible amount applied to the claim to be recouped must be adjusted on the CCDD to reflect that amount as an outstanding deductible. Any other credited deductible amount resulting from an individual claim adjustment will be offset from future claims received for the beneficiary. The Government has determined that it is not cost effective to collect any outstanding deductible amounts at the close of the timely filing period.

- END -

Chapter 9

TRICARE Duplicate Claims System - TRICARE Encounter Data (TED) Version

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Quick Start Instructions

This section provides instructions for using the Duplicate Claims System (DCS). The following components are necessary to access the system:

- A DCS User ID and password
- Microsoft® Internet Explorer (MSIE), Version 5.5, 6.0, or 7.0, or as directed by the Government
- The Government's DCS web address

Quick Start Instructions assumes familiarity with the personal computer (PC) environment, Windows®, and TRICARE Encounter Data (TED) records. Instructions are presented in the following order:

- Entering and Exiting the System
- Setting a View
- Looking for a Claim Set, Internal Control Number (ICN), or Patient ID
- Identifying a Duplicate Claim
- Resolving a Duplicate Claim Set
- Working with Multi-Contractor Sets
- Creating a Report
- Changing a Password
- Using the HELP System

The DCS verifies that the User ID and password are authorized. This process also identifies the user's organization and determines which claim records from the Duplicate Claims Database can be viewed. For example, if the user is associated with Contractor 1, they will have access to Contractor 1 data only. The system uses an **Owner FI** field for each claim set to assign ownership of each set to a specific contractor.

1.0 ENTERING AND EXITING THE DCS

1.1 To access the DCS, start up the MSIE browser. Go to the DCS web address:
<https://peprsite.csd.disa.mil/pepr/pepr/>.

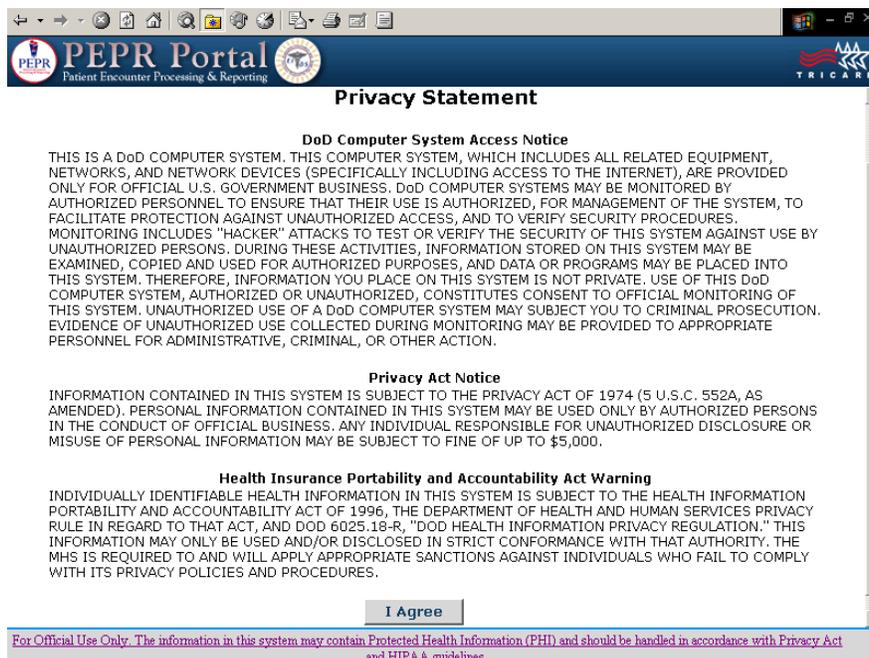
1.2 The **COMMON ACCESS CARD (CAC) SCREEN** (Figure 9.2-1) will be displayed. Until the CAC process has been implemented, click on the "If you don't have a CAC, click here" option.

FIGURE 9.2-1 COMMON ACCESS CARD (CAC) SCREEN



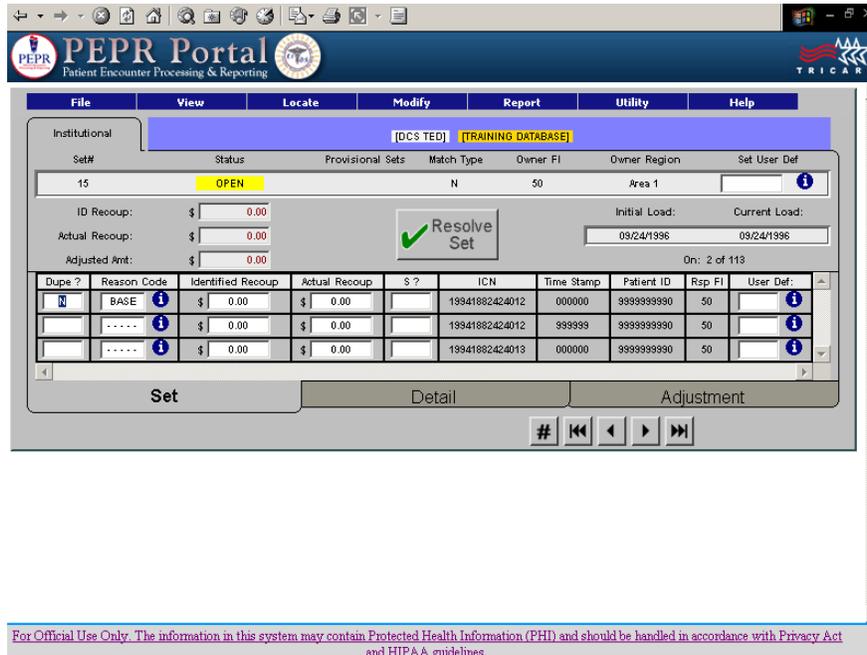
1.3 The **PRIVACY STATEMENT SCREEN** in the Patient Encounter Processing and Reporting (PEPR) Portal (Figure 9.2-2) will be displayed. Read it and then click the **I AGREE** button.

FIGURE 9.2-2 PRIVACY STATEMENT SCREEN



1.8 By clicking on the **ACTIVE DATABASE** or **HISTORY DATABASE** button(s), a box with the message: "**Accessing Database. Working... Please wait...**" will be displayed. When access has been achieved, the SET SCREEN will appear with the **Set** tab active (see Figure 9.2-7).

FIGURE 9.2-7 SET SCREEN



For Official Use Only. The information in this system may contain Protected Health Information (PHI) and should be handled in accordance with Privacy Act and HIPAA guidelines.

1.9 To exit the DCS, click on **F**ile in the menu bar and click on **E**xit to return to the ACCESS SCREEN. The user can then click the **EXIT** button to return to the PEPR PORTAL DCS SCREEN. Then click on **L**ogout on the PEPR Portal Toolbar in the upper right section of the screen.

1.10 To access the training database, click on the **TRAINING DATABASE** button on the ACCESS SCREEN.

1.11 If the user elected to access the **ACTIVE DATABASE**, the first set associated with the FI/ Contractor number will be displayed. The user may move within this set to the CLAIM DETAIL SCREEN or the LINE ITEM DETAIL SCREEN (if the set is a non-institutional set) by clicking on the **Detail** or **Line Item** tab. The user may also view the ADJUSTMENT SCREEN if there is an **Adjustment** tab indicating that an adjustment has been processed for one of the claims in the set. (The **Adjustment** tab will only appear when a TED adjustment associated with the set has been submitted and accepted and has been loaded to the DCS.)

1.12 The user can use the Video Cassette Recorder (**VCR**) buttons at the bottom of the screen to move to the next set (>), the previous set (<), the first set (|<) or the last set (>|). The user can also move to a particular set by clicking on the # button

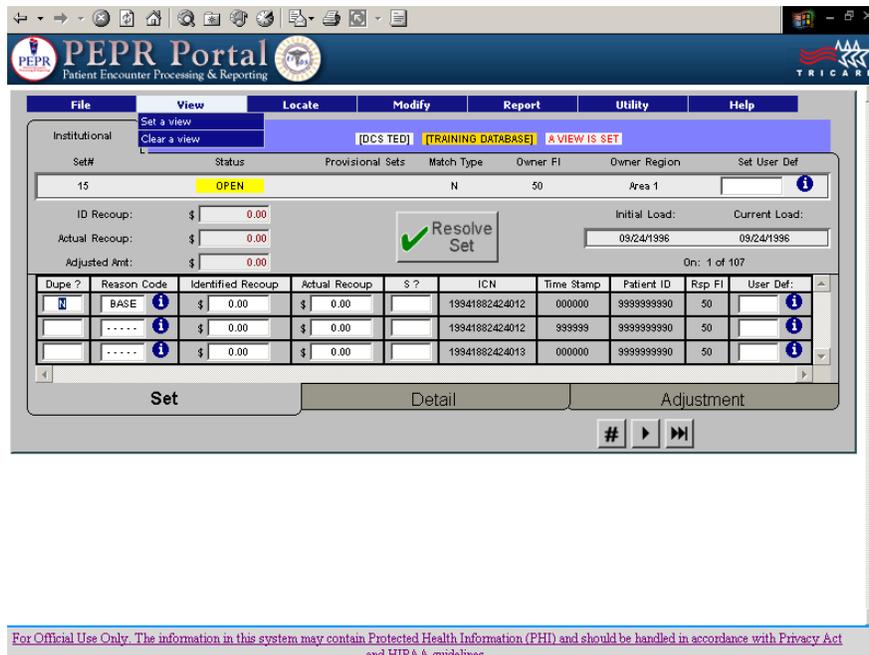
2.0 SETTING A VIEW

2.1 At any time, the user can click the **V**iew function on the menu bar to limit the view to certain categories of claim sets (see Figure 9.2-8). The SELECT DATA VIEW SCREEN, as shown in Figure 9.2-9, allows the user to specify a subset of claim sets to view. The user can select a subset of claim sets by:

- Status code.
- Institutional or non-institutional sets.
- Sets with or without adjustments.
- Single contractor sets or multi-contractor sets.
- Claim match criteria, e.g., exact match, date overlap, Current Procedural Terminology, 4th Edition (CPT-4) code match, etc.
- Sets within a date range for processed to completion (PTC) date, initial load date, current load date, or last update date.
- Sets belonging to a specific region or a specific contractor.
- Only sets with the specified enrollment codes.
- Sets with or without provisional claims.
- Other parameters as available.

2.2 Sets may be selected by combining various View options. For example, the user may request all claim sets with an *Open* status for Region 6 that meet the exact match criteria.

FIGURE 9.2-8 SET A VIEW SCREEN



The screenshot shows the 'Set a View' screen in the PEPR Portal. The interface includes a menu bar with 'View' selected, and a 'Set a view' dropdown menu. A 'Clear a view' button is visible. The main area displays a table with columns: Set#, Status (OPEN), Provisional Sets, Match Type (N), Owner FI (50), Owner Region (Area 1), and Set User Def. Below the table are input fields for ID Recoup, Actual Recoup, and Adjusted Amt, all set to 0.00. A 'Resolve Set' button with a green checkmark is present. A table below shows columns: Dupe?, Reason Code (BASE), Identified Recoup, Actual Recoup, S?, ICN, Time Stamp, Patient ID, Rsp FI, and User Def. The bottom of the screen has a navigation bar with 'Set', 'Detail', and 'Adjustment' buttons, and a footer with a disclaimer: 'For Official Use Only. The information in this system may contain Protected Health Information (PHI) and should be handled in accordance with Privacy Act and HIPAA guidelines.'

2.3 When the user uses the **V**iew function, the system will remind the user that a restricted view of claim sets is being displayed by "**A View is Set!**" message on the screen. The **V**iew function also allows the user to "**C**lear a View" and return to full access of all the user's claim sets. If the user views the claim sets by status, the user can view *Open* sets to see the sets that have not been researched enough to determine if a duplicate condition exists. Or the user can view *Pending* sets to see the

sets that have been researched enough to determine that a duplicate payment was made and recoupment is pending. The user can also view sets that are in *Closed* or *Validate* status. See [Section 4, paragraph 3.0](#), for additional details about claim set status.

FIGURE 9.2-9 SELECT DATA VIEW SCREEN



3.0 LOOKING FOR A SPECIFIC SET AND MODIFYING SETS

3.1 At any time, the user can click the **L**ocate function on the menu bar to view a specific set by set number, ICN, **S**ponsor ID, or Patient ID. Upon selection of one of these locate parameters, the system displays the claim set matching the selected parameters. If an ICN or Patient ID was entered, the user can go back to the **L**ocate function and see if other sets match the ICN, **S**ponsor ID, or Patient ID. If they do, the **L**ocate **N**ext and/or **L**ocate **P**revious options are displayed. If a previous or next option is not relevant to the ICN, **S**ponsor ID, or Patient ID, these choices are “grayed out” and not available to the user.

3.2 If a claim appears in more than one claim set, the ICN will be displayed in white characters. The user can double-click on the white ICN to view the set in which this same claim appears. When the user double-clicks on the white ICN in the “next” set, the system will prompt the user to move to the “Next” or “Previous” set, as appropriate.

3.3 A shortcut to locating a specific set by set number is provided as a **V**CR button at the bottom of the screen (#). To locate a specific set by its set number, click on the # button, enter the number in the pop up window that appears and click on the **O**K button.

3.4 In addition to locating a specific set, the user may use the **M**odify function to change the **O**wner **F**I field of a multi-contractor claim set. (See [Section 6](#), for more information about how and when the user might want to change the **O**wner **F**I field.) The **M**odify function also allows the user to apply the correct region to a set which has been transferred to the user.

3.5 The choices available in the **M**odify function maintain data integrity by allowing the user to select only those choices that are appropriate to the situation. In other words, the choices available to the user when changing the Owner FI of a set include only those Responsible FIs associated with the claims in that set.

3.6 The **M**odify function also has a Government option available to a limited number of the TRICARE Management Activity (TMA) users who are authorized to change the status of sets. The system-assigned status of a set will only be overridden by TMA in consult with the applicable contractor.

4.0 IDENTIFYING A DUPLICATE CLAIM

When viewing a claim set, the user should understand that every claim set contains potential duplicate claims, i.e., two or more payments made for the same services for the same beneficiary on the same dates of service. Refer to [Section 3](#), to see the criteria used to select potential duplicate claims. Prior to the implementation of the National Provider Identifier (NPI), the type of match criteria used to select potential duplicate claims ranges from an "Exact" match in which 12 fields are the same, to an "Other" match in which three, four, or five fields are the same, depending on whether the set involves institutional or non-institutional claims. Upon the implementation of the NPI, an "Exact" match will require 14 fields to be the same, and the "Other" match will require three, four, or five fields to be the same.

The user can view these fields and others in the CLAIM DETAIL SCREEN and LINE ITEM DETAIL SCREEN (non-institutional claims only) while researching the claims in the set. Note that institutional claims are matched at the claim level and non-institutional claims are matched at the line item level. **The user can** print out the data as they appear on these screens by accessing the **F**ile function on the menu bar and selecting **P**rint. The user will need to conduct the research on the user's proprietary claims processing system and pull claim copies, when necessary to comply with other contract requirements (e.g., duplicate prevention requirements, recoupments, etc.), to determine if an actual duplicate payment was made.

5.0 RESOLVING A DUPLICATE CLAIM SET

To resolve a claim set, the user must:

- Conduct research
- Determine the amount of overpayment, if any
- Initiate recoupment action, if required
- Record actual refunds/offsets received, if any
- Submit TED adjustments, where required and
- Apply any TED adjustments loaded to the DCS.

5.1 Steps Of Resolution

To resolve a claim set, the user must enter data in at least two fields for sets involving no duplicate overpayments and five fields for sets containing actual duplicate overpayments. (The user may also enter data into three additional, optional fields if the Managed Care Support Contractor (MCSC)/TRICARE Dual Eligible Fiscal Intermediary Contractor (TDEFIC) finds this optional data valuable.) **Note:** The user may be prompted to type in an explanation for the data

The **RESOLVE THE SET** button changes to an **UNRESOLVE THE SET** button when a claim set has been resolved and its status changed to *Closed* or *Validate*. New data cannot be entered into a set in *Closed* or *Validate* status. If the user wants to change data in a *Closed* or *Validate* set, the user must first unresolve the set by clicking the **UNRESOLVE THE SET** button, which automatically changes the status of the set to *Pending* or *Open*.

In the DCS *Open* and *Pending* are “working” statuses and *Closed* and *Validate* are “resolved” statuses. New data can be entered or changes to data can be made only to sets in a “working” status.

The **RESOLVE THE SET** and **UPDATE CHANGES** buttons described above allow the user to take definitive action to resolve and update a claim set. The system also has several default functions to manage these processes when the user enters new data and do not click the **UPDATE CHANGES** button. In other words, if the user leaves the claim set after entering data by one of the methods listed below, the system assumes the user forgot to click the **UPDATE CHANGES** button, and will do it. It also assumes the user wants to update the claim set with the data that was entered. In updating this data, the system invokes the rules of resolution to determine if the claim set meets the rules of resolution for changing the status of the set from *Open* to *Pending* or from *Pending* to *Open*. These actions will be triggered when the user leaves the claim set by one of the following methods:

- Click on one of the **VCR** movement buttons to move to the first, next, previous, or last claim set.
- Click on the **V**iew or **L**ocate menu bar function to move to a different claim set specified by the **V**iew or **L**ocate criteria.
- Click on the # VCR movement button to move to the claim set the user specifies.
- Exit from the DCS.

Be aware, however, that there is no default function for changing the claim set status to *Closed* or *Validate*. The only way a claim set can be fully resolved and the status changed to *Closed* or *Validate* is by clicking the **RESOLVE THE SET** button.

6.0 WORKING WITH MULTI-CONTRACTOR SETS

The important thing to remember when working with multi-contractor sets is that in every multi-contractor set, one or more jurisdictional errors were committed. One or more claims were paid by a contractor who did not have jurisdiction to do so. There must be at least one ‘Y’ claim in every multi-contractor set. If the user is the Owner FI, the user can view the set and enter data to try and resolve the set. If the user is not the Owner FI but paid one of the claims in the set, the user will not be able to view the set and, therefore, will not know that a jurisdictional error has been made until the Owner FI contacts the user.

The system designates the contractor who processed the latest claim as the Owner FI. If, after the two contractors discuss the jurisdictional facts, the other contractor (not the Owner FI) is the one responsible for the jurisdictional error, the current Owner FI should enter ‘N’ in the **Dupe?** field and a reason code, including BASE, if appropriate, for its claim, then change the **Owner FI** field to

the other contractor by clicking the **M**odify function on the menu bar and selecting the Owner FI option. The contractor who processed the other claim in the set will be displayed so that the user can click on this contractor and change the **O**wner FI field to the other contractor. The user will be required to document that the user discussed this change in ownership with the other contractor and received approval to make the transfer. See [Section 6](#), for additional details.

7.0 CREATING A REPORT

The user can click on the **R**eport function of the menu bar at any time to generate a report. The user **has** a choice of report formats and selection parameters from which to choose the layout and content of the report. For each report type, e.g., set reports, claim reports, summary/management reports, and graphs, the user will be prompted to select subsets within this report type (if applicable) and will be shown the REPORT PARAMETER SCREEN that looks similar to the **V**iew function screen. The REPORT PARAMETER SCREEN enables the user to select the claim types and set types that will be included in the report. See [Section 8](#), for more details about using the **R**eport function.

8.0 CHANGING A PASSWORD

Passwords can be changed at any time, just click on the Profile link on the PEPR Portal Toolbar (in the upper right side of the screen) and follow the prompts. Passwords must have at least nine but not more than twelve characters and use at least two of each of the following: uppercase, lowercase, numbers, and special characters [! @ # \$ % ^ * () _]. Passwords can be changed only once every 24 hours.

9.0 USING THE HELP SYSTEM

If the user needs additional assistance beyond that provided by this chapter, the user can call the **MHS Help Desk** in San Antonio at **1-800-600-9332**, then follow the prompts to DCS.

- END -

the Owner FI.

2.0 REQUIREMENTS FOR ACCESSING THE SYSTEM

User access to the system is controlled by security procedures that require an individual to have access to the Government's servers and the DCS. Security procedures require a valid user ID and password.

2.1 User ID And Password

A critical component of system security is the assignment of unique user identification numbers (IDs) and passwords for each individual authorized to access the system.

Individual users at contractor and TMA sites have the capability to define their own passwords for accessing the DCS. Users can change these passwords at the time of log on to the Patient Encounter Processing and Reporting (PEPR) Portal.

As previously stated, the system allows access to those functions authorized and associated with particular user IDs. For example, contractors are permitted access only to those potential duplicate claim sets for which they are the Owner FI. Also, they are permitted to generate reports based only upon their own data. The same restriction to accessing data applies to the downloading function. TMA users are authorized to access claim sets for any and all contractors. Additionally, they have access to a number of administrative functions, such as generating management reports containing the aging of claims data in the aggregate, by region, or by specific contractor.

2.2 Signing On To The System

After a user has passed the PRIVACY ACT SCREEN, user log-on is directed by a screen that queries the user for an ID and password. The User ID determines what level of access is permitted and what data (claim sets) can be viewed. Once a valid User ID and password are entered, the user is connected to the DCS.

The claim set life cycle and the resolution of duplicate claim sets begin when contractors sign on to the DCS to view and examine potential duplicate claims (see [Section 3, paragraph 2.0](#), for a description of the claims selection criteria). Through menus, contractors can define parameters to create a filter for the types of claim sets they want to view (see [paragraph 4.1.2](#), for details regarding the **View** function.)

2.3 Accessing Claims Data

The DCS uses the **Owner FI** field to identify and limit access to claims data. The Owner FI is responsible for resolving the claim set. The system allows only the Owner FI to view the claim set and enter data to resolve the set. The **Owner FI** is solely responsible for researching and resolving the claim set. No other contractor can view or access a claim set owned by another contractor.

3.0 USER SCREENS

Four user screens display TED data, permit users to enter resolution data, and provide feedback to users on the rules of resolution.

3.1 Becoming Familiar With The Screens

3.1.1 Each claim set uses multiple screens to display data. To access the different screens, users click on tabs. All sets have a CLAIM SET SCREEN and a CLAIM DETAIL SCREEN. If the set is composed of non-institutional claims, it also has a LINE ITEM DETAIL SCREEN. If the set has associated TED adjustments, the set also has an ADJUSTMENT DETAIL SCREEN.

3.1.2 Normally, the first screen to be displayed will be the CLAIM SET SCREEN. This screen reflects the current date and labels the set as either an institutional or non-institutional set. The top section of the screen contains the menu bar for initiating a number of user functions. Below the menu bar, in the upper portion of the screen, are the set number, status, match type, owner FI, owner region, and set level user defined code fields. Totals of individual claim recoupment amounts are also displayed in the upper section. In the lower portion of the screen, claim-level data extracted from TEDs are displayed. The lower portion also contains fields for indicating which claims are duplicates, reason codes, the amounts to be recouped and the amounts actually recouped for each duplicate claim. In addition, fields for entering claim level user defined codes are available as well as a "solicited" field that may be used to distinguish duplicates for which refunds must be solicited from those for which only a TED adjustment is required.

3.1.3 At the bottom of the CLAIM SET SCREEN is a **DETAIL** tab which allows the user to move to the CLAIM DETAIL SCREEN. Once in the CLAIM DETAIL SCREEN, the user can click on a SET tab to move back to the CLAIM SET SCREEN.

3.1.4 The top portion of the CLAIM DETAIL SCREEN contains set information. Below the set information, claim-level detailed data are displayed. Note that left and right arrows and a scroll bar appear on the bottom of the data box to allow the user to scroll through this data. Approximately 50 claim-level fields are shown for each claim.

3.1.5 If a claim set contains non-institutional claims, there will be a **LINE ITEM** tab at the bottom of the CLAIM SET SCREEN and the CLAIM DETAIL SCREEN to allow the user to move to the LINE ITEM DETAIL SCREEN.

3.1.6 Note that the LINE ITEM DETAIL SCREEN has a sort function above the line item data fields. The black dot in the diamond to the left of the Unsorted label indicates that the display is in Internal Control Number (ICN) order (i.e., all line items from one claim are shown before the next claim's line items). If the display contains more than two line items, it may be helpful to sort the display by grouping matched line items. To sort the line items by procedure code, the user clicks **on the SORTED button just to the left of the UNSORTED button.**

3.1.7 If a claim set has any adjustments corresponding to institutional claims or non-institutional line items, there will be an **ADJUSTMENT** tab at the bottom of all screens. This tab allows the user to move to the ADJUSTMENT SCREEN.

3.1.8 The bottom portion of the ADJUSTMENT SCREEN displays data for each adjusted claim. A vertical scroll bar will appear when appropriate to allow the user to view additional adjustments. Like all DCS system screens, the ADJUSTMENT SCREEN displays TED data. Adjustment data displayed includes claim ICN, TED line item and procedure code, and the paid amount of the adjustment.

3.1.9 All screens were designed to display relevant information to facilitate set resolution. Note that claims data is color-coded so that:

3.1.9.1 Extracted data from the TED database and claim-specific data created by the system appear in black.

3.1.9.2 The total amounts calculated by the system appear in red.

3.1.9.3 Data in user-controlled fields appear in blue or green.

3.1.9.4 ICNs which represent claims in multiple sets appear in white on the CLAIM SET SCREEN.

3.1.9.5 As explained in the preceding paragraphs, user screens have been designed to display claims data and associated adjustments and also provide for user entry of information needed to resolve the set. User screens also display information about the set, showing the set number, set status, match type, Owner FI, and Owner Region.

All screens display **VCR** movement buttons on the bottom of the screen to enable a user to move to another screen of the same set or to move to the first, next, previous, last, or a user designated set contained within the contractor's full or restricted "view." A contractor will have full view of all the sets for which the contractor has been assigned as the Owner FI if no restricted views (via the **V**iew function of the menu bar) have been set by the contractor. If, however, the contractor uses the View function to request a restricted view of, for example, only *Pending* institutional sets with an exact match, the contractor will see only those sets. (See [paragraph 4.1.2](#), for a description of the View function of the menu bar.)

There are four screens that display information about a set:

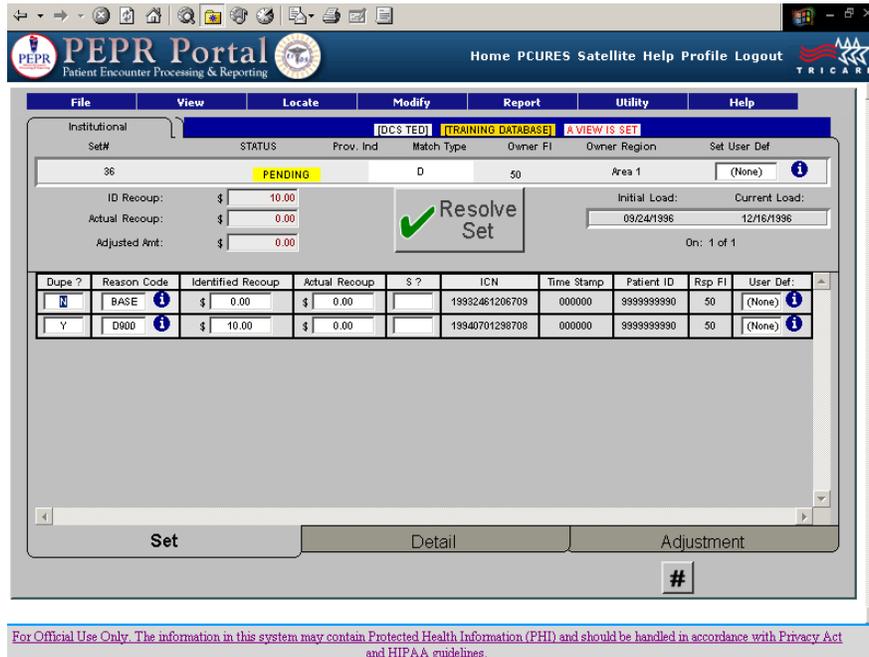
- CLAIM SET SCREEN
- CLAIM DETAIL SCREEN
- LINE ITEM DETAIL SCREEN (Non-institutional sets only)
- ADJUSTMENT SCREEN (Sets with adjustments)

3.2 Claim Set Screen

3.2.1 Set-Level Portion Of The Claim Set Screen

The CLAIM SET SCREEN displays general information about the claim set and the individual claims within the set. It is considered to be the first screen in each set. As shown in [Figure 9.5-1](#), this screen displays system-calculated totals of the amount identified for recoupment, amount actually recouped, and the adjustment amount. Note that these totals are calculated from the entries the user made in the claim level portion of the screen. The screen also displays the set number, the set status, the set match type, the owner FI and the owner region. It also displays the initial and current load dates and the set count of the current set versus the total number of sets in the contractor's full or restricted view of the sets, e.g., "53 of 3333", meaning the current set is the 53rd set of a total of 3,333 sets in the current view.

FIGURE 9.5-1 SAMPLE CLAIM SET SCREEN



3.2.2 Set Level User Defined Field

The upper portion of the screen also contains the **Set User Def** field. This field permits users to enter a user defined code to label the set to reflect additional information that the contractor wishes to track or to have available. While users may enter a user defined code, only certain contractor users have permission to define, activate, or de-activate the codes that may be used. User defined codes may be one or two characters in length. (See paragraph 4.1.2 for additional information.)

3.2.3 RESOLVE And UNRESOLVE Buttons

The screen also contains the **RESOLVE THE SET** button if the set is in *Open* or *Pending* status or the **UNRESOLVE THE SET** button if the set is in *Closed* or *Validate* status.

3.2.4 Set Recoupment Amounts

As noted above, the system-calculated totals of the amounts identified for recoupment, amounts actually recouped, and adjustment amounts for this set are based on the entries made by the user in the claim-level portion of this screen, the LINE ITEM SCREEN (for non-institutional sets) and the ADJUSTMENT SCREEN.

3.2.5 Claim Level Portion Of The Claim Set Screen

The claim level portion of the CLAIM SET SCREEN has headers that read: **Dupe?, Reason Code, Identified Recoup, Actual Recoup, S?, ICN, Time Stamp, Patient ID, Rsp FI, and User Def.** Of these 10 fields, six are designated as user entry fields and four are designated as read-only TED data fields. Specifically, the user-entry fields provide for entry of a 'Y' or 'N' in the **Dupe?** field to

and does not change the status from *Closed* or *Validate* to *Open* or *Pending* immediately after unarchiving the set, there is a risk that the set will be returned to the History database.

4.1.7 Help

The **H**elp function allows the user to select **A**bout from the pull-down menu. About informs the user of the version number of the DCS operating on that particular PC.

4.2 User Defined Fields

The DCS provides contractors with three user defined fields. The purpose of these fields is to provide mechanisms for contractors to meet their own administrative and tracking needs. Two of the three user defined fields allow certain identified users to create, modify, activate, de-activate, or delete contractor defined code values (set level user defined field and claim level user defined field). The third user defined field is the "Solicited Indicator" field (**S?**). This field has three valid values, 'Y', 'N', or blank. The following describes each of these fields and their use.

4.2.1 Set Level User Defined Field

The set level user defined field is located in the upper portion of the DCS screens. This field may contain any two-character alphanumeric value that has been defined by the user. The two-character codes are unique to each region and are deleted should the set be transferred to another contractor. These user defined codes may be used for any purpose needed by the user. Codes may be useful for tracking or reporting purposes. Values may be entered in this field when user defined codes have been defined for a region and the set is in *Open* or *Pending* status. Only contractor-specified users may define set level user defined field codes.

The contractor-specified users will see the "Modify Set User Defined Codes" selection on the Utility menu. Users who do not have permission to create, modify, activate, de-activate, or delete user defined codes will not see these selections. To define a code:

- Click on the **U**tility function on the menu and select "Modify Set User Defined Codes." A table will appear.
- Click on the **ADD CODE** button. A new record will be added to the table and the cursor will move to the **Contractor FI #** field.
- Click on the down arrow to select the applicable Contractor FI number. Only those numbers for which the user has permissions will be available to select.
- Click on the **Contract #** field to select the corresponding contract number associated with the Contractor FI # that was selected in the previous step.
- Click on the **Code** field and enter the two-character code desired.
- Click on the **Code Description** field and enter a description for the code created in the previous step.

- Once the description has been entered, either accept the default of 'Y' in the **Active? (Y/N)** field or change it to 'N' if the code will be activated at a later time.
- Click the **OK** button and save the changes when prompted. **Click the RETURN TO SET button to** return to the CLAIM SET SCREEN.

Once codes have been defined, users can click on the **blue i button** on any DCS screen and a list of entered codes will appear from which to select. By clicking on a code, it will be entered into the field. Use of this field is not required. Contractors may choose to use it or not use it as they see fit. A number of reports include this field on the Report Parameter Selection Form and in the reports themselves. This field is also included in contractor initiated downloads of set data.

4.2.2 Claim Level User Defined Field

The claim level user defined field is located in the claim level portion of the CLAIM SET SCREEN. This field may contain any two-character alphanumeric value that has been defined by the user. The two-character codes are unique to each region. These user defined codes may be used for any purpose needed by the user. Codes may be useful for tracking or reporting purposes. Values may be entered in this field when user defined codes have been defined for a region and the set is in *Open* or *Pending* status. Only contractor-specified users may define claim level user defined field codes.

The contractor-specified users will see the "Modify Claim User Defined Codes" selection on the Utility menu. Users who do not have permission to create, modify, activate, de-activate, or delete user defined codes will not see these selections. To define a code:

- Click on the **U**tility function on the menu and select "Modify Claim User Defined Codes." A table will appear.
- Click on the **ADD CODE** button. A new record will be added to the table and the cursor will move to the **Contractor FI #** field.
- Click on the down arrow to select the applicable Contractor FI number. Only those numbers for which the user has permissions will be available to select.
- **Click on the Contract # field** to select the corresponding contract number associated with the **Contractor FI #** that was selected in the previous step.
- Click on the **Code** field and enter the two-character code desired.
- Click on the **Code Description** field and enter a description for the code created in the previous step.
- Once the description has been entered, either accept the default of 'Y' in the **Active? (Y/N)** field or change it to 'N' if the code will be activated at a later time.
- Click the **OK** button and save the changes when prompted. **Click the RETURN TO SET button to** return to the CLAIM SET SCREEN.

Once codes have been defined, users can click **on the blue i button** on the **User Def:** field on the CLAIM SET SCREEN and a list of entered codes will appear from which to select. By clicking on a code, it will be entered into the field. Use of this field is not required. Contractors may choose to use it or not use it as they see fit. A number of reports include this field on the Report Parameter Selection Form and in the reports themselves. This field is also included in contractor initiated downloads of claim data.

4.2.3 Solicited Indicator Field (S?)

The **Solicited Indicator** field is located in the lower portion of the claim set screen. It is labeled "**S?**" and follows the **Actual Recoup** field. It also appears in the CLAIM DETAIL SCREEN and is labeled "Solicited Indicator." Use of this field is optional but is recommended that contractors use it to help differentiate actual duplicates requiring recoupment from those that require only TED adjustments. A 'Y' in this field indicates that a recoupment will be initiated. An 'N' means that no recoupment action is required (e.g., a refund has already been received or a claim has already been cancelled but a TED adjustment needs to be submitted since duplicate TEDs for the claims reside on the TED database. A blank indicates undetermined.

4.3 Finding Claims in Multiple Sets

The system alerts users when a claim appears in multiple sets. When a claim appears in more than one set, the ICN appears on the CLAIM SET SCREEN in white print. If a claim does not appear in other sets, the ICN will be in black or red print. A user wishing to move to the next set containing the claim with the same ICN and can double click on the ICN. A dialog box will appear with **Locate Next** and **Locate Previous** options. The user can select either option and the system will display the requested set(s).

5.0 USER ENTRY OF DATA TO RESOLVE CLAIM SETS

The DCS facilitates the resolution of duplicate claims by minimizing the amount of data that must be entered by users. It also provides an easy-to-use environment for data entry.

5.1 The entry of data by contractors is limited to 10 fields. Seven fields appear in the CLAIM SET SCREEN, two fields in the LINE ITEM SCREEN, and one field in the ADJUSTMENT SCREEN, as described below:

5.1.1 On the CLAIM SET SCREEN, the contractor may enter:

- 'Y' or 'N' in the **Dupe?** field [required for institutional]. (**Note:** For non-institutional, see [Section 2, paragraph 5.1.](#))
- A reason code selected from lists built into the system, and a supplemental explanation where necessary (see [Addendum B](#)) [required].
- An identified recoupment amount for each actual duplicate identified [required for institutional sets].
- An actual recoupment amount when refunds or offsets are collected [required].

- A user defined code at the set level [optional].
- A user defined code at the claim level [optional].
- A 'Y' or 'N' in the *S?* (Solicited Indicator) field [optional].
- On the LINE ITEM SCREEN, the contractor may enter:
 - A 'Y' or 'N' in the **Dupe?** [optional for non-institutional sets] (see [Section 2, paragraph 5.1.1](#)).
- An amount in the **Identified Recoup** field (the system will enter the Government Paid Amount here when the user a 'Y' in the **Dupe?** field. (The user may modify this amount.) [optional]

5.1.2 On the ADJUSTMENT SCREEN, the contractor may enter a 'Y' in the TED Adjustment (**TED Adjust?**) field for any claim that has an adjustment displayed on the screen. Note that the adjustment paid amount, which corrects a duplicate condition and resolves a claim set, appears as a negative number in parenthesis. When adjustments are selected in the system, the negative allowed amounts are converted to a positive value when they are added to the total Adjust Amount field and used by the rules of resolution to resolve claim sets.

5.2 After entering data on a CLAIM SET SCREEN, LINE ITEM SCREEN, or ADJUSTMENT SCREEN, a contractor will notice that the **UPDATE CHANGES** button appears. The contractor may click the **UPDATE CHANGES** button to see if a change in status (*Open to Pending* or *Pending to Open* only) will occur as a result of the newly entered data. Upon clicking the button, the user will be prompted to select one of the following:

- 'Yes' to commit to the database the changes just made.
- 'No' to rollback all the changes just made.
- 'Cancel' to cancel this operation and go back to the screen.

If the user moves off a claim set after entering data (i.e., by clicking one of the **VCR** buttons or by using the **View** or **Locate** functions), but before clicking on the **UPDATE CHANGES** button, the changes will be automatically sent to the database and the set will be updated.

In invoking the rules of resolution by clicking on the **RESOLVE** or **UPDATE CHANGES** button, the user instructs the system to look at the values in the three total amount fields. The three total amount fields are:

- Total Amount Identified for Recoupment (**ID Recoup**), computed from the sum of the amounts the user enters at the claim level on the CLAIM SET SCREEN.
- Total Amount Actually Recouped (**Actual Recoup**), computed from the sum of the amounts the user enters at the claim level on the CLAIM SET SCREEN.
- Total TED Adjustment Paid Amount (**Adjust Amount**), computed from the sum of TED paid amounts on the adjustments flagged with a 'Y' in the TED Adjustment (**TED Adjust?**) field on the ADJUSTMENT SCREEN.

Reports

The Duplicate Claims System (DCS) includes an integrated reporting system that generates standard and custom reports. These reports facilitate resolution activities and support contractor and the TRICARE Management Activity (TMA) auditing and management functions. In addition to the range of user-defined reports and graphs provided by the **R**eport function on the menu bar, the system provides the capability to download data to local tables. This capability, which is accessed through the **U**tility function on the menu bar, enables users to load DCS data into other database management or reporting software and subsequently generate a variety of ad hoc queries and reports. See [Addendum D](#), for report descriptions and sample reports.

There are predefined and semi ad hoc reports and graphs available to DCS users. Each report/graph has one or two parameter screens which allow the user to refine the report by choosing specific criteria to report on. The following is a list of “standard” parameters/criteria available for each report.

The “standard” parameters (available on most reports) are:

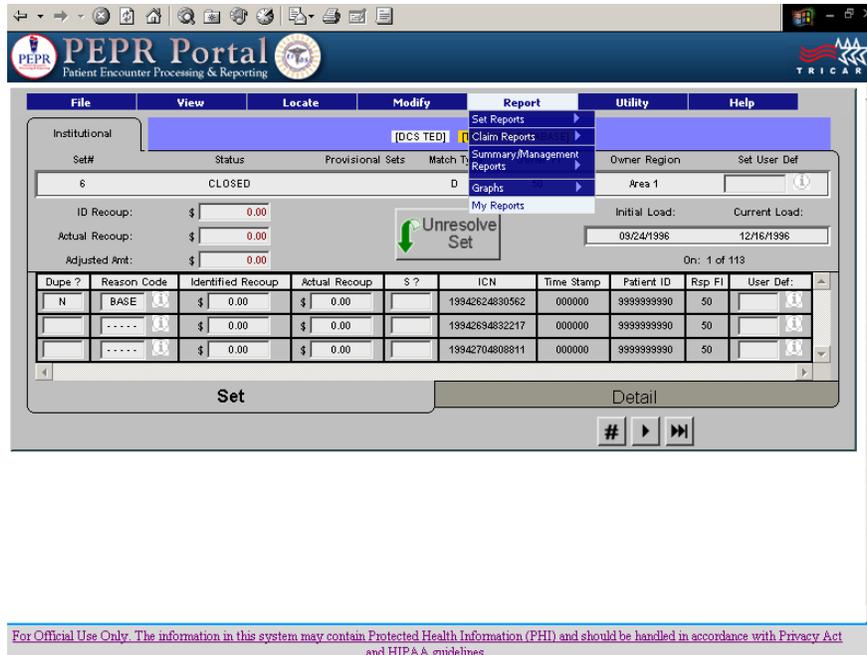
Claim Set Status	(All, C, O, P, V)
Adjustments	(All, Non-adjusted Sets, Adjusted Sets)
Set Owner Type	(All, Multi FI, Single FI)
Claim Type	(All, Institutional, Non-Institutional)
Match Type	(All, C, D, E, N, O)
Date Type	(Initial Load Date, Current Load Date, Last (Update) Date)
Set Range	(Beginning and Ending Set Numbers)
FI	(Select one from the list of available)
Region	(If FI selected, select one or more of available)
Exclude Base Claims	(Check to exclude, leave blank to include)
Solicited	(Yes, No, Blank)
Dupe Flag	(Yes, No, Blank)
Set User Codes	(Select one or many by pressing CTRL and clicking)
Claim User Codes	(Select one or many by pressing CTRL and clicking)

Some reports have other “special” parameters/criteria that may be selected depending on the report. (See [Addendum D](#), for report descriptions and available parameters.)

When a user selects a report, a Report Parameter Screen will appear. Every REPORT PARAMETER SCREEN will contain a **Most Common** tab on which the available “standard” parameters applicable for the selected report will be displayed. If the report has associated “special” parameters available, a second **Special** tab will be visible. Users may further refine their report criteria from the additional parameters on the **Special** tab.

1.0 USING THE REPORT FUNCTION

FIGURE 9.8-1 REPORT CATEGORIES MENU

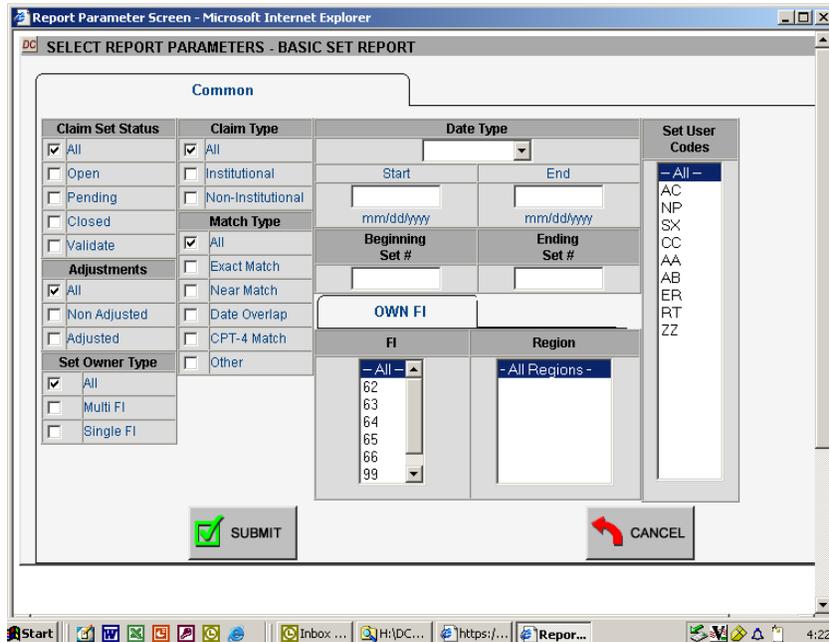


The menu bar on the top of every screen in the DCS includes a **R**eport function with a pull-down menu. When a user selects **R**eport from the menu bar, a report categories menu appears (shown in Figure 9.8-1) to display the four selections available to the user:

- Set Reports
- Claim Reports
- Summary/Management Reports
- Graphs
- My Reports

When a user selects one of the report categories, a list of the available report formats for that category appears. When a report format is selected, a parameter screen appears and presents the user with available options for limiting the sets and claims to be included in the report. The report parameter screen resembles the **V**iew screen. A number of options are presented from which the user can define the data to be included in the report. Figure 9.8-2, shows an example of options available for selecting data to be included in a report.

FIGURE 9.8-2 REPORT PARAMETER SCREEN



Note that the system recognizes if the user is a TMA or contractor user and will display the appropriate options. For example, a contractor is able to print only their own data (i.e., sets assigned to this contractor or region) and not data of other contractors. TMA users are able to generate reports containing data from all contractors.

The report parameter screen presents available options for data selection criteria based on the user type and the type of report format selected. For example, some report formats permit users to include institutional data, non-institutional data, or both in a report. Other formats are exclusively dedicated to either institutional or non-institutional data. Some report formats permit users to include data based on a range of dates while others do not.

The parameter screen detects the user type and the report format selected and displays only those data selection criteria options available for the user and the selected format.

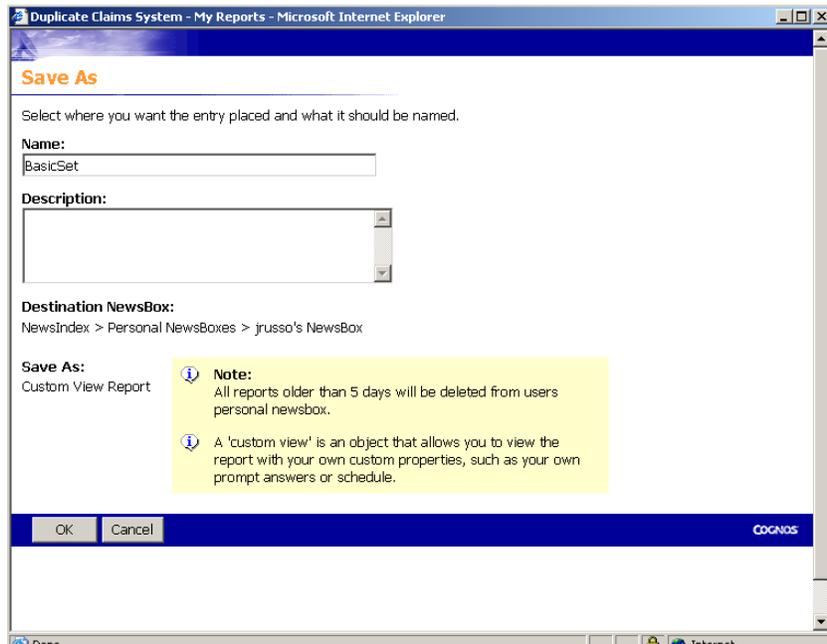
The date range options on the report parameter screen allow a user to specify a selection of sets or claims based on a range of different dates such as:

- Processed To Completion (PTC) Date - the date when the claim was PTC.
- Initial Load Date - the date when the set was initially loaded into the DCS.
- Current Load Date - the date when the set was loaded into the Duplicate Claims Database or when a claim was appended to the set or when set ownership was changed as a result of a mass change or a change in the **Owner FI** field.
- Last Update Date - the date when the set was last updated by a user or by the system.

Note: That regardless of the parameters the user selects, the reports will not include any data from provisional sets.

After a user selects a report format and data parameters and selects the **SUBMIT** button, the system displays the **SAVE AS SCREEN** (Figure 9.8-3). At this time the user can enter a name for the report and may also add a description. This screen allows the user to continue and produce the requested report by selecting the **OK** button or cancel the request and return to the set by selecting the **CANCEL** button.

FIGURE 9.8-3 SAVE AS SCREEN



If the user selects the **OK** button, the system brings the user to the **MY REPORTS SCREEN** (Figure 9.8-4) that lists all the reports that have been run or requested. The reports that have not been reviewed, will display the caption "New". After five days, the reports on this menu will be deleted automatically. To review and/or print a report, select the report name.

System Implementation And Operational Requirements

This section describes implementation requirements for the Duplicate Claims System (DCS). It also defines policies and procedures for the operation of the system.

1.0 SYSTEM COMPONENTS

The DCS is a web-based application operating as a customized graphical user interface. The application runs under Microsoft® Internet Explorer (MSIE), Version 5.5, 6.0, or 7.0, or as directed by the Government, and interfaces with tables that store the Duplicate Claims Database. Access to the DCS will be through MSIE, Version 5.5, 6.0, or 7.0, or as directed by the Government.

2.0 HARDWARE AND SOFTWARE REQUIREMENTS

The requirements below are for user personal computers (PCs), user printers, communications, software, and security.

2.1 Hardware Requirements

There are no specific minimum hardware requirements. As a general rule of thumb, the requirements, as specified by the vendor for the specific version of MSIE should be followed. In addition, using a high bandwidth connection is suggested.

2.2 Printer Requirements

Existing printers may be used for the DCS.

2.3 Communications Requirements

Contractors are required to connect their hardware to the DCS through the Patient Encounter Processing and Reporting (PEPR) Portal using MSIE, Version 5.5, 6.0, or 7.0, or as directed by the Government. The contractor must ensure that the connection has been tested.

2.4 Software Requirements

The software listed below must be installed and operational on each PC.

2.4.1 Operating System Software

No specific requirement.

2.4.2 Communications Software

MSIE, Version 5.5, 6.0, or 7.0, or as directed by the Government.

2.4.3 Application Software

No specific requirement.

2.4.4 Optional Software

Contractors may, at their own option and expense, procure and utilize full version database management software packages such as Microsoft Access®, dBase®, Paradox For Windows®, etc., on the DCS PCs for the purpose of generating customized queries and reports utilizing optionally downloaded **ASCII fixed length files** that can be created by the DCS. Downloaded **ASCII fixed length files** may also be imported into Microsoft Excel®.

2.5 Security Requirements

Security procedures require that all contractors identify a Security Manager to be responsible for overseeing the DCS registration process. DCS registration involves the submission of one security document, for each user, which may be copied from this chapter or obtained from the TRICARE web site on the Internet. The TRICARE web site address is: <http://www.tricare.mil>. The one document is: TRICARE DCS Account Activation Request Form (Figure 9.9-1). Each DCS user must complete and sign the required form(s).

In order to access the DCS, users must obtain a User ID and an initial password from the TRICARE Management Activity (TMA). User IDs and initial passwords will be issued following receipt and processing of properly completed registration and security forms. Users may obtain these forms from the TRICARE Home Page. Once on the TRICARE web site (<http://www.tricare.mil>), users should go to the "Browse A to Z" box and scroll and select "Duplicate Claims System." Once selected, the user should click on the **GO** button. Once on the Duplicate Claims screen, the user should scroll down and click on the "forms" link. Once on the forms page, the user may select the required form. Contractor users should print a copy of **the** form, provide the required information, and submit the completed form to their DCS Security Manager for signature and transmittal to TMA.

DCS data must be encrypted. Encryption specifications will be provided by TMA. See the TRICARE Systems Manual (TSM), [Chapter 1](#) for additional security and communications requirements.

2.6 DCS Log-On And Password Procedures

2.6.1 Change Password

The following are the steps for users to log-on to the DCS and change their password.

2.6.1.1 Passwords can be changed upon entering the PEPR Portal when the word **Profile** appears on the PEPR menu bar. Click on the **Profile** function of the menu bar.

3.0 CONNECTIVITY

Connectivity will be through the internet to the PEPR Portal via MSIE, Version 5.5, 6.0, or 7.0, or as directed by the Government.

4.0 SYSTEM SUPPORT

4.1 For DCS support, contractors should call the **MHS Help Desk** at **1-800-600-9332**, then follow the prompts to the DCS. This will take the user to the San Antonio Help Desk.

4.2 System upgrades will occur automatically when users sign on to the system.

5.0 SYSTEM INSTALLATION AND TRAINING

5.1 Contractor Installation Responsibilities

Contractors are responsible for installing the MSIE, Version 5.5, 6.0, or 7.0, or as directed by the Government, and Adobe Reader, on their hardware, and establishing connectivity to the PEPR Portal. In addition to the communications software required to establish connectivity to the web-based DCS, contractors are responsible for installing their preferred operating system on their hardware.

5.2 Training

TMA will provide training to prospective users of the DCS. The training may be on-line or in person at a central location. TMA will coordinate with each contractor once the approach is defined.

6.0 CONTRACTOR POINTS OF CONTACT (POC)

To resolve multi-contractor duplicate claim sets, contractors are required to communicate and coordinate with each other (see [Section 6](#)). For each regional contract for which a contractor is responsible, the contractor is required to identify at least one individual to serve as the DCS POC. Contractor POCs must be individuals who are, or will be, trained in the use of the DCS, and are able to perform the required research and determine whether a particular claim is within their processing jurisdiction. For each regional contract for which they are responsible, contractors shall provide the name(s), title(s), business address(es), and business telephone number(s) of their POCs to the Procuring Contracting Officer (PCO), with courtesy copies to the Contracting Officer Representatives (CORs) and to the TMA DCS Program Representative. The POCs shall be provided to the PCO no later than (NLT) two weeks prior to implementation of the DCS.

Prior to system implementation, TMA will provide each contractor with the list of all DCS POCs. Whenever a new contract is awarded, TMA will notify all contractors of the new contractor's POC. Once the initial listing is provided to the contractors, it is the responsibility of each contractor to maintain the listing and keep TMA and the other contractors informed of any changes.

7.0 OPERATING PROCEDURES

For each regional contract for which a contractor is responsible, or for the TRICARE Dual

Eligible FI Contract (TDEFIC), the contractor shall develop internal operating procedures for the DCS. These internal operating procedures shall designate the responsible areas for the various duplicate claims resolution functions and establish time lines. For example, one contractor may decide that the adjustment unit shall be responsible for scanning the DCS on a weekly basis for the appearance of adjustments submitted and for closing sets. Another contractor may decide that the unit responsible for researching potential duplicate claims should also be responsible for scanning for adjustments and closing the sets on a daily basis.

Contractor contract requirements for overpayment recovery, refunds and offsets, adjustments, etc., including timeliness requirements, apply to the operation of the DCS. As a result, operating procedures must be developed which are consistent with all applicable contract requirements. Procedures must be established to ensure that recoupments are initiated in a timely manner following the research determination that a duplicate payment had been made. In other words, procedures must specify that after a decision has been made by the person responsible for determining that a duplicate payment was made, recoupment must be initiated in a timely manner and must be consistent with all overpayment recovery timeliness standards.

Contractors shall develop these procedures within 60 days of the date of system implementation and have them available for TMA review.

8.0 CONTRACTOR PERFORMANCE REQUIREMENTS

8.1 Contractors shall use the TRICARE DCS to resolve TMA identified potential duplicate claims payments.

8.2 Contractors shall move *Open* status potential duplicate claim sets to *Pending*, *Validate*, or *Closed* status on a first-in/first-out basis. To this end, contractor performance will be measured against the percentage of claim sets in *Open* status at the end of a month with Current Load Dates over 30 days old. No more than 10% of the potential duplicate claim sets remaining in *Open* status at the end of a month shall have Current Load Dates over 30 days old. Contractor compliance with this standard shall be determined from the Performance Standard Report generated by the DCS (see [Addendum D](#), Summary Management Report titled "Performance Standards", for a description and example of the Performance Standard Report). The 10% standard becomes effective on the first day of the seventh month following the start of services or following system installation whichever is later.

8.3 Contractors shall not be responsible for meeting the performance standard during any month in which availability of the DCS is prevented for two working days due to failure of any system component for which the Government is responsible. The Government is responsible for: TMA servers on which the DCS data resides; Government-supplied communications lines, if any; Government-supplied routers, if any; Government-supplied Channel Sending Unit (CSU)/Data Sending Unit (DSU) equipment that connect the routers to the communication lines, if any; and the DCS application software.

8.4 Contractors are responsible for their own PCs, printers, PC operating system software, and in-house communications software and equipment, including in-house Wide Area Network (WAN)/Local Area Network (LAN) equipment, circuits, and routers. Contractors are responsible for any contractor-supplied communication lines, contractor-supplied routers, and contractor-supplied CSU/DSU equipment that connect the routers to the communication lines. Contractors are

Chapter 10

Section 1

General

1.0 SCOPE

1.1 This chapter consolidates procedures relating to claims adjustments and recoupments. Due to the nature of agreements between network providers and contractors, pharmacy recoupment procedures may be modified or adapted to conform to network agreements subject to approval by the TRICARE Management Activity (TMA). The **requirements** of this chapter shall apply if recoupment under the pharmacy network agreements is not successful within 60 calendar days from the date collection is initiated.

1.2 The method to be used in recouping funds depends on whether financially underwritten funds or non-financially underwritten funds are being recouped. (See [Section 3](#) for procedures for recovery of financially underwritten funds and [Section 4](#) for procedures for recovery of non-financially underwritten funds.) All recoveries made under third party liability (subrogation) statutes, whether financially underwritten or non-financially underwritten funds, shall be collected following procedures in [Section 5](#). See [Chapter 24](#) and TRICARE Policy Manual (TPM), [Chapter 12](#), for information on recoupment procedures for TRICARE Europe (TE) providers. **References** herein to provider or providers also applies to pharmacy or pharmacies.

2.0 THE FEDERAL CLAIMS COLLECTION ACT (FCCA) (31 UNITED STATES CODE (USC) 3701 ET SEQ.)

The Federal Claims Collection Act (FCCA) (31 USC 3701 et seq.) provides authority for the collection of non-financially underwritten fund recoupments. The FCCA was enacted to avoid unnecessary litigation in collecting debts owed to the United States. This statute, implemented by joint regulations of the Department of Justice (DOJ) and the General Accounting Office, requires federal agencies to attempt collection of all federal claims of the United States arising from their respective activities. Under this act, TMA is required to make necessary claims adjustments and initiate recoupment actions for erroneous payments, when Government funds are involved.

3.0 THE FEDERAL MEDICAL CARE RECOVERY ACT (FMCRA) (42 USC 2651-2653)

The Federal Medical Care Recovery Act (FMCRA) (42 USC 2651-2653), provides for the recovery of the costs of medical care furnished by the United States for the treatment of a disease or injury caused by the action or negligence of a third party. Under this act, the United States has a right to recover the reasonable value of the care and treatment from the person(s) responsible for the injury.

4.0 APPLICATION

The procedures which follow are for guidance and compliance by the contractor in the recoupment of funds which have been incorrectly disbursed as underpayments or overpayments

for whatever reason. Also included are procedures for correcting and making proper and timely disbursements when an underpayment is determined to exist and for processing claims which fall within the diagnostic code ranges relating to injuries where third party liability may be involved. In some cases, the contractor may be required to pursue and collect overpayments which occurred under a contract administered by a third party administrator, such as Continued Health Care Benefit Program (CHCBP). This could occur when the contractor has taken over a region and overpayments are subsequently discovered or when an installment collection is still in progress. Procedures of this chapter shall be applied.

5.0 ERROR CORRECTION

The contractor shall correct all erroneously processed claims. The required corrective actions may include making additional payments of \$1.00 or more, adjusting deductibles and cost-shares, adjusting amounts applied toward the catastrophic cap, recouping overpayments and correcting TRICARE Encounter Data (TED) records. When a claim is adjusted, the contractor shall query Defense Enrollment Eligibility Reporting System (DEERS) Catastrophic Cap and Deductible Data (CCDD) and apply deductible and cap updates. Do not review any intervening claims processed between the initial claim and the adjustment for the purpose of adjusting deductible or cap amounts. The TRICARE Systems Manual (TSM), [Chapter 2](#), provides instructions for submission of claim adjustment transactions to the TMA. The contractor will normally use the original Internal Control Number (ICN) to make any adjustments to a processed claim, but there are exceptions.

6.0 TIME LIMITATIONS ON REQUESTS FOR ADJUSTMENTS

(Applies to all non-network claims; for network claims, it applies only to beneficiary submitted claims.) Acceptance of a request for an adjustment to a processed claim is subject to the time limitation guidelines below: (These guidelines do not apply to required adjustments identified by the contractor, TMA or an audit agency.)

Note: For adjustments made to claims that predate the two profiles maintained by the contractor, use the prior or earlier year's profile. Refer to TRICARE Reimbursement Manual (TRM), [Chapter 3, Section 1](#) for calculation of payment amounts based on the appropriate profiles and the date of service on the claim.

6.1 Timely Filing One Year From Date Of Service/Discharge/Prescription Fill Rule

Adjustments which have the effect of a new obligation of Government funds shall be processed in accordance with the one year from date of service/date of discharge/prescription fill rule (refer to [Chapter 8, Section 3](#)). An example would be a supplemental (late) billing from a hospital. Beneficiary requested adjustments for pharmacy claims must be received by the contractor No Later Than (NLT) one year from the date of the prescription fill.

6.2 Ninety (90) Day Rule

A request for a reconsideration must be received by the contractor within 90 calendar days from the issue date of the Explanation Of Benefits (EOB). Examples include the claimant providing additional information about a service or supply already processed (paid or denied) or the claimant's questioning the accuracy of processing. This does not include claims denied at 35 days for failure to provide requested information.

6.3 Time Limitations For Other Adjustments

Requests for adjustments which do not fall into the above categories must be mailed within nine months (with an additional 10-day grace period) of the date of the initial EOB. Examples include the refiling of a claim after a retroactive eligibility determination or the report of nonreceipt of a benefit check.

7.0 VOLUNTARILY RETURNED OR REFUNDED PAYMENTS

Occasionally, benefit payments will be returned to the contractor on a voluntary basis separate from any recoupment action.

7.1 Reasons For Voluntary Refunds

- Payment unwanted
- Amount of payment questioned
- Overpayment
- Incorrect payee

7.2 Disposition Of Voluntary Refunds

If payment is confirmed as accurate and the check is still negotiable, the contractor shall return it to the correct payee within five workdays of receipt. In all returned check cases the correct payee must be expeditiously identified and paid. Some special procedural requirements are:

- Research the accuracy of the payment and payee.
- Handle underpayment situations in accordance with [Section 2](#).
- Handle overpayment recoveries in accordance with [Sections 2](#) and [4](#).
- In the event of unwanted payments, the contractor shall inform the participating provider that return of a TRICARE payment does not relieve the obligations assumed by submitting a participating claim. The provider cannot return a payment and then bill the beneficiary. (See [Chapter 13](#), for assignment violations.)
- Pharmacy refunds will be deposited into applicable bank accounts and credit TEDs will be submitted.

- END -

Overpayments Recovery - Financially Underwritten Funds

This section pertains to funds for which the contractor is financially underwritten. **These procedures shall be followed when a contractor initiates recoupment of an overpayment for underwritten funds. Also, see Chapter 3, Section 3, for instructions on reporting overpayments to the TRICARE Management Activity (TMA) made with underwritten funds.**

1.0 CAUSES OF OVERPAYMENTS

An overpayment adjustment for recoupment action may be a result of any one or more of a number of circumstances, such as issuance of a duplicate payment, correction of a coding error, or erroneous calculation of the allowable amount.

2.0 DETERMINATION OF LIABILITY FOR OVERPAYMENT

The general rule for determining liability for overpayments is that the person who received the erroneous payment is responsible to return such payment. This provision may be modified by applicable state laws. In the case of care delivered by a contractor owned or operated network provider to a person not eligible for care under TRICARE, the provider shall not submit a claim for such care and will collect payment directly from the patient. If a claim is erroneously paid for care delivered to an ineligible person then the contractor shall be responsible for collection.

3.0 PROVIDER OVERPAYMENTS

3.1 Overpayment refunds shall be sought from the provider who received the incorrect payment in the following situations:

3.2 The payment was based on an amount in excess of that allowable.

3.3 The provider received and retained duplicate TRICARE payments.

3.4 The overpayment was due to a mathematical or clerical error; e.g., an error in calculation of overlapping or duplicate bills. This does not include a failure to properly assess the deductible. Where a provider has been incorrectly paid a deductible, recovery shall be sought from the beneficiary.

3.5 The overpayment was for noncovered services or supplies.

3.6 The services or supplies were not received by the beneficiary, or there is no documentation to substantiate that the provider performed the services claimed. (See [Chapter 13](#), if fraud is suspected.)

3.7 The services or supplies were furnished by a provider not authorized under TRICARE.

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Overpayments Recovery - Financially Underwritten Funds

3.8 The TRICARE payment was made to the participating provider and a primary health insurance plan also made a benefit payment to the provider or beneficiary for the same services or supplies, and the combined payments exceed the lower of the amount remaining after the double coverage plan paid its benefits or the amount TRICARE would have paid as primary payer (see the TRM, [Chapter 4](#)).

3.9 The payment was made to the wrong provider or to a nonparticipating provider. In such cases, the contractor shall issue payment to the correct payee and initiate recoupment action against the erroneously paid provider concurrently. The contractor shall **not** postpone issuing payment to the correct payee pending completion of the recoupment. If only network providers are involved, follow the agreement and/or administrative procedures for this situation.

3.10 The patient was not eligible for TRICARE when the services were provided.

3.11 The patient had OHI coverage primary to TRICARE and the contractor's efforts to recover the overpayment through coordination of benefits with the OHI were not successful in whole or in part (see [paragraph 9.0](#)).

4.0 BENEFICIARY LIABLE

Recoupment should be sought from the beneficiary in the following situations:

4.1 The overpayment was caused by incorrect application of the deductible, copayment, or other cost-share.

4.2 The patient was not an eligible beneficiary at the time services were provided and the payment was made to a participating provider for whom a good faith payment has been authorized by TMA (see [paragraph 6.0](#)).

4.3 The TRICARE payment was made to the beneficiary and his or her primary health insurance plan made a benefit payment for the same services or supplies.

4.4 The TRICARE payment was made to the beneficiary instead of the non-network participating provider. The contractor shall immediately issue payment to the non-network participating provider and concurrently take recoupment action against the beneficiary.

4.5 Any other instance in which the erroneous payment was made directly to the beneficiary.

4.6 The beneficiary who received the TRICARE payment had Other Health Insurance (OHI) primary to TRICARE.

5.0 OVERPAID PARTY IS DECEASED

If the contractor determines that liability for an overpayment rests with a beneficiary or provider who is deceased, the contractor shall seek recoupment of the overpayment from the estate of the deceased person under state laws. The procedures described in this section shall be followed.

6.0 GOOD FAITH PAYMENT

6.1 With prior approval from TMA, a contractor may make a good faith payment to a participating provider, or allow a previous payment to stand, for care provided to a patient, but only in the following situations.

- An ineligible patient holds an ID card showing TRICARE eligibility and the provider exercised reasonable care in accepting the apparently valid ID card as evidence of eligibility; or
- An ineligible patient/person enrolls in Prime, claims are filed and denied as TRICARE ineligible, and the contractor can document via evidence from DEERS that the individual had in fact been shown on DEERS as eligible on the date of Prime enrollment and for the period covering the dates of medical care.

6.2 Whether the claim is initially paid or denied, the provider is expected to make reasonable efforts to collect payment from the ineligible patient prior to requesting approval of a good faith payment. Documentation of the unsuccessful effort is to be submitted to the Beneficiary and Provider Services (BPS) Directorate, TMA, Aurora, Colorado, Attn: Good Faith Payment Considerations with the request. Immediately prior to submitting a request for approval of a good faith payment, the contractor shall recheck the current DEERS records to confirm that the person is not eligible and include the documentation of the results. The contractor is not financially responsible for making good faith payments. The contractor's costs will be separately reimbursed by the Government.

6.3 If the contractor made payment to the participating provider, the contractor shall advise the participating provider and the patient of the patient's ineligibility and then follow recoupment procedures. If, during the recoupment process, the participating provider alleges that he or she relied on the information on the patient's ID card showing TRICARE eligibility, the contractor shall forward the file to TMA BPS for consideration of a good faith payment and advise the participating provider of the action taken. The file shall include documentation of all contact with the participating provider and patient.

6.4 If the contractor has not made payment to the participating provider, the contractor shall deny the claim based upon ineligibility of the patient. If the participating provider alleges that he/she/it relied on the information on the patient's ID card showing TRICARE eligibility, the contractor shall forward the file to TMA BPS and advise the participating provider of the action taken. The file shall include documentation of all contacts with the participating provider and patient.

6.5 If TMA notifies the contractor that a good faith payment has been granted, the contractor shall terminate collection from the provider, refund any monies collected from the provider and initiate recoupment against the ineligible beneficiary.

6.6 A provider who erroneously furnishes services and/or supplies to an ineligible patient as a result of careless identification procedures is not entitled to a good faith payment. Defense Manpower Data Center (DMDC) is responsible for providing beneficiaries with accurate and appropriate means of identification.

6.7 TEDs Related to Good Faith Payments

6.7.1 If a previously made payment is determined to be eligible for a good faith payment, the contractor may adjust the payment from underwritten to non-underwritten by cancelling the initial TRICARE Encounter Data (TED) (financially underwritten) record and submitting a new (non-financially underwritten) TED record. Any subsequent collection actions shall be initiated and reported per [Section 4](#).

6.7.2 Claims that have not been paid which are determined to be eligible for a good faith payment, may be paid to the provider from the non-financially underwritten bank account. If paid from the non-financially underwritten account, any subsequent collection actions shall be initiated and reported per [Section 4](#).

7.0 OVERPAYMENTS RESULTING FROM ALLEGED MISINFORMATION

An allegation by a patient or provider that information obtained from an Health Benefits Advisor (HBA), contractor, or other party caused the overpayment does not alter the liability for the overpayment, nor is it grounds for termination of recoupment activity.

8.0 DENIAL OF BENEFITS PREVIOUSLY PROVIDED

In those instances in which clarification, interpretation or a change in the TRICARE Regulation would result in denial of services or supplies previously covered, no action should be taken to recover payments expended for those benefits paid prior to the date of such clarification or change, unless specifically directed by TMA.

9.0 DOUBLE COVERAGE SITUATIONS

A "Primary Plan," under TRICARE Law and Regulation is any other health insurance coverage the patient has, except Medicaid (Title XIX) or a supplement plan which is specifically designed to pay only TRICARE deductibles, coinsurance and other cost-shares. (See the TRICARE Reimbursement Manual (TRM), [Chapter 4](#).) Prior to payment of any claim for services or supplies rendered to any TRICARE beneficiary, regardless of eligibility status, it must be determined whether double coverage exists. If the reason for the overpayment is that another coverage plan primary to TRICARE was not considered in whole or in part in the coordination of benefits, then the following actions are required to recover the overpayment:

9.1 If the primary plan has not made payment to the beneficiary or provider, the contractor shall attempt to recover the overpayment from the primary plan following the contractor's coordination of benefits procedures;

9.2 If the overpayment cannot be recovered from the primary plan, or if the primary plan has made payment, the overpayment will be recovered from the party that received the erroneous payment from TRICARE.

10.0 THIRD PARTY RECOVERIES

When potential recovery from or actual payment by a liable third party is discovered, the contractor shall take action under the provisions of [Section 5](#).

11.0 IDENTIFICATION OF OVERPAYMENTS

For the purpose of determining the amount of the overpayment in a particular case, the contractor should include all claims overpaid for the same reason/case/Episode Of Care (EOC). The contractor should **establish its own threshold for economically feasible** recoupments. However, if the overpayment is attributable to failure to properly assess the deductible, it **shall** be recouped, even if less than **a contractor's** established threshold. **A contractor's decision not to recoup when an overpayment is reported to TMA shall never result in the beneficiary paying more than the minimum deductible, copay/cost-share amount, or the amount of any erroneous payment that the beneficiary received.**

12.0 OVERPAYMENTS RECOVERY

The contractor should take recovery actions in accordance with applicable laws of the states in the jurisdiction. The procedures for recovery shall be documented and subject to review and approval by TMA. The recovery actions shall include issuing a letter to the participating provider requesting payment and establishing a system for offsetting from subsequent claims. At the same time, the beneficiary shall be notified, in writing, that a recoupment action has been initiated against the rendering provider. This letter shall identify the beneficiary specific claims included in the recoupment action. The letter should advise the beneficiary that no response is required and refer the beneficiary to the Beneficiary Service Representative (BSR) if they have further questions. The contractor has discretion in developing its own demand letters as long as it includes the information required by [paragraph 14.0](#) (see [Addendum A, Figure 10.A-1](#)). Because the recovery actions are for the collection of "financially underwritten" funds, demand letters should not reference the Federal Claims Collection Act as authority for collection nor should they advise debtors that delinquent debts may be collected by administrative offset from other federal monies owed, or referred to the Department of Justice (DOJ) for enforced collection or offset from tax refunds.

13.0 OFFSET PROCEDURES

If the initial and follow-up refund requests and the offset attempt, if any, are unsuccessful for a period of 60 days from the date of the initial demand letter, the contractor should leave an offset flag or similar control on the file of the overpaid party (including a provider) for the term of the TRICARE contract for potential future offset. If at any time all or part of an overpayment is offset, prepare an Explanation Of Benefits (EOB) for each claim against which offset was made and send a notice to the overpaid party explaining the overpayment and the offset. If the offset is against the provider, the provider shall be advised that reimbursement for the claim against which the offset was made may not be sought from the patient on whose behalf the services were provided. Any requests for offset from other government agencies and orders for garnishment issued by the courts shall be handled under the laws of the state(s).

14.0 REFUND REQUESTS

Refund requests shall include a preaddressed return envelope and the following:

- Name and Address of the Beneficiary and Provider
- Last four digits of sponsor's Social Security Number (SSN)
- Internal Control Number (ICN)

- Date(s) and Type(s) of Service
- Principal Amount of Debt
- Date(s) of Check(s)
- Name of Payee

14.1 A clear explanation of why the payment was not correct.

14.2 The amount of the overpayment and how it was calculated, and the amount of the correct payment, if any.

14.3 A notice that the overpaid party is required to refund the overpayment, or make acceptable arrangements to make the refund, within 30 days of the date of the request.

14.4 A notice that:

- Interest shall be assessed at the rate of ___ percent. (**Enter the rate which would be collected under the Federal Claims Collection Act or the rate allowed by applicable state law, whichever is lower.**) Interest shall begin to accrue from the date of this letter.
- Accrued interest will be waived if payment is received within 30 days.
- Administrative costs may also be assessed for expenses in collecting the debt. TMA must be informed of the procedures, policies, and any charges, which are subject to TMA approval.

14.5 A notice of the possibility of offset if the overpayment is not refunded.

14.6 Instructions that the refund shall be by check or money order made payable to the contractor.

14.7 A notice, when appropriate, that unless a refund is made, or arrangements for a refund are made, the case may be referred to a credit reporting agency which could result in the assessment of added administrative costs, penalties and interest.

14.8 An explanation of rights to an administrative review and/or to appeal rights (see [paragraph 18.0](#)).

15.0 CONTRACTOR RESPONSES TO DEBTORS

There shall be no undue time lag in responding to any communication from debtors. The contractor shall respond within normal correspondence timeliness standards, but in no case shall there be a delay in excess of 30 days from receipt of any communication from the debtor.

16.0 BENEFICIARY INSTALLMENT REFUNDS

16.1 If, in responding to the request for refund, the beneficiary alleges that immediate repayment of the overpayment in full would be a financial hardship and requests an installment refund plan, the contractor shall exercise its judgment in providing such a plan. The size of the overpayment and the financial status of the beneficiary are the primary considerations. If installment payments are

approved, the contractor shall enter into a repayment agreement with the debtor. The repayment agreement may include a provision for payment of interest. If the debtor fails to sign and return a written agreement, the contractor may still collect installment payments. However, if the debtor fails to remit the agreed-upon monthly installments, the case shall be treated in accordance with the instructions for handling delinquent installments (see [paragraph 17.0](#)). The contractor shall acknowledge each payment received in writing. The acknowledgment shall indicate the amount of the payment received, the amounts applied to interest, if applicable, and principal and the current balance due. The contractor shall maintain an accounting record of such payments which shall be subject to audit at all times.

16.2 The size of the monthly installment should normally allow for complete refund of the overpayment within 24 months. Monthly installments of less than \$50 should be allowed by the contractor if evidence is presented that financial hardships or other justifiable reasons exist. If it is alleged by the beneficiary that monthly installments cannot be made to complete the refund within 24 months, the case should be carefully reviewed by the contractor. The beneficiary should be assisted to the fullest reasonable extent by allowing reasonable terms.

16.3 If an offset flag was previously established on an account, it should be lifted once a repayment agreement is established, unless the debtor requests that the offset remain. Any offsets so collected shall be treated as an installment payment. Suspended claims should be processed and paid normally.

16.4 The contractor shall make the collection of overpayments under conditions which will not create severe hardship on the beneficiary/sponsor debtor. Policies related to such collections shall be subject to TMA approval and shall comply with all applicable state and local laws governing collections and promissory notes. If the contractor elects to charge interest on overpayments, it shall not begin to accrue earlier than 30 calendar days following notice of the overpayment, if payment is made within the 30 calendar days following notice. Interest rates charged shall not exceed the rate which would be collected under the Federal Claims Collection Act (FCCA) or the rate allowed by applicable state law, whichever is the lower.

17.0 INSTALLMENT DELINQUENCIES

If the debtor fails to comply with an established repayment agreement, the contractor shall notify the debtor of the delinquent amount and urge that the account be brought current. A written delinquency notice shall be sent 35 days after the established due date if an installment payment, or any portion thereof, remains outstanding. If the delinquent amount is not remitted within 30 calendar days of the initial delinquency notice, the contractor should take appropriate action under the laws of the appropriate state. Should the debtor fail to bring the account to a current status, but, instead, remit the missed installment or a portion thereof, the contractor shall contact the debtor and attempt to resolve the delinquency problem. A delinquent case should not be referred to collection agencies, or other similar action taken until at least two full installment payments are past due. An offset flag may, however, be set and maintained on all delinquent installment cases.

18.0 RECOUPMENT ACTION AND THE APPEALS PROCESS

The determination that an overpayment was made is not, in itself, an appealable issue. If a service or supply which is not a TRICARE benefit was paid in error, the reversal of the payment

decision constitutes an initial adverse determination. The overpaid party may appeal if an appealable issue exists. Such appeals are subject to the requirements and time limits outlined in [Chapter 12](#). Any funds recouped by offset after a reconsideration has been requested are to be identified and properly accounted. The appealing party is to be notified that the recoupment of the overpayment shall continue by offset. The contractor should not terminate offset action because of an appeal. When a requirement to recoup TRICARE funds is identified in a Formal Review Decision or a Final Decision resulting from a hearing, the case will be forwarded to the contractor for possible recoupment action in accordance with this section.

19.0 REQUESTS FOR RELIEF OF INDEBTEDNESS

The contractor may compromise, suspend, or terminate collection actions on claims arising out of overpayments to beneficiaries if it is evident that severe hardship will be imposed and/or there is a reason of equity involved because the overpayment was the result of an initial error by the contractor. All requests from debtors for relief from all or a portion of their indebtedness, including requests for relief from the assessment of interest, penalties, and administrative charges shall be carefully reviewed. This does not apply to automatic waiver of interest on accounts paid within the first 30 days. After a case is established, the contractor shall take appropriate corrective action to stop or amend a recoupment when a contractor error is discovered.

20.0 ADMINISTRATIVE REVIEW OF INDEBTEDNESS

20.1 If a debtor requests an administrative review of his indebtedness, the contractor shall review the documentation contained in the case file and any additional information or documents submitted by the debtor. The contractor review shall be conducted by someone in a position of higher authority within the contractor organization than the individual who originated the recoupment action. Following the review, the contractor shall respond to the debtor. When the debtor questions a contractor's determination that the care is not a covered benefit, the debtor's request for review will be referred to the appropriate unit within the contractor's organization for issuance of a reconsideration pursuant to [32 CFR 199.10](#) unless the issue is not appealable under the provisions of [Chapter 12](#), the issue has been resolved through or is currently pending in the appeal system, or the recoupment action was initiated for one of the following reasons:

- TRICARE payment was issued without regard to other health insurance, or the TRICARE liability, after taking into consideration payments made by other health insurance, was inaccurately calculated.
- The action was initiated to recoup a duplicate payment.
- The action was initiated because an error was made in the original determination that a claim was a participating or a nonparticipating claim.
- The action was initiated because the payee was incorrect.

20.2 Based upon the above instructions, if it is inappropriate to provide the debtor a reconsideration, the contractor shall issue a response to the debtor's request for administrative review. The contractor's response shall describe the documentation reviewed, including any submitted by the debtor, and explain the reviewing party's rationale for the decision to pursue or terminate the recoupment action. The response shall explain that further administrative appeal is

not available. If the review results in a decision to recoup the overpayment, the debtor will be advised that full payment or other satisfactory arrangements for repayment must be made within 30 days. A debtor's request for an administrative review of his or her indebtedness does not result in suspension of the accrual of interest from the date of the initial demand letter.

21.0 SUSPICION OF FRAUD

If there is reason to believe that the overpayment may have been caused by fraud, no request for refund shall be made until the fraud issue is resolved. However, the contractor should retain any amount voluntarily refunded pending resolution of the fraud issue. These funds shall be deposited in the contractor's account and an accounting record maintained which is capable of audit. Copies, only, of documentation of the refund and all other evidence relating to the case shall be sent to the TMA Program Integrity Office (PI). Any recoupment action shall be taken in accordance with [Chapter 13](#).

22.0 BANKRUPTCY

When the contractor learns that any debtor has filed a petition in a bankruptcy, all recoupment actions shall cease. If the debtor is on offset, the contractor shall terminate the offset immediately. Until the bankruptcy is resolved, no further recoupment action shall occur and the contractor shall be bound by the laws of the state and the court ruling. Bankruptcy cases for debts which were paid with financially underwritten funds are retained by the contractor for appropriate action. **All bankruptcy notices shall be** forwarded to TMA.

23.0 INTEREST, PENALTIES AND ADMINISTRATIVE COSTS

23.1 The debtor shall be notified in the initial demand letter that interest, if required by established corporate policy, and allowed by state law and the TRICARE contract, will accrue from the date of that letter. However, the collection of interest shall be automatically waived on the debt or any portion thereof which is paid within 30 days after the date of the initial demand letter.

23.2 If the contractor applies penalties, debtors shall be notified in the initial demand letter. A penalty shall not exceed 6% per year, if to be charged. It will only be applied on any portion of the debt which is delinquent for more than 90 days. Administrative costs, based on costs incurred in processing and handling the debt because it became delinquent, may be added to the amount of the indebtedness.

23.3 The contractor shall collect interest only when the debtor enters into an installment repayment agreement as described in above. The rate of interest shall be the rate established as described above. Each installment payment shall be applied first to the accrued interest and then to the outstanding principal balance.

23.4 Interest will not be charged on previously accrued interest. When the debtor and the contractor enter into an installment repayment agreement, interest will be charged for the period which began with the date of the initial demand letter and ended on the due date of the first payment. Interest shall be calculated at the current rate, on that portion of the debt which was outstanding 30 days after the date of the initial demand letter. Interest will be applied to the debtor's account for any balance remaining after the due date of the first installment payment. The payments shall be first applied to interest and then to principal. Subsequently, interest shall be

computed daily on the outstanding principal balance, at the rate current when the debtor entered into a repayment agreement, or at the rate specified in the note, if the debtor signs a promissory note. The note rate shall be that which is current at the time the note is signed.

23.5 The rate of interest shall remain fixed unless a debtor defaults on a repayment agreement and seeks to enter into a new agreement. The new interest rate shall be set reflecting the current value of funds, and in accordance with the contractor's rate and/or state laws at the time the new agreement is executed. The current value of funds is the value of funds to the U.S. Treasury.

24.0 RECOUPMENT OF HOSPICE OVERPAYMENTS

The contractor shall calculate the cap and inpatient amounts for each TRICARE hospice program and request a refund for those payments exceeding the calculated amounts (refer to the TRM, [Chapter 11, Section 4](#) for additional information).

24.1 The contractor may develop its own letter/notice as long as it includes the data elements used in establishing each of its calculations and informs the hospice of the reconsideration provisions allowed in the TRM, [Chapter 11, Section 4](#).

24.2 If the hospice fails to submit the refund, the contractor shall issue additional demand letters as required under [paragraph 11.0](#) and [Section 4, paragraph 11.0](#). Copies of the demand letters shall not be sent to the beneficiary, and providers shall not be placed on offset to collect overpayments.

24.3 The method for processing recoupments under a Managed Care Support (MCS) contract is dependent on whether financially underwritten funds or non-financially underwritten funds are being used. In the case of financially underwritten funds, recoupments are retained by the contractor while those associated with non-financially underwritten funds shall be returned to TMA.

24.3.1 Under the above provision, the contractor shall apportion the hospice recoupment (i.e., the amount paid in excess of the aggregate cap amount and/or inpatient limitation) based on the number of TRICARE beneficiaries receiving care in a hospice who reside within the contract area versus those coming in from outside the area.

Example: It is determined at the end of the cap year that Denver Hospice had been paid \$20,000 more than the cap allowed for the previous cap period. There were a total of 30 TRICARE beneficiaries electing hospice care during the period, of which five resided outside the Prime Service Area (PSA). The separation of funding would dictate that 16.7% of the recoupment be returned to TRICARE while the remaining amount would be retained by the contractor.

24.3.2 If the providers do not voluntarily refund the indebtedness in full, or do not enter into an installment repayment agreement, the non-financially underwritten portion of the recoupment case shall be transferred to TMA in compliance with [Section 4, paragraph 11.0](#).

- END -

Reconsideration Procedures

1.0 REQUIREMENTS FOR REQUESTING A RECONSIDERATION

1.1 Must Be In Writing

1.2 Must Be Made By A Proper Appealing Party

A network provider is never a proper appealing party. Disputes between a network provider and the contractor concerning authorization of services are not subject to the appeal process. Network provider disputes are addressed under the provider contract provisions, the contractor's administrative procedures, or through the state courts. Because non-network, nonparticipating providers are not proper appealing parties, non-network, nonparticipating provider disputes regarding waiver of liability determinations are addressed as allowable charge reviews rather than reconsideration reviews. If the contractor or the TRICARE Quality Monitoring Contractor (TQMC) receives a timely appeal request for reconsideration from a person who is not authorized to participate in the appeal, before the expiration of the appeal filing deadline, the contractor or the TQMC shall treat the request as routine correspondence, and add the request to the claim file. The contractor or the TQMC shall advise the proper appealing party in writing (see [Addendum A, Figure 12.A-4](#)) with a copy to the improper appealing party. A blank "Appointment of Representative," form shall be enclosed with the letter to the proper appealing party (see [Addendum A, Figure 12.A-1](#)). The proper appealing party shall be told that an appeal must be filed within 20 calendar days of the date of the contractor's or the TQMC's letter or by the expiration of the appeal filing deadline, whichever is the later.

1.3 Must Include An Appealable Issue

1.3.1 Appealable Issues

1.3.1.1 A TRICARE Prime enrollee, a TRICARE Extra user or a TRICARE Standard beneficiary making use of the authorization process who requests authorization to receive services and such authorization is denied by the contractor, may appeal even though no care has been provided and no claim submitted. (Refer to [paragraph 7.2](#) and [Section 4, paragraph 3.1.2](#), for additional information relating to preadmission/preprocedure denials).

1.3.1.2 The decision by the contractor to cost-share services under the Point-of-Service (POS) Option is not appealable; with the exception of the issue of whether services were related to an emergency and, therefore, exempt from the requirement for referral and authorization. Whether services were related to an emergency is a factual determination and is appealable. The TRICARE Prime enrollee must demonstrate that the care would qualify as an emergency under the criteria for emergency care set forth in [32 CFR 199.4](#). Should the beneficiary prevail in the appeal, the amount cost-shared would be the difference between the amount cost-shared under the POS option and the amount that would have been cost-shared had the beneficiary received the care

from a network provider. A determination by the contractor that services received under the point-of-service option are not a TRICARE benefit would be appealable as a medical necessity or factual denial determination.

1.3.1.3 The decision by a contractor to deny a request by the Primary Care Manager (PCM) to refer a beneficiary to a specialist is an appealable issue, if the reason for the denial is a determination by the contractor that a referral is not needed.

1.3.1.4 Concurrent review authorizations granting 48 hours or less of additional services beyond the previous authorization when the provider has requested more than 48 hours of additional services. If the concurrent review authorization grants more than 48 hours of additional services beyond the previous authorization, but less than the period requested by the provider, an appeal does not exist. In such a case, the letter authorizing the additional period would inform the provider that a subsequent concurrent review will be conducted within 48 hours prior to the expiration of the newly authorized period.

1.3.2 Nonappealable Issues

The following issues are not appealable and shall not be accepted for reconsideration. They should be counted as correspondence for both workload report and processing purposes.

1.3.2.1 Allowable Charge

The amount of the TRICARE-determined allowable cost or charge for services or supplies is not appealable, since the methodology for determining allowable costs or charges is established by regulation. One example involving an allowable charge issue would be the contractor's decision to pay benefits under the POS option (absent any claim that the care was emergency in nature and was, therefore, exempt from the requirement for referral and authorization). In cases involving contractor cutbacks or downcoding of diagnoses or procedure codes, there is no issue with respect to the medical necessity of the services provided and therefore, no appealable issue (i.e., the contractor does not determine that the services are not a benefit under TRICARE). The sole issue in these cases is the level of payment for the medically necessary services - an allowable charge issue. If, however, the contractor cutback or downcoding results in the noncoverage of a furnished service, then an appealable issue would exist. See [Chapter 11, Section 8](#).

1.3.2.2 Eligibility

Determination of a person's eligibility as a TRICARE beneficiary is not appealable since this determination is the responsibility of the Uniformed Services. See the TRICARE Policy Manual (TPM), [Chapter 10, Section 1.1](#).

1.3.2.3 Denial of NAS Issuance

Determinations relating to the issuance of a Non-Availability Statement (NAS) (DoD Document (DD) Form 1251) based on the availability of care at the MTF are not appealable since these determinations are the responsibility of the Uniformed Services. For non-enrolled beneficiaries, when the issuance of an NAS is denied based on a medical necessity or a factual determination (including a determination that the facts of the case do not demonstrate an emergency for which an NAS is not required), the beneficiary and/or civilian participating provider

has the right to reconsideration. Refer to the TPM, [Chapter 1, Section 6.1](#).

1.3.2.4 Provider Sanction

If the decision is to disqualify or exclude a provider because of a determination against that provider resulting from abuse or fraudulent practices or procedures under another federal or federally-funded program is not appealable, the provider is limited to exhausting administrative appeal rights offered under the federal or federally-funded program that made the initial determination. However, a determination to sanction a provider because of abuse or fraudulent practices or procedures under TRICARE is an initial determination which is made by the contractor and is appealable under 32 CFR 199. See [Chapter 13](#). A sanction imposed pursuant to [32 CFR 199.15\(m\)](#) is appealable as described in [32 CFR 199.15\(m\)\(3\)](#).

1.3.2.5 Network Provider/Contractor Disputes

Disputes between a network provider and the contractor concerning payment for services provided by the network provider are not appealable.

Note: Network pharmacies are not subject to hold harmless provisions, and, therefore, beneficiary liability and appeal rights arise from a denial issued at a network pharmacy. The beneficiary may appeal such a denial.

1.3.2.6 Provider Not Authorized

The denial of services or supplies received from a provider not authorized to provide care under TRICARE is not appealable.

1.3.2.7 Denial Of A Treatment Plan

The denial of a treatment plan when an alternative treatment plan is selected is not appealable. Peer to peer dialogue resulting in selection and approval of another treatment option is not a denial of care.

1.3.2.8 Denial Of Services By A Primary Care Manager

The refusal of a PCM to provide services or to refer a beneficiary to a specialist is not an appealable issue. A beneficiary who has been refused services or a referral by a PCM may file a grievance under [Chapter 11, Section 9, paragraph 1.0](#). The decision by the contractor to deny a PCM's request to refer a beneficiary to a specialist is an appealable issue and is addressed in [paragraph 1.3.1.3](#).

1.3.2.9 Designation Of Providers

The contractor's designation of a particular network or non-network provider to perform requested services is not appealable.

1.3.2.10 Point Of Service (POS)

The decision by the contractor to cost-share services under the POS option is not

appealable, with the exception of the issue of whether the services were related to an emergency and are therefore exempt from the requirement for referral and authorization.

1.4 Must Be Filed Timely

An appeal must be filed before the expiration of the appeal filing deadline or within 20 calendar days of the date of the contractor's letter, referenced in [paragraph 1.2](#). In calculating the number of days elapsed, the day following the date of the previous determination is counted as day "one" with the count progressing through actual calendar days including the date the request is filed. The contractor or TQMC shall treat an untimely request for reconsideration as routine correspondence, and add the request to the claim file.

1.4.1 By Mail

If the appeal is not filed timely, the contractor shall advise the appealing party that the appeal cannot be accepted since the time limit for filing was exceeded, based on the receipt date of the appeal request or the postmark date on the envelope. For the purposes of TRICARE, a postmark is a cancellation mark issued by the United States Postal Service (i.e., private mail carriers do not issue postmarks). If there is no postmark or the date of the postmark is illegible, the date of receipt by the contractor shall be used to determine timeliness of filing.

1.4.2 By Facsimile

A request for reconsideration submitted by facsimile transmission (fax) is considered filed on the date the fax is received by the contractor.

1.4.3 By Electronic Mail

A request for reconsideration submitted by electronic mail (e-mail) is considered filed on the date the e-mail is received by the contractor.

1.5 Must State The Issue In Dispute And Include Previous Determination

The request should state the specific issue in dispute and be accompanied by a copy of the previous denial determination notice. If a contractor or the TQMC receives a request for reconsideration which otherwise satisfies the requirements as stated above, the request shall be accepted notwithstanding the failure of the appealing party to provide a copy of the previous denial determination notice or to state the specific issue in dispute. In such cases, the contractor or the TQMC shall accept the request for reconsideration and shall supply a copy of the previous denial determination notice from its files or shall initiate communication with the appealing party to clarify the specific issue in dispute, as appropriate.

2.0 EXTENSION OF APPEAL FILING DEADLINE

If the appeal is untimely the appealing party shall be told that if it can be shown to the satisfaction of the contractor or the TQMC, that timely filing of the request was not possible due to extraordinary circumstances over which the appealing party had no practical control, an extension of the appeal filing deadline may be granted. A determination by the contractor or the TQMC that extraordinary circumstances do not exist is not appealable.

determine if claims are being billed inappropriately. The results of a sample audit may trigger the need for the contractor to perform a statistically valid random sample of 100% audit sample.

3.2.2 Statistically Valid Random Sample

3.2.2.1 If the case involves more than 50 claims/encounters (or other unit of measurement) within the most recent 24 months, a sample audit which is statistically valid, at a 90% confidence level, plus or minus 10% with a 50% occurrence rate shall be randomly selected from a claims/encounter history arrayed in claim/encounter Internal Control Number (ICN) ascending order. The contractor must have the capacity to electronically generate sample sizes and random numbers using a government approved system. [Addendum A](#) provides guidance concerning selection of samples, calculating overpayments, testing the validity of the sample by calculation of the standard deviation of the sample(s) and standard error of the mean(s). While this approach is geared towards "claims", it would be appropriate for treatment encounters (or other units of measurement) where no "claim" exists. Zero paid claims shall be eliminated from the universe before the sample selection. This includes claims which were not denied, have allowable amounts, but zero dollars were paid.

3.2.2.2 In a stratified sample, the contractor should determine the low, middle and high dollar stratum. The middle dollar stratum is determined by the dollar range of the vast majority of claim paid amounts. The middle dollar stratum is the stratum to be used for the statistical sample. The paid claims in the middle dollar stratum are the claims in the sample universe. The low dollar stratum should not be reviewed. The high dollar stratum while not part of the universe, may be separately 100% reviewed.

Note: A stratified sample is not necessary if all claims in the original universe are in a close dollar range.

3.2.3 One-Hundred Percent (100%) Claims Audit

If the case involves less than 50 claims/encounters within the most recent 24 months, the contractor shall audit the entire universe or for the specific period identified/required.

3.2.4 External Audit

A secondary method of determining probable fraudulent practices is an external audit to beneficiaries for confirmation of services. This may be used to supplement a claims audit method. These audits shall address 100% of the beneficiaries who received services from a provider within a recent period of no more than one year. If the case involves a provider seeing more than 50 beneficiaries for whom a claim has been submitted, a systematic sample (a sample selection using an interval such as every fifth, 10th, etc., claim) may be used to select beneficiaries for external audit validation of services. Generally, no less than 50 external audit letters shall be sent ([Addendum A, Figure 13.A-2](#)). In cases where the beneficiary has altered a bill, an external audit to the provider shall be conducted ([Addendum A, Figure 13.A-3](#)). The suspense period for receipt of the response to the letters is 30 days with a follow-up, either written or by phone, at the 30th day.

3.3 Reporting Audit Findings

3.3.1 Audit findings must be reported in a clear and concise manner in an automated spreadsheet, accompanied by a description of the audit with summary information in quantifiable terms. The audit spreadsheets shall provide the criteria used for determination of overpayments (e.g., no entry, not a benefit). An analysis of the frequency of the occurrence of overpayments can lead to conclusions concerning further investigative actions. Other methods of analyses may be used concerning abusive practices.

3.3.2 Individual audit sheets shall be included documenting individual findings (which will then be summarized in the automated spreadsheet). Individual file folders, with identifying information, shall be generated as appropriate and must contain all applicable documentation/ data used and obtained in the audit process.

4.0 CASE DISPOSITION

4.1 General

Contractors shall refer to TMA only those cases that involve more than a \$25,000 loss to the government (more than \$10,000 for pharmacy and dual eligible) or cases with any loss where patient harm has occurred. Contractor shall handle administratively, those cases that involve less than a \$25,000 loss to the government (less than \$10,000 for pharmacy and dual eligible).

4.2 Potential Fraud and Abuse Exposure Cases Under \$25,000 Loss without Patient Harm

4.2.1 Cases determined on review to support allegations of fraud but are under \$25,000, (\$10,000 for pharmacy and dual eligible cases) without patient harm the case should not be referred to TMA.

Note: For purposes of this chapter, patient harm refers to a fraudulent or abusive practice directly causing a patient who is undergoing treatment for a disease, injury, or medical condition to suffer actual physical injury or psychological injury or acceleration of an underlying condition. The determination that patient harm has occurred must be based on the opinion of a qualified medical provider.

4.2.2 The contractor's required administrative actions for cases not referred will routinely include: education, warning of the penalty for filing false claims, recoupment, prepayment review, and post-payment review monitoring. See [paragraph 5.0](#). A record of the action taken by the contractor must be completed and retained. All monies paid by previous TRICARE contractors and recouped by the current contractor will be refunded to the TMA Chief, Finance and Accounting Office. The contractor shall send providers/pharmacies educational letters advising them to curtail their aberrant billing practices and provide guidance on how to bill correctly. These letters should be sent certified mail return receipt.

4.2.3 Recoupment action should be taken on any monies paid in error. Re-evaluate the providers in six months to a year to determine if the aberrant billing practices have been discontinued. If they have not, follow the procedures for referring the case to TMA. A critical piece of evidence to include in the referral is the educational letter with the signed receipt.

4.2.4 Exception, if clear and convincing evidence of fraud/abuse is identified, circumstances may warrant referral of a case less than \$25,000, (\$10,000 for pharmacy and dual eligible), and will require the contractor to contact TMA PI to discuss allegations and findings.

4.3 Potential Fraud and Abuse Exposure Cases Over \$25,000 Loss (\$10,000 for Pharmacy and Dual Eligible Cases) or Any Loss with Patient Harm

4.3.1 Cases determined on review to support allegations of fraud that are over \$25,000, (\$10,000 for pharmacy and dual eligible cases) or cases of any loss with patient harm shall be developed for potential referral to TMA for forwarding to the Department of Justice (DOJ), United States Attorney's Office (USAO).

4.3.2 The contractor shall develop the case to determine the probable method of fraud/abuse and potential dollar value of the case, such as cases which involve an allegation that the provider or pharmacy is billing for services not rendered, the provider is not providing or referring the beneficiary for appropriate care which is medically necessary per medical standards, or provider or pharmacy is falsifying medical records.

4.3.3 The contractor's review shall include all the provider or pharmacy numbers used by that provider or pharmacy. An audit shall be accomplished if there is evidence of possible fraud (e.g., repetitive occurrences of a pattern of abnormal billing).

4.3.4 The contractor or its representative shall not conduct personal interviews with beneficiaries, pharmacies, or providers in developing the potential fraud/abuse case. Such interviews will be conducted, if necessary, by the appropriate Government investigative agency.

4.3.5 Administrative actions shall not be initiated without prior TMA PI approval. (See also [paragraph 5.0](#).)

4.4 Special Interest Cases

4.4.1 Unbundling

Unbundling of services refers to a form of procedure code manipulation which involves separately billing the component parts of a procedure instead of billing only the single/entire comprehensive procedure. See [Section 3, paragraph 3.7](#).

4.4.2 Problem Provider Cases

See [Section 4, paragraph 5.0](#).

4.4.3 Pharmacy Fraud

See [Section 3, paragraph 3.11](#).

4.4.4 Conflict of Interest; Federal Employees and Active Duty Military

See [Section 3, paragraph 3.4](#).

4.4.5 Eligibility Fraud

Cases of beneficiary eligibility fraud require the Social Security Number (SSN) to be flagged to prevent further claims from being processed or providing services by a network provider or network pharmacy. Develop and refer to TMA only those cases that involve more than a \$25,000 loss to the government (less than \$10,000 for pharmacy and dual eligible). Handle administratively those cases that involve less than a \$25,000 loss to the government (less than \$10,000 for pharmacy and dual eligible). Only at the direction of the Chief, TMA PI, with the concurrence of the TMA Office of General Counsel (OGC), will a provider's, pharmacy's, or beneficiary's claims be indefinitely suspended from payment due to potential fraud. In this case, formal notification to the provider, pharmacy, or beneficiary by the contractor will occur ([Addendum A, Figure 13.A-4](#) and [Figure 13.A-5](#)). The contractor, upon written request from the TMA PI, shall notify in writing the Regional Director (RD) and the Health Benefits Advisors (HBAs) in close proximity to the provider. For pharmacies, upon written request from the TMA PI, the contractor shall notify in writing the COR and HBAs in close proximity to the network pharmacy. For those cases where a beneficiary submits a claim, or one is submitted on his or her behalf, which includes services involving a suspended provider or network pharmacy, the contractor, under the guidance of the TMA PI, shall send a special and specific notice to the beneficiary ([Addendum A, Figure 13.A-6](#)). See also [Section 3, paragraph 3.2](#).

4.4.6 Identification Theft

Cases involving identification theft are time sensitive and shall be expeditiously referred to TMA. Upon notification of beneficiary identification theft the contractor shall immediately flag the beneficiaries file for prepay review monitoring. After flagging the file the beneficiary should be contacted before payment of future claims to verify that the claims are valid. The contractor should provide the beneficiary with a copy of their billing history along with a request that the beneficiary review the billing history information to verify the validity of past claims. Identification theft cases shall be developed to determine if health care fraud/abuse has occurred. See [paragraph 4.0](#) for further guidance.

4.4.7 Drug Seeking Beneficiaries

4.4.7.1 The contractor shall screen drug claims and/or medical claims for potential overutilization and substance abuse. If a potential drug abuse situation is identified by a private physician, a physician reviewer in the course of business for the contractor, or a physician in a hospital setting, as representing an addictive state in the beneficiary, the beneficiary shall be placed on 100% prepayment review. The [32 CFR 199.4](#) precludes government cost-sharing of benefits to support or maintain potential drug abuse situations. This is true, whether or not the drugs are obtained by legal means and are otherwise eligible for benefit consideration under other circumstances. The contractor shall:

- Pend all claims for the beneficiary;
- Establish the necessity for the drugs and their appropriateness on the basis of diagnosis or definitive symptoms;
- Deny all related claims if a drug abuse situation does exist including office visits or emergency room visits if the purpose of the visit was to obtain drugs; and

- Reopen prior claims (most recent 12 months) for the beneficiary and review those claims to determine whether or not drug abuse existed at the time the earlier claims were paid. If drug abuse is ascertained for prior claims, recoupment action shall be taken for the erroneous payments.

4.4.7.2 The contractor shall request the beneficiary to select a physician, who will act as the primary care physician coordinating all care and making referrals when appropriate. For Prime enrollees, the contractor shall take action to manage the beneficiary's treatment as appropriate. The contractor shall not submit these cases to the TMA PI unless potential fraud is identified, such as altered prescriptions or drug receipts, or aberrant prescribing patterns by the physician. When appropriate, the contractor shall develop the case as stated in [paragraph 4.3](#). The contractor shall also coordinate efforts with other TRICARE contractors as needed to ensure medical, dental, and pharmacy benefits are not being abused and to ensure the beneficiary's care is appropriately managed.

Note: Beneficiaries are entitled to benefits by law. Beneficiaries cannot be sanctioned to preclude them from seeking benefits for medical care which is appropriate and medically necessary.

4.4.8 Possible Forgery of Check Endorsement

When the payee of a benefits check alleges that the endorsement on the check was forged, the contractor shall immediately initiate reclamation proceedings to have its bank credit the amount of the forged check to the account. This shall be accomplished as follows:

4.4.8.1 Affidavit Required

The contractor shall request the payee to submit an affidavit of the forgery. A supply of these forms can usually be obtained from the bank. In requesting the payee to complete the affidavit, the contractor shall explain to him or her that the issuance of a replacement check is contingent upon timely return of the completed affidavit and receiving a credit on the forged check.

4.4.8.2 Request for Credit

When the affidavit is received from the payee, the contractor shall forward it, along with the original of the allegedly forged check, to the contractor's bank with a request that the bank credit the amount of the forged check to the contractor's account. Under the Uniform Commercial Code (UCC), generally adopted by all states, a bank is liable for cashing a forged check and must credit the payment back to the account upon which the check was drawn when the forged check affidavit, executed by the payee, is received.

4.4.8.3 Issuing a Replacement Check

When the bank sends notice that it has credited the account for the amount of the forged check, the contractor can issue a replacement check to the payee.

4.4.8.4 Cooperating in Investigation/Prosecution

The forgery of a contractor check is a violation of state law; it also may violate several statutes. However, it is generally more efficient for local authorities to handle such cases. Therefore, the contractor shall rely upon the bank for appropriate referral of the matter for investigation by state authorities. When requested to do so, the contractor shall cooperate with the state authorities in their investigating efforts. Questions concerning the release of information to state authorities in these cases shall be directed to TMA OGC.

4.4.8.5 Reporting

Cases involving forgery and other unusual circumstances shall be reported immediately to TMA PI. Such circumstances might include a suspicion that the forgery involves contractor employee fraud or a pattern of forgery suggesting an organized effort. One time occurrence forgery cases shall be reported using the TRICARE Fraud and Abuse Report TMA Form 435 ([Addendum A, Figure 13.A-1](#)).

4.4.8.6 Time Limits

Contractors are required to take timely action. While the UCC holds the bank strictly liable for cashing forged checks, the states have generally adopted statutes of limitation relieving the banks of liability for any reclamation action not initiated within a specified time. These time limits generally vary from one to three years. Therefore, it is essential that the contractor promptly act upon notice that a payee did not receive a check or upon notice of an alleged forgery.

5.0 TMA REFERRALS

5.1 The contractor shall establish policies, procedures and organizational units for the purpose of preventing, detecting, developing, reporting and evaluating cases of suspected fraud and program abuse for referral to TMA. The contractor shall collect information on the effectiveness of its health care fraud detection and prevention programs by maintaining statistics on the costs of the fraud detection compared to the proportionate amount of health care funds recovered. Reports or a summary statement shall be submitted to the TMA PI quarterly with the fraud and abuse summary report.

5.2 In suspected cases of fraud/abuse, the contractor shall not send an educational letter or attempt recoupment unless an exception is specifically permitted elsewhere in this chapter (e.g., violation of participation agreement in reimbursement limitation, potential loss is less than \$25,000). Administrative remedies can adversely impact civil or criminal prosecution of a case and are inappropriate if fraud is suspected.

5.3 The contractor shall refer all developed (i.e., clerical and/or processing errors have been ruled out and the case exceeds the exception provided in [paragraph 5.0](#)) allegations of potential fraud to the TMA PI within 180 calendar days of identification of potential fraud and abuse, in accordance with [paragraph 5.0](#). Identification means the contractor has been made aware of allegations of fraud/abuse by a beneficiary, provider, law enforcement, other source, or proactive measures. The contractor shall not report fraud and abuse cases which are suspected of violating Federal law directly to the Defense Criminal Investigating Service (DCIS), Military Criminal Investigation

Organizations (MCIOs), Federal Bureau of Investigation (FBI) or any other investigative organization. All cases shall be reported to TMA PI in accordance with the procedures in this chapter.

Note: Up to 180 days is allowed to develop a case. Once a case is developed the case should be referred within 30 days of development completion. Exception to the 180 day referral must be requested in writing and approved by the Director, TMA PI or designee.

5.4 The contractor shall not respond to direct requests for documentation from investigative agencies, private payer plans, anti-fraud associations, or other entities. The contractor shall promptly notify the TMA PI of any requests made directly to the contractor. If the contractor responds directly to a request for documentation from an investigative agency or other entity, the costs of responding shall not be charged to the contract.

5.5 It is Department of Defense (DoD) policy that all employees, contractors and subcontractors shall cooperate fully with investigative agencies of the United States (US) upon the direction of the TMA PI. All requests for claims histories, medical and other records, regulatory/manual provisions, correspondence, audits and other documentation (e.g., newsletters, claims, checks) shall be provided by the contractor. Requests for witnesses and technical support will be completed by the contractor regardless of the time frames or dates of service identified in the request should this cross contractor jurisdiction or involve legacy contracts.

6.0 FRAUD AND ABUSE CASE REFERRAL CONTENT

6.1 General

[Addendum A, Figure 13.A-18](#) will be used by TMA to evaluate each referred case. Each case referred to TMA PI by the contractor shall be submitted in duplicate. The contractor is required to provide complete copies of any case files TMA PI requests (i.e., utilization reviews, patterns of practice, etc.) at no cost to the government.

6.2 Case Summary

The contractor shall submit a Case Summary when referring cases of potential fraud or abuse that describes at a minimum the following:

- The allegations citing all the applicable TRICARE regulatory provisions that have been violated in regards to each allegation.
- A description of the individual or institution suspected of committing or attempting to commit the alleged wrongful behavior, including all appropriate information, such as the beneficiary's name, sponsor's status and SSN, beneficiary's relationship to sponsor, provider's specialty (e.g., General Practitioner or Pharmacy) and identification number, address, telephone number, etc.
- A description how the suspicious behavior was uncovered, e.g., audit, prepayment screen, beneficiary, pharmacy, provider complaint, tip, DoD Hotline, investigator notification, etc. In addition, indicate the date the allegations were identified.

- A description clearly summarizing the behavior which is suspected to be in violation of Federal law, regulation or policy; for example, billing for services, pharmaceuticals or supplies that were not provided, altering receipts or claim forms, duplicate billing, providing incorrect information when seeking preauthorization, etc. This shall include identifying specific facts that illustrate the pattern or summary conclusions. For example: submitted probable false claims to the contractor through the U.S. Post Office or via electronic mail, altered checks, misrepresented the description and coding of services, falsified the name of the actual provider of care, falsified the name of the actual pharmacy dispensing the prescription, altering medical records, etc.
- A description of all action taken during developmental stage, to include contacts made, information obtained, potential problematic issues, etc.
- A description of the estimate the number of claims or encounters, the length of time the suspicious behavior has occurred and the government's and contractor's loss.
- A description of the current status of claims or other requests submitted by the suspected provider, pharmacy or beneficiary, i.e., regular development, processing and payment or denial, claims suspension, prepayment review, etc.
- A description of any relevant documents provided, such as any correspondence with the provider, pharmacy or beneficiary, telephone conversation records, provider certification files, requests for medical records, educational letters, recoupment letters, etc.
- A description of previous and/or ongoing administrative measures (educational efforts, prepay review, etc.).
- A description of all actions taken to identify and determine the total TRICARE exposure, including coordination with other contractors. The Case Summary shall indicate the total monetary exposure to TRICARE and if actual patient harm has occurred.
- A description of any other facts that may establish a pattern of practice or indicate that the provider, pharmacy or beneficiary intended to defraud the government or the contractor.

6.3 Copies of Supporting Documents

The contractor shall include a copy of all relevant supporting document(s) when referring cases of potential fraud or abuse that includes at a minimum the following:

- A completed TRICARE Fraud and Abuse Report (TMA Form 435, [Addendum A, Figure 13.A-1](#)).
- Copies of the applicable TRICARE regulatory provisions violated.
- Enclose copies of each claim, explanation of benefits forms, medical records, pharmacy records, provider certification file and other documents demonstrating the suspicious behavior in individually labeled file folders.

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Case Development And Action

- Enclose a history covering the most recent 24 month period (or the identified period of time, if longer than 24 months) in electronic media in dBase IV, or MS/EXCEL spreadsheet (Version 2000 or later) to electronic media and have the capability to compress the data using WIN-Zip self extracting software, with no less than version 2.4 or provide the data on a CD-ROM. Hard copy histories are acceptable only for histories of less than 100 claims/encounters.
- Enclose a copy of any relevant documents, such as any correspondence with the provider, pharmacy or beneficiary, telephone conversation records, provider certification files, requests for medical records, educational letters, recoupment letters, etc.
- Provide a copy of all contractor audits on the suspected provider, pharmacy or beneficiary. All audits will include a summary spreadsheet that clearly identifies the audit parameters, the findings for each patient audited (or claim, depending on how the audit is set up), and totals all applicable columns. Each patient's claim(s) and supporting documentation shall be filed in a separate manila folder which clearly identifies, by last name, the patient and sponsor's SSN. Each folder shall contain the contractor's individual audit sheet for those claims.
- Provide copies of relevant procedure codes, revenue codes, etc.

7.0 CONTRACTOR ADMINISTRATIVE ACTIONS

7.1 General

7.1.1 Fraudulent and abusive practices are violations of the 32 CFR 199 may constitute violations of the US Criminal Code (title 18).

Investigations, criminal, civil or administrative, are matters within the jurisdiction of the Federal Government. The US reserves the right(s) to resolve any disputes with third parties over the submittal of false claims under TRICARE or claims that potentially may be false claims. The definition of "false claims" in the False Claims Act, 31 U.S.C. 3729, applies to this contract provision.

7.1.2 The contractor shall take administrative action under the following circumstances:

- The total number of claims/encounters involved is less than 25 and the total potential loss to the contractor or government for the claims is less than \$25,000.00 (\$10,000 for pharmacy and dual eligible) without patient harm. The time period for the claims involved is 12 or more months.
- The government has not provided written declination or taken any action on a case for 12 months after receipt from the contractor. The contractor shall contact TMA PI first to ensure the case is not under active investigation.
- The contractor has received a written declination from the government for the case.

7.1.3 The contractor shall not take administrative action (including quality interventions) without TMA approval under the following circumstances:

- The case has been identified for referral to TMA PI.
- The case has been referred to TMA PI and the government has not provided a declination or taken action for a period of less than 12 months.
- The case is under active law enforcement investigation (federal, state or local).
- The case is being prosecuted criminally or civilly.

7.1.3.1 Exception, if the contractor determines that circumstances warrant initiation of administrative actions, the contractor must contact TMA PI to seek approval before initiating administrative measures.

7.1.4 Administrative actions may include:

- Referring case to local or state investigations for referral to district attorney or state attorney general. If this course of action is taken no other administrative actions should be initiated unless a declination is received from the investigative body the case was referred to. TMA and the contractor will provide assistance to local or state authorities in their investigation and prosecution of a case administratively referred.
- Removal from the preferred provider network.

7.1.5 Administrative actions routinely include:

- Educating the beneficiary/provider.
- Placing the beneficiary or provider on prepayment or postpayment review.
- Initiating recoupment action. This should include initiating recoupment action on extrapolated damages determined as a result of billing errors identified in a statistically random sample audit.

7.2 Administrative Measures Routinely Implemented

7.2.1 Educational Efforts

Beneficiaries and providers may be certified mailed education letters when inappropriate behavior is identified. Education letters provide guidance on how to bill correctly and warn of the penalty for filing false claims and describing the inappropriate behavior (for example, an education letter advising a provider that a billing agency may not include its administrative costs when submitting claims to TRICARE). If the inappropriate behavior continues after education efforts are made the mere fact that education was provided strengthens a potential case for future referral to an investigative agency.

2.3.2 The contractor shall establish a public education program addressed to beneficiaries, providers, and pharmacies which provides information about identified fraudulent or abusive practices and how individuals may identify and report such practices. This may be accomplished by including information in the provider quarterly newsletters and by periodic notices on explanation of benefits or envelope stuffers to beneficiaries. Newsletters and notices shall be provided to TMA PI at the same time distribution is made to providers/beneficiaries. Electronic versions are acceptable.

2.4 Claim/Encounter Review Procedures And Controls

The contractor shall subject all TRICARE claims/encounters to appropriate review, analysis, and/or audit to ensure payment for only authorized medically or psychologically necessary benefits provided by authorized providers to eligible beneficiaries and to identify potentially fraudulent or abusive practices. [Section 2](#) provisions shall be followed as necessary.

2.5 Beneficiary And Provider Flags

The contractor must have the capability for automated flagging of specific providers of care, pharmacies, and TRICARE beneficiaries for prepayment or postpayment review when fraud, overutilization or other abuses are known or suspected. If a network Primary Care Manager (PCM) or pharmacy is determined to be engaged in potential fraudulent practices, the contractor at its discretion, may terminate the network agreement. The contractors shall reassign the beneficiaries to another PCM. The contractor's actions shall be in a manner so as to not jeopardize the Government's investigation.

2.6 Gag Clauses

The contractor shall ensure there are no gag clauses in their contracts or policies with providers. Gag clauses are provisions that prevent providers, explicitly or implicitly, from giving patients information about treatment options that may be taken or from referring very ill patients outside the network to authorized providers with rare expertise in the types of care needed. The American Medical Association's (AMA's) Code of Ethics has declared gag clauses an unethical interference in the physician-patient relationship.

3.0 EXAMPLES OF FRAUD AND ABUSE SITUATIONS

3.1 Managed Care Fraud

3.1.1 Misrepresenting actual provider of service when the services were provided by a lower level provider or a provider not authorized to provide the service by virtue of failing to meet regulatory requirements.

3.1.2 Misrepresenting patient encounters, treatment outcomes and/or diagnoses to disguise undertreatment or to artificially inflate the amounts of future capitation payments. In some cases it may be necessary to look at the financial arrangements (contract) with the provider to determine the financial incentive of the provider.

3.1.3 Referral patterns that indicate kickbacks or result in additional expenses.

3.1.4 Frequent changes in contracts or agreements with supplier groups (Durable Medical Equipment (DME) and supplier companies) in an effort to preclude payment to them at the discounted amount.

3.1.5 Failure to document verbal referrals in writing resulting in claims denial for lack of authorization.

3.1.6 Inclusion of gag clauses in managed care provider contracts/agreements or that which prevents providers from providing information to their patients regarding benefits, risks and costs or appropriate treatment alternatives.

3.1.7 Where the provider or the providers' employee has an investment and/or financial interest, the patient shall be informed prior to the referral and provided information regarding alternative referral sources whenever such alternatives exist. Failure to inform the patient constitutes a potential fraudulent/abusive situation.

3.2 TRICARE Beneficiary Eligibility Questionable

3.2.1 If there is reason to question the eligibility of a beneficiary and fraud is suspected, e.g., through correspondence, Defense Enrollment Eligibility Reporting System (DEERS) response, or contractor file data which raises some question about the eligibility of a beneficiary, the contractor shall immediately investigate internally to eliminate obvious clerical errors. If the internal investigation does not resolve the possibility of fraud, the contractor shall contact the Defense Manpower Data Center (DMDC), 400 Gigling Road, Seaside, California 93955.

3.2.2 In cases where eligibility fraud is evident, the contractor shall take the following action:

3.2.2.1 Prime Enrollees

No care shall be approved for services on/after the date eligibility reportedly ended.

3.2.2.2 Non-Enrollees and Pharmacy Claims

Flag the beneficiary file to suspend all claims for services provided on/after the date eligibility reportedly ended. The beneficiary is not to be contacted or informed of the investigation. If the participating provider inquires about the claim he/she can be advised that the claim is under review and requested to send in a copy of the Identification (ID) card, both sides, if the provider has one on file. Upon receipt, a "good faith" payment may be considered. See [Chapter 10, Section 3, paragraph 6.0](#). The contractor shall retain a copy of the Explanation Of Benefits (EOB) and cancelled check in the case file. If the beneficiary inquires about the claim(s), he or she will be informed that the claim requires review and he or she will be advised when processing is complete. The contractor shall establish procedures for control of these claims and for keeping them in a suspense status until the eligibility status has been established.

3.2.3 If the DEERS response indicates that the beneficiary is not eligible, the contractor shall research claims/encounter history for other erroneous claims from the date TRICARE eligibility ended. If the contractor's history does not date back far enough, request a history printout from TMA PI. The contractor shall report the circumstances to TMA PI in accordance with the procedures for case referrals.

Special Reports

1.0 GENERAL

1.1 The contractor shall provide special programming reports to the TRICARE Management Activity (TMA) on an "as needed" basis. The TMA Procuring Contracting Officer (PCO) will not request a special programming report more than six times per contract period. The PCO will tell the contractor what information to include in the report. Examples of these reports include claims history data (either limited or complete) by provider, including one or more sub-identifiers; beneficiary; specific diagnosis(es); specific procedure code(s); and/or geographic region delineated by zip code(s). The contractor shall submit the reports by means of electronic medium or a disc as specified by the PCO. The contractor shall provide the completed reports to the PCO at TMA-Aurora within 60 calendar days of the date on the written request from the PCO.

1.2 If special reports are requested by TMA, the contractor must inform the PCO of the cost, if any. Upon approval of the cost estimate, the contractor shall complete the special report within the time requested by TMA unless a different delivery date is approved.

2.0 REPORTS TO MILITARY TREATMENT FACILITY (MTF) COMMANDERS

The contractor shall submit to MTF Commanders the following reports with information specific to their MTF or Prime Service Areas (PSAs) (frequencies shall be the same as those specified in the contract Contract Data Requirements List (CDRL)). Unless otherwise directed, the reports shall be provided directly to the MTF Commander by means of electronic medium or disk as specified by the MTF Commander. A copy of all MTF specific reports plus a summary report of all MTFs in the region shall be provided to the Regional Director (RD) at the same time the reports are provided to MTF Commanders. Only information concerning the specific RD's region should be provided. All reports shall be submitted in the formats required by the RD.

- Network Adequacy Report
- Enrollment Report (Active Duty Enrollees to MTF)
- Provider and Beneficiary Satisfaction Surveys
- Utilization Management Report
- Case Management Report
- Enrollment Program Progress Report
- Contingency Program Plan
- Referrals from Right of First Refusals (ROFRs)
- Clinical Support Agreement (CSA) Report

3.0 INTERNAL QUALITY MANAGEMENT/QUALITY IMPROVEMENT (QM/QI) PROGRAM

The contractor shall electronically submit documents describing the QM/QI Program to the RD and PCO within 30 calendar days of contract award. All updates or changes to the program are

to be submitted within 20 calendar days of the update or change.

4.0 INTERNAL QUALITY MANAGEMENT/QUALITY IMPROVEMENT (QM/QI) REPORT

If problems are identified through the contractor's internal QM/QI Program, the contractor shall electronically submit a QM/QI report to the RD and PCO within 10 days of the month when the problem was identified. The report shall include corrective actions planned/initiated. A monthly update/status report shall be submitted until all corrective actions have been achieved.

- END -

Chapter 16

TRICARE Prime Remote (TPR) Program

Section/Addendum	Subject/Addendum Title
1	General
2	Health Care Providers And Review Requirements
3	Marketing, Enrollment, And Support Services
4	Contractor Responsibilities And Reimbursement
5	Reports
6	TRICARE Prime Remote For Active Duty Family Member (TPRADFM) Program
A	Points Of Contact (POCs)
B	Active Duty Care Guidelines
C	Service Point Of Contact (SPOC) Review For Fitness For Duty: Protocols And Procedures

General

1.0 INTRODUCTION

The TRICARE Prime Remote (TPR) program provides health care to Active Duty Service Members (ADSMs) in the United States and the District of Columbia (DC) who meet the eligibility criteria listed below.

2.0 ELIGIBILITY

Contractors have no responsibility for determining eligibility or for deciding in which region an ADSM shall enroll. Regional Directors (RDs) will furnish contractors with enrollment information (refer to [paragraph 3.0](#)). If a contractor receives a claim for care provided to an ADSM who is not enrolled in TPR or who is not enrolled in TRICARE Prime at a Military Treatment Facility (MTF), the contractor shall process the claim according to the applicable guidelines of the Supplemental Health Care Program (SHCP) ([Chapter 17](#)).

3.0 TPR PROGRAM UNITS

The RD will supply the contractor with an electronic directory, updated as needed, that lists, by region, the designated TPR zip codes for the contractor's region(s). The RD will also provide unit listings to the contractor so that the contractor can mail educational materials to the units. In some instances, individual member listings (as opposed to units) may be provided.

4.0 BENEFITS

4.1 ADSMs enrolled in the TPR program are eligible for the Uniform Health Maintenance Organization (HMO) Benefit, even in areas without contractor networks. Some benefits (see [Section 2](#) and [Addendum B](#)) require review by the member's Service Point of Contact (SPOC) so that the services are aware of fitness-for-duty issues. In addition, if the contractor determines that services on a TPR enrollee's claim are not covered under the Uniform Benefit, or that the provider of services is not a TRICARE-authorized provider, or that the provider has not been certified as a TRICARE-authorized provider, the contractor shall supply the claim information ([Addendum C](#)) to the SPOC for a coverage determination. The contractor shall continue with provider certification procedures but shall follow SPOC direction for claim payment with no delay even if the provider certification process is not completed. The SPOC may authorize health care services not included in the Uniform Benefit and services furnished by providers who are not TRICARE-authorized/certified providers. The contractor shall not make claims payments to sanctioned or suspended providers (see [Chapter 13, Section 6](#)). The claim shall be denied if a sanctioned or suspended provider bills for services. SPOCs do not have the authority to overturn TMA or Department of Health and Human Services (DHHS) provider exclusions. See [Section 2](#) for referral and authorization requirements.

4.2 SPOC-authorized services will be covered even if they are not ordinarily covered under the TRICARE Prime program and/or if they are supplied by a provider who is not TRICARE-authorized or certified. A SPOC authorization shall be deemed to constitute referral, authorization, and direction to bypass edits as appropriate to ensure payment of SPOC-approved claims. Contractors shall implement appropriate measures to recognize SPOC authorization in order to expedite claims processing.

5.0 SPOC

Special Uniformed Service controls and rules apply to ADSMs due to unique military requirements to maintain readiness. The Services will always retain health care oversight of their personnel through their SPOCs. The SPOC serves as liaison among the ADSM, the ADSM's Uniformed Service, and the contractor for managing the ADSM's health care services. The SPOC reviews referrals for proposed care as well as information about care already received in order to determine impact on an individual's fitness for duty (see [Section 2](#) and [Addendum C](#) for referral and review/authorization procedures). The SPOC, the PCM (if assigned) and the contractor shall work together in making arrangements for the ADSM's required examinations. The SPOC will provide the protocol, procedures, and required documentation through the contractor to the provider for these examinations. For required care that may not be obtainable in the civilian community, the SPOC will refer the ADSM to a military MTF or other military source of care. Refer to [Addendum A](#) for the addresses and telephone numbers of the SPOCs.

6.0 APPEAL PROCESS

6.1 If the contractor, at the direction of the SPOC, denies authorization of, or authorization for reimbursement, for a TPR enrollee's health care services, the contractor shall, on the Explanation of Benefits (EOB) or other appropriate document, furnish the enrollee with clear guidance for requesting a reconsideration from or filing an appeal with the SPOC (see [paragraph 6.2](#)). The SPOC will handle only those issues that involve SPOC denials of authorization or authorization for reimbursement. The contractor will handle allowable charge issues, grievances, etc.

6.2 A TPR enrollee must appeal SPOC denials of authorization or authorization for reimbursement through the SPOC rather than through the contractor. If the enrollee disagrees with a denial, the first level of appeal will be through the SPOC. The enrollee may initiate the appeal by contacting his/her SPOC. If the SPOC upholds the denial, the SPOC will notify the enrollee of further appeal rights with the appropriate Surgeon General's office.

6.3 If the denial is overturned at any level, the SPOC will notify the contractor and the ADSM.

6.4 The contractor shall forward all written inquiries and correspondence related to SPOC denials of authorization, or authorization for reimbursement to the appropriate SPOC. The contractor shall refer telephonic inquiries related to SPOC denials to 1-888-MHS-MMSO.

7.0 ACTIVE DUTY FAMILY MEMBERS (ADFM)s AND OTHERS

TRICARE-eligible ADFMs accompanying ADSMs who are either eligible for or enrolled in the TPR program may enroll in TRICARE Prime Remote for Active Duty Family Members (TPRADFM)s Program in accordance with [Section 6](#).

Health Care Providers And Review Requirements

1.0 NETWORK DEVELOPMENT

The TRICARE Prime Remote (TPR) program has no network development requirements.

2.0 UNIFORMED SERVICES FAMILY HEALTH PLAN (USFHP)

2.1 In addition to receiving claims from civilian providers, the contractor may also receive TPR Program claims from certain USFHP designated providers (DPs). The provisions of TPR 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 Office of the Assistant Secretary of Defense, Health Affairs (OASD(HA)). However, the contractor shall process claims according to the requirements in this chapter for any services not included in the USFHP DP agreement.

2.2 The USFHP, administered by the DPs listed below currently have negotiated agreements that provide the Prime benefit (inpatient and outpatient care). Since these facilities have the capability for inpatient services, they can submit claims that the contractor will process according to applicable TRICARE and TPR reimbursement rules:

- 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 VETERAN'S AFFAIRS

The contractor shall reimburse for services under the current national Department of Defense/Department of Veterans Affairs (DoD/DVA) Memorandum of Agreement (MOA) for "Referral of Active Duty Military Personnel Who Sustain Spinal Cord Injury (SCI), Traumatic Brain Injury (TBI), or Blindness to Veterans Affairs Medical Facilities for Health Care and Rehabilitative Services." (See [Section 4, paragraph 2.2](#) for additional information.) The contractor shall not

reimburse for services provided to TPR enrollees under any local Memoranda of Understanding (MOU) between the DoD (including the Army, Air Force and Navy/Marine Corps facilities) and the Department of Veteran's Affairs (DVA). Claims for these services will continue to be processed by the Military Services. However, the contractor shall process claims according to the requirements in this chapter for any services not included in the local MOU.

4.0 DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) [INDIAN HEALTH SERVICE (IHS), PUBLIC HEALTH SERVICE (PHS), ETC.]

Claims for services not included in the current MOU between the DoD (including the Army, Air Force and Navy/Marine Corps facilities) and the DHHS (including the IHS, PHS, etc.) shall be processed in accordance with the requirements in this chapter.

5.0 REVIEW REQUIREMENTS

5.1 Provision Of Documents

If the Service Point of Contact (SPOC) requests copies of supporting documentation related to care reviews, appeals, claims, etc., the contractor shall send the requested copies to the SPOC within four work days of receiving the request.

5.2 Primary Care

Active Duty Service Members (ADSMs) enrolled in the TPR program can receive primary care services under the Uniform HMO Benefit without a referral, an authorization, or a fitness-for-duty review by the ADSM's SPOC (see [Addendum A](#)). ADSMs with assigned Primary Care Managers (PCMs) will receive primary care services from their PCMs. ADSMs without assigned PCMs will receive primary care services from TRICARE-authorized civilian providers, where available--or from other civilian providers where TRICARE-authorized civilian providers are not available. If a contractor receives claims for primary care services that are not covered under TRICARE and/or that are furnished to a TPR enrollee by a provider who is not TRICARE-authorized or certified, the contractor shall pend the claim and supply required information ([Addendum C](#)) to the SPOC for coverage determination (refer to [Section 1, paragraph 4.0](#) for additional information). If the SPOC does not notify the contractor of the review determination or ask for an extension for further review within two workdays after submitting the request for a coverage determination, the contractor shall enter the designated authorization code into their system and release the claim for payment.

5.3 Non-Emergency Specialty Care, All Inpatient Care, Mental Health Care, And Other Care

The following care requires SPOC review: non-emergency specialty care, all inpatient hospitalization, mental health care, and invasive medical and surgical procedures (with the exception of laboratory services) furnished in ambulatory settings. The contractor shall not, however, delay claim processing for a SPOC review determination.

5.3.1 Referred Care

5.3.1.1 The requesting provider shall follow the contractor's referral procedures and shall contact the contractor for an authorization. If an authorization is required, the contractor shall enter the

information in [Addendum C](#), required by the SPOC for a fitness-for-duty review. The SPOC will respond to the contractor within two working days. When a SPOC referral directs evaluation or treatment of a condition, as opposed to directing a specific service(s), the Managed Care Support Contractor (MCSC) shall use its best business practices in determining the services encompassed within the Episode Of Care (EOC), indicated by the referral. The services may include laboratory tests, radiology tests, echocardiograms, holter monitors, pulmonary function tests, and routine treadmills associated with the EOC. A separate SPOC authorization for these services is not required. If a civilian provider requests additional treatment outside the original EOC, the MCSC shall contact the SPOC for approval. The contractor shall not communicate to the provider or patient that the care has been authorized until the SPOC review process has been completed. The contractor shall use the same best business practices as used for other Prime enrollees in determining EOC when claims are received with lines of care that contain both referred and non-referred lines. Laboratory tests, radiology tests, echocardiogram, holter monitors, pulmonary function tests, and routine treadmills logically associated with the original EOC may be considered part of the originally requested services and do not need to come back to the PCM for approval. Claims received which contain services outside the originally referred EOC on an ADSM must come back to the PCM for approval.

5.3.1.2 If the SPOC determines that the ADSM may receive the care from a civilian source, the SPOC will enter the appropriate code into the authorization/referral system. The contractor shall notify the ADSM of approved referrals. The ADSM may receive the specialty care from an MTF, a network provider, or a non-network provider according to TRICARE access standards, where possible. In areas where providers are not available within TRICARE access standards, community norms shall apply. (An ADSM may always choose to receive care at an MTF even when the SPOC has authorized a civilian source of care and even if the care at the MTF cannot be arranged within the Prime access standards subject to the member's unit commander [or supervisor] approval.) If the appointment is with a non-network provider, the contractor shall instruct the provider on payment requirements for ADSMs (e.g., no deductible or cost-share) and on other issues affecting claim payment (e.g., the balance billing prohibition).

5.3.1.3 If the contractor does not receive the SPOC's response or request for an extension within two work days, the contractor shall, within one work day after the end of the two work day waiting period, enter the contractor's authorization code into the contractor's claims processing system. The contractor shall document in the contractor's system each step of the effort to obtain a review decision from the SPOC. The first choice for civilian care is with a network provider; if a network provider is not available within Prime access standards, the contractor may authorize the care with a TRICARE-authorized provider. The contractor shall help the ADSM locate an authorized provider.

5.3.1.4 If the SPOC directs the care to a military source, the SPOC will manage the EOC. If the ADSM disagrees with a SPOC determination that the care must be provided by a military source, the ADSM may appeal only through the SPOC who will coordinate the appeal with the Regional Director (RD); the contractor shall refer all appeals and inquiries concerning the SPOC's fitness-for-duty determination to the SPOC.

5.3.1.5 If the ADSM's PCM determines that a specialty referral or test is required on an emergency or urgent basis (less than 48 hours from the time of the PCM office visit) the PCM shall contact the contractor for a referral and send required information to the SPOC for a fitness for duty review. The ADSM shall receive the care as needed without waiting for the SPOC determination, and the contractor shall adjudicate the claim according to TRICARE Prime provisions. If further specialty

care is warranted, the PCM shall request a referral to specialty care. The contractor shall contact the SPOC with a request for an additional SPOC review for the specialty care.

5.3.2 Care Received With No Authorization or Referral

5.3.2.1 The contractor may receive claims for care that require referral, authorization, and SPOC review, that have not been authorized or reviewed. If the claim involves care covered under TPR, the contractor shall pend the claim and supply the required information ([Addendum C](#)) to the SPOC for review. If the SPOC does not notify the contractor of the review determination or ask for an extension for further review within two workdays after submitting the request for coverage determination, the contractor shall then authorize the care. The contractor shall then release the claim for payment, and apply any overrides necessary to ensure that the claim is paid with no fees assessed to the active duty member. However, the contractor shall not make claims payments to sanctioned or suspended providers (see [Chapter 13, Section 6](#)).

5.3.2.2 If the contractor determines that the services on the claim are not covered under TRICARE Prime and/or that the provider of care is not TRICARE-authorized, or is not certified, the contractor shall pend the claim and supply required information ([Addendum C](#)) to the SPOC for a coverage determination as well as for a fitness-for-duty screening (refer to [Addendum B](#) for information and examples of covered services). If the SPOC does not notify the contractor of the review determination or ask for an extension for further review within two workdays after submitting the request for a coverage determination, the contractor shall then authorize the care. The contractor shall then release the claim for payment and apply any overrides necessary to ensure that the claim is paid. However, the contractor shall not make claims payments to sanctioned or suspended providers (see [Chapter 13, Section 6](#)).

Note: If the SPOC retroactively determines that the payment should not have been made, the contractor shall initiate recoupment actions according to [Chapter 10, Section 4](#).

6.0 ADDITIONAL INSTRUCTIONS

6.1 Wellness Examinations

The contractor shall reimburse charges for wellness examinations covered under TRICARE Prime (see the TRICARE Policy Manual (TPM), [Chapter 7, Section 2.2](#)) without SPOC review. The contractor shall supply information related to requests for follow-up or additional GYN care that requires SPOC review ([paragraph 5.2](#)) to the SPOC (see [Addendum B](#)).

6.2 Optometry And Hearing Examinations

The ADSM may directly contact the contractor for assistance in arranging for optometry and hearing examinations. The contractor shall refer ADSMs to SPOCs for information on how to obtain eyeglasses, hearing aids, and contact lenses as well as examinations for them, from the Military Health System (MHS) (see [Addendum B](#)).

6.3 No PCM Assigned

ADSMs who work and reside in areas where a PCM is not available may directly access the contractor for assistance in arranging for routine primary care and for urgent specialty or inpatient

care with a TRICARE-authorized provider. Since a non-network provider is not required to know the fitness-for-duty review process, it is important that the ADSM coordinate all requests for specialty and inpatient care through the contractor. The contractor shall contact the SPOC as required for reviews and other assistance as needed.

6.4 Emergency Care

For emergency care, refer to the TPM for guidelines.

6.5 Dental Care

Claims for **active duty** dental services will be processed and reimbursed by a single separate active duty dental **program contractor**. **Claims for adjunctive dental care will be processed and reimbursed by the MCSC or the TRICARE Overseas Program (TOP) contractor for overseas care.**

6.6 Immunizations

The contractor shall reimburse immunizations as primary care under the guidelines in the TRICARE Reimbursement Manual (TRM).

6.7 Ancillary Services

A SPOC authorization for health care includes authorization for any ancillary services related to the health care authorized.

7.0 ADSM MEDICAL RECORDS

7.1 For TPR-enrolled ADSMs with assigned PCMs, the contractor shall follow contract requirements for maintaining medical records.

7.2 ADSMs will be instructed by their commands to sign annual medical release forms with their PCMs to allow information to be forwarded as necessary to civilian and military providers. The contractor may use the current "signature on file" procedures to fulfill this requirement ([Chapter 8, Section 4, paragraph 6.0](#)). When an ADSM leaves an assignment as a result of a Permanent Change of Station (PCS) or other service-related change of duty status, the PCM shall provide a complete copy of medical records, to include copies of specialty and ancillary care documentation, to ADSMs within 30 calendar days of the ADSM's request for the records. The ADSM may also request copies of medical care documentation on an ongoing, EOC basis. The contractor shall be responsible for all administrative/copying costs. Network providers shall be reimbursed for medical records photocopying and postage costs incurred at the rates established in their network provider participation agreements. Participating and non-participating providers shall be reimbursed for medical records photocopying and postage costs on the basis of billed charges. ADSMs who have paid for copied records and applicable postage costs shall be reimbursed for the full amount paid to ensure they have no out of pocket expenses. All providers and/or patients must submit a claim form, with the charges clearly identified, to the contractor for reimbursement. ADSM's claim forms should be accompanied by a receipt showing the amount paid.

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Note: The purpose of the copying of medical records is to assist the ADSM in maintaining accurate and current medical documentation. The contractor shall not make payment to the provider who photocopies medical records to support the adjudication of a claim.

7.3 ADSMs without assigned PCMs are responsible for maintaining their medical records when receiving care from civilian providers.

8.0 PROVIDER EDUCATION

The contractor shall familiarize network providers and, when appropriate, other providers with the TPR Program, special requirements for ADSM health care, and billing procedures (e.g., no cost-share or deductible amounts, balance billing prohibition, etc.). On an ongoing basis, the contractor shall include information on ADSM specialty care procedures and billing instructions in routine information and educational programs according to contractual requirements.

- END -

Contractor Responsibilities And Reimbursement

1.0 CONTRACTOR RECEIPT AND CONTROL OF CLAIMS

1.1 The contractor may establish a dedicated post office box to receive claims related to the TRICARE Prime Remote (TPR) Program. This dedicated post office box, if established, may also be the one used for handling Supplemental Health Care Program (SHCP) claims.

1.2 The contractor shall follow appropriate SHCP requirements for claims received for medical care furnished to Active Duty Service Members (ADSMs) not enrolled in the TPR Program.

2.0 CLAIMS PROCESSING

2.1 Jurisdiction

2.1.1 The contractor shall process inpatient and outpatient medical claims for health care services provided worldwide to the contractor's TPR enrollees, except in the case of care provided overseas (i.e., outside of the 50 United States and the District of Columbia). Civilian health care while traveling or visiting overseas shall be processed by the TRICARE Overseas Program (TOP) contractor, regardless of where the beneficiary is enrolled.

2.1.2 The contractor shall forward claims for ADSMs enrolled in TPR in other regions to the contractors for the regions in which the members are enrolled according to provisions in [Chapter 8, Section 2](#).

2.1.3 The contractor shall process claims received for ADSMs who receive care in their regions, but who are not enrolled in TPR, according to the instructions applicable to the SHCP.

2.1.4 The contractor shall forward ADSM dental claims and inquiries to the active duty dental **program contractor**.

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

2.2.1 Effective January 1, 2007, the contractor shall process claims for ADSM care provided by the DVA for SCI, TBI, and Blind Rehabilitation. Claims shall be processed in accordance with this chapter and the following.

2.2.2 Claims received from a DVA health care facility for ADSM care with any of the following diagnosis codes (principal or secondary) shall be processed as an MOA claim: V57.4; 049.9; 139.0; 310.2; 323.x; 324.0; 326; 344.0x; 344.1; 348.1; 367.9; 368.9; 369.01; 369.02; 369.05; 369.11; 369.15; 369.4; 430; 431; 432.x; 800.xx; 801.xx; 803.xx; 804.xx; 806.xx; 851.xx; 852.xx; 853.xx; 854.xx; 905.0; 907.0; 907.2; and 952.xx.

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2.2.3 The contractor shall verify whether the MOA DVA-provided care has been authorized by Military Medical Support Office (MMSO). MMSO will send authorizations to the contractor by fax. If an authorization is on file, the contractor shall process the claim to payment. The contractor shall not deny claims for lack of authorization. Rather, if a required authorization is not on file, the contractor will place the claim in a pending status and will forward appropriate documentation to MMSO for determination (following the procedures in [Addendum B](#) for MMSO SPOC referral and review procedures).

2.2.4 MOA claims shall be reimbursed as follows:

2.2.4.1 Claims for inpatient care shall be paid using DVA interagency rates. 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 TRICARE Management Activity (TMA) (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 may apply to one inpatient stay. 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 rates. (For example, a stay for SCI may include days paid with the SCI rate and days paid at a surgery rate.)

2.2.4.2 Claims for outpatient services shall be paid at the appropriate TRICARE allowable rate (e.g., CHAMPUS Maximum Allowable Charge (CMAC)) with a 10% discount applied.

2.2.4.3 Claims for the following care shall be paid at the interagency rate if one exists and, if not, then at billed charges: transportation; prosthetics; orthotics; durable medical equipment (DME); adjunctive dental care; home care; personal care attendants; and extended care (e.g., nursing home care).

2.2.4.4 Since this is care for ADSMs, normal TRICARE coverage limitations do not apply to services rendered for MOA care. As long as a service has been authorized by MMSO, it will be covered regardless of whether it would have ordinarily not been covered under TRICARE policy.

2.2.5 All TRICARE Encounter Data (TED) records for this care must include Special Processing Code 17 - DVA medical provider claim.

3.0 CLAIM REIMBURSEMENT

3.1 For network providers, the contractor shall pay TPR medical claims at the CHAMPUS allowable charge or at a lower negotiated rate.

3.2 No deductible, cost-sharing, or copayment amounts shall be applied to ADSM claims.

3.3 If a non-participating provider requires a TPR enrollee to make an "up front" payment for health care services, in order for the enrollee to be reimbursed, the enrollee must submit a claim to the contractor with proof of payment and an explanation of the circumstances. The contractor shall process the claim according to the provisions in this chapter. If the claim is payable without SPOC review the contractor shall allow the billed amount and reimburse the enrollee for the charges on the claim. If the claim requires SPOC review the contractor shall pend the claim to the SPOC for

determination. If the SPOC authorizes the care, the contractor shall allow the billed amount and reimburse the enrollee for charges on the claim.

3.4 If the contractor becomes aware that a civilian provider is trying to collect “balance billing” amounts from a TPR enrollee or has initiated collection action for emergency or authorized care, the contractor shall follow contract procedures for notifying the provider that balance billing is prohibited. If the contractor is unable to resolve the situation, the contractor shall pend the file and forward the issue to the SPOC for determination. The SPOC will issue an authorization to the contractor for payments in excess of the applicable TRICARE payment ceilings provided the SPOC has requested and has been granted a waiver from the Deputy Director, TMA, or designee.

3.5 If required services are not available from a network or participating provider within the medically appropriate time frame, the contractor shall arrange for care with a non-participating provider subject to the normal reimbursement rules. The contractor initially shall make every effort to obtain the provider’s agreement to accept, as payment in full, a rate within the 100% of CMAC limitation. If this is not feasible, the contractor shall make every effort to obtain the provider’s agreement to accept, as payment in full, a rate between 100% and 115% of CMAC. If the latter is not feasible, the contractor shall determine the lowest acceptable rate that the provider will accept. The contractor shall then request a waiver of CMAC limitation from the Regional Director (RD), as the designee of the Deputy Director, TMA, before patient referral is made to ensure that the patient does not bear any out-of-pocket expense. The waiver request shall include the patient name, TPR location, services requested (Current Procedural Terminology, 4th Edition [CPT-4] codes), CMAC rate, billed charge, and anticipated negotiated rate. The contractor must obtain approval from the RD before the negotiation can be concluded. The contractors shall ensure that the approved payment is annotated in the authorization/claims processing system, and that payment is issued directly to the provider, unless there is information presented that the ADSM has personally paid the provider.

4.0 THIRD PARTY LIABILITY (TPL)

TPL processing requirements ([Chapter 10](#)) apply to all claims covered by this chapter. However, the contractor shall not delay adjudication action on a claim while awaiting completion of the TPL questionnaire and compilation of documentation. Instead, the contractor shall process the claim(s) to completion. When the contractor receives a completed TPL questionnaire and/or other related documentation, the contractor shall forward the documentation as directed in [Chapter 10](#).

5.0 END OF PROCESSING

The contractor shall issue Explanations of Benefits (EOBs) and provider summary vouchers for TPR claims according to TRICARE Prime claims processing procedures.

6.0 TED VOUCHER SUBMITTAL

The contractor shall report the TPR Program claims on vouchers according to TRICARE Systems Manual (TSM), [Chapter 2, Section 2.3](#). The TED for each claim must reflect the appropriate data element values.

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Contractor Responsibilities And Reimbursement

7.0 STANDARDS

All TRICARE Program claims processing standards apply to TPR claims, see [Chapter 1, Section 3](#).

- END -

Active Duty Care Guidelines

These guidelines are intended as a sampling of treatment situations. They are not all-inclusive and are provided to help providers and the contractor determine what types of health care services require a fitness-for-duty review by the Service Point Of Contact (SPOC) (Addendum A). Providers and Health Care Finders (HCFs) are encouraged to contact the SPOC in specific situations for information and clarification on health care for Active Duty Service Members (ADSMs). The contractor shall conduct the Prime medical necessity reviews as required by contract.

HEALTH CARE SERVICE	SPOC REVIEW REQUIRED	*WHERE IS CARE PROVIDED?
Primary care medical services	No	Primary Care Manager (PCM) (or TRICARE-authorized civilian provider) or Military Treatment Facility (MTF).
Emergency/Urgent consults and tests required within 48 hours	Yes, but care will not be delayed while waiting for SPOC response	TRICARE-authorized civilian provider. Note: Emergency claims (to include institutional costs) for treatment of "dental pain" or a similar diagnosis where no actual dental procedure is performed, shall be processed and paid by the MCS contractors.
	Follow-up specialty care requires SPOC review	TRICARE-authorized civilian provider if approved by SPOC, or MTF.
Periodic health assessments offered under Prime enhanced benefit	No	PCM (or TRICARE-authorized Civilian Provider), or MTF.
Periodic eye and hearing examinations	No	TRICARE-authorized civilian provider or MTF as designated by SPOC.
Eye glasses/contacts	Yes	MTF or Service Labs; SPOC will provide information to ADSM.
Annual GYN/Pap exam	No	PCM (or TRICARE-authorized civilian provider), or MTF.
	SPOC to review follow-on visits	PCM (or TRICARE-authorized civilian provider if approved by SPOC), or MTF.
Service specific physical exams (for DoD/Service forms)	Yes	TRICARE-authorized civilian provider or MTF as designated SPOC).
HIV testing incidental to an Episode Of Care (EOC)	No	PCM (or TRICARE-authorized civilian provider).
* An ADSM may always choose to receive care from a military source even when the SPOC authorizes civilian care.		

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Chapter 16, Addendum B

Active Duty Care Guidelines

HEALTH CARE SERVICE	SPOC REVIEW REQUIRED	*WHERE IS CARE PROVIDED?
Maternity Care: Routine--	First OB visit requires SPOC review; Routine OB follow-up visits and clinically indicated evaluations not related to complications (such as ultrasounds done for dating determinations) do not require SPOC review.	TRICARE-authorized civilian provider.
Complicated pregnancies--	Care for complications of pregnancy, including care that requires invasive procedures or hospitalization(s) require SPOC review.	
Hearing appliances	Yes	MTF; SPOC will provide information to ADSM.
Orthotics	Yes	TRICARE-authorized civilian provider.
Physical Therapy	Yes	TRICARE-authorized civilian provider
Service-required immunizations	No	PCM (or TRICARE-authorized civilian provider), or MTF.
Routine dental care and dental procedures	Yes	Civilian dentist (active duty dental claims processor processes and pays claims).
Health Care Service	SPOC Review Required	*Where Care Is Provided?
Counseling by a marriage & family therapist	Yes	TRICARE-authorized civilian provider.
Mental health counseling, psychiatric care and testing	Yes	TRICARE-authorized civilian provider or MTF.
Invasive surgical-medical procedures - inpatient/outpatient, non-emergency	Yes	TRICARE-authorized civilian provider or MTF as designated by SPOC.
Family planning (tubal ligation/vasectomy)	Yes	TRICARE-authorized civilian provider or MTF as designated by SPOC.
Infertility evaluation	No	PCM (or TRICARE-authorized civilian provider).
	Yes (for follow-up specialty care/surgery)	TRICARE-authorized civilian provider or MTF as designated by SPOC.
Drug, alcohol & follow-on care for substance abuse	Yes	TRICARE-authorized civilian provider or MTF if designated by SPOC.
Transplants	Yes	Specialized Treatment Service (STS) (or authorized Civilian Transplant Center if STS not available).
Experimental protocols, as allowed by the Uniform Benefit	Yes	TRICARE-authorized civilian provider or MTF as designated by SPOC.
Specialty dental care (crowns, bridges, endodontics, etc.)	Yes	Civilian dentist (active duty dental claims processor processes and pays claims).
Adjunctive dental care	Yes	TRICARE-authorized civilian provider.
Ambulatory surgery or inpatient care	Yes	TRICARE-authorized civilian provider or MTF as designated by SPOC.
(retrospective)	TRICARE-authorized civilian provider	

* An ADSM may always choose to receive care from a military source even when the SPOC authorizes civilian care.

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Active Duty Care Guidelines

HEALTH CARE SERVICE	SPOC REVIEW REQUIRED	*WHERE IS CARE PROVIDED?
All inpatient care	Yes	TRICARE-authorized civilian provider.
* An ADSM may always choose to receive care from a military source even when the SPOC authorizes civilian care.		

- END -

Service Point Of Contact (SPOC) Review For Fitness For Duty: Protocols And Procedures

1.0 INTERCONNECTIVITY BETWEEN THE CONTRACTOR AND MILITARY MEDICAL SUPPORT OFFICE (MMSO) (THE SPOC FOR ARMY, AIR FORCE, NAVY, MARINE CORPS, COAST GUARD, AND NATIONAL GUARD TPR ENROLLEES)

1.1 ADP Protocols

1.1.1 The contractor shall provide access for entry and edit of referrals into existing systems supporting this contract. The contractor shall propose one of the following access options:

- Government staff physically located in Great Lakes, IL, accessing the contractor's system, or
- Contractor staff physically located in Great Lakes, IL, accessing the contractor's system, and Government personnel performing a backup role in the event contractor personnel are unavailable due to annual or sick leave or another reason.

1.1.2 For all referrals meeting the criteria for SPOC review, the contractor shall provide a status code indicating SPOC review is required.

1.1.3 The contractor shall create a standard management listing for all pending referrals requiring SPOC review. The listing will be made available on-line to the SPOC. The contractor shall propose the design for the listing to the SPOC for approval 30 days prior to health care delivery.

1.1.4 The contractor shall provide the capability to edit the status and entry of a 13 digit disposition code indicating if the referral was approved for Military Treatment Facility (MTF) or civilian network treatment (see [paragraph 1.2](#)). This disposition code may be used during the claims adjudication process.

1.1.5 The contractor shall provide the logic to automatically approve the referral if the SPOC determination is not received within two work days of referral entry.

1.1.6 The contractor shall provide the telecommunications, hardware, and software necessary for data entry and report printing from the MMSO location. The contractor shall provide initial and ongoing application training and support on an "as needed" basis.

1.1.7 The contractor shall provide a data dictionary of available data elements to be sent to the MMSO automated information system. The contractor shall send all care referral records to the MMSO in a tab delimited data flat file. The method of transfer can be File Transfer Protocol (FTP) or an e-mail attachment.

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Service Point Of Contact (SPOC) Review For Fitness For Duty: Protocols And Procedures

1.1.8 The contractors shall provide the MMSO read only access to their subcontractor's claims history database. The contractors shall provide the necessary training to the MMSO staff in order to access the claims history database.

1.2 SPOC Referral Data

1.2.1 The format of the referral number will be "DMISYYYYJJNNNS" where:

1.2.1.1 "DMIS" = the DMIS ID Code of the issuing facility--(5203 = MMSO);

1.2.1.2 "YYYY" = the year in which the referral number was issued;

1.2.1.3 "JJJ" = the Julian date on which the referral number was issued;

1.2.1.4 "NNNN" = the Facility Sequence Number, i.e., the type of care to which MMSO is referring the Active Duty Service Member (ADSM):

- 0001 through 4000 indicates that MMSO is referring the ADSM for Acute Medical Care (the expiration date of the referral equals the issue date + 60 days)
- 4001 through 6000 indicates that MMSO is referring the ADSM for Chronic Medical Care (the expiration date of the referral equals the issue date + 180 days)
- 6001 through 9999 indicates that MMSO is referring the ADSM for Dental Care (the expiration date of the referral equals the issue date + 60 days).

1.2.1.5 "S" = Status (the type of provider)

- "C" = Civilian Care (refer to [Section 2, paragraph 5.3.1.2](#) for referral requirements)
- "M" = Military Care (military MTF or clinic)
- "V" = Veterans' Affairs (VA) Care (VA hospital or medical facility)

1.2.2 The format of the effective date is "YYYYMMDD" where:

- "YYYY" = the year in which the SPOC referral is effective;
- "MM" = the month in which the SPOC referral is effective; and
- "DD" = the day on which the SPOC referral is effective. A retroactive authorization is indicated by an effective date prior to the issue date.

1.2.3 The format of the expiration date is "YYYYMMDD" where:

- "YYYY" = the year in which the SPOC referral expires;
- "MM" = the month in which the SPOC referral expires; and
- "DD" = the day on which the SPOC referral expires.

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1.3 Data Elements

The following data elements are the minimum elements required by MMSO for determining fitness-for-duty and for determining if care not covered under TRICARE Prime will be covered under TPR. The MMSO will return the data elements furnished by the contractor when responding to a request for a fitness-for-duty or coverage/benefit determination. If the contractor is asking for a coverage/benefit determination, the contractor shall include the applicable elements marked with asterisks (*) below. If, for example, the contractor cannot authorize the care it is not a benefit under the Uniform HMO Benefit, the contractor will include **"Not a benefit."* If the contractor cannot authorize the care because the care is not medically necessary, the contractor will include ***Not medically necessary.* If the contractor cannot authorize the care because the provider is not an authorized provider, the contractor shall include ****Provider not authorized.*

DATA ELEMENT	CONTRACTOR TO MMSO	MMSO TO CONTRACTOR
Patient Name	X	X
Patient's DOB	X	X
Patient's Sex	X	X
Contact Date (for retroactive authorizations)	X	X
ADSM SSN	X	X
ADSM Branch of Service	X	X
Duty Status	X	X
PCM Location Code	X	X
DMIS-ID	X	X
Contractor's Authorization Number	X	X
Effective Date of Authorization	X	X
*Not a Benefit	*If applicable	
**Not Medically Necessary	**If applicable	
***Provider Not Authorized	***If applicable	
SPOC Fitness-for-Duty Referral Number or Benefit Determination Number		X
Effective Date of SPOC Referral		X
Expiration Date of SPOC Referral		X
Status of Authorization (may be imbedded number)		X
Number/Frequency of Services Requested for SPOC Referral	X	X
Diagnosis	X	X
Procedure Code Range	X	X
Type of Service	X	X
Place of Service	X	X
Free Text (for available clinical information)	X	

- END -

Chapter 17

Supplemental Health Care Program (SHCP)

Section/Addendum Subject/Addendum Title

1	General
2	Providers Of Care
3	Contractor Responsibilities
A	Points Of Contact (POC)
B	Service Point Of Contact (SPOC) Review For Authorization: Protocols And Procedures

General

1.0 INTRODUCTION

1.1 The Supplemental Health Care Program (SHCP), with specific exceptions discussed in this chapter, allows for payment of claims for civilian services rendered pursuant to a referral by a provider in a Military Treatment Facility (MTF), as well as for Civilian Health Care (CHC) received in the United States by eligible Uniformed Service members. The SHCP exists under authority of 10 USC 1074(c) and [32 CFR 199.16\(a\)\(3\)](#). The use of the SHCP for pay for care referred by MTF providers is governed by Assistant Secretary of Defense (Health Affairs) (ASD(HA)) Policy Memorandum 96-005, "Policy on Use of Supplemental Care Funds by the Military Departments" (October 18, 1995). That policy states, in pertinent part:

"Circumstances where supplemental funds may be used to reimburse for care rendered by non-governmental health care providers to non-active duty patients are limited to those where a medical treatment facility (MTF) provider orders the needed health care services from civilian sources for a patient, and the MTF provider maintains full clinical responsibility for the episode of care. This means that the patient is not disengaged from the MTF that is providing the care."

1.2 Eligible Active Duty Service Members (ADSMs) may include members in travel status (leave, TDY/TAD, permanent change of station), Navy/Marine Corps service members enrolled to deployable units and referred by the unit Primary Care Manager (PCM) (not an MTF), eligible Reserve Component (RC) personnel, Reserved Officer Training Corps (ROTC) students, cadets/midshipmen, and eligible foreign military.

1.3 The provisions of this Chapter do not apply to services rendered to enrollees in the TRICARE Prime Remote program (see [Chapter 16](#)) or to ADSMs enrolled overseas (see [Chapter 24](#)).

1.4 The fact that civilian services have been rendered to an individual who is enrolled to an MTF PCM does not mean that those services were MTF referred care. If a claim is received for an ADSM MTF enrollee and no authorization is on file, the MTF must be contacted to determine if the care was MTF referred.

2.0 SERVICE POINT OF CONTACT (SPOC)/MILITARY SERVICE PARTICIPATION

2.1 For care that is not referred by an MTF, the SPOC for members of the Army, Air Force, Navy, Marine Corps, and Coast Guard will be the Military Medical Support Office (MMSO). The MMSO is established to provide a means to identify, manage and provide medical oversight of CHC furnished to service members. MMSO's functions include preauthorization of care when required, medical oversight for specialty care, the coordination and management of civilian routine and emergency hospital admissions; the initiation or coordination of medical boards; and the coordination of other military personnel-related actions. The Public Health Service (PHS) and

National Oceanic and Atmospheric Administration (NOAA) have their own SPOCs for their service members. A list of Uniformed Service SPOCs is provided in [Addendum A](#). The SPOCs will interact directly with the Managed Care Support Contractor (MCSC) using telephone, facsimile and automation links when available. [Addendum B](#) describes the protocols and procedures for coordination of authorizations with MMSO.

2.2 Contractors will also receive claims for MTF patients who may require medical care that is not available at the MTF (e.g., MRI) and the MTF refers a patient for civilian medical care (this include all civilian care provided to an ADSM MTF enrollee). In these cases, the contractor shall contact the referring MTF for any necessary medical oversight or authorization of care.

3.0 CONTRACTOR RESPONSIBILITIES

3.1 The contractor shall provide payment for inpatient and outpatient services, for MTF-referred civilian care within the 50 United States and the District of Columbia ordered by an MTF provider for an MTF patient for whom the MTF provider maintains responsibility. After payment of the claim, the contractor shall furnish the Services with information regarding payment of the claim as specified in the contract.

3.2 The contractor shall provide payment for inpatient and outpatient medical services for CHC received in the 50 United States and the District of Columbia by eligible uniformed service members in accordance with the provisions of this chapter. After payment of the claim, the contractor shall furnish reports as specified in the contract.

4.0 SHCP DIFFERENCES

4.1 ADSMs have no cost-shares, copayments or deductibles. If they have been required by the provider to make "up front" payment they may upon approval be reimbursed in full for amounts in excess of what would ordinarily be reimbursable under TRICARE. Application of Other Health Insurance (OHI) is generally not considered ([Section 3, paragraph 1.2.3](#)).

4.2 Non-Availability Statement (NAS) requirements do not apply.

4.3 If Third Party Liability (TPL) is involved in a claim, claim payment will not be delayed while the TPL information is developed (see [Section 3, paragraph 1.3](#)).

4.4 The contractor shall provide MTF-referred patients the full range of services offered to TRICARE Prime enrollees.

5.0 SERVICE PROJECT OFFICERS

Each Service will designate a Service Project Officer to be the Service's official POC with TMA and the contractor to resolve any overall service-related matters regarding the program (refer to [Addendum A](#) for the list of Service Project Officers).

- 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 uniformed service members for Civilian Health Care (CHC) received within the 50 United States and the District of Columbia. For 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 Service Points of Contact (SPOC) ([Addendum A](#)) or the MCSC. However, when the patient initiates contact prior to treatment and the SPOC has authorized the care being sought, the MCSC will make referrals to 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., Reserved Officer Training Corps (ROTC), Reserve Component (RC), foreign military, etc.), the contractor, upon receiving an authorization from the SPOC, will record and enter the authorization to enable appropriate claims processing, and, if necessary, will assist the patient with referral to a network provider or TRICARE-authorized provider (if available).

1.4 Claims for active duty dental services 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. The provisions of the SHCP will not apply to services furnished by a USFHP designated provider if the services are included as covered services under the current negotiated agreement between the USFHP designated provider and the TRICARE Management Activity (this includes care for a USFHP enrollee). However, any services not included in the USFHP designated provider agreement shall be paid by the contractor in accordance with the requirements in this chapter.

2.2 The USFHP, administered by the designated providers 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 local Memoranda of Understanding between the **Department of Defense (DoD)** (including the Army, Air Force and Navy/Marine Corps facilities) and the DVA. Claims for these services will continue to be paid by the Services as outlined in the individual MOUs. However, any services not included in the Memorandum of Understanding (MOU) shall be paid by the MCSC in accordance with the requirements in this chapter.

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

3.1.1 The contractor shall reimburse for services provided under the current national DoD/DVA MOA for "Referral of Active Duty Military Personnel Who Sustain Spinal Cord Injury, Traumatic Brain Injury, or Blindness to Veterans Affairs Medical Facilities for Health Care and Rehabilitative Services." MOA claims shall be processed in accordance with this chapter and the following.

3.1.2 Claims received from a DVA health care facility for **Active Duty Service Member (ADSM)** care with any of the following diagnosis codes (principal or secondary) shall be processed as an MOA claim: V57.4; 049.9; 139.0; 310.2; 323.x; 324.0; 326; 344.0x; 344.1; 348.1; 367.9; 368.9; 369.01; 369.02; 369.05; 369.11; 369.15; 369.4; 430; 431; 432.x; 800.xx; 801.xx; 803.xx; 804.xx; 806.xx; 851.xx; 852.xx; 853.xx; 854.xx; 905.0; 907.0; 907.2; and 952.xx.

3.1.3 The contractor shall verify whether the MOA DVA-provided care has been authorized by the Military Medical Support Office (MMSO). MMSO will send authorizations to the contractor by fax. If an authorization is on file, the contractor shall process the claim to payment. The contractor shall not deny claims for lack of authorization. Rather, if a required authorization is not on file, the contractor will place the claim in a pending status and will forward appropriate documentation to

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MMSO for determination (following the procedures in [Addendum B](#) for MMSO SPOC referral and review procedures).

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. 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 TRICARE Management Activity TMA (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 traumatic brain injury care. Blind rehabilitation and spinal cord injury care each have their own separate interagency rate. Additionally, it is possible that two or more separate rates may apply to one inpatient stay. 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 spinal cord injury may include days paid with the spinal cord injury rate and days paid at a surgery rate.)

3.1.4.2 Claims for outpatient services shall be paid at the appropriate TRICARE allowable rate (e.g., CMAC) with a 10% discount applied. All TRICARE Encounter Data (TED) records for this care must include Special Processing Code 17 - DVA medical provider claim.

3.1.4.3 Claims for the following care shall be paid at the interagency rate if one exists and, if not, then at billed charges: transportation; prosthetics; orthotics; durable medical equipment; adjunctive dental care; home care; personal care attendants; and extended care (e.g., nursing home care).

3.1.4.4 Since this care is for ADSMs, normal TRICARE coverage limitations do not apply to services rendered for MOA care. As long as a service has been authorized by MMSO, it will be covered regardless of whether it would have ordinarily not been covered under TRICARE policy.

- END -

1.2 Eligibility Verification

1.2.1 MTF Referred Care

If an MTF referral is on file, process the claim in accordance with the provisions in [paragraph 1.2.2.2](#). The contractor shall verify that care provided was authorized by the MTF. If an authorization is not on file, then the contractor shall place the claim in a pending file and verify authorization with the MTF to which the ADSM is enrolled (except for care provided by the DVA under the current national MOA for SCI, TBI, and Blind Rehabilitation, see [Section 2, paragraph 3.1](#)). The contractor shall contact the MTF within one working day. If the MTF retroactively authorizes the care, then the contractor shall enter the authorization and notify the claims processor to process the claim for payment. If the MTF determines that the care was not authorized, the contractor shall notify the claims processor and an Explanation of Benefits (EOB) denying the claim shall be initiated. If the contractor does not receive the MTF's response within four working days, the contractor shall, within one working day, enter the contractor's authorization code into the contractor's claims processing system. Claims authorized due to a lack of response from the MTF shall be considered as "Referred Care".

1.2.2 Non-MTF Referred Care

1.2.2.1 Check DEERS Status

If the patient is listed in the DEERS as Direct Care (DC) eligible, process the claim in accordance with [paragraph 1.4, Types of Care](#). If, in the process of the DEERS check, the contractor determines the ADSM is enrolled in TRICARE Prime Remote (TPR), then the claim shall be processed as a TPR claim in accordance with [Chapter 16](#). The contractor for the region in which the member is enrolled shall process the claim to completion. If the ADSM is enrolled to an MTF, the claim shall be processed in accordance with [paragraph 1.2.2](#). If the ADSM is not enrolled (or is a member of the RC), the claim shall be processed in accordance with [paragraph 1.2.3](#).

1.2.2.2 Check for Service Point of Contact (SPOC) Preauthorization

If a SPOC preauthorization exists, process the claim to completion in accordance with this chapter whether or not the patient is listed in DEERS.

1.2.2.3 Check Claim For Attached Documentation

If the patient is listed in DEERS as not direct care eligible, but the claim or its attached documentation indicates potential eligibility (e.g., military orders, commander's letter), pend the case and forward a copy of the claim and attached documentation to the SPOC for an eligibility determination.

1.2.2.4 National Guard and Reserve

Claims for National Guard or Reserve sponsors with treatment dates outside their eligibility dates cannot be automatically adjudicated. Claims for ineligible sponsors are to be suspended and routed to MMSO for payment approval or denial. If a payment determination is not received within the 115th day of receipt, the claim is to be denied.

1.2.2.5 Criteria Not Met

If none of the conditions stated above are met, the claim may be returned uncontrolled to the submitting party in accordance with established procedures.

1.2.3 For outpatient active duty and non-TRICARE eligible patients, and for all SHCP inpatients, there will be no application by the contractor of the DEERS Catastrophic Cap and Deductible Data (CCDD) file, Third Party Liability (TPL), or Other Health Insurance (OHI) processing procedures, for supplemental health care claims. Normal TRICARE rules will apply for all TRICARE eligible outpatients' claims. Outpatient claims for non-enrolled Medicare eligibles will be returned to the submitting party for filing with the Medicare claims processor.

1.3 TPL

TPL processing requirements ([Chapter 10](#)) shall be applied to all claims covered by this chapter. However, adjudication action on claims will not be delayed awaiting completion of the requisite questionnaire and compilation of documentation. Instead, the claim will be processed to completion and the TPL documentation will be forwarded to the appropriate uniformed service claims office when complete.

1.4 Types Of Care

Contractor staff shall receive and accept calls directly from Active Duty Service Members (ADSMs) requesting authorization for care which has not been MTF referred. If the caller is requesting after hours authorization for care while physically present in the Prime service area of the MTF to which he/she is enrolled, the care shall be authorized in accordance with the MCSC-MTF Memoranda of Understanding (MOU) established between the contractor and the local MTF. If the caller is traveling away from his/her duty station, the care shall be authorized if a prudent person would consider the care to be urgent or emergent. Callers seeking authorization for routine care shall be referred back to their MTF for instructions. Overseas enrollees shall be referred to the SPOC. The contractor shall send daily notifications to the ADSMs' enrolled MTF for all care authorized after hours according to locally established business rules.

1.4.1 Emergency Care (As Defined In The TPM)

Subsequent to the eligibility verification process described in [paragraph 1.2](#), the contractor shall pay all emergency claims for eligible uniformed service members. **This includes emergency claims for treatment of "dental pain" or a similar diagnosis, to include institutional costs, when no dental procedure is actually performed.** If an emergency civilian hospitalization comes to the attention of the contractor, it shall be reported to the SPOC or the MTF to which the active duty member is enrolled. The SPOC or the MTF to which the active duty member is enrolled will have primary case management responsibility, including authorization of care and patient movement for all civilian hospitalizations.

1.4.2 Non-Emergent Care

Subsequent to eligibility verification as described in [paragraph 1.2](#), the contractor shall verify whether the non-emergent medical civilian health care provided was already authorized by the SPOC or the contractor. If there is an authorization on file, the contractor shall process the claim

to payment. If a required authorization is not on file for a non-enrollee, then the contractor will place the claim in a pending status and will forward copies of appropriate documentation to SPOC for determination. See [Addendum B](#) for SPOC referral and review procedures.

1.4.2.1 If the SPOC authorizes care, the claim shall be processed for payment.

1.4.2.2 If the SPOC determines that the civilian health care was not authorized, the contractor shall follow normal TRICARE requirements for issuing EOB and summary vouchers.

2.0 COVERAGE

2.1 Normal TRICARE coverage limitations will not apply to services rendered for supplemental health care for ADSMs. For ADSMs, the Director, TRICARE Management Activity (TMA), at the request of an authorized official of the uniformed service concerned, may authorize coverage for services that would not have ordinarily been covered under TRICARE policy based on that such waiver is necessary to assure adequate availability of health care services to active duty members. TRICARE coverage limits apply to services to TRICARE-eligible covered beneficiaries provided under the SHCP. In no case shall a payment be made for outpatient institutional services listed on the inpatient only procedure list except for inpatient procedures performed in an emergency room on a beneficiary who dies prior to admission. Reference the TRICARE Reimbursement Manual (TRM), [Chapter 13, Section 2, paragraph 3.4](#). On occasion care may be referred or authorized for services from a provider of a type which is not TRICARE authorized. The contractor shall not make claims payments to sanctioned or suspended providers. (See [Chapter 13, Section 6](#).) The claim shall be denied if a sanctioned or suspended provider bills for services. MTFs do not have the authority to overturn TMA or Department of Health and Human Services (DHHS) provider exclusions. TRICARE utilization review and utilization management requirements will not apply.

2.2 Unlike a normal TRICARE authorization, an MTF or SPOC authorization shall be deemed to constitute referral, authorization, eligibility verification, and direction to bypass provider certification and Non-Availability Statement (NAS) rules. The contractor shall take measures as appropriate to enable them to distinguish between the two authorization types.

2.3 Ancillary Services

The Regulation governing the SHCP requires that each service under the SHCP be authorized, with very limited exceptions. For purposes of SHCP claims processing, an MTF authorization for care will be deemed to include authorization of any ancillary services directly and clearly related to the specific episode of health care authorized (e.g., evaluation or treatment of a specific medical condition). Any questions of whether a particular service is related to the care already authorized should be resolved by means of seeking MTF authorization for the service in question.

3.0 ENROLLMENT STATUS EFFECT ON CLAIMS PROCESSING

3.1 Active duty claims shall be processed without application of a cost-share, copayment, or deductible. These are SHCP claims.

3.2 Claims for TRICARE Prime enrollees who are in MTF inpatient status shall be processed without application of a cost-share, copayment, or deductible. These are SHCP claims.

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3.3 Claims for services provided under the current MOU between the DoD (including Army, Air Force, and Navy/Marine Corps facilities) and the DHHS (including the Indian Health Service, Public Health Service, etc.) are not SHCP claims. They should be adjudicated under the claims processing provisions applicable to those specific agreements.

3.4 Claims for services provided under any local MOU between the DoD (including the Army, Air Force and Navy/Marine Corps facilities) and the Department of Veterans' Affairs (DVA) are not SHCP claims. They should be adjudicated under the claims processing provisions applicable to those specific agreements. (Claims for services provided under the current national MOA for Spinal Cord Injury (SCI), Traumatic Brain Injury (TBI), and Blind Rehabilitation are covered, see [Section 2, paragraph 3.1.](#))

3.5 Claims for participants in the Comprehensive Clinical Evaluation Program (CCEP) shall be processed for payment solely on the basis of MTF authorization. There will not be a cost-share, copayment, or deductible applied to these claims. These are SHCP claims.

3.6 Claims for non-TRICARE eligibles shall be processed for payment solely on the basis of MTF or SPOC authorization. There will not be a cost-share, copayment, or deductible applied to these claims. These are SHCP claims.

3.7 Outpatient claims for non-TRICARE Medicare eligibles will be returned to the submitting party for filing with the Medicare claims processor. These are not SHCP or TRICARE claims.

4.0 MEDICAL RECORDS

The current contract requirements for medical records shall also apply to ADSMs in this program, with the additional requirement that ADSMs must also be given copies directly. Narrative summaries and other documentation of care rendered (including laboratory reports and X-rays) shall be given to the ADSM for delivery to his/her Primary Care Manager (PCM) and inclusion in his/her military health record. The contractor shall be responsible for all administrative/copying costs. Under no circumstances will the ADSM be charged for this documentation. Network providers shall be reimbursed for medical records photocopying and postage costs incurred at the rates established in their network provider participation agreements. Participating and non-participating providers shall be reimbursed for medical records photocopying and postage costs on the basis of billed charges. ADSMs who have paid for copied records and applicable postage costs shall be reimbursed for the full amount paid to ensure they have no out of pocket expenses. All providers and/or patients must submit a claim form, with the charges clearly identified, to the contractor for reimbursement. ADSM's claim forms should be accompanied by a receipt showing the amount paid.

5.0 REIMBURSEMENT

5.1 Allowable amounts are to be determined based upon the TRICARE payment reimbursement methodology applicable to the services reflected on the claim, (e.g., Diagnostic Related Groups (DRGs), mental health per diem, CHAMPUS Maximum Allowable Charge (CMAC), Outpatient Prospective Payment System (OPPS), or TRICARE network provider discount). Reimbursement for services not ordinarily covered by TRICARE and/or rendered by a provider who cannot be a TRICARE authorized provider shall be at billed amounts. Cost-sharing and deductibles shall not be applied to supplemental health care claims.

Service Point Of Contact (SPOC) Review For Authorization: Protocols And Procedures

1.0 INTERCONNECTIVITY BETWEEN THE CONTRACTOR AND MILITARY MEDICAL SUPPORT OFFICE (MMSO) (THE SPOC FOR ARMY, AIR FORCE, NAVY, MARINE CORPS AND COAST GUARD)

1.1 ADP Protocols

1.1.1 The contractor shall provide access for entry and edit of referrals into existing systems supporting this contract. The contractor shall propose one of the following access options:

- Government staff remotely, physically located in Great Lakes, IL, accessing the contractor's system, or
- Contractor staff remotely, physically located in Great Lakes, IL, accessing the contractor's system, and Government personnel performing a backup role in the event contractor personnel are unavailable.

1.1.2 For all referrals meeting the criteria for SPOC review, the contractor shall provide a status code indicating SPOC review is required.

1.1.3 The contractor shall create a standard management report for all pending referrals requiring SPOC review. The contractor shall propose a report design to MMSO for approval 30 days prior to health care delivery.

1.1.4 The contractor shall provide the capability to edit the status and entry of a 16 digit disposition code indicating if the referral was approved for civilian network treatment (see [paragraph 1.2](#)). This disposition code may be used during the claims adjudication process.

1.1.5 The contractor shall provide the logic to automatically approve the referral if the SPOC determination is not received within two work days of referral entry.

1.1.6 The contractor shall provide the telecommunications, hardware, and software necessary for data entry and report printing from the MMSO location. The contractor shall provide application training and support.

1.1.7 The contractor shall provide a data dictionary of available data elements to be sent to the MMSO automated information system. The contractor shall send all care referral records to the MMSO in a tab delimited data flat file. The method of transfer can be File Transfer Protocol (FTP) or an e-mail attachment.

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1.1.8 The contractors shall provide the MMSO read only access to their subcontractor's claims history database. The contractors shall provide the necessary training to the MMSO staff in order to access the claims history database.

1.2 SPOC Referral Data

1.2.1 The format of the referral number shall be "DMISYYJJNNS" where:

1.2.1.1 "DMIS" = the DMIS ID Code of the issuing facility (5203 = MMSO);

1.2.1.2 "YY" = the last two digits of the year in which the referral number was issued;

1.2.1.3 "JJJ" = the Julian date on which the referral number was issued;

1.2.1.4 "NNN" = the Facility Sequence Number, i.e., the type of care to which MMSO is referring the Active Duty Service Member (ADSM):

- 001 through 400 indicates that MMSO is referring the ADSM for Acute Medical Care (the expiration date of the referral equals the issue date + 60 days)
- 401 through 600 indicates that MMSO is referring the ADSM for Chronic Medical Care (the expiration date of the referral equals the issue date + 180 days)
- 601 through 999 indicates that MMSO is referring the ADSM for Dental Care (the expiration date of the referral equals the issue date + 60 days).

Note: This element is for use by MMSO only; contractors do not process or pay dental claims (refer to [Chapter 16, Addendum C](#)).

1.2.1.5 "S" = Status (the type of provider)

- "C" = Civilian Care (refer to [Chapter 16, Section 2, paragraph 5.3.1.2](#) for referral requirements)
- "M" = Military Care (medical Military Treatment Facility (MTF) or clinic)
- "V" = Veterans' Affairs (VA) Care (VA hospital or medical facility)

1.2.2 The format of the effective date is "YYYYMMDD" where:

- "YYYY" = the year in which the SPOC referral is effective;
- "MM" = the month in which the SPOC referral is effective; and
- "DD" = the day on which the SPOC referral is effective. A retroactive authorization is indicated by an effective date prior to the issue date.

1.2.3 The format of the expiration date is "YYYYMMDD" where:

- "YYYY" = the year in which the SPOC referral expires;
- "MM" = the month in which the SPOC referral expires; and
- "DD" = the day on which the SPOC referral expires.

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1.3 Data Elements

The following data elements are the minimum elements required by MMSO for determining whether to authorize civilian care. The MMSO will return the data elements furnished by the contractor when responding to a request for authorization determination.

DATA ELEMENT	CONTRACTOR TO MMSO	MMSO TO CONTRACTOR
Patient Name	X	X
Patient's DOB	X	X
Patient's Sex	X	X
Contact Date (for retroactive authorizations)	X	X
ADSM SSN	X	X
ADSM Branch of Service	X	X
Duty Status	X	X
PCM Location Code	X	X
DMIS-ID	X	X
Contractor's Authorization Number	X	X
Effective Date of Authorization	X	X
SPOC Fitness-for-Duty Referral Number		X
Effective Date of SPOC Referral		X
Expiration Date of SPOC Referral		
Status of Authorization (may be imbedded number)		X
Number/Frequency of Services Requested for SPOC Referral	X	X
Diagnosis	X	X
Procedure Code Range	X	X
Type of Service	X	X
Place of Service	X	X

- END -

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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.

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](#)).

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 Beneficiary and host nation provider signatures.

6.6.2 Complete beneficiary and host nation provider name and address.

6.6.3 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, or notify the TAO Director as appropriate.

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

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

6.6.5 Identification of the 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.

6.6.6 Claims received with a narrative description of services provided shall be coded by the TOP contractor with as accurate-coding as possible based upon the level of detail provided in the narrative description or as directed by the TMA CO. The provisions of [paragraph 6.1](#) apply for narrative claims that cannot be accurately coded due to insufficient or vague information. Claims received with [International Classification of Diseases, 10th Revision \(ICD-10\)](#) codes shall be converted to [International Classification of Diseases, 9th Revision \(ICD-9\)](#) codes by the TOP contractor. Refer to [Chapter 8, Section 6, paragraph 4.0](#) regarding the use of "V" codes.

6.6.7 Care authorizations (when required).

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- 6.6.8** Itemization of total charges. (Itemization of hospital room rates are not required on institutional claims).
- 6.7** The TOP contractor shall return all claims for overseas pharmacy services submitted by high volume overseas providers without National Drug Code (NDC) coding (where required), unless the provider has been granted a waiver by the TMA CO as outlined below.
- 6.8** Non-prescription (Over-The-Counter (OTC)) drugs are to be denied. This includes drugs that are considered OTC by U.S. standards, even when they require a prescription in a foreign country.
- 6.9** The TOP contractor may use Blue Book pricing identified by First DataBank as a reference source for processing drug related TRICARE overseas claims.
- 6.10** Claims for medications prescribed by a host-nation physician, and commonly used in the host-nation country, may be cost-shared.
- 6.11** The TOP contractor shall use \$3,000 as the overseas pharmacy service drug tolerance. A limited waiver to the NDC coding and payment requirements (where required) may be granted for overseas claims for pharmaceuticals submitted from low volume/small overseas pharmacy providers or TRICARE eligible beneficiaries from the Philippines, Panama and Costa Rica and any other country designated by TMA, when it would create an undue hardship on a beneficiary. High volume providers who provide pharmaceuticals in the Philippines, Panama and Costa Rica (and any other country designated by TMA) would not qualify for the limited waiver. See [Section 14](#) for specific NDC coding and payment requirements.
- 6.12** When an office visit is billed along with prescription drugs dispensed by a provider in the Philippines, the TOP contractor shall utilize best business practices in determining the appropriateness of the charges. The contractor shall develop internal procedures to determine whether these claims represent an office visit in conjunction with dispensing of prescription drugs (e.g., presenting symptoms or diagnosis that would be considered appropriate for the dispensing of a prescription), or whether the beneficiary only obtained a prescription refill with no accompanying provider services.
- 6.13** Claims for DME involving lease/purchase shall always be developed for missing information.
- 6.14** The TOP contractor shall use ECHO claims processing procedures outlined in TPM, [Chapter 9, Section 18.1](#), when processing ECHO overseas claims.
- 6.15** The TOP contractor shall deny claims from non-certified or non-confirmed host nation providers when the TMA CO has directed contractor certification/confirmation of the host nation provider prior to payment.
- 6.16** Requests for missing information shall be sent on the TOP contractor's TRICARE/TOP letterhead. When development is necessary in TRICARE Europe 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.

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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 Europe, TLAC and Pacific ADSM health care even when not a TRICARE covered benefit when the claim is:

6.22.1 Submitted by the MTF or other military command personnel, or by a designated POC; and

6.22.2 Accompanied by a completed and signed TRICARE claim form; and

6.22.3 Accompanied by either a Standard Form (SF) 1034, a Standard Form 1035 continuation sheet, a Naval Medical (NAVMED) Form 6320/10 (these forms shall be considered an authorization for payment), or electronic authorization via the E-NAS module; and

6.22.4 DEERS verification indicates the TRICARE Europe, 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, or E-NAS authorization 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.

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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, or E-NAS authorization 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 Europe, 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 Europe, 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 TRICARE Systems Manual (TSM) for TED development and submission. Claim information will be able to be accessed through the TRICARE Patient Encounter Processing and Reporting (PEPR) Purchased Care Detail Information System (PCDIS).

6.30 The TOP contractor shall establish Utilization Management (UM) high dollar/frequency thresholds in accordance with [Section 6](#).

6.31 Claims either denied as "beneficiary not eligible" or "found to be not eligible on DEERS" may be processed as a "good faith payment" when received from the TMA Beneficiary and Provider Services (BPS). 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 10.0](#) 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](#).

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Acronyms And Abbreviations

FISMA	Federal Information Security Management Act
FL	Form Locator
FMCRA	Federal Medical Care Recovery Act
FOC	Full Operational Capability
FOIA	Freedom of Information Act
FPO	Fleet Post Office
FQHC	Federally Qualified Health Center
FR	Federal Register Frozen Records
FRC	Federal Records Center
FTE	Full Time Equivalent
FTP	File Transfer Protocol
FX	Foreign Exchange (lines)
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GAO	General Accounting Office
GBL	Government Bill of Lading
GDC	Guglielmi Detachable Coil
GFE	Government Furnished Equipment
GHz	Gigahertz
GIFT	Gamete Intrafallopian Transfer
GIQD	Government Inquiry of DEERS
GP	General Practitioner
GPCI	Geographic Practice Cost Index
H/E	Health and Environment
HAC	Health Administration Center
HAVEN	Home Assessment Validation and Entry
HBA	Health Benefits Advisor
HBO	Hyperbaric Oxygen Therapy
HCC	Health Care Coverage
HCDP	Health Care Delivery Program
HCF	Health Care Finder
HCFA	Health Care Financing Administration
HCG	Human Chorionic Gonadotropin
HCIL	Health Care Information Line
HCP	Health Care Provider
HCPC	Healthcare Common Procedure Code (formerly HCFA Common Procedure Code)
HCPCS	Healthcare Common Procedure Coding System (formerly Healthcare Common Procedure Coding System)
HCPR	Health Care Provider Record
HCSR	Health Care Service Record
HDC	High Dose Chemotherapy

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HDC/SCR	High Dose Chemotherapy with Stem Cell Rescue
HDL	Hardware Description Language
HEAR	Health Enrollment Assessment Review
HEDIS	Health Plan Employer Data and Information Set
HepB-Hib	Hepatitis B and Hemophilus influenza B
HHA	Home Health Agency
HHA PPS	Home Health Agency Prospective Payment System
HHC	Home Health Care
HHC/CM	Home Health Care/Case Management
HHRG	Home Health Resource Group
HHS	Health and Human Services
HI	Health Insurance
HIC	Health Insurance Carrier
HICN	Health Insurance Claim Number
HINN	Hospital-Issued Notice Of Noncoverage
HIPAA	Health Insurance Portability and Accountability Act (of 1996)
HIPPS	Health Insurance Prospective Payment System
HIQH	Health Insurance Query for Health Agency
HIV	Human Immunodeficiency Virus
HL7	Health Level 7
HLA	Human Leukocyte Antigen
HMAC	Hash-Based Message Authentication Code
HMO	Health Maintenance Organization
HNPCC	Hereditary Nonpolypsis Colorectal Cancer
HPA&E	Health Program Analysis & Evaluation
HPSA	Health Professional Shortage Area
HPV	Human Papilloma Virus
HRG	Health Resource Group
HRT	Heidelberg Retina Tomograph Hormone Replacement Therapy
HSCRC	Health Services Cost Review Commission
HTML	HyperText Markup Language
HTTP	HyperText Transfer (Transport) Protocol
HTTPS	Hypertext Transfer (Transport) Protocol Secure
HUAM	Home Uterine Activity Monitoring
HUS	Hemolytic Uremic Syndrome
HVPT	Hyperventilation Provocation Test
IA	Information Assurance
IATO	Interim Approval to Operate
IAVA	Information Assurance Vulnerability Alert
IAVB	Information Assurance Vulnerability Bulletin
IAVM	Information Assurance Vulnerability Management

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IAW	In accordance with
IC	Individual Consideration Integrated Circuit
ICASS	International Cooperative Administrative Support Services
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICF	Intermediate Care Facility
ICMP	Individual Case Management Program
ICMP-PEC	Individual Case Management Program For Persons With Extraordinary Conditions
ICN	Internal Control Number
ICSP	Individual Corporate Services Provider
ID	Identification Identifier
IDE	Investigational Device Exemption Investigational Device
IDEA	Individuals with Disabilities Education Act
IDET	Intradiscal Electrothermal Therapy
IDME	Indirect Medical Education
IdP	Identity Protection
IE	Interface Engine Internet Explorer
IEP	Individualized Educational Program
IFSP	Individualized Family Service Plan
IG	Implementation Guidance
IGCE	Independent Government Cost Estimate
IHI	Institute for Healthcare Improvement
IHS	Indian Health Service
IIHI	Individually Identifiable Health Information
IIP	Implantable Infusion Pump
IM	Information Management Intramuscular
IND	Investigational New Drugs
INR	Intramuscular International Normalized Ratio
INS	Immigration and Naturalization Service
IOC	Initial Operational Capability
IOD	Interface Operational Description
IOLs	Intraocular Lenses
IOM	Internet Only Manual
IORT	Intra-Operative Radiation Therapy
IP	Inpatient
IPC	Information Processing Center (outdated term, see SMC)
IPN	Intraperitoneal Nutrition
IPPS	Inpatient Prospective Payment System
IPS	Individual Pricing Summary

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IPSEC	Secure Internet Protocol
IQ	Intelligence Quotient
IQM	Internal Quality Management
IRB	Institutional Review Board
IRR	Individual Ready Reserve
IRS	Internal Revenue Service
IRTS	Integration and Runtime Specification
IS	Information System
ISN	Investigation Schedule Notice
ISO	International Standard Organization
ISP	Internet Service Provider
IT	Information Technology
ITSEC	Information Technology Security Evaluation Criteria
IV	Initialization Vector Intravenous
IVF	In Vitro Fertilization
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCOS	Joint Chiefs of Staff
JFTR	Joint Federal Travel Regulations
JNI	Japanese National Insurance
JTF-GNO	Joint Task Force for Global Network Operations
JUSDAC	Joint Uniformed Services Dental Advisory Committee
JUSMAC	Joint Uniformed Services Medical Advisory Committee
JUSPAC	Joint Uniformed Services Personnel Advisory Committee
KB	Knowledge Base
KO	Contracting Officer
LAA	Limited Access Authorization
LAC	Local Agency Check
LAK	Lymphokine-Activated Killer
LAN	Local Area Network
LASER	Light Amplification by Stimulated Emission of Radiation
LCF	Long-term Care Facility
LDL	Low Density Lipoprotein
LDLT	Living Donor Liver Transplantation
LOC	Letter of Consent
LOD	Letter of Denial/Revocation
LOI	Letter of Intent
LOS	Length-of-Stay
LOT	Life Orientation Test
LPN	Licensed Practical Nurse
LSIL	Low-grade Squamous Intraepithelial
LSN	Location Storage Number

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LTC	Long-Term Care
LUPA	Low Utilization Payment Adjustment
LVEF	Left Ventricular Ejection Fraction
LVN	Licensed Vocational Nurse
LVRS	Lung Volume Reduction Surgery
MAC	Maximum Allowable Charge Maximum Allowable Cost
MAC III	Mission Assurance Category III
MAID	Maximum Allowable Inpatient Day
MB&RS	Medical Benefits and Reimbursement Systems
MCIO	Military Criminal Investigation Organization
MCS	Managed Care Support
MCSC	Managed Care Support Contractor
MCSS	Managed Care Support Services
MCTDP	Myelomeningocele Clinical Trial Demonstration Protocol
MD	Doctor of Medicine
MDI	Mental Developmental Index
MDR	MHS Data Repository
MDS	Minimum Data Set
MEC	Marketing and Education Committee
MEI	Medicare Economic Index
MEPS	Military Entrance Processing Station
MEPRS	Medical Expense Performance Reporting System
MFCC	Marriage and Family Counseling Center
MGCRB	Medicare Geographic Classification Review Board
MGIB	Montgomery GI Bill
MHO	Medical Holdover
MHS	Military Health System
MHSO	Managing Health Services Organization
MHSS	Military Health Services System
MI&L	Manpower, Installations, and Logistics
MIA	Missing In Action
MIDCAB	Minimally Invasive Direct Coronary Artery Bypass
MIRE	Monochromatic Infrared Energy
MMA	Medicare Modernization Act
MMP	Medical Management Program
MMSO	Military Medical Support Office
MMWR	Morbidity and Mortality Weekly Report
MNR	Medical Necessity Report
MOA	Memorandum of Agreement
MOMS	Management of Myelomeningocele Study
MOP	Mail Order Pharmacy

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MOU	Memorandum of Understanding
MPI	Master Patient Index
MR	Medical Review Mentally Retarded
MRA	Magnetic Resonance Angiography
MRI	Magnetic Resonance Imaging
MRPU	Medical Retention Processing Unit
MS	Microsoft®
MSA	Metropolitan Statistical Area
MSC	Military Sealift Command
MSIE	Microsoft® Internet Explorer
MSP	Medicare Secondary Payer
MST	Mountain Standard Time
MSUD	Maple Syrup Urine Disease
MSW	Masters of Social Work Medical Social Worker
MT	Mountain Time
MTF	Military Treatment Facility
MV	Multivisceral (transplant)
MVS	Multiple Virtual Storage
MWR	Morale, Welfare, and Recreation
N/A	Not Applicable
N/D	No Default
NAC	National Agency Check
NACI	National Agency Check Plus Written Inquiries
NACLC	National Agency Check with Law Enforcement and Credit
NADFM	Non-Active Duty Family Member
NARA	National Archives and Records Administration
NAS	Non-Availability Statement
NATO	North Atlantic Treaty Organization
NAVMED	Naval Medical (Form)
NBCC	National Board of Certified Counselors
NCCI	National Correct Coding Initiatives
NCF	National Conversion Factor
NCI	National Cancer Institute
NCPAP	Nasal Continuous Positive Airway Pressure
NCPDP	National Council of Prescription Drug Program
NCQA	National Committee for Quality Assurance
NCVHS	National Committee on Vital and Health Statistics
NDAA	National Defense Authorization Act
NDC	National Drug Code
NDMS	National Disaster Medical System

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NED	National Enrollment Database
NETT	National Emphysema Treatment Trial
NF	Nursing Facility
NHLBI	National Heart, Lung and Blood Institute
NHSC	National Health Service Corps
NICHD	National Institute of Child Health and Human Development
NIH	National Institutes of Health
NII	Networks and Information Integration
NIPRNET	Nonsecure Internet Protocol Router Network
NIS	Naval Investigative Service
NISPOM	National Industrial Security Program Operating Manual
NIST	National Institute of Standards and Technology
NLT	No Later Than
NMES	Neuromuscular Electrical Stimulation
NMOP	National Mail Order Pharmacy
NMR	Nuclear Magnetic Resonance
NMT	Nurse Massage Therapist
NOAA	National Oceanic and Atmospheric Administration
NoPP	Notice of Private Practices
NOSCASTC	National Operating Standard Cost as a Share of Total Costs
NP	Nurse Practitioner
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPR	Notice of Program Reimbursement
NPS	Naval Postgraduate School
NQF	National Quality Forum
NRC	Nuclear Regulatory Commission
NTIS	National Technical Information Service
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claims Committee
O/ATIC	Operations/Advanced Technology Integration Center
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)
OASD (H&E)	Office of the Assistant Secretary of Defense (Health and Environment)
OASD (MI&L)	Office of the Assistant Secretary of Defense (Manpower, Installations, and Logistics)
OASIS	Outcome and Assessment Information Set
OB/GYN	Obstetrician/Gynecologist
OBRA	Omnibus Budget Reconciliation Act
OCE	Outpatient Code Editor
OCHAMPUS	Office of Civilian Health and Medical Program of the Uniformed Services
OCONUS	Outside of the Continental United States

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OCR	Office of Civil Rights
OCSP	Organizational Corporate Services Provider
OD	Optical Disk
OGC	Office of General Counsel
OGP	Other Government Program
OHI	Other Health Insurance
OHS	Office of Homeland Security
OIG	Office of Inspector General
OMB	Office of Management and Budget
OP/NSP	Operation/Non-Surgical Procedure
OPD	Outpatient Department
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
OSA	Obstructive Sleep Apnea
OSAS	Obstructive Sleep Apnea Syndrome
OSD	Office of the Secretary of Defense
OSHA	Occupational Safety and Health Act
OSS	Office of Strategic Services
OT	Occupational Therapy (Therapist)
OTC	Over-The-Counter
OUSD	Office of the Undersecretary of Defense
OUSD (P&R)	Office of the Undersecretary of Defense (Personnel and Readiness)
P/O	Prosthetic and Orthotics
P&T	Pharmacy And Therapeutics (Committee)
PA	Physician Assistant
PACAB	Port Access Coronary Artery Bypass
PACO ₂	Partial Pressure of Carbon Dioxide
PAO ₂	Partial Pressure of Oxygen
PAK	Pancreas After Kidney (transplant)
PAP	Papanicolaou
PatID	Patient Identifier
PAVM	Pulmonary Arteriovenous Malformation
PBM	Pharmacy Benefit Manager
PCMBN	PCM By Name
PCMRS	PCM Reassignment System
PC	Personal Computer Professional Component
PCA	Patient Controlled Analgesia
PCDIS	Purchased Care Detail Information System
PCM	Primary Care Manager
PCMRA	PCM Research Application
PCMRS	PCM Panel Reassignment (Application)

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PCO	Procurement (Procuring) Contracting Officer
PCP	Primary Care Physician Primary Care Provider
PCS	Permanent Change of Station
PD	Passport Division
PDA	Patent Ductus Arteriosus Personal Digital Assistant
PDDBI	Pervasive Developmental Disorders Behavior Inventory
PDDNOS	Pervasive Developmental Disorder Not Otherwise Specified
PDF	Portable Document Format
PDQ	Physicians's Data Query
PDR	Person Data Repository
PDS	Person Demographics Service
PDTS	Pharmacy Data Transaction System
PE	Physical Examination
PEC	Pharmacoeconomic Center
PEP	Partial Episode Payment
PEPR	Patient Encounter Processing and Reporting
PERMS	Provider Education and Relations Management System
PET	Positron Emission Tomography
PFCRA	Program Fraud Civil Remedies Act
PFP	Partnership For Peace
PPPWD	Program for Persons with Disabilities
Phen-Fen	Pondimin and Redux
PHI	Protected Health Information
PHIMT	Protected Health Information Management Tool
PHP	Partial Hospitalization Program
PHS	Public Health Service
PI	Program Integrity (Office)
PIA	Privacy Impact Assessment (Online)
PIC	Personnel Investigation Center
PIE	Pulsed Irrigation Evacuation
PIN	Personnel Identification Number
PIP	Personal Injury Protection Personnel Identity Protection
PIT	PCM Information Transfer
PIV	Personal Identity Verification
PK	Public Key
PKE	Public Key Enabling
PKI	Public Key Infrastructure
PKU	Phenylketonuria
PL	Public Law
PLS	Preschool Language Scales

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PM-DRG	Pediatric Modified-Diagnosis Related Group
PMR	Percutaneous Myocardial Laser Revascularization
PNET	Primitive Neuroectodermal Tumors
PNT	Policy Notification Transaction
POA	Power of Attorney
POA&M	Plan of Action and Milestones
POC	Pharmacy Operations Center Plan of Care Point of Contact
POL	May 1996 TRICARE/CHAMPUS Policy Manual 6010.47-M
POS	Point of Sale (Pharmacy only) Point of Service Public Official's Statement
POV	Privately Owned Vehicle
PPD	Per Patient Day
PPN	Preferred Provider Network
PPO	Preferred Provider Organization
PPS	Prospective Payment System Ports, Protocols and Services
PPSM	Ports, Protocols, and Service Management
PPV	Pneumococcal Polysaccharide Vaccine
PQI	Potential Quality Indicator Potential Quality Issue
PR	Periodic Reinvestigation
PRC	Program Review Committee
PRG	Peer Review Group
PRO	Peer Review Organization
ProDUR	Prospective Drug Utilization Review
PROM	Programmable Read-Only Memory
PRP	Personnel Reliability Program
PRPP	Pharmacy Redesign Pilot Project
PSA	Prime Service Area Physician Scarcity Area
PSAB	Personnel Security Appeals Board
PSCT	Peripheral Stem Cell Transplantation
PSI	Personnel Security Investigation
PST	Pacific Standard Time
PT	Pacific Time Physical Therapist Physical Therapy Prothrombin Time
PTA	Pancreas Transplant Alone Percutaneous Transluminal Angioplasty
PTC	Processed To Completion

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PTCA	Percutaneous Transluminal Coronary Angioplasty
PTK	Phototherapeutic Keratectomy
PVCs	Premature Ventricular Contractions
QA	Quality Assurance
QC	Quality Control
QI	Quality Improvement Quality Issue
QII	Quality Improvement Initiative
QIO	Quality Improvement Organization
QIP	Quality Improvement Program
QLE	Qualifying Life Event
QM	Quality Management
QUIG	Quality Indicator Group
RA	Remittance Advice
RAM	Random Access Memory
RAP	Request for Anticipated Payment
RAPIDS	Real-Time Automated Personnel Identification System
RC	Reserve Component
RCN	Recoupment Case Number Refund Control Number
RCS	Report Control Symbol
RD	Regional Director
RDBMS	Relational Database Management System
RDDDB	Reportable Disease Database
REM	Rapid Eye Movement
RFI	Request For Information
RFP	Request For Proposal
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RhoGAM	RRho (D) Immune Globulin
RN	Registered Nurse
RNG	Random Number Generator
RO	Regional Office
ROC	Resumption of Care
ROFR	Right of First Refusal
ROM	Read-Only Memory Rough Order of Magnitude
ROT	Read-Only Table
ROTC	Reserved Officer Training Corps
ROVER	RHHI Outcomes and Assessment Information Set Verification
RPM	Record Processing Mode
RRA	Regional Review Authority
RTC	Residential Treatment Center

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RUG	Resource Utilization Group
RV	Residual Volume
RVU	Relative Value Unit
SAAR	System Authorization Access Request
SAD	Seasonal Affective Disorder
SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier
SAO	Security Assistant Organizations
SAP	Special Access Program
SAS	Sensory Afferent Stimulation
SAT	Service Assist Team
SBCC	Service Branch Classification Code
SBI	Special Background Investigation
SCH	Sole Community Hospital
SCHIP	State Children's Health Insurance Program
SCI	Sensitive Compartmented Information Spinal Cord Injury
SCIC	Significant Change in Condition
SCOO	Special Contracts and Operations Office
SCR	Stell Cell Rescue
S/D	Security Division
SD (Form)	Secretary of Defense (Form)
SEP	Sensory Evoked Potentials
SES	Senior Executive Service
SelRes	Selected Reserve
SF	Standard Form
SGDs	Speech Generating Devices
SHCP	Supplemental Health Care Program
SI	Sensitive Information Small Intestine (transplant) Status Indicator
SIDS	Sudden Infant Death Syndrome
SII	Special Investigative Inquiry
SI/L	Small Intestine-Live (transplant)
SIOP-ESI	Single Integrated Operational plan-Extremely Sensitive Information
SIP	System Identification Profile
SIT	Standard Insurance Table
SMC	System Management Center
SNF	Skilled Nursing Facility
SNS	Sacral Nerve Root Stimulation
SOC	Start of Care
SOFA	Status Of Forces Agreement
SOIC	Senior Officer of the Intelligence Community
SON	Submitting Office Number

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SOR	Statement of Reasons
SP	Special Processing Code
SPA	Simple Power Analysis
SPECT	Single Photon Emission Computed Tomography
SPK	Simultaneous Pancreas Kidney (transplant)
SPOC	Service Point of Contact
SPR	SECRET Periodic Reinvestigation
SQL	Structured Query Language
SRE	Serious Reportable Event
SSA	Social Security Act Social Security Administration
SSAA	Social Security Authorization Agreement
SSAN	Social Security Administration Number
SSBI	Single-Scope Background Investigation
SSL	Secure Socket Layer
SSM	Site Security Manager
SSN	Social Security Number
SSO	Short-Stay Outlier
STF	Specialized Treatment Facility
STS	Specialized Treatment Services
STSF	Specialized Treatment Service Facility
SUDRF	Substance Use Disorder Rehabilitation Facility
SVO	SIT Validation Office
SVT	Supraventricular Tachycardia
SWLS	Satisfaction With Life Scale
TAD	Temporary Additional Duty
TAFIM	Technical Architecture Framework for Information Management
TAMP	Transitional Assistance Management Program
TAO	TRICARE Alaska Office TRICARE Area Office
TARO	TRICARE Alaska Regional Office
TB	Tuberculosis
TBD	To Be Determined
TBE	Tick Borne Encephalitis
TBI	Traumatic Brain Injury
TC	Technical Component
TCP/IP	Transmission Control Protocol/Internet Protocol
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Plan
TDY	Temporary Duty
TED	TRICARE Encounter Data
TEFRA	Tax Equity and Fiscal Responsibility Act

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TEOB	TRICARE Explanation of Benefits
TEPRC	TRICARE Encounter Pricing (Record)
TEPRV	TRICARE Encounter Provider (Record)
TET	Tubal Embryo Transfer
TF	Transfer Factor
TFL	TRICARE For Life
TFMDP	TRICARE (Active Duty) Family Member Dental Plan
TGRO	TRICARE Global Remote Overseas
TGROHC	TGRO Host Country
TIFF	Tagged Imaged File Format
TIL	Tumor-Infiltrating Lymphocytes
TIMPO	Tri-Service Information Management Program Office
TIN	Taxpayer Identification Number
TIPS	Transjugular Intrahepatic Portosystemic Shunt
TIS	TRICARE Information Service
TLAC	TRICARE Latin America/Canada
TLC	Total Lung Capacity
TMA	TRICARE Management Activity
TMA-A	TRICARE Management Activity - Aurora
TMAC	TRICARE Maximum Allowable Charge
TMI&S	Technology Management Integration & Standards
TMOP	TRICARE Mail Order Pharmacy
TMR	Transmyocardial Revascularization
TNEX	TRICARE Next Generation (MHS Systems)
TOB	Type of Bill
TOE	Target of Evaluation
TOL	TRICARE Online
TOM	August 2002 TRICARE Operations Manual 6010.51-M February 2008 TRICARE Operations Manual 6010.56-M
TOP	TRICARE Overseas Program
TPA	Third Party Administrator
TPC	Third Party Collections
TPharm	TRICARE Pharmacy
TPL	Third Party Liability
TPM	August 2002 TRICARE Policy Manual 6010.54-M February 2008 TRICARE Policy Manual 6010.57-M
TPN	Total Parenteral Nutrition
TPOCS	Third Party Outpatient Collections System
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote Active Duty Family Member
TPRADSM	TRICARE Prime Remote Active Duty Service Member
TPRC	TRICARE Puerto Rico Contract(or)

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TQMC	TRICARE Quality Monitoring Contractor
TRDP	TRICARE Retiree Dental Program
TRI	TED Record Indicator
TRM	August 2002 TRICARE Reimbursement Manual 6010.55-M February 2008 TRICARE Reimbursement Manual 6010.58-M
TRO	TRICARE Regional Office
TRPB	TRICARE Retail Pharmacy Benefits
TRRx	TRICARE Retail Pharmacy
TRS	TRICARE Reserve Select
TRSA	TRICARE Reserve Select Application
TSC	TRICARE Service Center
TSF	Target of Evaluation Security Functions
TSM	August 2002 TRICARE Systems Manual 7950.1-M February 2008 TRICARE Systems Manual 7950.2-M
TSP	Target of Evaluation Security Policy
TSR	TRICARE Select Reserve
TSRDP	TRICARE Select Reserve Dental Program
TSRx	TRICARE Senior Pharmacy
TSS	TRICARE Senior Supplement
TSSD	TRICARE Senior Supplement Demonstration
TTY	Teletypewriter
TUNA	Transurethral Needle Ablation
UAE	Uterine Artery Embolization
UB	Uniform Bill
UBO	Uniform Business Office
UCBT	Umbilical Cord Blood Stem Cell Transplantation
UCC	Uniform Commercial Code
UCCI	United Concordia Companies, Inc.
UCSF	University of California San Francisco
UIC	Unit Identification Code
UIN	Unit Identifier Number
UM	Utilization Management
UMO	Utilization Management Organization
UMP	User Maintenance Portal
UPIN	Unique Physician Identification Number
URF	Unremarried Former Spouses
URL	Universal Resource Locator
US	United States
USA	United States of America
USACID	United States Army Criminal Investigation Division
USAF	United States Air Force
USAO	United States Attorneys' Office

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USC	United States Code
USCG	United States Coast Guard
USCO	Uniformed Services Claim Office
USD	Undersecretary of Defense
USD (P&R)	Undersecretary of Defense (Personnel and Readiness)
USDI	Undersecretary of Defense for Intelligence
USFHP	Uniformed Services Family Health Plan
USHBP	Uniformed Services Health Benefit Plan
USMC	United States Marine Corps
USMTF	Uniformed Services Medical Treatment Facility
USN	United States Navy
USPDI	United States Pharmacopoeia Drug Information
USPHS	United States Public Health Service
USPS	United States Postal Service
USPSTF	U.S. Preventive Services Task Force
USS	United Seaman's Service
USTF	Uniformed Services Treatment Facility
UV	Ultraviolet
VA	Veteran Affairs (hospital) Veteran Administration
VAD	Ventricular Assist Device
VAMC	VA Medical Center
VATS	Video-Assisted Thoroscopic Surgery
VAX-D	Vertebral Axial Decompression
VD	Venereal Disease
VO	Verifying Office (Official)
VPN	Virtual Private Network
VPOC	Verification Point of Contact
VSAM	Virtual Storage Access Method
VSD	Ventricular Septal Defect
WAC	Wholesale Acquisition Cost
WAN	Wide Area Network
WATS	Wide Area Telephone Service
WC	Worker's Compensation
WEDI	Workgroup for Electronic Data Interchange
WIC	Women, Infants, and Children (Program)
WLAN	Wireless Local Area Network
WORM	Write Once Read Many
WRAMC	Walter Reed Army Medical Center
WTC	World Trade Center
WTRR	Wire Transfer Reconciliation Report
X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome

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XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer

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