



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY
AURORA, COLORADO 80011-9066

TRICARE
MANAGEMENT ACTIVITY

OD

CHANGE 53
6010.56-M
JUNE 27, 2011

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE OPERATIONS MANUAL (TOM), FEBRUARY 2008**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

CHANGE TITLE: SKILLED NURSING FACILITY (SNF) CARE PREAUTHORIZATION
REQUIREMENT FOR DUAL ELIGIBLE BENEFICIARIES

CONREQ: 15001

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change adds language requiring preauthorization for SNF care for TRICARE dual eligibles in the U.S. and U.S. territories beginning on day 101, when TRICARE becomes primary payer.

EFFECTIVE DATE: April 1, 2010.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Feb 2008 TPM, Change No. 50 and Feb 2008 TRM, Change No. 50.


Reta M. Michak
Director, Operations Division

ATTACHMENT(S): 18 PAGES
DISTRIBUTION: 6010.56-M

CHANGE 53
6010.56-M
JUNE 27, 2011

REMOVE PAGE(S)

INSERT PAGE(S)

CHAPTER 7

Section 2, pages 1 and 2

Section 2, pages 1 and 2

CHAPTER 20

Section 3, pages 1 through 3

Section 3, pages 1 through 3

CHAPTER 24

Section 9, pages 5 through 15

Section 9, pages 5 through 15

Section 20, pages 1 and 2

Section 20, pages 1 and 2

Preauthorizations

1.0 GENERAL

Preauthorization review shall be performed for all care and procedures listed below. The contractor may propose additional authorization reviews. (See [Section 1](#) for additional guidance.) The admissions/procedures are subject to change over time based upon the Government's assessment of the efficacy of the review. The changes will include adding and/or removing admissions/procedures. When the beneficiary has other insurance that provides primary coverage, exception to the preauthorization requirements will apply as provided in the TRICARE Policy Manual (TPM), [Chapter 1, Section 7.1, paragraph 1.9](#). When the contractor is acting as a secondary payor any medically necessary reviews shall be performed on a retrospective basis.

THE FOLLOWING INPATIENT ADMISSIONS WILL BE PREAUTHORIZED:

Adjunctive Dental

Mental Health

Substance Abuse

Skilled Nursing Facility (SNF) care for dual eligible beneficiaries

Note: Effective for dates of service **June 1, 2010**, SNF care received in the U.S. and U.S. territories must be preauthorized for TRICARE dual eligible beneficiaries. The TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) contractor will preauthorize SNF care beginning on day 101, when TRICARE becomes primary payer. For those beneficiaries inpatient on the effective date, a preauthorization will be required August 1, 2010.

Organ and Stem Cell Transplants

THE FOLLOWING OUTPATIENT SERVICES WILL BE PREAUTHORIZED:

Adjunctive Dental

Mental Health Care after the **eighth** visit each fiscal year. Primary Care Manager (PCM) referral is not required; however, the Managed Care Support Contractor (MCSC) shall steer all beneficiaries who contact them to the Military Treatment Facility (MTF) or appropriate network provider. Additionally, the MCSC shall expound upon the benefits of using the MTF and network providers during all appropriate beneficiary and provider briefings.

Note: Active Duty Service Members (ADSMs) require preauthorization before receiving mental health services. The contractor shall comply with the provisions of [Chapters 16](#) and [17](#) when processing requests for service for active duty personnel.

THE FOLLOWING SERVICES WILL BE PREAUTHORIZED IN ANY SETTING:

Extended Care Health Option (ECHO) Services

Hospice

2.0 INPATIENT MENTAL HEALTH

Inpatient mental health requires preauthorization. In the event that inpatient mental health services were not preauthorized, the contractor shall obtain the necessary information and complete a retrospective review. Penalties for failing to obtain preauthorization apply (see [32 CFR 199.15](#)). **Non-Availability Statement (NAS)** requirements also apply to inpatient mental health admissions.

3.0 EFFECTIVE AND EXPIRATION DATES

The preauthorization shall have an effective date and an expiration date. For organ and stem cell transplants, the preauthorization shall remain in effect as long as the beneficiary continues to meet the specific transplant criteria set forth in the TPM, or until the approved transplant occurs.

- END -

Claims Processing For Dual Eligibles

1.0 GENERAL

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

2.0 DETERMINING PAYMENTS DUE AFTER COORDINATION WITH MEDICARE

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

3.0 EXCEPTIONS TO TIMELY CLAIMS FILING

3.1 Medicare

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

3.2 Other Health Insurance (OHI)

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

4.0 CLAIMS DEVELOPMENT REQUIREMENTS

4.1 Medicare Providers

4.1.1 The contractor shall accept the Medicare certification of individual professional providers who have a like class of individual professional providers under TRICARE without further authorization. An exception to this general rule occurs if there is information indicating Medicare, TRICARE or other federal health care program integrity violations by the physician or other health care practitioner. In such cases the Managed Care Support Contractor (MCSC) shall seek guidance from TRICARE Management Activity (TMA) Program Integrity (PI) prior to accepting the Medicare certification as valid for TRICARE purposes. Individual professional providers without a like class (e.g., chiropractors) under TRICARE shall be denied.

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

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

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

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

4.3 Preauthorization Requirements

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

4.3.1 The TDEFIC contractor shall develop a communication/education plan for Skilled Nursing Facilities (SNFs) and TRICARE dual eligible beneficiaries related to the SNF preauthorization requirement and the general SNF benefit. In addition to the initial education, this plan shall accommodate periodic SNF education (not to exceed two per year) that the contractor will conduct at the request of the TMA. The plan shall be coordinated with TMA.

4.3.2 The TDEFIC contractor preauthorization standards for SNFs shall be as follows: 90% of all requests for preauthorization/authorization will be completed within five working days following receipt of the request and all required information, and 100% of such requests will be completed within eight working days following receipt of the request and all requested information. As such, SNF preauthorizations should be tracked separately from the required preauthorizations noted in [Chapter 7, Section 2](#). A SNF preauthorization shall not be extended for more than 30 days per instance.

5.0 UTILIZATION MANAGEMENT

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

6.0 END OF PROCESSING

6.1 Beneficiary Cost-Shares

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

cost-shares shall be applied. In all other cases, the TRICARE Standard cost-shares shall be applied.

6.2 Application Of Catastrophic Cap

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

6.3 Appeals And Grievances

6.3.1 Initial Determinations

Services and supplies denied payment by Medicare will not be considered for coverage by TRICARE if the Medicare denial of payment is appealable under the Medicare appeal process. If, however, a Medicare appeal results in some payment by Medicare, the services and supplies covered by Medicare will be considered for coverage by TRICARE. Services and supplies denied payment by Medicare will be considered for coverage by TRICARE, if the Medicare denial of payment is not appealable under the Medicare appeal process. The appeal procedures set forth in [Chapter 12](#) are applicable to initial denial determinations by TRICARE under TDEFIC.

6.3.2 Grievance System

The contractor shall develop and implement a grievance system, separate and apart from the appeal process. The grievance system shall allow full opportunity for aggrieved parties to seek and obtain an explanation for and/or correction of any perceived failure of contractor or subcontractor personnel to furnish the level or quality of service to which the beneficiary may believe he/she is entitled. Any TRICARE beneficiary, sponsor, parent, guardian, or other representative who is aggrieved by any failure or perceived failure of the contractor or subcontractor to meet the obligations for timely, quality service may file a grievance. All grievances must be submitted in writing. If the written complaint reveals a TRICARE appealable issue, the correspondence shall be forwarded to the contractor's appeals unit for a reconsideration review. If the complaint reveals a Medicare appealable issue or regards care for which Medicare was the primary payer and the issue does not involve any actions by a TRICARE contractor, the complaint shall be forwarded to Medicare for resolution. The beneficiary shall be notified that the complaint was forwarded to Medicare and the address and phone number of where the complaint was forwarded.

7.0 TED SUBMISSION

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

8.0 TRICARE PROCESSING STANDARDS

All TRICARE Processing Standards in [Chapter 1, Section 3](#) apply except for [Chapter 1, Section 3, paragraph 1.2](#), and the following wording replaces the [Chapter 1, Section 3, paragraph 1.7.1](#), Claim Payment Errors, requirements: "The absolute value of the payment errors shall not exceed 1.5% of the total billed charges."

- END -

5.3 Referral/Preauthorization/Authorization Requirements for all other TOP beneficiaries.

5.3.1 TRICARE-eligible beneficiaries residing in an overseas location who are not enrolled in TOP Prime/TOP Prime Remote typically do not need to obtain preauthorization/authorization for care. However, preauthorization reviews shall be performed for all care and procedures listed in [Chapter 7, Section 2](#).

5.3.2 The TOP contractor may propose additional authorization reviews for non-enrolled TOP beneficiaries to the government.

5.4 Referral/Preauthorization/Authorization Requirements for Beneficiaries Who Reside in the 50 United States and the District of Columbia.

5.4.1 TRICARE beneficiaries whose health care is normally provided under one of the three regional MCSCs who require care while traveling in an overseas location shall request any necessary preauthorizations/authorizations through the TOP contractor, regardless of where the beneficiary resides or is enrolled.

Note: This process does not apply to beneficiaries enrolled to the USFHP or the CHCBP.

5.4.2 Effective for dates of service **June 1, 2010**, Skilled Nursing Facility (SNF) care received in the U.S. and U.S. territories must be preauthorized for Medicare/TRICARE dual eligible beneficiaries. The dual eligible contractor will preauthorize SNF care beginning on day 101, when TRICARE becomes primary payer.

5.5 Point of Service (POS) Provisions

5.5.1 Unless specifically excluded by this section, all self-referred, non-emergency care provided to TOP Prime/TOP Prime Remote-enrolled ADFMs which is not either provided/referred by the beneficiary's PCM or specifically authorized shall be reimbursed under the POS option. This provision applies regardless of where the care is rendered. POS provisions also apply to the following stateside beneficiaries when traveling overseas: ADFMs, retirees, and retiree family members who are enrolled in TRICARE Prime, and ADFMs enrolled in TPR for ADFMs.

5.5.2 POS cost-sharing only applies to TRICARE-covered services. Claims for services that are not a covered TRICARE benefit shall be denied.

5.5.3 The TOP contractor shall adjust POS deductibles and cost-shares when TOP PCMs or Health Care Finders (HCFs) do not follow established referral/authorization procedures. For example, if the contractor processes a claim under the POS option because there was no evidence of a referral and/or an authorization, and the contractor later verifies that the PCM or other appropriate provider referred the beneficiary for the care, the contractor shall adjust the claim and reverse the POS charges. The contractor need not identify past claims that may be eligible for POS adjustment; however, the contractor shall adjust these claims as they are brought to their attention.

5.5.4 On a case-by-case basis, following stabilization of the patient, the TRICARE Area Office (TAO) Director or Military Treatment Facility (MTF) Commander may require an enrolled beneficiary to transfer to a TOP network facility or an MTF. The TAO Director or MTF Commander shall provide written notice to the beneficiary (or responsible party) advising them of the impending transfer to

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 24, Section 9

Claims Processing Procedures

a TOP network facility/MTF. If a beneficiary who is subject to TOP POS provisions elects to remain in the non-network facility after such notification, POS cost-sharing provisions will apply beginning 24 hours following the receipt of the written notice. Neither the TOP Director nor the MTF Commander may require a transfer until such time as the transfer is deemed medically safe.

5.5.5 The following deductible and cost-sharing amounts apply to all TOP POS claims for health care support services:

- Enrollment year deductible for outpatient claims: \$300 per individual; \$600 per family. No deductible applies to inpatient services.
- Beneficiary cost-share for inpatient and outpatient claims: 50% of the allowable charge after the deductible has been met (deductible only applies to outpatient claims).
- POS deductible and cost-share amounts are not creditable to the enrollment/Fiscal Year (FY) catastrophic cap and they are not limited by the cap.
- POS deductible and cost-share amounts do not apply to claims for care received by newborns and newly adopted children who are deemed enrolled in TOP Prime or TOP Prime Remote.

5.5.6 POS deductible and cost-share amounts do not apply if a TOP enrollee has Other Health Insurance (OHI) that provides primary coverage (i.e., the OHI must be primary under the provisions of the TRM, [Chapter 4, Section 1](#)). Evidence of OHI claims processing (including the exact amount paid on the claim) must be submitted with the TOP claim.

5.5.7 EOB shall clearly indicate that a claim has been processed under the POS Option.

5.5.8 POS is not applicable to ADSMs or to TOP non-enrollees.

5.6 Extended Care Health Option (ECHO) benefits in overseas locations must be authorized by the TAO Director or designee. Refer to [Section 23](#) and the TRICARE Policy Manual (TPM), [Chapter 9](#) for additional guidance.

5.7 Refer to [Section 10](#) for referral/preauthorization/authorization requirements for ADSM dental care in remote overseas locations.

6.0 CLAIM DEVELOPMENT

6.1 Development of missing information shall be kept to a minimum. The TOP contractor shall use available in-house methods, contractor files, telephone, Defense Enrollment Eligibility Reporting System (DEERS), etc., to obtain incomplete or discrepant information. If this is unsuccessful, the contractor may return the claims to sender with a letter which indicates that the claims are being returned, the reason for return and requesting the required missing documentation. The contractor's system must identify the claim as returned, not denied. The government reserves the right to audit returned claims as required, therefore the contractor shall retain sufficient information on returned claims to permit such audits. The contractor shall review all claims to ensure TOP required information is provided prior to payment.

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 24, Section 9

Claims Processing Procedures

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).

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.

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 24, Section 9

Claims Processing Procedures

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 For the Philippines, prescription drugs may only be cost-shared when dispensed by a certified retail pharmacy or hospital-based pharmacy. The TOP contractor shall deny claims for prescription drugs dispensed by a physician's office. Certification requirements outlined in [Section 14](#) apply.

Note: This does not apply to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).

6.13 Claims for DME involving lease/purchase shall always be developed for missing information.

6.14 The TOP contractor shall use ECHO claims processing procedures outlined in TPM, [Chapter 9, Section 18.1](#), when processing ECHO overseas claims.

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.

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.

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 24, Section 9

Claims Processing Procedures

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.

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.

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 24, Section 9

Claims Processing Procedures

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](#).

8.0 EOB VOUCHERS

8.1 The TOP contractor shall follow the EOB voucher requirements in [Chapter 8, Section 8](#), where applicable, with the following exceptions and additional requirements:

8.1.1 The letterhead on all TOP EOB shall also reflect "TRICARE Overseas Program" and shall be annotated Prime or Standard.

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 24, Section 9

Claims Processing Procedures

- 8.1.2** TOP EOB may be issued on regular stock, shall provide a message indicating the exchange rate used to determine payment and shall clearly indicate that "This is not a bill".
- 8.1.3** TOP EOB shall include the toll-free number for beneficiary and provider assistance.
- 8.1.4** TOP EOB for overseas enrolled ADSM claims shall be annotated "ACTIVE DUTY."
- 8.1.5** For Point of Sale or Vendor pharmacy overseas claims, TOP EOB must have the name of the provider of service on the claim.
- 8.1.6** For beneficiary submitted pharmacy claims, TOP EOB shall contain the name of the provider of service, if the information is available. If the information is not available, the EOB shall contain "your pharmacy" as the provider of service.
- 8.1.7** The TOP contractor shall insert the provider's payment invoice numbers in the patient's account field on all provider EOBs, if available.
- 8.1.8** The following EOB message shall be used on overseas claims rendered by non-network host nation providers who are required to be certified, but have not been certified by the TOP contractor - "Your provider has not submitted documentation required to validate his/her training and/or licensure for designation as an authorized TRICARE provider".
- 8.1.9** When a provider's/beneficiary's EOB, EOB and check, or letter is returned as undeliverable, the check shall be voided.

9.0 DUPLICATE PAYMENT PREVENTION.

The TOP contractor shall follow the duplicate payment prevention requirements outlined in [Chapter 8, Section 9](#).

10.0 DOUBLE COVERAGE.

- 10.1** TOP claims require double coverage review as outlined in the TRM, [Chapter 4](#).
- 10.2** Beneficiary/provider disagreements regarding the contractor's determination shall be coordinated through the overseas TAO Director for resolution with the contractor.
- 10.3** Overseas insurance plans such as German Statutory Health Insurance, Japanese National Insurance (JNI), and Australian Medicare, etc., are considered OHI. When necessary, the TOP contractor may contact the appropriate TAO Director for assistance.

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

11.0 THIRD PARTY LIABILITY (TPL)

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

12.0 REIMBURSEMENT/PAYMENT OF OVERSEAS CLAIMS

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

12.1 Reimburse claims for host nation services/charges for care rendered to TOP eligible beneficiaries which is generally considered host nation practice and incidental to covered services, but which would not typically be covered under TRICARE. An example of such services may be, charges from host nation ambulance companies for driving host nation physicians to accidents or private residences, etc.

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

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

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

12.5 Not reimburse for administrative charges billed separately on claims, except for individual administrative charges for Germany, and other locations as determined by the government. The contractor shall reimburse these charges only in instances when the fee is billed concurrently with the corresponding health care services. If a bill is received for these charges without a corresponding health care service, the charges should be denied.

12.6 Determine exchange rates as follow:

12.6.1 Use the exchange rate in effect on the ending date that services were received unless evidence of OHI and then the TOP contractor shall use the exchange rate of the primary insurer, not the rate based on the last date of service to determine the TOP payment amount, and/or;

12.6.2 Use the ending dates of the last service to determine exchange rates for multiple services.

12.6.3 Use the exchange rate in [paragraph 12.6.1](#) to determine deductible and copayment amounts, if applicable, and to determine the amount to be paid in foreign currency.

12.6.4 Overseas drafts/checks and EOBs. Upon completion of processing, checks (payable in U.S. dollars) shall be created by the TOP contractor within 48 hours, after Contract Resource Management (CRM) approval. Drafts (payable in foreign currency units) shall be created by the TOP contractor within 96 hours following CRM approval, unless a different process has been authorized by TMA. Payments that need to be converted to a foreign currency shall be calculated based on the

exchange rate in effect on the last date of service listed on the EOB. Drafts/checks shall be matched with the appropriate EOB, and mailed to the beneficiary/sponsor/host nation provider/POC as applicable.

12.7 The TOP contractor shall convert lump sum payments instead of line items to minimize conversion problems.

12.8 Provider claims for all overseas locations (excluding claims from Korean providers) will be paid by foreign currency/drafts. Drafts may not be changed to a U.S. dollar check after the contractor has issued a foreign draft. Claims from Korean providers will be paid in U.S. dollars.

12.9 Foreign overseas drafts (in local currency) are good for 190 days and may be cashed at any time, unless a different process has been established by TMA. U.S. dollar checks are good for 120 days unless a different process has been established by TMA. The provisions of [Chapter 3, Section 4](#) regarding staledated, voided, or returned checks/Electronic Funds Transfers (EFTs) are applicable to the TOP.

12.10 TOP claims submitted by a beneficiary shall be paid in U.S. dollars, unless there is a beneficiary request on the claim at the time of submission for payment in a foreign currency. The payment may not be changed to U.S. dollars after the foreign draft has been issued.

12.11 Payment to Germany, Belgium, Finland, France, Greece, Ireland, Italy, Luxembourg, Netherlands, Austria, Portugal, Spain, Cyprus, and Malta shall be made in Euros. As other countries transition to Euro, the TOP contractor shall also switch to Euros.

12.12 The contractor shall issue drafts/checks for German claims which look like German drafts/checks.

Note: In order for TRICARE drafts/checks to look like German drafts/checks, a German address must be used. The TOP contractor may use a corporate address in Germany or the TAO Europe address for this purpose.

12.13 U.S. licensed Partnership providers claims for treating patients shall be paid based upon signed agreements. Refer to [Section 29](#) for additional information related to the Partnership Program.

12.14 Pay all beneficiary-submitted claims for TRICARE covered drugs dispensed by a U.S. embassy health clinic to the beneficiary. The contractor is not to make payments directly to the embassy health clinic.

12.15 Professional services rendered by a U.S. embassy health clinic are not covered by TRICARE/TOP. These services are covered under International Cooperative Administrative Support Services (ICASS) agreements. Embassy providers (acting as PCMs) may refer TOP enrollees to host nation providers, these claims shall be processed per TOP policy and procedures.

12.16 Claims for drugs or diagnostic/ancillary services purchased overseas shall be reimbursed by the TOP contractor following applicable deductible/cost-share policies.

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 24, Section 9

Claims Processing Procedures

12.17 Not honor any draft request for currency change, except when directed by the appropriate TMA COR, once a foreign currency draft has been issued by the TOP contractor and the draft has been returned with the request.

12.18 Shall mail the drafts/checks and EOB to host nation providers unless the claim indicates payment should be made to the beneficiary. In conformity with banking requirements, the drafts/checks shall contain the contractor's address. Drafts and EOBs shall be mailed using U.S. postage. Additionally, payments/checks may be made to network providers, with an Embassy address.

12.19 Benefit payment checks and EOB to Philippine providers, and other nations' providers as directed by the TMA CO, shall be mailed to the place of service identified on the claim. No provider for Philippine providers, and other nations' providers as directed by the TMA CO may be sent to any other address.

12.20 Inpatient and outpatient claims for TRICARE overseas eligible beneficiaries, including ADSM claims, are to be processed/paid as indicated below:

12.20.1 The TPharm contractor shall allow TOP ADSM to use the TPharm retail pharmacy network under the same contract requirements as other Military Health System (MHS) eligible beneficiaries (see TPM, [Chapter 8, Section 9.1](#)).

12.20.2 The TPharm contractor shall allow TOP enrolled ADFM beneficiaries to use their stateside retail pharmacy network under the same contract requirements as other MHS eligibles (see TPM, [Chapter 8, Section 9.1](#)).

12.20.3 The TOP contractor shall process claims for overseas health care received by TRICARE beneficiaries enrolled to or residing in a stateside MCSC's region following the guidelines outlined in this chapter. Payment shall be made from applicable bank accounts and shall be based on billed charges unless a lower reimbursement rate has been established by the government or the contractor.

12.21 Provider requests for EFT payment. Upon host nation provider request, the TRICARE Overseas health care support contractor shall provide EFT payment to a U.S. or overseas bank on a weekly basis. Bank charges incurred by the provider for EFT payment shall be the responsibility of the provider. No EFT payment may be made to providers in the Philippines.

12.22 The TOP contractor shall process 85% of all retained and adjustment TOP claims to completion within 21 calendar days from the date of receipt. Claims pending per government direction are excluded from this standard. However, the number of excluded claims must be reported on the Overseas Weekly/Monthly Workload/Cycletime Aging report. 100% of all claims (both retained and excluded, including adjustments) shall be processed to completion within 90 calendar days from the date of receipt, unless the CO specifically directs the contractor to continue pending a claim or group of claims.

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

13.0 CLAIMS ADJUSTMENT AND RECOUPMENT

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

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

13.2.1 Send an initial demand letter.

13.2.2 Send a second demand letter at 90 days.

13.2.3 Send a final demand letter at 120 days.

13.2.4 Refer the case to TMA at 240 days, if the case is over \$600.00, and if under \$600.00 the case shall remain open for an additional four months and then shall be written off at 360 days.

13.3 Recoupment letters (i.e., the initial letter, the 90 day second request and the 120 day final demand letter) shall be modified to delete references to U.S. law. Invoice numbers shall be provided on all recoupment letters. The TOP contractor shall include language in the recoupment letter requesting that refunds be returned/provided in the exact amount requested.

13.4 Provider recoupment letters sent to Germany, Italy and Spain, shall be written in the respective language.

13.5 The TOP contractor may hand write the dollar amount and the host nation provider's name and address, on all recoupment letters.

13.6 If the recoupment action is the result of an inappropriately processed claim by the TOP contractor, recoupment is the responsibility of the contractor, not the beneficiary/provider.

13.7 The TOP contractor shall have a TOP bank account capable of receiving/accepting wire transfers from TRICARE Europe overseas for host nation provider recoupment/overpayment returns. The TOP contractor shall accept the amount received as payment against the amount owed. Any fees associated with the wire transfer will be the responsibility of the payer/provider.

14.0 DUPLICATE PAYMENT PREVENTION

The provisions of [Chapter 8, Section 9](#) are applicable to the TOP.

- END -

TRICARE Overseas Program (TOP) TRICARE For Life (TFL)

1.0 GENERAL

1.1 The TRICARE Overseas Program (TOP) TRICARE For Life (TFL) program provides health care administration and claims processing for individuals with dual eligibility under both Medicare and TRICARE who receive care in locations where Medicare is not available.

1.2 The provisions of [Chapter 20](#) regarding TFL are applicable to beneficiaries residing in locations where Medicare is available. These areas include the 50 United States, the District of Columbia, and the U.S. territories of Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands.

2.0 JURISDICTION

2.1 Dual eligible beneficiaries are covered under TOP TFL if they receive care in a location where Medicare is not available. TOP TFL benefits, cost-shares, and deductibles are identical to TOP Standard.

2.2 Dual eligible beneficiaries residing in Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands are not covered under TOP TFL. These beneficiaries receive TRICARE coverage under the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) according to the provisions of [Chapter 20](#).

2.3 Services rendered on board a commercial ship are the responsibility of the TDEFIC contractor if the care was rendered in the territorial waters adjoining the land areas of the United States. Services rendered on board ship while outside U.S. territorial waters are the responsibility of the TOP contractor.

3.0 CONTRACTOR RESPONSIBILITIES

3.1 The TOP contractor shall provide administration and claims processing services for the TOP TFL program.

3.2 TOP TFL has the same cost-shares and deductibles as TOP Standard.

3.3 TOP TFL has the same requirements for referrals or prior authorizations as TOP Standard. All TOP requirements regarding provider certification apply.

3.4 The TOP contractor is not required to develop host nation provider networks to support the TOP TFL beneficiary population.

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 24, Section 20

TRICARE Overseas Program (TOP) TRICARE For Life (TFL)

3.5 The TOP contractor is not required to provide health care on a cashless, claimless basis for TOP TFL beneficiaries.

3.6 The TOP contractor is not required to make appointments with host nation providers for TOP TFL beneficiaries. However, upon beneficiary request, the contractor shall provide the beneficiary with the name, telephone number, and address of host nation network or non-network providers of the appropriate clinical specialty located within the beneficiary's geographic region.

Note: See Section 9, paragraph 5.4.2 for requirements related skilled nursing care received in the U.S. and U.S. territories.

- END -