

Pharmacy Claims Processing

1.0 CLAIM TYPES

1.1 Mail Order

A claim under the mail order program is the processing of a prescription order that results in a dispensed pharmaceutical. A prescription order that does not result in a dispensed pharmaceutical is not a claim.

1.2 Retail Pharmacy

1.2.1 A network retail pharmacy claim is a Health Insurance Portability and Accountability Act (HIPAA) compliant electronic transaction between the contractor and the network pharmacy which results in a dispensed pharmaceutical. An electronic transaction that does not result in a dispensed pharmaceutical is not a claim.

1.2.2 A paper claim is a request for reimbursement of a dispensed pharmaceutical or covered medical supply. (See [Section 2](#) for information regarding what pharmaceutical claims are not covered by the Pharmacy contract.) Paper claims constitute any of the following: (1) claims for beneficiaries who use non-network providers, (2) claims for beneficiaries who have Other Health Insurance (OHI) and are requesting TRICARE reimbursement as second payor, (3) claims from State Medicaid agencies (may be in an electronic batch format), and (4) claims for covered pharmaceuticals and supplies purchased in a retail pharmacy that do not require a prescription. (Claims from a non-network pharmacy may be received in a paper format or electronically through a claims clearinghouse or on a tape or CD.)

1.2.3 A completed paper claim can result in either benefit allowance or denial. However, a claim will not be denied for missing, incomplete or discrepant information. Rather, the contractor will first use in-house methods (e.g., contractor files, telephone, Defense Enrollment Eligibility Reporting System (DEERS)) to obtain the missing or discrepant information. If this is unsuccessful, the contractor may return the claim to the sender requesting all known missing information or required documentation (see [Chapter 8, Section 6](#)). While a claim may be returned for missing or discrepant information, it may not be processed to completion and denied for this reason. A TRICARE Encounter Data (TED) record will not be submitted for a returned claim. Otherwise, for every claim processed to completion, the contractor shall submit a TED record to the TRICARE Management Activity (TMA) in accordance with the TRICARE Systems Manual (TSM).

2.0 OHI AND CLAIMS PROCESSING

2.1 All pharmacy claims must be investigated for possible OHI coverage prior to a pharmaceutical being dispensed (for mail order and retail network claims) or prior to adjudication

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(for paper claims). (See the TRICARE Reimbursement Manual (TRM), [Chapter 4](#), for double coverage review requirements.)

2.2 If a beneficiary has OHI that includes pharmacy coverage (except for Medicaid), the other insurer must be first payor.

2.3 TRICARE cost-sharing of medications through a Medicare Part D prescription drug plan is subject to the double coverage provisions found in [32 CFR 199.8](#) and TRM, [Chapter 4](#).

2.4 A "Primary Plan" under TRICARE Law and Regulation is any OHI or pharmacy coverage the patient has except Medicaid (Title XIX) or a supplemental plan. (Supplemental plans are specifically designed to pay only TRICARE deductibles, coinsurance and other cost-shares.) Prior to payment of any claim for services or supplies rendered to any TRICARE beneficiary, regardless of eligibility status, it must be determined whether other coverage exists. TRICARE requirements relating to double coverage and coordination of benefits are addressed in the TRM, [Chapter 4](#). If the reason for an 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:

- 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 through coordination of benefits;
- 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.

3.0 CATASTROPHIC CAP AND DEDUCTIBLE DATABASE (CCDD)

The contractor shall update catastrophic cap and deductible amounts on DEERS using the CCDD file application in accordance with the TSM. As part of a pharmacy transaction when the contractor initially queries DEERS for eligibility information using the "Claims Coverage" inquiry, the response will include catastrophic cap totals. The contractor will use this information to determine whether a beneficiary has met their catastrophic cap. If the query response shows that the catastrophic cap has been met, no copayment amount will be applied or collected. If the query response shows the catastrophic cap has not been met, the contractor shall apply and collect the appropriate copayment amount (or portion thereof if application of the full copayment amount would result in the catastrophic cap total being exceeded). After a copayment has been collected, the contractor must submit a CCDD file update transaction to update the catastrophic cap amount on DEERS. If during this update, CCDD file shows that the cap is now met (due to an intervening transaction that occurred from the time between the initial eligibility inquiry and the update transaction), the following actions will be taken. The contractor will proceed with the update transaction and apply the copayment amount to the CCDD file catastrophic cap totals (which will result in the cap being exceeded). The contractor shall initiate a refund of the copayment amount (or appropriate portion thereof which exceeds the cap amount) to the beneficiary. Once the refund has been sent, the contractor will adjust (i.e., correct) the CCDD file catastrophic cap totals to reflect the refunded copayment amount. This correction action should result in the CCDD file catastrophic cap total reflecting that the cap has been met, but not exceeded. (If a TED record has been previously submitted, it will be necessary to submit an adjustment to the TED to correct the

copayment amount.)

4.0 MEDICAL NECESSITY AND PRIOR AUTHORIZATION

4.1 Medical Necessity Reviews

The Government will determine the formulary status of all drugs. When a drug is designated as non-formulary, the contractor shall check to see if a medical necessity determination for the non-formulary drug has previously been completed for a Direct Care (DC) dispensing. Medical necessity determinations for DC dispensings will be made available from the Pharmacy Data Transaction System (PDTs). If PDTs shows that medical necessity has previously been determined, the contractor shall dispense the prescription applying a formulary copayment.

4.1.1 If a medical necessity determination has not previously been completed, the contractor shall apply the non-formulary copayment to the dispensed prescription. At the request of the beneficiary or provider, the contractor shall conduct a medical necessity review using Government-provided review criteria. If the contractor establishes medical necessity, the prescription shall be dispensed with the formulary copayment amount applied.

4.1.2 The contractor will be given at least a 30-day notice before a drug is moved to a non-formulary status. Non-formulary drugs, medical necessity forms, and review criteria can be found at <http://www.tricare.mil/pharmacy>.

4.1.3 In general, in order to establish medical necessity for a pharmaceutical agent designated non-formulary under the Uniform Formulary Rule, one or more of the following criteria must be met for ALL of the available formulary alternatives:

4.1.3.1 The use of the formulary alternative is contraindicated;

4.1.3.2 The patient experiences, or is likely to experience, significant adverse effects from the formulary alternative, and the patient is reasonably expected to tolerate the non-formulary medication;

4.1.3.3 The formulary alternative results in therapeutic failure, and the patient is reasonably expected to respond to the non-formulary medication;

4.1.3.4 The patient previously responded to a non-formulary medication, and changing to a formulary alternative would incur unacceptable clinical risk; or

4.1.3.5 There is no formulary alternative.

4.2 Prior Authorizations

Some medications require prior authorization before being dispensed through the mail order program or by a retail network pharmacy. Medications requiring prior authorization include, but may not be limited to, those established as such by the Government, brand name medications with a generic equivalent, medications with age limitations, and medications requiring a quantity limit override. Before a prescription is dispensed, the contractor shall check to see if a prior authorization for the medication in question currently exists. Prior authorizations for DC dispensings will be made

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available by PDTS. If a valid authorization exists, the contractor shall dispense the prescription. If a prior authorization has previously not been completed, the contractor shall complete a prior authorization review before the prescription can be dispensed. Drugs requiring prior authorization, prior authorization forms, and review criteria can be found at www.tricare.osd.mil/pharmacy.

Note: Government review criteria are not available for all circumstances requiring prior authorization. If Government review criteria are not available, the contractor shall develop review criteria for these circumstances. For example, there is no Government-provided review criteria for quantity limit overrides.

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