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TRICARE  
MANAGEMENT ACTIVITY

MB&RS

CHANGE 74  
6010.54-M  
APRIL 7, 2008

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL  
FOR  
TRICARE POLICY MANUAL (TPM)

The TRICARE Management Activity has authorized the following addition(s)/  
revision(s) to the 6010.54-M, issued August 2002.

**CHANGE TITLE:** IMPLEMENTATION OF FOREIGN FEE SCHEDULE(S)

**PAGE CHANGE(S):** See page 2.

**SUMMARY OF CHANGE(S):** Foreign fee schedule for the Philippines and  
Panama.

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

This change is made in conjunction with Aug 2002 TRM, Change No. 73.

A handwritten signature in black ink, appearing to read "Reta Michak".

Reta Michak  
Chief, Office of Medical Benefits  
and Reimbursement Systems

ATTACHMENT(S): 25 PAGE(S)  
DISTRIBUTION: 6010.54-M

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

**CHANGE 74**  
**6010.54-M**  
**APRIL 7, 2008**

**REMOVE PAGE(S)**

**INSERT PAGE(S)**

**CHAPTER 1**

Section 17.1, pages 1 and 2

Section 17.1, pages 1 and 2

**CHAPTER 12**

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Section 4.2, pages 5 and 6

Section 4.2, pages 5 and 6

Section 7.1, pages 5 through 11

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Section 10.1, pages 1 and 2

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Section 11.1, pages 25, 26, 33 and 34

Section 11.1, pages 25, 26, 33 and 34

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## HEALTHCARE COMMON PROCEDURE CODING SYSTEM (HCPCS) "C" AND "S" CODES

ISSUE DATE: November 6, 2007

AUTHORITY:

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### I. HCPCS "C" AND "S" CODES

C1000 - C9999; S0000 - S9999

### II. DESCRIPTION

A. HCPCS "C" codes include device categories, new technology procedures, and drugs, biologicals and radiopharmaceuticals that do not have other HCPCS assigned.

B. HCPCS "S" codes are temporary codes used by the private sector to report drugs, services, and supplies for which there are no national codes.

### III. POLICY

A. Upon implementation of TRICARE's Outpatient Prospective Payment System (OPPS), HCPCS "C" codes shall be paid according to OPPS guidelines as outlined in the TRICARE Reimbursement Manual (TRM), [Chapter 13](#). For hospital outpatient department (HOPD) services provided prior to the implementation of TRICARE's OPPS, and thereafter, for services by exempt OPPS hospitals, the contractor shall allow payment of HCPCS "C" codes consistent with current policy as stated in the TRM, [Chapter 1, Section 34, paragraph IV.B](#).

B. Under TRICARE, "S" codes are not reimbursable except as follows:

1. S9122, S9123, and S9124 for the ECHO respite care benefit and the ECHO Home Health Care (EHHC) benefit; and

2. S0812, S1030, S1031, S1040, S2066, S2067, S2068, S2075, S2076, S2077, S2083, S2202, S2360, S2361, S2400, S2401, S2402, S2403, S2405, S2411, S3818, S3819, S3820, S3822, S3823, S8185, S8265, S8270, and S9430 for all beneficiaries; and

3. S5108 for direct Educational Interventions for Autism Spectrum Disorders (EIA) services provided to TRICARE beneficiaries and S5110 for training services provided to family members of beneficiaries receiving EIA services under the Department of Defense (DoD) Enhanced Access to Autism Services Demonstration. (See the TRICARE Operations Manual (TOM), [Chapter 20, Section 10](#)).

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"S" CODES

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C. Under TRICARE, HCPCS code S9999 is a recognized code for purposes of reporting sales tax but is not payable.

IV. EXCLUSIONS

HCPCS "C" codes are not allowed to be billed by independent professional providers.

- END -

## TRICARE OVERSEAS PROGRAM (TOP)

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- 4) Address the MTF Partnership Program in the Commander's annual statement of assurance.
- b. Report annually to the TMA Executive Director, through their TAO Director and Surgeon General, on all Internal Partnership Agreements. The report should include information on the number of Internal Partnership Agreements in place, new Agreements and expired/cancelled Agreements during the reporting period, the medical service discipline or provider category associated with the Agreement, and an annual justification (see [Enclosure 4](#)) of the Partnership Program which supports continuation/modification of the Partnership Program and individual Agreements. The report will be due annually in sufficient time for consideration in development of the TRICARE Overseas Area Health Services Plan. The TMA business case analysis (BCA) guidance will be used to conduct BCAs (see [Enclosure 5](#)). If MTFs have questions on how to conduct a BCA, each service Surgeon's General Support Office is listed in [Enclosure 1](#).
- c. Analyze potential applications of the Partnership Program on a case-by-case basis and make a determination prior to entering into each Internal Partnership Agreement that all of the following criteria are met:
  - 1) Use of the Partnership Program will meet a need for health care services that is not adequately being met by, and cannot be met with, existing MTF resources.
  - 2) Use of the Partnership Program is more economical to the Government than referring the need for health care services to the civilian community under TRICARE.
  - 3) Use of the Partnership Program is consistent with the mission of the MTF.
  - 4) Use of the Partnership Program is consistent with high standards of quality health care established for military treatment facilities.
- d. In applying the criteria listed in paragraph 4.c. above, take into account the following points of consideration:
  - 1) In verifying an unmet need for health care services, consider appointment waiting times, number of Nonavailability Statements issued for a particular service, TRICARE use in the area, and other pertinent factors.
  - 2) In reviewing cost impacts, make a comparison between TRICARE costs for the health care service in the community without use of the Partnership Program and providing the service through the Partnership Program. The negotiated rate(s) for each Agreement should be a discounted rate off the applicable TRICARE CMAC rate(s) in the state of Alaska, [the Philippines](#), [Panama](#), or a negotiated fee schedule in TOP areas appropriately discounting the host nation rate which would normally be applicable if the beneficiary had received care in a "downtown" host nation setting. All negotiated rates shall take into account the extent, if at all, that the Partnership Program provider will be supported by his or her own personnel and other resources under his or her direct control and supervision.

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- 3) Ensure that the Agreement does not compromise the mission of the facility, and that the health care resources to be provided are consistent with the level and type of health care resources generally provided by the MTF, including appropriate consideration of the availability/adequacy of clinical and administrative support and the impact in the areas of ancillary services, appointment and scheduling, etc. resulting from the Internal Partnership Agreement.
- e. Ensure that all liability issues relating to the Partnership Program are properly addressed and ensure that the civilian Partnership Program Provider has sufficient liability insurance coverage to protect TRICARE beneficiaries as well as the government.
- f. Provide quality assurance controls through the medical staff appointment and reappointment procedures, the specific delineation of clinical privileges, periodic in-depth health care provider review and appraisal, and the stipulation that Partnership Providers adhere to MTF instructions and medical staff bylaws to the same extent required of Military Department health care providers. In addition, Partnership Providers shall be required to comply with the state of Alaska or host nation laws, tax requirements, and applicable licensing requirements, as well as TRICARE requirements for approved authorized provider status. The usual Service procedures will be used to ensure notification of the Federation of State Medical Boards, the National Practitioner Data Bank, and TMA Executive Director (or designated TMA Partnership Program Manager) of those practitioners who have had their clinical privileges limited, suspended, or revoked while a participant in the Partnership Program.
- g. Monitor partnership visits on a quarterly basis to ensure there is no abuse of the system by partnership providers scheduling medically inappropriate visits. The MTF and applicable service will determine how to monitor this.
- h. Ensure that health care services provided TRICARE beneficiaries under the terms of the Partnership Program are consistent with authorized TRICARE benefits established by regulation and policy. An Internal Partnership Agreement may contain a provision to allow for MTF supplemental care funds to be used to pay a Partnership Program provider for care furnished to **ADSMs** or for non-active duty TRICARE beneficiaries only if payment to civilian sources of care would otherwise be authorized in accordance with DoD policy on use of supplemental care funds.
- i. In overseas locations, excluding U.S. Territories and the state of Alaska where Medicare is the primary payor, Military Treatment Facilities have the option of offering health care, services under the Internal Partnership Agreement to Medicare-eligible beneficiaries, including TRICARE For Life (TFL) eligibles enrolled in Medicare Part B. Prior to offering any such services to Medicare-eligible beneficiaries under an Internal Partnership Agreement, a determination must be made that such care will be cost effective based on the required BCA and final approval of the Internal Partnership Agreement must be granted.
- j. Ensure that providers who are potential participants in the Partnership Program are given fair selection opportunities to participate in the program through appropriate notification of opportunities, such as notice to local medical and professional societies, and objective selection standards.

**ENCLOSURE 1      SAMPLE OF OVERSEAS TRICARE AREA OFFICE (TAO) DIRECTOR TOP PREFERRED PROVIDER NETWORK AGREEMENTS**

**TRICARE OVERSEAS PROGRAM (TOP) PREFERRED PROVIDER NETWORK AGREEMENT**

**MEMORANDUM OF UNDERSTANDING (MOU)**

This MOU establishes an agreement between a Host Nation Health Care Provider and the local U.S. Military Commander. The purpose of the agreement is to facilitate, when care is not available in a United States Military hospital or clinic, 1) access for U.S. Department of Defense (DoD) beneficiaries to quality Host Nation Health Care Providers, 2) efficient systems for prompt payment to those health care providers of their services and 3) coordination of health care resources of the Host Nation Health Care Delivery System and the U.S. DoD Health Care Delivery System.

Host Nation TRICARE Overseas Program Preferred Provider

Military Treatment Facility (MTF), Type, Service, City or

in Geographically Isolated Areas, the Military Community, Service City

**A. GENERAL:**

1. This MOU is entered into by and between the USMTF Commander or, in geographically isolated areas the U.S. Military Community Commander (referred to in this agreement as the U.S. Military Commander or designee) and a Host Nation Health Care Provider (referred to as the Preferred Provider).

2. This MOU establishes the basis for participation in the TOP Preferred Provider Network (PPN) and the conditions for providing services to TRICARE eligible beneficiaries. All terms of this MOU are in addition to, and not instead of, the terms, conditions, and requirements established by the regulations, and policies with regard to the administration of TRICARE and the treatment of active duty service members (ADSMs). The TOP Preferred Provider may review these regulations and policies by contacting the MTF Commander's designated TOP Network Coordinator or the TOP Overseas TAO Director for the area in which services are being provided for assistance in obtaining this information. (The names, addresses and telephone numbers for these individuals will be provided upon finalizing this agreement).

3. This MOU does not provide a guarantee or commitment by the U.S. Military Commander or designee of any specific or general number or level of beneficiary referrals to the TOP Preferred Provider.

**B. TERMS OF THE MOU:**

1. The U.S. Military Commander or designee, shall:

a. Designate a TOP local Network Coordinator (NC), whenever possible, who may act in behalf of area TOP Overseas TAO Director in the creation and ongoing maintenance of the local TOP PPN. The overseas TAO Director/NC will be the main interface for the TOP Preferred Provider to obtain guidance and training regarding, 1) TRICARE issues, 2) Active Duty Centrally Managed Allotment (CMA), 3) Supplemental Care claims processing, 4) DoD eligibility and 5) use of other U.S. Military medical resources (i.e., Medical Evacuation, MTF referrals).

**ENCLOSURE 1    SAMPLE OF OVERSEAS TRICARE AREA OFFICE (TAO) DIRECTOR TOP PREFERRED PROVIDER NETWORK AGREEMENTS (CONTINUED)**

b. Inform and update both the TOP Preferred Provider and the TOP Overseas TAO Director of their designated TOP local Network Coordinator's name and telephone numbers and any changes to them.

c. Discuss any requested modification to this MOU with the potential TOP Preferred Provider and submit these modifications/proposals to the TOP Overseas TAO Director for coordination with TRICARE Management Activity - Aurora for consideration/approval.

d. Review all of the potential TOP Preferred Provider's credentials to ascertain their compliance with host nation standards.

e. Encourage eligible beneficiaries (if care cannot be provided in a U.S. Military hospital or clinic), to receive health care services from a TOP Preferred Provider.

f. Use TOP Preferred Providers when it is determined that an ADSM requires referral services to a host nation provider.

g. Establish a mechanism that allows for review of beneficiaries feed back and appraisal of the TOP Preferred Provider's services (Beneficiary Survey).

h. Forward a copy of the completed MOU to the TOP Overseas TAO Director or their designee.

2. The TOP Preferred Provider shall:

a. Practice no discrimination based upon sex, race, color, creed, or religion. The TOP Preferred Provider will not be requested to perform service(s) that violate the provider's medical ethics or host nation law.

b. Maintain medical records for all U.S. beneficiaries treated and make those records available for inclusion into the beneficiary's official U.S. Military medical record.

c. Accept and assist all eligible beneficiaries who seek emergency care.

d. After review of MTF referral or other predetermined authorization documents, or individual payment agreements, accept and assist all eligible beneficiaries who seek routine care with the intent to use payment mechanisms of either TRICARE, Supplemental Care, CMA or private insurance.

e. Verify eligibility of the beneficiary, by means of the beneficiary's identification card (I.D. card) and assist TRICARE beneficiary with completion of the TRICARE claim form.

f. Provide claim filing assistance to U.S. DoD civilian employees that have private health insurance and establish with the patient a plan for the coordination of medical bill payment. The local overseas TAO Director/NC is available to assist in this matter but, like the military in general, has no authority to influence the processing of claims by individual private insurance companies.

g. Acknowledge that TRICARE is always second payer if the beneficiary has Other Health Insurance (OHI), and that all medical bills must be filed with the OHI first.

**ENCLOSURE 1      SAMPLE OF OVERSEAS TRICARE AREA OFFICE (TAO) DIRECTOR TOP PREFERRED PROVIDER NETWORK AGREEMENTS (CONTINUED)**

h. Submit billings priced in accordance with the standards and generally accepted practice of the country where the care is rendered (unless modified by this agreement). **In the locations where TRICARE has established fee schedules, billings shall be reimbursed at the lower of the billed charges or TRICARE's established fee schedule.** Submit billings not later than 90 days following the date of treatment together with a completed TRICARE claim form (when applicable). Billings will include the following minimum information:

1. TOP Preferred Provider's complete physical and billing address, in letterhead format.
  2. Itemization of costs and services rendered.
  3. TOP Preferred Provider's Identification Number assigned by the TRICARE claims processor upon submission of initial claim.
  4. The patient/beneficiary's name and date of birth.
  5. The sponsor's Social Security Number.
  6. The patient/beneficiary's diagnosis (please note: release of information authorization is provided on the TRICARE claim form).
  7. Beneficiary signature.
  8. Other health insurance information including amount paid by OHI.
- i. Demand no payment from the eligible beneficiaries before treatment is rendered.
- j. After filing a claim, await a claim disposition from the overseas claims processor and notify the TOP Overseas TAO Director/NC if a claim disposition is not received, from the TRICARE claims processor, within 35 days of filing the claim.
- k. Review the TRICARE Explanation of Benefits (EOB) and immediately contact the overseas claims processor in the event of a discrepancy.
- l. Demand no payment from referred TRICARE Prime beneficiaries until the medical claim has been processed and patients' cost (if any) is identified.
- m. Demand no prepayment from other Department of Defense beneficiaries for inpatient care.
- n. Collect from the eligible beneficiary only those fees that are determined, by the EOB, to be the beneficiary's responsibility.
- o. Provide emergency services to ADSMs on the same basis as the TRICARE beneficiary but coordinate payment and preauthorization for any routine and elective procedures, first, with the local U.S. Military Commander or designee, such as TGRO or TPRC call centers.
- p. Notify the U.S. Military Commander or designated TOP Overseas TAO Director/NC when any eligible beneficiary is hospitalized and assist with the coordination of possible transfer to the USMTF. Notification will be initiated as soon as possible and transfers will be accomplished as soon as clinically appropriate.

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TRICARE AREA OFFICE (TAO) DIRECTOR REQUIREMENTS

**ENCLOSURE 1      SAMPLE OF OVERSEAS TRICARE AREA OFFICE (TAO) DIRECTOR TOP PREFERRED PROVIDER NETWORK AGREEMENTS (CONTINUED)**

q. When a transfer or referral back to a USMTF is not possible, any additional referrals or transfers to civilian sources shall, when clinically feasible and appropriate, be accomplished within the TOP PPN.

r. Participate in the program which encourages the TOP Preferred Provider to have U.S. non-controlled substance prescriptions filled by their local USMTF when the program is available. Check with the TOP Overseas TAO Director/NC for more information.

s. Display the sign, provided by the TOP Overseas TAO Director/NC which designates them as a TOP Preferred Provider.

t. Requested provider information which may be as a summary of the provider's qualifying criteria and may be used to assist ADSMs and beneficiaries with selection of a provider.

u. Inform the NC, 30 days, prior to temporary or permanent cessation of services.

3. TOP and the claims processor will ensure that:

a. All MOUs will be included in the TOP Central Health Care Finder System and the TOP Preferred Provider's name and provider identification number will be recorded with the TRICARE claims processing contractor.

b. All claims are processed (normally within 30 days) and when applicable, payments made directly to the Preferred Provider or billing agent in amounts or percentages (as illustrated in the below matrix) which corresponds to the patient's eligibility status (at the time the care was rendered). Please see below:

	PRIME TOP		STANDARD TOP	
	ADSMs	ADFMs	ADFMs	RETIRES & FAMILY MEMBERS
<b>INPATIENT</b>	100% of all authorized services	100% of all referred covered services	Greater of \$25.00 or \$11.90/day of inpatient hospital care	Lesser of \$414.00/day or 75% of all covered services plus 75% of all covered professional services
<b>OUTPATIENT</b>	100% of all authorized services	100% of all referred covered services	80% of all covered services except deductible	75% of all covered services except deductible

c. If the TRICARE beneficiary's sponsor is an ADSM, and the beneficiary does not have OHI, the TRICARE claims processor will pay in full all TRICARE covered health services. If the beneficiary has OHI, the TRICARE claims processor will process the claim after the OHI has paid its share. The payment combinations will not exceed the total of the original bill.

d. If the TRICARE beneficiary's sponsor is not an ADSM and the beneficiary does not have OHI, the TRICARE claims processor will pay 75% of the TRICARE covered charges for inpatient care. For outpatient care, TRICARE pays 75% of the covered services after the patient has met a \$150/person or \$300/family per fiscal year (1 October - 30 September) deductible. If the beneficiary has OHI, TRICARE will process the claim after the OHI has paid its share. The payment combinations will not exceed the total of the original bill.

e. Payments will be made directly to the TOP Preferred Provider in a timely manner.

**ENCLOSURE 1      SAMPLE OF OVERSEAS TRICARE AREA OFFICE (TAO) DIRECTOR TOP PREFERRED PROVIDER NETWORK AGREEMENTS (CONTINUED)**

f. The TOP Preferred Provider will be notified of any additional documentation that may be needed to process the claim in a timely manner. The claims processor will also provide the TOP Preferred Provider with a TRICARE/CHAMPUS Explanation of Benefits (CEOB) for every claim processed. The CEOB can be used to determine account status and for reconciliation.

g. The TOP Preferred Provider will be provided claim forms, informational materials and staff training.

h. Telephonic claims disposition, benefit coverage guidance and on site visits will be performed to the TOP Preferred Provider when it is determined to be necessary by the TOP local Overseas TAO Director/NC.

**C. QUALITY ASSURANCE TERMS:**

1. The TOP Preferred Provider will provide a resume, education certificates, license(s) to practice medicine and specialty, if designated, and any additional qualifications/updates, upon request, to the U.S. Military Commander or designee.

2. The U.S. Military Commander or designee will ensure that all required credentials are obtained and reviewed by a qualified medical authority to determine their compliance with host nation and U.S. Military criteria, prior to signing the MOU and shall exclude any provider if a written extension is not granted by the Military Commander or TOP Overseas TAO Director.

3. The U.S. Military Commander, or designee, will, in accordance with the Privacy Act, compile and maintain all credentials associated with the local TOP Preferred Provider Network. These files will be made a part of any inspection or review of the quality that looks at the quality standards within the USMTF or other Military Service specific Command Inspections.

4. The U.S. Military Commander or designee will periodically conduct beneficiary surveys to provide feedback about the TOP Preferred Provider and staff. These surveys will be based upon non-clinical aspects of care rendered by the TOP Preferred Provider and their staff. The results of these surveys will be shared with the specific TOP Preferred Provider, to communicate those areas of proficiency and areas deemed unsatisfactory.

5. If after discussions between the U.S. Military Commander or designee and the TOP Preferred Provider, a situation is deemed unsatisfactory and cannot be resolved, the U.S. Military Commander or designee may immediately exclude (temporarily or permanently) the TOP Preferred Provider from the TOP Preferred Provider Network.

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**ENCLOSURE 1 SAMPLE OF OVERSEAS TRICARE AREA OFFICE (TAO) DIRECTOR TOP PREFERRED PROVIDER NETWORK AGREEMENTS (CONTINUED)**

6. The U.S. Military Commander's, or designee's, medical authority will communicate with the TOP Preferred Provider about any issues pertaining to clinical aspects of medical care provided to U.S. DoD beneficiaries covered by this MOU. Communication will be made with the intent of understanding and correcting the issues. If, in the opinion of the U.S. Military Commander, or designee, the issue is of such a nature as to potentially place undue risk on the ADSM or beneficiary, the U.S. Military Commander or designee may immediately exclude (temporarily or permanently) the TOP Preferred Provider from the TOP PPN. Appeals regarding exclusion from the TOP PPN will be performed by the area TOP Overseas TAO Director. (The names of the MTF medical authority and the area TOP Overseas TAO Director will be provided by the TOP Overseas TAO Director/NC upon finalization of this MOU).

D. OTHER CONSIDERATIONS:

1. No parties to this MOU shall assign, transfer, or otherwise dispose of this MOU or any of its interest to any other person or entity without the other party's written consent.
2. No parties to this MOU shall make any representations to U.S. DoD beneficiaries regarding the TOP Provider Network or the TOP Preferred Provider's status, except accurate statements consistent with the terms of the MOU.
3. The TOP Preferred Provider, the U.S. Military Commander or designee, acknowledge that noncompliance with the terms of this MOU may result in immediate cancellation initiated by any party.
4. All parties understand that this MOU is not a contract under the U.S. Federal Acquisition Regulations (FAR) and other U.S. Federal procurement laws, regulations and procedures.
5. This MOU may be canceled without cause by either of the participating parties upon 30 day written notification to the other party.
6. The term of this MOU shall be for two years from the date of signing unless canceled as provided in paragraph D.5 of this part.
7. The MTF Commander or his designee has sole authority to extend the MOU beyond the end of the initial two year period. The local TOP Overseas TAO Director/NC will provide a written notice to the TOP PPN 90 days prior to the expiration of the MOU. Included within this notice should be a request for any updated information necessary for extension of the MOU. It is the TOP PPN's responsibility to respond to the request for an extension of the MOU. This request should be submitted by the TOP Preferred Provider not less than 30 days before the expiration date of the current MOU to ensure continued listing as a TOP PPN.

1. \_\_\_\_\_  
TOP Preferred Provider Date

2. \_\_\_\_\_  
U.S. Military Commander or designee Date

**Addendum(s) attached** Yes \_\_\_\_\_ No \_\_\_\_\_

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TRICARE AREA OFFICE (TAO) DIRECTOR REQUIREMENTS

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**ENCLOSURE 1      SAMPLE OF OVERSEAS TRICARE AREA OFFICE (TAO) DIRECTOR TOP PREFERRED PROVIDER NETWORK AGREEMENTS (CONTINUED)**

The completed MOU must be photocopied, together with any attachments and forwarded to the appropriate TOP Overseas TAO Director or their designee for inclusion in the TOP "Central Health Care Finder System" database.

Upon receipt, the TOP Overseas TAO Director/NC or their designee will issue a provider MOU number and mail a TOP Preferred Provider Certificate, to the TOP local NC, for inclusion in the TOP Preferred Provider's Welcome Packet. The TOP Overseas TAO Director or their designee will also coordinate provider registration with the claims processor.

For TOP Overseas TAO Director or their Designee Use Only

Provider Last Name \_\_\_\_\_ Date \_\_\_\_\_  
Effective Date \_\_\_\_\_ Expiration Date \_\_\_\_\_ TRICARE PPN \_\_\_\_\_

- END -



## PAYMENT POLICY

ISSUE DATE:

AUTHORITY: [32 CFR 199.17](#)

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### I. POLICY

A. With the exception of **all hospital inpatient and professional charges in Philippines and; Panama subject to the foreign fee schedule**, Puerto Rico, and prescription drugs, reimbursement of **all other** TOP beneficiary claims for overseas health care shall be based upon the billed charges. (See [Chapter 12, Section 11.1](#), TRICARE Reimbursement Manual (TRM), Chapter 1, [Sections 34](#) and [35](#), for additional guidelines). Puerto Rico claims shall be reimbursed following continental United States (CONUS) reimbursement guidelines.

B. Payment of Skilled Nursing Facility (SNF) claims from Puerto Rico and the U.S. Territories (Guam, the Virgin Islands and American Samoa) shall be processed as routine foreign claims and shall be subject to the Prospective Payment System (PPS), as required under Medicare in accordance with the Social Security Act. These SNFs will be subject to the same rules as applied to SNFs in the U.S. (see the TRM, [Chapter 8](#)):

1. Preauthorization is not a requirement for SNF care. TRICARE contractors, at their discretion, may conduct concurrent or retrospective review for Standard and TRICARE for Life (TFL) patients when TRICARE is the primary payer. The review required for the lower 18 Resource Utilization Groups (RUGs) is a requirement for all TRICARE patients when TRICARE is primary (see TRM, [Chapter 8, Section 2, paragraph IV.C.16.](#)). There will be no review for Standard or TFL patients where TRICARE is the secondary payer. The existing referral and authorization procedures for Prime beneficiaries will remain unaffected.

2. Beneficiaries in the lower 18 RUGs do not automatically qualify for SNF coverage. These beneficiaries will be individually reviewed to determine whether they meet the criteria for skilled services and the need for skilled services (see the TRM, [Chapter 8, Section 2](#)). If these beneficiaries do not meet these criteria, the SNF PPS claim shall be denied.

3. The TRICARE Managed Care Support Contractor (MCSC), South Region (hereinafter known as “overseas claims processing contractor”), at their own discretion, may collect MDS assessment data per the TRM, [Chapter 8, Section 2](#).

4. The overseas claims processing contractor shall be responsible to enter into participation agreements with SNFs in Puerto Rico, Guam, the Virgin Islands, and American Samoa.

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5. The overseas claims processing contractor, at their own discretion, may conduct any data analysis to identify aberrant SNF PPS providers or those providers who might inappropriately place TRICARE beneficiaries in a high RUG. The contractor shall also assist the TRICARE Area Office (TAO) Directors in obtaining/providing SNF data, for conducting any SNF PPS data analysis they deem necessary.

6. The overseas claims processing contractor shall be required to submit the quarterly report to the government contractor as designated by TRICARE Management Activity (TMA) as required by the TRM, [Chapter 8, Section 2](#).

C. Balance billing provisions do not apply to TOP beneficiary claims for TOP overseas health care paid as billed.

D. For health care rendered in Puerto Rico and in the U.S., reimbursement for all TOP beneficiary care shall follow the TRICARE payment policies except as outlined in [paragraph I.E.](#)

E. Non-assigned provider claims for active duty service member (ADSM) CONUS health care shall be paid following normal TRICARE CONUS reimbursement rules for institutional and non-institutional care. The contractor shall make every effort to obtain the provider's agreement to accept, as payment in full, first a rate within the 100% CHAMPUS Maximum Allowable Charge (CMAC) limitation and then second, 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 TAO Director, as the designee of the Chief Operating Office (COO), TMA, to ensure that the patient does not bear any out-of-pocket expense. The waiver request shall include the patient name, ADSM's location, services requested (CPT-4) codes, CMAC rate, billed charge, and anticipated negotiated rate. The contractor must obtain approval from the TAO Director before the negotiation can be concluded. The contractors shall ensure that the approval 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.

1. TOP ADSM who have been required by the provider to make "up front" payment at the time services are rendered will be required to submit a claim to the contractor with an explanation and proof of such payment. If the claim is payable, the contractor shall allow the billed amount and reimburse the ADSM for charges on the claim. After processing the claim, the contractor shall initiate recoupment action from the non-participating provider for any amount above the maximum allowed by law.

2. In no case shall a uniformed service member be subjected to "balance billing" or ongoing collection action by a civilian provider for emergency or authorized care. If the contractor becomes aware of such situations that they cannot resolve, they shall pend the file and forward the issue to the appropriate TAO Director. The appropriate TAO Director will issue an authorization to the contractor for payments in excess of CMAC or other applicable TRICARE payment ceilings, provided the TAO Director has requested and has been granted a waiver from the COO, TMA, or designee.

## OUTSIDE THE 50 UNITED STATES AND THE DISTRICT OF COLUMBIA LOCALITY-BASED REIMBURSEMENT RATE WAIVER

ISSUE DATE: April 7, 2008

AUTHORITY: [32 CFR 199.14\(n\)](#) and [\(o\)](#)

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### I. APPLICABILITY

A. This policy is mandatory for waiver of TRICARE established reimbursement schedules for professional providers outside the 50 United States and the District of Columbia locations. Reimbursement rate waivers are available to all TRICARE eligible beneficiaries in specified locations outside the 50 United States and the District of Columbia where the government has established reimbursement rate schedules. Please reference the TRICARE Reimbursement Manual (TRM), Chapter 1, [Sections 34](#) and [35](#).

B. As the commonwealth of Puerto Rico adheres to reimbursement rates used for the 50 United States and the District of Columbia (which align with Medicare's prospective payment systems) please refer the TRM, [Chapter 5, Section 2](#) for the applicable waiver process for Puerto Rico.

### II. POLICY

A. Under this reimbursement rate waiver process, a locality-based waivers may be submitted for consideration in the waiver of professional providers receiving TRICARE established reimbursement rates:

1. If it is determined that access to specific health care services is impaired, higher payment rates may be authorized or established, by the Director, TRICARE Management Activity (TMA), for specific services that are covered under TRICARE. For specified areas outside the 50 United States and the District of Columbia, locality waivers are defined geographically as a city or country.

2. When the Director, TMA, or designee, determines beneficiary access to health care services in a locality is impaired, the Director, TMA, or designee, may establish rates, as deemed appropriate and cost efficient by the following methodologies to assure adequate access to healthcare services.

o. A percent factor may be applied or added to the allowed and established by TRICARE under the TRM, Chapter 1, [Sections 34](#) and [35](#).

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b. A prevailing charge for a specified location outside the 50 United States and the District of Columbia may be applied. TRICARE may use any appropriate methodology to substantiate and establish prevailing charges.

c. Other appropriate payment schedules, if applicable.

B. All waiver requests for specified locations outside the 50 United States and the District of Columbia shall be submitted to the Director, TRICARE Area Offices (TAOs), to ensure that the TAO agrees with such request and that all available evidence in support of the locality-based waiver request has been submitted for consideration.

C. The procedure to be followed for specified locations outside the 50 United States and the District of Columbia is as follows:

1. The Director, TAO shall validate that the access to care is impaired in localities where the government has established reimbursement schedules.

2. Who can apply:

a. Director, TAO.

b. Providers in the affected specified localities outside the 50 United States and the District of Columbia.

c. Overseas claims processing contractor.

d. TRICARE beneficiaries in the locality.

3. How to apply:

a. Applicant must submit a written waiver request to the Director, TAO. The request must specify the type of waiver the application is for and justify that access to health care services is impaired due to low TRICARE reimbursement rates.

b. Justification for the waiver must include at the minimum:

(1) Total number of providers (primary care, specialty, or other) in a designated locality.

(2) Mix of primary/specialty providers needed to meet patient access standards (refer to the Department of Defense (DoD) access standards. Example, DoD access standards require one Primary Care Physician (PCP) per 1,000 beneficiaries).

(3) Current number of providers who accept or work with TRICARE.

(4) Number of eligible beneficiaries in the locality.

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- (5) A description of any efforts that have been attempted to locate alternative providers of service, as well as the results of those efforts.
- (6) Availability of Military Treatment Facilities (MTFs) and MTF providers, if applicable.
- (7) Geographic characteristics or other unique characteristics.
- (8) Applicable defined cultural issues.
- (9) Cost effectiveness of granting a waiver.
- (10) Provider letters of intent.
- (11) Evidence of the existence and/or evidence of provider acceptance of country specific prevailing fees, usual and customary fees, or commercial fee schedules.
- (12) Other relevant factors, unique to the specified location outside the 50 United States and the District of Columbia.
- (13) Medical Readiness issues.

D. Exceptions.

1. A provider request for beneficiary payment “up front” for health care services or beneficiary payment for higher cost share amounts in specified locations outside the 50 United States and the District of Columbia, shall not be considered as a basis for requesting a locality-based waiver.

2. Any provider who has been placed on Program Integrity Watch by TMA’s Chief, Program Integrity Office, or designee, or the overseas claims processor is not eligible for a reimbursement fee waiver until removed from Program Integrity Watch status.

E. The Director, TAO or designated staff shall conduct a thorough analysis of the information submitted and supply any missing information to the waiver request. The Director, TAO shall review and forward their recommendations with a preliminary cost estimate to the Director, TRICARE Overseas Program (TOP). The Director, TOP will indicate agreement, document the receipt of the waiver and track the waiver request. The Director, TOP, will subsequently forward the waiver request to the TMA Contracting Officer (CO) and to TMA Medical Benefits and Reimbursement Systems (MB&RS). Should the Director, TOP, disagree with the TAO waiver request it shall be returned to the TAO and the request shall be cancelled. In processing waivers, the appropriate TRICARE Contracting staff (CO, Contracting Officer’s Representative (COR), etc.) along with TMA MB&RS will confer with other TRICARE analysts, other Subject Matter Experts, obtain an Independent Government Cost Estimate (IGCE), and/or perform additional analysis to ensure that the requested increase in reimbursement shall alleviate access problems.

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F. Disapprovals by the Director, TAO, will be forwarded to the Director, TOP, for recording purposes, but will not be forwarded for additional action or waiver process completion.

G. Final Authority. The Director, TMA, or designee is the final approval authority. A decision by the Director, TMA, or designee to authorize, not authorize, terminate, or modify the authorization of higher payment amounts is not subject to appeal or hearing procedures. The Director, TMA, or designee has the discretion to review at unspecified intervals any previously enforced decision for fee schedule modifications, revisions, reversals, or other actions as he/she deems appropriate.

H. Implementation of waivers in specified areas outside the 50 United States and the District of Columbia. If the Director, TMA, or designee approves a higher payment rate for certain services in a locality, reimbursement rates for those procedure codes in those locations would be adjusted by the overseas claims processor, in order to improve the access to services.

- END -

O. Third Party Liability (TPL).

1. The overseas claims processing contractor shall reimburse TOP claims suspected of TPL and then develop for TPL information. Upon receipt of the information, the overseas claims processing contractor shall refer claims/documentation to the appropriate Judge Advocate General (JAG) office, as outlined in the TOM, [Chapter 11, Addendum B](#), except for TGRO contractor/TPRC claims.

2. For TGRO contractor and TPRC claims involving TPL, the overseas claims processing contractor shall pay the claim and then follow procedures for obtaining the required TPL information. Upon receipt of the information, the overseas claims processing contractor shall refer the TPL claims to the appropriate overseas TAO Director for action/review. If the overseas TAO Director determines that the claims involves TPL, the overseas TAO Director is responsible for forwarding the claims to the appropriate JAG office as indicated in the TOM, [Chapter 11, Addendum B](#).

P. Fraud and Abuse.

1. The overseas claims processing contractor, when processing overseas claims including the TGRO contractor claims shall follow the Fraud and Abuse requirements outlined in the TOM, [Chapter 14](#).

2. In cases involving check fraud, the overseas claims processing contractor is not required to reissue checks until the investigation is finalized, fraud has been determined, and the overseas claims processing contractor has received the money back from the investigating bank.

3. The TGRO contractor and TPRC is required to notify appropriate overseas TAO Directors and the overseas claims processing contractor in writing of any new or ongoing fraud and abuse issues.

Q. Reimbursement/Payment Of Overseas Claims.

1. When processing TOP claims, the overseas claims processing contractor shall follow the reimbursement payment guidelines outlined in [TRM, Chapter 1, Sections 34 and 35 and Chapter 12, Section 10.1](#) and the cost-sharing and deductible policies outlined in [TRM, Chapter 2, Section 1 and Chapter 12, Sections 2.1 and 2.3](#) and shall:

a. Reimburse claims for host nation services/charges for care rendered to TOP eligible beneficiaries which is generally considered host nation practice 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. For professional services rendered in the Philippines and Panama, reimbursement shall be the lower of the billed amount or the TRICARE allowable amount as established in [TRM, Chapter 1, Sections 34 and 35](#). The balance billing provision will be applied.

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

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- c. Not reimburse for administrative charges billed separately on claims.
- d. Determine exchange rate as follow:
  - (1) Use the exchange rate in effect on the ending date that services were received unless evidence of OHI and then the overseas claims processing 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;
  - (2) Use the ending dates of the last service to determine exchange rates for multiple services.
  - (3) Use the exchange rate in [paragraph V.Q.1.d.\(1\)](#) to determine deductible and co-payment amounts, if applicable, and to determine the amount to be paid in foreign currency.
- e. The overseas claims processing contractor shall code lump sum payments instead of line items to minimize conversion problems.
- f. Provider claims for all overseas locations (excluding TGRO contractor/TPRC claims and claims from Korean providers) will be paid in foreign currency. TGRO contractor/TPRC claims and claims from Korean providers will be paid in U.S. dollars.
- g. 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.
- h. The TGRO contractor and TPRC claims shall be paid in U.S. dollars. Payment shall be made via EFT as requested. The payment will be issued weekly for all claims finalized during that week. The TGRO contractor and TPRC shall provide the overseas claims processing contractor necessary banking information for the EFT payment.
- i. For TGRO contractor and TPRC claims, the overseas claims processing contractor shall provide a Wire Transfer Reconciliation Report (WTRR) by overseas region, as required, to the TGRO contractor and the respective overseas TAO Directors no later than 15 days in the month following the report period. At a minimum, each WTRR shall contain, DMIS-ID sponsor name, sponsor SSN, patient name, dates of service, and country. The WTRR shall also include provider name, amount of payment, and the ICN. The overseas TAO Directors shall provide audit functions related to these reports for the identification of duplicate payments necessitating recoupment. When the overseas TAO Director identifies claims for recoupment, they shall notify the overseas claims processing contractor to initiate recoupment.
- j. Upon payment to the TGRO contractor and TPRC, the overseas claims processing contractor shall send payment information to them at the time of transfer. At the same time, the associated EOB will be expressed mailed to the TGRO contractor and TPRC. A lag time may occur between wire transfer and EOB arrival. The TGRO contractor and TPRC

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3. The overseas claims processing contractor shall identify a specific individual and an alternate as the TOP Debt Collection Officer and shall provide direct telephone and e-mail access to resolve TOP beneficiary debt collection issues.

4. The overseas claims processing contractor shall be responsible for establishing and operating a dedicated TRICARE overseas claims/correspondence processing department with a dedicated staff. This department and staff shall be under the direction of a supervisor, who shall function as the overseas claims processing contractor's POC for TRICARE overseas claims and related operational and support services. The overseas claims processing contractor's special department for TRICARE overseas claims shall include at a minimum the following functions/requirements:

a. The overseas claims processing contractor shall provide toll-free telephone service to Germany, Italy and England Monday through Friday from 9:00 a.m. to 5:00 p.m., Central European Time or 2:00 a.m. to 10:00 a.m., Central Standard Time and staff with personnel capable of speaking German. The overseas claims processing contractor shall also provide toll-free telephone service to Puerto Rico, Monday through Friday from 9:00 a.m. to 5:00 p.m., Eastern Standard Time, or 8:00 a.m. to 5:00 p.m. Central Standard Time and staff with personnel capable of speaking Spanish. Except for Puerto Rico, toll-free lines may only be used by host nation providers, HBAs and designated POCs.

b. The overseas claims processing contractor's TRICARE overseas staff shall have the ability to translate claims submitted in a foreign language and write in German, Italian, Japanese, Korean, Tagalog (Filipino) and Spanish, or shall have the ability to obtain such translation or writing.

c. The overseas claims processing contractor shall have a designated TRICARE overseas coordinator as primary contact for the overseas TAO Directors and for the TGRO contractor and TPRC claims. The overseas claims processing contractor shall work with the TGRO contractor and the contractor responsible for processing Puerto Rico TOP Prime overseas remote area claims when necessary to resolve issues relative to the submission of TGRO contractor and TPRC submitted claims. When the overseas claims processing contractor and the TGRO contractor and/or the contractor responsible for processing Puerto Rico TOP Prime overseas remote area claims are not able to resolve issues, the unresolved issues shall be referred to the appropriate TMA COR.

d. The overseas claims processing contractor shall provide to each TOP TAO Director on-line read only access to their claims processing system. The overseas claims processing contractor shall refer beneficiary, provider, HBAs, and Congressional inquires not related to claims status to TMA Chief, Beneficiary and Provider Services Office. The overseas claims processing contractor shall refer unresolved TAO Director issues to the appropriate TMA COR.

e. The overseas claims processing contractor shall provide an internet address for receipt of customer claims status inquiries (<http://www.tricare4U.com>).

f. The overseas claims processing contractor/TAO Directors shall work together when necessary to resolve beneficiary/provider overseas claims issues.

g. The overseas claims processing contractor is required to assist traveling TOP beneficiaries to ensure beneficiary access/receipt of urgent or emergent care in the U.S.

h. U.S. Regional Directors/MTFs are required to ensure TOP Prime enrollees access to MTF care as any other Prime enrollee.

i. The overseas claims processing contractor is required to provide, upon overseas TAO Director request, documentation, for auditing purposes, of the TGRO contractor and TPRC claims.

#### T. Appeals And Hearings.

The overseas claims processing contractor is required to follow the requirements outlined in [32 CFR 199.10](#), [32 CFR 199.15](#), and the TOM, [Chapter 13](#) related to the appeals and hearing process. The overseas claims processing contractor is responsible for notifying TOP Prime and Standard beneficiaries of denial or preauthorization requirements unless the beneficiary is a TOP Prime enrollee in remote overseas areas. For TGRO contractor and TPRC claims, the appeals and hearing process is amplified as follows:

1. Pre-Authorization. The TGRO contractor and TPRC shall be responsible for providing initial determinations and notifying the beneficiary (ADSM/ADFM) of any denial of services which are non-covered, including appeal rights, in writing.

2. Denial of Treatment for ADFM. When authorization is denied by the TGRO contractor and TPRC after initial denial determination by the TGRO contractor and TPRC, the appeals procedures of the [32 CFR 199.10](#) apply for the appealing party.

3. Denial of Treatment for ADSM. When authorization is denied by the TGRO contractor and TPRC after initial determination by the TGRO contractor and TPRC, the ADSM or their appointed representative may appeal the denial of benefit/treatment to the appropriate TAO Director. The decision of the appropriate TAO Director is the final determination. The overseas claims processing contractor is required to maintain a log by TAO Director of overturned disputes.

4. Reconsiderations. The TGRO contractor and TPRC initial denial determinations shall be appealed/directed to the overseas claims processing contractor. The overseas claims processing contractor shall perform the reconsideration review.

5. Improperly Authorized Treatment. Should the overseas claims processing contractor determine that earlier treatment authorized by the TGRO contractor and TPRC was improperly authorized, and the TGRO contractor and TPRC wishes to dispute that determination, the matter shall be submitted to the TAO Director for final review. The overseas claims processing contractor shall maintain a log by TAO Director of all overturned disputes.

6. Government established fee schedules are non-appealable.

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