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TRICARE
MANAGEMENT ACTIVITY

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CHANGE 76
6010.54-M
APRIL 15, 2008

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE POLICY MANUAL (TPM)

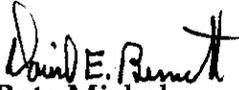
The TRICARE Management Activity has authorized the following addition(s)/
revision(s) to the 6010.54-M, issued August 2002.

CHANGE TITLE: REPORTS

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change modifies reporting requirements for
overseas claims. This change will only impact the overseas claims processor,
Wisconsin Physicians Service (WPS) as a subcontractor under the Humana South
Region Managed Care Support contract. See pages 3 through 5.

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


Reta Michak
Chief, Office of Medical Benefits
and Reimbursement Systems

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

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CHAPTER 12

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SUMMARY OF CHANGES

CHAPTER 12

1. Section 11.1:
 - a. Page 13, paragraph V.E.1. Clarified the data submission.
 - b. Page 13, paragraph V.E.21. Clarified that the report is all providers of pharmacy services.
 - c. Page 26, paragraph Q.i. Changed the submission time from monthly to weekly
 - d. Pages 35 - 38, paragraph V.V. Removed duplicate language and referenced Section 11.2. (The Monthly Summary Progress Report and the Quarterly Host Nation Provider Report requirements have been deleted)
2. Section 11.2 (New Section):
 - a. Page 1, paragraph I.B. Specified submission requirements for deliverables.
 - b. Page 2, paragraph I.G. Clarified that the contractor is to submit a data dictionary defining each of the fields within a report.
 - c. Page 2, paragraph II.B. Corrected the reporting requirements to reflect current reporting practices for the telephone report. Renamed the "Toll-Free Telephone Report" to "Foreign Customer Service Telephone Report."
 - d. Page 3, paragraph II.C. Corrected the reporting requirements for the Weekly and Monthly Cycle Time and Aging reports to reflect current reporting practices.
 - e. Page 4, paragraph II.F.2. Added the requirements for the Weekly TGRO/TPRC Denied and Removed Claims Report.
 - f. Page 4, paragraph II.F.3. Listed the Weekly Claims Status/Location Report. It is currently being reported, but was not listed in the manual.
 - g. Page 5, paragraph II.F.5. Corrected the Wire Transfer Reconciliation report to reflect the weekly submission which is the current practice rather than the monthly requirement.

SUMMARY OF CHANGES (Continued)

CHAPTER 12 (Continued)

2. Section 11.2 (New Section) (Continued):

- h. Pages 5-7, paragraphs I.F.8, I.F.9, I.F.10, I.F.11, and I.F.12. Added the following new fields: processed date, CEOB message, number of days to process, lagtime (DOS to receipt), denial indicator when claim is denied in total, identification of PCM, provider specialty (taxonomy code), and enrollment health plan code, to be reported for the Monthly Paid Claims and Current Inventory Active Duty Report, Monthly Paid Claims and Current Inventory Active Duty Family Report, Monthly Paid Claims and Current Inventory TOP Remote Site Active Duty Report, Monthly Paid Claims and Current Inventory TOP Remote Site ADFM Report, Monthly Paid Claims and Current Inventory Retirees and Dependents of Retirees Report. Also, corrected the distribution of the reports to reflect current practices.
- i. Page 7, paragraph I.F.13. Added two reporting fields, TFL and TSRx, to the Monthly Total Claims by Country for ADSMs, ADFMs, Retirees, and Dependents of Retirees report.
- j. Page 7, paragraph I.F.14. Clarified that for Europe the reporting information will be broken out by network, non-network, and partnership providers for the Monthly Host Nation Network Progress Report.
- k. Page 7, paragraph I.F.15. Corrected the distribution of the Monthly Overseas Region ADSM and Other ADSM CONUS/OCONUS claims report to reflect current practices.
- l. Page 8, paragraph I.F.18. Clarified the data submission.
- m. Page 8, paragraph I.F.19. Clarified that the Annual Report of High Volume Pharmacy Providers is all providers of pharmacy services. Renamed the report Annual Report of High Volume Providers of Pharmacy Services.
- n. Page 9, paragraph III.A. Clarified for the Daily Admission/Case Management Reports that the active cases are inpatient and outpatient.
- o. Page 10, paragraphs III.I and III.J. Clarified that the Quarterly Management Report and the Semi-Annual Beneficiary Survey Summary of Findings report will be submitted to the Regional Director and the COR.

SUMMARY OF CHANGES (Continued)

CHAPTER 12 (Continued)

2. Section 11.2 (New Section) (Continued):

- p. Page 11, paragraph IV.4. Clarified that the Monthly Progress and Status Report will be submitted to the Regional Director and the COR.

TRICARE OVERSEAS PROGRAM (TOP)

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18. Effective September 1, 2002 for the Philippines, Panama and Costa Rica, providers exceeding the \$3000 per year billing cap for pharmacy service are required to submit claims using National Drug Coding (NDC).

19. For the Philippines, Panama, and Costa Rica, the overseas claims processing contractor shall, annually, review billings to determine if providers in these areas have exceeded the \$3,000 per year billing cap for pharmacy services. **The reports shall identify the provider, the provider ID, the effective date of the NDC implementation, the provider total billed amount, the allowed amount, and the total amount paid to the provider, and the total amount paid by the government.** High volume providers (determined by total pharmacy services billings exceeding \$3,000 in the previous 12 months) identified shall be sent the provider notification letter (see [Figure 12-12.2-8](#)) advising them of the TOP NDC submission requirements and payment for drugs as required in TRM, [Chapter 1, Section 15](#) and this section. The electronic report shall arrive no later than the 15th of month in which it is due. As other countries are added, the report shall include these countries.

20. For the Philippines and other nations as may later be determined by the Government, the contractor shall quarterly determine the top 10% of institutional and individual professional providers. The contractor shall return a copy of all claims received from these providers to the provider's practice address requesting the providers signature on the attestation at [Figure 12-12.2-17](#). Only the original signature of the provider is acceptable. For institutional providers, the signature shall be that of the institution's chief executive. Claims shall be pending for 35 calendar days following the mailing of the attestation and a copy of the claim. If no response is received within 35 calendar days, the contractor shall deny the claim.

21. The overseas claims processing contractor shall provide an electronic report, annually (by fiscal year), identifying all high volume overseas providers **of pharmacy services** that have exceeded the \$3000, per year billing cap for pharmacy services to the appropriate TMA COR, 16401 East Centretech Parkway, Aurora, CO 80011-9066. The reports shall identify the provider, **the provider ID**, the provider total billed amount, the total amount paid to the provider, and the total amount paid by the government. Upon receipt, the government shall review the report and may notify the overseas claims processing contractor to issue a provider notification letter (see [Figure 12-12.2-8](#)) to TMA identified overseas providers **of pharmacy services** in other countries than the Philippines, Panama and Costa Rica that have exceeded the \$3000 per year billing cap on pharmacy services. The report shall arrive by the 15th of October for the preceding fiscal year (October 1 through September 30). As other countries are added, the report shall include these countries.

22. For those providers identified annually as high volume providers (determined by total pharmacy services billings exceeding \$3,000 in the previous 12 months), the overseas claims processing contractor shall be required to submit a report annually, by country and provider, which tracks the number of claims, dollars amounts billed vs. paid before the above process was implemented and compares it to the number of claims, dollars amounts billed vs. paid after the above process was implemented. The report shall arrive no later than the 15th of the month in which it is due. As other countries are added, the report shall include these countries.

23. The CONUS claims processing contractor is not required to certify host nation providers for care received by CONUS beneficiaries (Prime/Standard) who travel overseas and required/received care.

F. Enrollment.

1. The overseas claims processing contractor is not responsible for enrollment requirements outlined in the TOM, [Chapter 6, Section 1](#), for TOP eligible beneficiaries.

2. When processing claims, the overseas claims processing contractor shall consider the requirements for Enrollment Portability, Split Enrollment, Disenrollment and TRICARE Plus outlined in the TOM, [Chapter 6](#) and related requirements outlined in this chapter.

G. Utilization Management/Authorizations.

1. The overseas claims processing contractor is not required to develop a Utilization Management Plan/Program, a Clinical Quality Management Program or develop a plan for interacting with the National Quality Monitoring contractor as outlined in the TOM, [Chapter 7](#).

2. The overseas claims processing contractor is required to advise their customers of those overseas benefits/countries requiring preauthorization/authorization before payment can be made and of the procedures for requesting preauthorization/authorization. Although beneficiaries are required to obtain authorization for care prior to receiving payment for the care requiring TOP preauthorization/authorization, TOP preauthorization/authorization may be requested following the care from the appropriate authority for issuing authorizations (see [Chapter 12, Section 8.1](#)). The overseas claims processing contractor shall document preauthorization/authorizations according to current contract requirements.

3. If medical review is required to determine medical necessity of a service rendered, the overseas claims processing contractor shall follow the requirements outlined in the TOM, [Chapter 7, Section 1](#) related to medical review staff qualifications and review processes.

4. The TOP preauthorization/authorization must be submitted with the claim or be available on Defense Enrollment Eligibility Reporting System (DEERS) or when fully implemented the TRICARE Enterprise Wide Referral and Authorization Program (EWRAP).

5. Upon instruction from the TMA Contracting Officer, Nonavailability Statement (NAS) reason for issuance codes 7, 8, and 9 will be conveyed via ANSI ASC X12N 278 transactions from the TRICARE EWRAP. When fully implemented, the overseas claims processing contractor is required to accept and store and access the NAS (care authorization) information for claims processing and other contractual purposes. When fully implemented, the overseas claims processing contractor shall no longer accept paper authorizations from MTFs. The overseas claims processing contractor must be able to receive NASs (care authorizations) in ANSI X12N 278 transactions and later referral and authorization data from the EWRAP in the form of HIPAA-compliant ANSI X12N 997 Functional Acknowledgements to the EWRAP should such acknowledgements be required and specified in the trading partner agreement between the overseas claims processing contractor and EWRAP.

6. The overseas claims processing contractor must maintain a preauthorization/authorization file.

7. When necessary, clarification of discrepancies between authorization data and data on the claims shall be made by the overseas claims processing contractor with the appropriate authorizing authority (see [Chapter 12, Section 8.1](#)).

8. The overseas claims processing contractor shall consider authorizations valid for 90 days (i.e., date of service must be within 90 days of issue date). The overseas claims processing contractor shall consider retroactive and chronic authorizations valid for the specific date/care authorized.

9. Procedures for preauthorizations/authorizations for CONUS inpatient mental health care have been developed between the overseas claims processing contractor's mental health contractor responsible for processing foreign claims and the overseas TAO Directors in coordination with the appropriate TMA COR. The mental health contractor is responsible for authorizing/review of all CONUS non-emergency inpatient mental health care for enrolled ADFM (i.e., Residential Treatment Center (RTC), Substance Use Disorder Rehabilitation Facility (SUDRF), etc.) and outpatient mental health care sessions nine and above per fiscal year for Prime overseas beneficiaries. To perform this requirement, the overseas claims processing contractor shall at a minimum provide three 24-hour telephone lines: one CONUS toll free, one commercial and one fax for overseas inpatient mental health review requirement, sample forms for use by the referring physician when requesting pre-authorization/authorization for care and the system for notification of the overseas claims processing contractor when care has been authorized. Additionally, the overseas claims processing contractor responsible for foreign claim shall:

a. Inform the beneficiary/provider if a desired facility is not a TRICARE authorized facility and offer the beneficiary/provider a choice of alternative facilities and assist with identifying CONUS facilities for referring providers.

b. Upon request, either telephonically or by fax, from a referring provider, the mental health review contractor will initiate preauthorization prior to admission for non-emergency inpatient care, including RTC, SUDRF, Partial Hospitalization Program (PHP), etc. (Essentially, all admissions defined by [Chapter 1, Section 7.1](#), as requiring preauthorization). The overseas claims processing contractor responsible for processing overseas claims will arrange ongoing utilization review, as indicated, for overseas beneficiaries admitted to any level of inpatient mental health care.

c. The review determination must conclude in either authorization or denial of care. Review results must be faxed to the beneficiary/provider within 24 hours of the request. The review and denial process will follow, as applicable the processes outlined in TOM, [Chapter 7](#).

(1) The mental health contractor will provide an opportunity to discuss the proposed initial denial determination with the patient's attending physician AND referring physician (if different providers). The purpose of this discussion is to allow further explanation of the nature of the beneficiary's need for health care services, including all factors which preclude treatment of the patient as an outpatient or in an alternative level of

inpatient care. This is important in those beneficiaries designated to return overseas, where supporting alternative level of care is limited, as well as support for intensive outpatient treatment. If the referring provider does not agree with the denial determination, then the contractor will contact the appropriate overseas TAO Director to discuss the case. The Overseas TAO Director will provide the schedule and contact information for all overseas TAO mental health advisors. The final decision on whether or not to issue a denial will be made by the mental health contractor.

(2) The mental health contractor will notify the referring provider if the patient is returning to ensure coordination of appropriate after-care arrangements, as well as facilitate discussion with the attending provider to ensure continuity of care is considered with the proposed after-care treatment plan.

d. The mental health contractor will adhere to the appeals process outlined in the TOM, [Chapter 13](#).

e. The mental health contractor will also notify the overseas claims processing contractor of the initial review determination and any pending appeals. The overseas claims processing contractor will use this information to process the claim.

f. The overseas claims processing contractor responsible for processing foreign claims shall notify the TAO Directors and TMA of any changes to phone and fax numbers.

10. If the overseas claims processing contractor has no record of referral/ authorization, prior to denial/payment of the claim, the overseas claims processing contractor will follow the TOP POS rules, assuming the service would otherwise be covered under TOP, as outlined in [Chapter 12, Section 10.2](#).

11. For other than the TGRO contractor and TPRC, the overseas claims processing 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. The overseas claims processing contractor shall provide an electronic file to be Microsoft Office compatible and sortable by all fields of all claims received without preauthorization/authorization or for services rendered by a host nation non-network provider sorted by TAO, DMIS-ID on the date of service, sponsor SSN, patient name, date of birth, date of care, Health Care Delivery Plan (HCDP) Coverage code, host nation provider of care, host nation providers address, with an ICD-9, CPT-4 code, or brief description of the purpose of the visit or reason for referral (i.e., A=No Authorization, P=Non-Network Providers) and Internal Control Number (ICN) order weekly for appropriate TAO Director review. (See [Figure 12-12.2-2](#), [Figure 12-12.2-3](#), and [Figure 12-12.2-7](#).) Upon receipt of the first claim for a TOP-enrolled ADFM submitted by a TOP host nation designated or non-designated overseas host nation provider without preauthorization/ authorization, the overseas claims processing contractor shall process the claim and waive application of POS charges for that claim. The overseas claims processing contractor shall use specific EOB messages advising the beneficiaries/host nation providers that authorizations are required on future claims to avoid POS payment. Upon receipt of the second and subsequent ADFM claims submitted by a TOP host nation designated or non-designated overseas host nation provider without preauthorization/authorization, the overseas claims processing contractor shall process the claims following POS payment procedures.

12. For the TGRO contractor and TPRC, the overseas claims processing contractor shall develop procedures for the identification and tracking of TOP enrolled claims submitted by either a beneficiary, a TOP host nation designated or non-designated overseas host nation provider without preauthorization/authorization. The overseas claims processing contractor shall provide weekly an electronic file to be Microsoft Office compatible and sortable by all fields of all claims received without preauthorization/authorization or for services rendered by a host nation non-network provider sorted by TAO, DMIS-ID on the date of service, sponsor SSN, patient name, date of birth, date of care, HCDP Coverage code, host nation provider of care, host nation provider's address, with an ICD-9, CPT-4 code, or brief description of the purpose of the visit or reason for referral (i.e., A=No Authorization, P=Non-Network Providers) and ICN order for appropriate TAO Director review (see [Figure 12-12.2-2](#), [Figure 12-12.2-3](#), and [Figure 12-12.2-7](#)). Upon receipt of the first claim for a TGRO- or TPRC-enrolled ADFM submitted without preauthorization/authorization, the overseas claims processing contractor shall process the claim and waive application of POS charges. The overseas claims processing contractor shall use specific EOB messages advising the beneficiary/host nation providers that authorizations are required on future claims to avoid POS payment. Upon receipt of the second and subsequent ADFM claims submitted without preauthorization/authorization, the overseas claims processing contractor shall process the claims following POS payment procedures.

a. The following message shall be used on TGRO EOBs in Europe when a one-time waiver of POS charges has been granted:

"This claim has been processed and paid in full. However, we have no record of the services being coordinated with the TRICARE Global Remote Overseas (TGRO) Contractor. As a TGRO enrollee, all future health care must be coordinated with TGRO or these claims will be processed at Point-of-Service rates, including annual deductibles of \$300 per individual or \$600 per family, and a 50 percent cost share that you would be responsible to pay. If you have questions regarding your TGRO enrollment, please call the TGRO contractor at (44) 20-8762-8133 or contact your local TRICARE POC for the local toll-free access number. You may also call the TRICARE Europe Centralized TRICARE Service Center at DSN: 496-7433 or commercial at (49) 6302-67-7433."

b. The following message shall be used on TGRO EOBs in TLAC when a one-time waiver of POS charges has been granted:

"This claim has been processed and paid in full. However, we have no record of the services being coordinated with the TRICARE Global Remote Overseas (TGRO) Contractor. As a TGRO enrollee, all future health care must be coordinated with TGRO or these claims will be processed at Point-of-Service rates, including annual deductibles of \$300 per individual or \$600 per family, and 50 percent cost share that you would be responsible to pay. If you have questions regarding your TGRO enrollment, please call the TGRO contractor toll-free at 800.834.5514 or collect at 215.701.2800 or contact your local TRICARE Point of Contact or the TRICARE Area Office (Latin America & Canada) toll free at 888.777.8343, option #3, or 706.787.2424, or DSN 773.2424."

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c. The following message shall be used on TGRO EOBs in TRICARE Pacific when a one-time waiver of POS charges has been granted:

“This claim has been processed and paid in full. However, we have no record of the services being coordinated with the TRICARE Global Remote Overseas (TGRO) Contractor. As a TGRO enrollee, all future health care must be coordinated with TGRO or these claims will be processed at Point-of-Service rates, including annual deductibles of \$300 per individual or \$600 per family, and 50 percent cost share that you would be responsible to pay. If you have questions regarding your TGRO enrollment, please call the TGRO contractor collect at 65-6338-9277 (Singapore) or 61-29273-2760 (Sydney) or your local TRICARE Overseas Remote Point-of-Contact or the TRICARE Area Office (Pacific) at COMM: (81)6117-43-2036, DSN: 643-2036, or toll-free 1-888-777-8343, option #4.”

d. The following message shall be used on TPRC EOBs when a one-time waiver of POS charges has been granted:

“This claim has been processed and paid in full. However, we have no record of the services being coordinated with the TRICARE Puerto Rico Contractor (TPRC). As a TPRC enrollee, all future civilian health care must be coordinated with TPRC or these claims will be processed at Point-of-Service rates, including annual deductibles of \$300 per individual or \$600 per family, and 50 percent cost share that you would be responsible to pay. If you have questions, please contact your local TRICARE Point of Contact or the TRICARE Area Office (Latin America & Canada) toll free at 888.777.8343, option #3, or 706.787.2424, or DSN 773.2424. The TPRC Call Center is available around the clock to assist you with your healthcare needs by calling toll free at 800.700.7104.”

H. Claim Development.

1. General.

a. Development of missing information shall be kept to a minimum. The overseas claims processing contractor shall use available in-house methods, overseas claims processing contractor files, telephone, DEERS, etc., to obtain incomplete or discrepant information. If this is unsuccessful, the overseas claims processing 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 overseas claims processing contractor's system must identify the claim as returned, not denied. The overseas claims processing contractor shall review all claims to ensure TOP required information is provided prior to payment.

NOTE: The overseas claims processing contractor shall accept APO/FPO for the beneficiary address.

b. The following minimal information is required on each overseas claim prior to payment.

- (1) Beneficiary/host nation provider signatures.

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.

- 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 **weekly**, a Wire Transfer Reconciliation Report (WTRR) by overseas region, as required, to the TGRO contractor and the respective overseas TAO Directors. 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 shall notify the overseas claims processing contractor of excessive delays (greater than 14 days) in receipt of the mailed EOB.

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k. Payment to Germany, Belgium, Finland, France, Greece, Ireland, Italy, Luxemburg, Netherlands, Austria, Portugal and Spain shall be made in Euros. As other countries transition to Euro, the overseas claims processing contractor shall also switch to Euros. The overseas claims processing contractor shall issue drafts/checks for German claims which look like German drafts/checks.

l. U.S. licensed Partnership providers claims for treating patients shall be paid based upon signed agreements.

m. Pay all beneficiary-submitted healthcare claims for TRICARE covered services for care received at an overseas embassy health clinic to the beneficiary. The contractor is not to make payments directly to the embassy health clinic.

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

o. 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 overseas claims processing contractor and the draft has been returned with the request.

p. Shall mail the drafts/checks and EOBs to host nation providers unless the claim indicates payment should be made to the beneficiary or TRICARE Europe, TRICARE Pacific, or TLAC ADSM. If the host nation provider has been excluded by the TAO Director from the TRICARE overseas host nation Preferred Provider Network (PPN) no payment should be made. In conformity with banking requirements, the drafts/checks shall contain the contractor's address. Drafts and EOB shall be mailed using U.S. postage. Additionally, payments/checks may be made to network providers, with an Embassy address.

q. Benefit payment checks and EOBs to Philippine providers, and other nations' providers as determined by the Government, shall be mailed to the place of service identified on the claim. No provider payments may be sent to any other address.

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

TOP ELIGIBLE STANDARD BENEFICIARIES

IF THE CLAIM IS SUBMITTED:	AUTHORIZATION REQUIRED	PROCESSING ACTION:	AND PAYMENT IS MADE IN THE FOLLOWING MANNER:
Partnership Provider	No	No deductible or cost-share	Directly to provider.
Host Nation Providers	No	TRICARE Standard cost-shares and deductibles apply.	Directly to the host nation provider in TRICARE Europe unless claims indicate pay beneficiary. All other areas as noted on the claim.
TRICARE Europe Host Nation Pharmacy	No	TRICARE Standard cost-shares and deductibles apply.	To beneficiary unless otherwise indicated on the claim form.

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MANAGED CARE SUPPORT CONTRACTOR (MCSC) RESPONSIBILITIES FOR CLAIMS PROCESSING

TOP ELIGIBLE STANDARD BENEFICIARIES (CONTINUED)

IF THE CLAIM IS SUBMITTED:	AUTHORIZATION REQUIRED	PROCESSING ACTION:	AND PAYMENT IS MADE IN THE FOLLOWING MANNER:
Retail Pharmacy Network in Puerto Rico, the U.S. Virgin Islands, and Guam	No	TRICARE Standard cost-shares and deductibles apply.	Directly to provider.
Retail Pharmacy Network in American Samoa	No	TRICARE Standard cost-shares and deductibles apply.	Directly to provider unless claim indicates pay beneficiary.
Retail Pharmacy Non-Network	No	TRICARE Standard cost-shares and deductibles apply.	Directly to host nation provider in TRICARE Europe unless claim indicates pay beneficiary. All other areas as noted on the claim.
Retail Pharmacy Non-Network when in CONUS	No	TRICARE Standard cost-shares and deductibles apply.	Pay as indicated on the claims.

REMOTE/NON-REMOTE ADFMS ENROLLED IN TOP

IF THE CLAIM IS SUBMITTED:	AUTHORIZATION REQUIRED	PROCESSING ACTION:	AND PAYMENT IS MADE IN THE FOLLOWING MANNER:
Partnership Provider	No	No deductible/cost-share.	Directly to Partnership Provider..
Outpatient Mental Health Care Session (dx 290-319).	No authorization required for first eight sessions; 9th and subsequent visits require authorization.	No deductible/cost-share.	Directly to the host nation provider in TRICARE Europe unless claim indicates pay beneficiary. All other areas as noted on the claim.
Inpatient non-urgent/emergent Mental Health Care (dx 290-319) without authorization in countries requiring authorization: Belgium, Germany, Guam, Iceland, Italy, Japan, Korea, Portugal (Azores), Spain, Turkey, the United Kingdom, and Puerto Rico or not rendered by a host nation network provider.	Yes	POS.	Directly to the host nation provider in TRICARE Europe unless claim indicates pay beneficiary. All other areas as noted on the claim.
CONUS inpatient non-emergent mental health care with authorization.	Yes	No deductible. Cost-share. Pay allowable rate for area.	Pay as indicated on the claim.
CONUS inpatient non-emergent mental health care without authorization.	Yes	POS.	Directly to the provider unless claim indicates pay beneficiary.

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MANAGED CARE SUPPORT CONTRACTOR (MCSC) RESPONSIBILITIES FOR CLAIMS PROCESSING

U. Health Insurance Portability And Accountability Act (HIPAA).

The overseas claims processing contractor shall comply with the HIPAA requirements related to foreign claims processing, in the TOM, [Chapter 21](#) and as required in this chapter.

V. Audits, Inspections, And Reports. [See Chapter 12, Section 11.2](#)

- END -

AUDITS, INSPECTIONS, REPORTS, AND PLANS

ISSUE DATE: October 15, 1999

AUTHORITY: [32 CFR 199.1\(b\)\(1\)](#)

I. GENERAL

A. TRICARE Management Activity (TMA) requires contractors to prepare and submit routine workload and management reports used to establish a uniform format for recording data on contractor operations and to provide historical data for continued evaluation of contractor performance. While the data contained in the reports are essential to TMA for purposes of program management, they are equally essential for a contractor's management of the program. A contractor is accountable for assuring that reports contain accurate and complete data. Each contractor shall prepare written procedures describing the source of information as well as the specific steps followed in the collection and preparation of data for each report. In addition, each contractor shall establish a quality assurance program to assure a high degree of reporting accuracy. All reports must be supported with sufficient documentation and audit trails by the contractor for TMA on-site and desk audit inspections.

NOTE: This section is a consolidated listing of all deliverables that are also identified within the contracts and/or the TRICARE manuals.

B. Unless otherwise specified, contractors shall submit all deliverables to TMA via the E-commerce Extranet (<https://tma-ecomextranet.ha.osd.mil>). This system permits the contractor to log on to a secure system and enter deliverables (contract plans, reports, etc.) into a provided template or upload the required deliverables. The system is accessed via the Internet through a workstation browser. The application is "thin client" meaning that no software needs to be installed on the client workstation and that no software is downloaded into the browser. Javascript and cookies need to be enabled in the browser to utilize the application. The application is best viewed at a resolution of 1024 X 768 pixels in an Internet Explorer (IE) browser. The system must be accessed using the Secure Socket Layer (SSL) protocol (<https://>) and is protected by individually assigned username and password. Access to the Extranet must be requested using the E-commerce Extranet Access Form which will be provided by the Government. While files are being submitted over the Internet, they are encrypted within the secure layer. When files are stored on the TRICARE server, they are renamed with a randomly generated name of varying length. Access to information is granted to users at the contract level. Information submitted by one contractor will not be accessible to any other contractor.

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1. Certain deliverables as identified by the Government will require entry of the required data into a report template which will be maintained on the E-commerce Extranet web site.

2. Remaining deliverables will require submission into the Extranet in a format approved by the Government to include Microsoft Office Excel, Word, PDF, or other specified format.

3. Delivery of deliverables to other Government agencies will be as specified by the Government in a method and format as determined by the Government.

C. Reports must be sortable by all fields and by TOP Region/TRICARE Area Office (TAO) Director unless a different format is specified by the Government.

D. All deliverables (plans, reports, etc.) shall be titled as listed in this section.

E. For reports where there is no data to report, the contractor shall submit a report indicating no data.

F. All reports required from the overseas claims processing contractor, the TRICARE Global Remote Overseas (TGRO) healthcare contractor, and the TRICARE Puerto Rico Contract (TPRC) healthcare contractor shall arrive no later than the 15th of the month according to the monthly, quarterly, or annual reporting schedule described below. The reports shall be sent to the appropriate TMA Contracting Officer Representative (COR) and TAO Directors.

G. The contractor shall submit a data dictionary defining each of the fields contained within a report, unless indicated otherwise within the reporting requirements.

H. The TGRO contractor and TPRC are required to provide to the Government identified Points of Contact (POCs) to receive daily, weekly, monthly, quarterly, semi-annual, and/or annual reports as required in this chapter or in the TGRO/TPRC healthcare contracts to the Government identified POCs.

II. SPECIFIC DELIVERABLES - OVERSEAS CLAIMS PROCESSING CONTRACTOR

A. The overseas claims processing contractor is required to follow the requirements outlined in the TRICARE Operations Manual (TOM), [Chapter 15](#) related to Audits and Inspections, except TOP claims shall not be included in the TMA quarterly claim audit.

B. The overseas claims processing contractor shall submit a monthly Foreign Customer Service Telephone report. The report shall include:

- Day/Week Ending
- Calls Received
- Calls Answered
- Abandon
- Calls Disconnected in 0-30 Seconds
- Calls Abandoned Over Threshold

Average Reps on the Phone
Average Talk Time
Average Wait Time
Longest Wait Time
Calls Over Threshold
Percent of all Lines Busy
Total Calls Attempting to Reach Contractor on Toll-Free Lines
Percent of Calls Answered Within 20 Seconds
Percent of Calls Answered Within 30 Seconds
Number of Calls Exceeding 30 Seconds Hold Time (entire phone call)
Number of Contacts Totally Answered During Initial Call
Number of Contacts Not Fully Completed within 10 Calendar Days
Number of Contracts Not Fully Completed Within 20 Calendar Days

C. The overseas claims processing contractor shall submit Weekly and Monthly Cycle Time and Aging reports to TMA in a format that is mutually agreed upon between the contractor and the Program Director. The overseas claims processing contractor shall process 85 percent of all TOP claims to completion within 21 days. Claims pending per government direction are excluded from this standard. However, the number of excluded claims must be reported on the weekly and monthly cycle time and aging reports. Correspondence pending due to stop payment orders, check tracers on foreign banks and conversion of currency is excluded from the routine 45 calendar day correspondence standard and the priority ten calendar day correspondence standard. However, the number of excluded routine and priority correspondence must be reported on the weekly and monthly cycle time and aging reports. A data dictionary is not required for these reports.

D. The overseas claims processing contractor is required to submit the quarterly Fraud and Abuse reports outlined in the TOM, [Chapter 14, Section 5](#).

E. The overseas claims processing contractor is required to submit the annual Fraud Prevention Savings report outlined in the TOM, [Chapter 14, Section 5](#).

F. The overseas claims processing contractor shall submit the following TOP reports, sorted by TOP Region/TAO Director:

1. SEMIWEEKLY PHILIPPINE PROVIDER CERTIFICATION REQUESTS. To assist in identifying the Philippine provider priorities identified in [Chapter 12, Section 11.1, paragraph V.E.3. - 5](#), the overseas claims processing contractor is required to send to the TMA designee provider certification requests as outlined in the references. New provider requests will be sent by the overseas claims processing contractor to the TGRO contractor and the Pacific Region TAO Director two times per week on Mondays and Wednesdays. If these days fall on a national holiday, the reports will be provided the next business day.

2. WEEKLY TGRO/TPRC DENIED AND REMOVED CLAIMS REPORT. The overseas claims processing contractor shall provide a report to the TGRO and TPRC contractors on claims submitted by these remote contractors that did not result in full payment to the remote contractors. This shall be accomplished through weekly reports, split by remote contractor, overseas region, Active Duty Service Member (ADSM) and Active Duty Family Member (ADFM), the TGRO and TPRC submitter IDs, and the TGRO/TPRC

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patient control number (TGRO/TPRC claim number). These reports should include claims submitted by the remote contractors which were completely or partially denied, rejected, removed, or redirected from the overseas claims processing contractor's claims adjudication system during the reporting period. The reports shall include all data fields reported in the weekly Wire Transfer Reconciliation Report (WTRR), as well as the provider's address and the reason for the given outcome. Reports shall be delivered via e-mail using password protected Excel documents to the appropriate remote contractor by noon (MT) on the first workday of the week following the week reported, with a copy furnished to each TAO Director.

3. WEEKLY CLAIMS STATUS/LOCATION REPORT. The overseas claims processing contractor shall provide a Claims Status/Location report on the first workday following the reporting week. This report shall be sorted to enable a count of the total number of claims pending for a specified length of time; e.g., over 30 days, over 60 days and over 120 days. The contractor shall include excluded and retained claims on each report. Unless specifically requested by TMA or unless the contractor customarily makes a run of these reports concurrent with preparation of the month-end reports to TMA, they need not balance with the end-of-month reports. The contractor shall prepare an explanation of the individual reports and interpretation of the locations specific to each report to enable the Government to effectively review the data.

4. WEEKLY DENIED CLAIMS REPORT. The overseas claims processing contractor shall provide weekly an electronic file to be Microsoft compatible and sortable by all fields of all claims received without preauthorization/authorization or for services rendered by a host nation non-network provider sorted by TAO, Defense Medical Information System Identification (DMIS-ID) on the date of service, sponsor Social Security Number (SSN), patient name, date of birth, date of care, Health Care Delivery Program (HCDP) Coverage code, host nation provider of care, host nation provider's address, with an International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM), Current Procedural Terminology, 4th Edition (CPT-4) code, or brief description of the purpose of the visit or reason for referral (i.e., A=No Authorization, P=Non-Network Providers) and Internal Control Number (ICN) order for appropriate TAO Director review (See [Chapter 12, Section 11.1](#), [Chapter 12, Section 12.2](#), [Figure 12-12.2-2](#), [Figure 12-12.2-3](#), and [Figure 12-12.2-7](#)). Upon receipt of the first claim for a TGRO- or TPRC-enrolled ADFM submitted without preauthorization/authorization, the overseas claims processing contractor shall process the claim and waive application of Point of Service (POS) charges. The overseas claims processing contractor shall use specific Explanation of Benefit (EOB) messages advising the beneficiary/host nation providers that authorizations are required on future claims to avoid POS payment (see [Chapter 12, Section 11.1, paragraph V.G.12.a. - d.](#)). Upon receipt of the second and subsequent ADFM claims submitted without preauthorization/authorization, the overseas claims processing contractor shall process the claims following POS payment procedures.

5. WEEKLY WIRE TRANSFER RECONCILIATION REPORT. For TGRO contractor and TPRC claims, the overseas claims processing contractor shall provide a WTRR by overseas region as required, to the TGRO contractor and respective TAO Directors. 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

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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.

6. MONTHLY EUROPE ADSM FINANCE AND ACCOUNTING REPORT.

TRICARE Europe ADSM claims shall be submitted on batches and the overseas claims processing contractor shall, on a monthly basis, submit a request for payment of TRICARE Europe ADSM overseas claims in the format of a single bill delineated by military branch of service to Defense Finance and Accounting Service (DFAS), Europe. Each bill shall include total weekly charges separated by benefit dollars with administrative charges per claim. Additionally each bill shall be accompanied by a monthly summary report of total expenditures by currency (e.g., for the month of January \$600,000 worth of claims were paid, of the \$600,000, \$300,000 were paid in Euros, \$200,000 were paid in Kronen, etc.). A copy of this report identifying PHS and NOAA ADSM claims shall also be sent to the Public Health Service POC, at Medical Affairs Branch, 5600 Fishers Lane, Room 4C-04, Rockville, MD 20874.

7. MONTHLY OVERSEAS CURRENCY REPORT. The overseas claims processing contractor shall provide TRICARE Overseas Currency Reports identifying the gain or loss for the month reported to arrive by the 10th calendar day following the month reported, excluding TGRO contractor/TPRC claims, per the instructions in [Chapter 12, Section 11.1, paragraph IV.B.1. - 3](#). The reports for net gains/losses shall be sent in an electronic format to TMA, Attn: Finance and Accounting Branch, 16401 East Centretech Parkway, Aurora, CO 80011-9066.

8. MONTHLY PAID CLAIMS AND CURRENT INVENTORY ACTIVE DUTY REPORT. The fields to be reported are: DMIS-ID, branch of service (to include a breakout for National Guard), fiscal year in which services were provided, country where services are provided, TOP region, ADSM's name, duty station address, full sponsor's SSN, begin and end dates of service, ICD-9-CM code, CPT-4 code, host nation provider name, host nation provider address, amount billed, amount paid, name of payee/person paid, payee/person paid address, amount allowed, processed date, CHAMPUS Explanation of Benefit (CEOB) message, number of days to process, lag time (DOS to receipt), denial indicator when claim is denied in total, identification of Primary Care Manager (PCM), provider specialty (taxonomy code), enrollment health plan code, if available TRICARE Encounter Data (TED) ICN number. This report will also have a summary page showing current claim inventory and processing cycle time. The contractor shall distribute the report to the offices listed in [paragraph II.F.16](#).

9. MONTHLY PAID CLAIMS AND CURRENT INVENTORY ACTIVE DUTY FAMILY REPORT. The fields to be reported are: DMIS-ID, branch of service (to include a breakout for National Guard), fiscal year in which services were provided, country where services are provided, TOP region, ADSM's name, duty station address, full sponsor's SSN, begin and end dates of service, ICD-9-CM code, CPT-4 code, host nation provider name, host nation provider address, amount billed, amount paid, name of payee/person paid, payee/person paid address, amount allowed, processed date, CEOB message, number of days to process, lag time (DOS to receipt), denial indicator when claim is denied in total, identification of PCM, provider specialty (taxonomy code), enrollment health plan code, if available TED ICN number. This report shall have a separate breakout for ADFM CONUS

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claims. This report will also have a summary page showing current claim inventory and processing cycle time. The contractor shall distribute the report to the offices listed in [paragraph II.F.16](#).

10. MONTHLY PAID CLAIMS AND CURRENT INVENTORY TOP REMOTE SITE ACTIVE DUTY REPORT. The fields to be reported are: DMIS-ID, Branch of Service (to include a breakout for National Guard), fiscal year in which services were provided, country where services are provided, TOP region, ADSM's name, duty station address, full sponsor's SSN, begin and end dates of service, ICD-9-CM code, CPT-4 code, host nation provider name, host nation provider address, amount billed, amount paid, name of payee/person paid, payee/person paid address, amount allowed, processed date, CEOB message, number of days to process, lag time (DOS to receipt), denial indicator when claim is denied in total, identification of PCM, provider specialty (taxonomy code), enrollment health plan code, if available TED ICN number. This report will also have a summary page showing current claim inventory and processing cycle time. The contractor shall distribute the report to the offices listed in [paragraph II.F.16](#).

11. MONTHLY PAID CLAIMS AND CURRENT INVENTORY TOP REMOTE SITE ADFM REPORT. The fields to be reported are: DMIS-ID, branch of service (to include a breakout for National Guard), fiscal year in which services were provided, country where services are provided, TOP region, ADSM's name, duty station address, full sponsor's SSN, begin and end dates of service, ICD-9-CM code, CPT-4 code, host nation provider name, host nation provider address, amount billed, amount paid, name of payee/person paid, payee/person paid address, amount allowed, processed date, CEOB message, number of days to process, lag time (DOS to receipt), denial indicator when claim is denied in total, identification of PCM, provider specialty (taxonomy code), enrollment health plan code, if available TED ICN number. This report will also have a summary page showing current claim inventory and processing cycle time. The contractor shall distribute the report to the offices listed in [paragraph II.F.16](#).

12. MONTHLY PAID CLAIMS AND CURRENT INVENTORY RETIREES AND DEPENDENTS OF RETIREES REPORT. The fields to be reported are: branch of service (to include a breakout for National Guard), fiscal year in which services were provided, country where services are provided, TOP region, ADSM's name, duty station address, full sponsor's SSN, begin and end dates of service, ICD-9-CM code, CPT-4 code, host nation provider name, host nation provider address, amount billed, amount paid, name of payee/person paid, payee/person paid address, amount allowed, processed date, CEOB message, number of days to process, lag time (DOS to receipt), denial indicator when claim is denied in total, identification of PCM, provider specialty (taxonomy code), enrollment health plan code, if available TED ICN number. This report shall include separate breakouts for TRICARE For Life (TFL) and TRICARE Senior Pharmacy (TSRx) claims and CONUS claims. This report will also have a summary page showing current claim inventory and processing cycle time. The contractor shall distribute the report to the offices listed in [paragraph II.F.16](#).

13. MONTHLY TOTAL CLAIMS BY COUNTRY FOR ADSMs, ADFMs, RETIREES, AND DEPENDENTS OF RETIREES REPORT. For each region the report shall include the following fields sorted by country, number of claims, amount billed, amount paid, amount allowed, branch of service, beneficiary status (i.e., enrolled (remote/non-remote)/standard), beneficiary categories (i.e., ADFM, retiree, etc.) fiscal year in which services were provided

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and institutional and non-institutional. There will be separate lines for ADSMs, ADFMs, retirees, dependents of retirees, TFL, TSRx, and a total run. This report shall be submitted as two reports, one for institutional claims and one for non-institutional claims. The report shall be supplied electronically on an Excel spreadsheet. The contractor shall distribute the report to the offices listed in [paragraph II.F.16](#).

14. MONTHLY HOST NATION NETWORK PROGRESS REPORT. The report shall include full host nation provider information for those host nation providers whose claims were processed during the previous month. This report shall include the following fields: TOP Region, country, provider information (name, address, specialty code, eligibility code (i.e., provider status), eligibility begin and end date), number of claims billed, amount paid, and amount allowed. For Europe, this information will be broken out by network, non-network, and partnership providers. This report shall be supplied electronically on an Excel spreadsheet.

15. MONTHLY OVERSEAS REGION ADSM AND OTHER ADSM CONUS/OCONUS CLAIMS REPORT. This is a one page summary report sent to overseas TAO Directors showing current claims and adjustment inventory and processing cycle time. The contractor shall distribute the report to the offices listed in [paragraph II.F.16](#).

16. DISTRIBUTION LIST FOR CLAIMS PAID AND INVENTORY SUMMARY REPORTS. The following offices shall receive the reports as stated in the above paragraphs.

- a. Director, TRICARE Area Office - Europe
Unit 10310, Bldg 214
Sembach AB, Germany
APO AE 09136-0005
- b. Fleet Surgeons Office, U.S. Navy Europe
Fleet Medical Officer
CNE-C6F Medical
PSC 817, Box 111
FPO AE 09622
- c. U.S. Air Force In Europe
HQ USAFE/SG
Unit 3050 Box 130
APO AE 09094-0130
- d. Commander, U.S. Army Europe (ERMC)
Attn: ERMC Managed Care POC
CMR 442, Box 380
APO AE 09042
- e. U.S. Central Command
HQ USCENTCOM (CCSG)
715 South Boundary Blvd
MacDill AFB, FL 33621-5101

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- f. CMDR EUCOM TRICARE Liaison
Attn: EUCOM TRICARE Liaison POC
Unit 30400, Box 3055
APO AE 09128-4209

- g. TRICARE Area Office - Latin America and Canada
TAO-LAC, Bldg 38716, 38th Alley
Fort Gordon, GA 30905-5650

- h. TRICARE Area Office - Pacific (TAO-P)
Attn: Regional Service Center Manager
PSC 482, Box 2749
FPO AP 96362

17. ANNUAL REPORT OF TOTAL CLAIMS BY COUNTRY FOR ADFMs. For each region the report shall be sorted by country, by type of provider (i.e., institutional, professional and drug) and shall include total claims and total dollars paid. The report shall be submitted electronically in an Excel spreadsheet by the 15th of October for the preceding fiscal year (October 1 through September 30).

18. ANNUAL REPORT OF HIGH VOLUME PROVIDERS OF PHARMACY SERVICES IN COSTA RICA, PANAMA AND PHILIPPINES (INITIAL IDENTIFICATION). For the Philippines, Panama, and Costa Rica, the overseas claims processing contractor shall, annually, review billings to determine if providers in these areas have exceeded the \$3,000 per year billing cap for pharmacy services. The reports shall identify the provider, the provider ID, the effective date of the National Drug Code (NDC) implementation, the provider total billed amount, the total amount paid to the provider, and the total amount paid by the government. High volume providers (determined by total pharmacy services billings exceeding \$3,000 in the previous 12 months) identified shall be sent the provider notification letter (see [Chapter 12, Section 12.2, Figure 12-12.2-8](#)) advising them of the TOP NDC submission requirements and payment for drugs as required in the TRICARE Reimbursement Manual (TRM), [Chapter 1, Section 15](#) and this section. The electronic report shall arrive no later than the 15th of month in which it is due. As other countries are added, the report shall include these countries.

19. ANNUAL REPORT OF HIGH VOLUME PROVIDERS OF PHARMACY SERVICES (INITIAL IDENTIFICATION). The overseas claims processing contractor shall provide an electronic report, annually (by fiscal year), identifying all high volume overseas providers of pharmacy services that have exceeded the \$3000 per year billing cap for pharmacy services to the appropriate TMA COR. The reports shall identify the provider, the provider ID, the provider total billed amount, the total amount paid to the provider, and the total amount paid by the government. Upon receipt, the government shall review the report and may notify the overseas claims processing contractor to issue a provider notification letter (see [Chapter 12, Section 12.2, Figure 12-12.2-8](#)) to TMA identified overseas providers of pharmacy services in other countries than the Philippines, Panama and Costa Rica that have exceeded the \$3000 per year billing cap on pharmacy services. The report shall arrive by the 15th of October for the preceding fiscal year (October 1 through September 30). As other countries are added, the report shall include these countries.

20. ANNUAL REPORT OF HIGH VOLUME PROVIDERS OF PHARMACY SERVICES (ONGOING TRACKING). For those providers identified annually as high volume providers (determined by total pharmacy services billings exceeding \$3,000 in the previous 12 months), the overseas claims processing contractor shall be required to submit a report annually, by country and provider, which tracks the number of claims, dollar amounts billed vs. paid before the process outlined in [Chapter 12, Section 11.1, paragraph V.E.21](#). was implemented and compares it to the number of claims, dollar amounts billed vs. paid after the above process was implemented. The report shall arrive by the 15th of October for the preceding fiscal year (October 1 through September 30). As other countries are added, the report shall include these countries.

III. SPECIFIC DELIVERABLES - TGRO HEALTHCARE CONTRACTOR

The TGRO contractor shall submit the following reports, sorted by TOP Region/TAO Director:

A. DAILY ADMISSION/CASE MANAGEMENT REPORTS. The contractor shall provide a daily status report on all admissions and all inpatient and outpatient active case management cases by region and area of responsibility.

B. UTILIZATION MANAGEMENT OUTLIERS REPORT. The contractor shall conduct utilization review of all inpatient admissions and major outpatient care (that exceeds \$5,000 per individual or \$10,000 per family). Each TAO Director may further define this requirement by providing a listing of additional services for utilization review. The contractor's program shall provide for routine reviews to ensure all healthcare services provided are medically necessary and that quality standards are maintained. Criteria and process for review shall be included in the contractor's Quality Assurance Plan. Outliers shall be reported immediately to the appropriate TAO Director, but no later than five working days after identification.

C. CASE MANAGEMENT REPORT FOR HIGH COST CHRONIC CONDITIONS. The contractor shall implement a case management program for high cost chronic cases (for claims greater than \$5,000 for an individual or \$10,000 per family per fiscal year for the same related diagnosis). Each TAO under this contract may provide a listing of additional chronic services that the contractor shall track. The Government reserves the right to submit additional beneficiaries to the TOP Prime report, who shall be tracked by the contractor for case management. The contractor shall notify the Government, in writing, of all chronic conditions that may affect AD member fitness for duty status, or family members who appear to be inappropriately assigned overseas due to their medical and dental needs, as soon as possible after identification of the condition, but not later than five days after identification.

D. MONTHLY PROGRESS AND STATUS REPORTS. These reports shall outline the number of eligible patients by region and by country, the number of patient evacuations conducted in the reporting period, any problems or issues that arose during the reporting period, and status of issues raised previously. The report must also list invoices due, submitted, and paid to date. The reports shall include additional statistical detail as may be mutually defined by the Primary Regional POC and the Government HSR. Additionally, the TGRO healthcare contractor shall provide the Government with a report of patient level data and claims information database on a monthly basis to include at a minimum: name,

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sponsor's social security number, date of service, branch of service, type of care received, cost of care, and country/place of care where the service was provided. All reports must include beneficiaries' service affiliation and status (AD and ADFM).

E. MONTHLY MILITARY SERVICE REPORTS. The contractor shall provide a monthly report, in an electronic format, to each of the Military Service Representatives, that provides the following information: member's name, if AD or ADFM, if member is on a ship-based, and if ship-based, if the member is on liberty or on leave from the ship, duty status (temporary duty, deployed, leave, etc.). If they are on temporary duty or deployed, note the purpose of trip (the type of operation or exercise deployed for), branch of service, member's rank, member's social security number, member's unit of assignment, billed charges, type of care received, date of service, and the country where care was provided.

F. MONTHLY NAVY REPORTS. The contractor shall provide the Navy a monthly summary report of billed charges to include access fees, if applicable, by active duty member, and by service (Navy/Marine Corps), for those bills submitted to the Line of the Navy for payment. The reports shall include member's name, social security number, type of care received, country/place in which care was received, and date of service.

G. MONTHLY URGENT/EMERGENCY CARE REPORT. The contractor shall provide a monthly report of AD patients who are TAD/TDY, deployed, deployed on liberty, or in an authorized leave status who were treated for urgent or emergent care. This report shall include as a minimum: name, social security number, date of service, patient's command, status (leave, TDY as part of military exercise/deployment, or TDY for other reasons), branch of service, type of care provided, country/place of care, and cost of care.

H. MONTHLY PHILIPPINES REPORTS. If ordered for the Philippines, the contractor shall provide monthly the number of providers visited or reviewed compared to the number credentialed, and the number rejected to include the corresponding reason why rejected. This report shall also include the names and locations of the providers who are rejected. This report shall be submitted in Excel format to the TMA, Chief, Claims Operations Office by the 15th of each month. The contractor shall also provide a milestone chart showing what has been accomplished and what remains to be accomplished on a monthly basis.

I. QUARTERLY MANAGEMENT REPORTS. The contractor shall prepare and submit quarterly management reports to the Regional Director and COR. The reports shall include a statistical accounting of the number of calls from TRICARE Prime beneficiaries and measures of responsiveness by the contractor to these calls, the U.S. dollar amount of healthcare services provided, the number of pre-admission authorizations issued, the number of inpatient bed days consumed, the number and significant findings of utilization reviews conducted, and the number and status of patients under case management. Regional variations may occur in report formats and specific procedures for submission.

J. SEMI-ANNUAL BENEFICIARY SURVEY SUMMARY OF FINDINGS REPORT. The contractor shall perform semi-annual beneficiary surveys to determine the satisfaction of ADs and ADFMs in using the contractor's services. The survey shall measure beneficiary satisfaction with regard to access to primary care providers, access to specialty care providers, ability to contact the Call Center, quality of providers, and assistance received from the Call Center. The contractor shall submit the proposed plan for these surveys to the

Regional Director and COR for Government review and approval. Within 120 days of submission of the plan to the Government, the contractor shall implement the plan, to include any recommendations provided by the Government, unless specifically informed by the Government that the plan is not adequate for implementation. Following Government approval of the plan, the Contractor shall implement the plan and provide summary reports of survey findings to the Regional Director and COR.

K. INTERNET REPORTS. The contractor shall develop and maintain a site accessible via the Internet that provides information on its network of primary care providers, dentists, hospitals and clinics throughout the overseas TOP Prime areas and indicate if providers speak English. The provider listings shall be updated as changes occur. Also, the educational brochure will be made available on this site and will be updated to ensure it remains current with TRICARE policies. All updates on Internet reports shall include the last date the page was updated.

IV. SPECIFIC DELIV'ERABLES - TPRC HEALTHCARE CONTRACTOR

The TRICARE Puerto Rico Contractor shall submit the following reports:

A. DAILY ADMISSION/CASE MANAGEMENT STATUS REPORTS. The contractor shall provide a daily status report on all admissions and all active case management cases by area of responsibility to the TAO Director - TRICARE Latin America/Canada (TLAC).

B. UTILIZATION MANAGEMENT OUTLIERS REPORT. The contractor shall conduct utilization review of all inpatient admissions and major outpatient care (that exceeds \$5,000 per individual or \$10,000 per family). The TAO Director may further define this requirement by providing a listing of additional services for utilization review. The contractor's program shall provide for routine reviews to ensure all healthcare services provided are medically necessary and that quality standards are maintained. Criteria and process for review shall be included in the contractor's Quality Assurance Plan. Outliers shall be reported immediately to the TAO Director - TLAC, but no later than five working days after identification.

C. CASE MANAGEMENT REPORT FOR HIGH COST CHRONIC CONDITIONS. The contractor shall implement a case management program for high cost chronic cases (for claims greater than \$5,000 for an individual or \$10,000 per family per fiscal year for the same related diagnosis). The TAO Director - TLAC may provide a listing of additional chronic services that the contractor shall track. The Government reserves the right to submit additional beneficiaries to the TOP Prime report, who shall be tracked by the contractor for case management. The contractor shall notify the Government, in writing, of all chronic conditions that may affect AD member fitness for duty status, or family members who appear to be inappropriately assigned overseas due to their medical and dental needs, as soon as possible after identification of the condition, but not later than five days after identification.

D. MONTHLY PROGRESS AND STATUS REPORT. The contractor shall prepare and submit to the Regional Director and COR, monthly status and progress reports to the Government no later than 15 days after the end of each month. These reports shall outline the number of patient evacuations conducted in the reporting period, any problems or issues that arose during the reporting period, and status of issues raised previously.

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CHAPTER 12, SECTION 11.2

AUDITS, INSPECTIONS, REPORTS, AND PLANS

E. MONTHLY PATIENT LEVEL DATA AND CLAIMS INFORMATION. The contractor shall provide the Regional Director and COR with a monthly report of patient level data and claims information to include at a minimum: name, full social security number, date of service, branch of service, if temporary duty or deployed or deployed on liberty, or in an authorized leave status, type of care received, cost of care, and place of care where the service was provided. All reports must include beneficiaries' service affiliation and status (AD and ADFM).

F. MONTHLY MILITARY SERVICE REPORTS. The contractor shall provide a monthly report, in an electronic format, to each of the Military Service Representatives, that provides the following information: member's name, if AD or ADFM, if member is on a ship-based, and if ship-based, if the member is on liberty or on leave from the ship, duty status (temporary duty, deployed, leave, etc.). If they are temporary duty or deployed, note the purpose of trip (the type of operation or exercise deployed for), branch of service, member's rank, member's social security number, member's unit of assignment, CMAC for claim charges, administrative fee charges, type of care received, date of service, and the place where care was provided.

G. MONTHLY URGENT/EMERGENCY CARE REPORT. The contractor shall provide to the Regional Director and COR a monthly report of AD patients who are TAD/TDY, deployed, deployed on liberty, or in an authorized leave status that were treated for urgent or emergent care. This report shall include, as a minimum: name, full social security number, date of service, patient's command, status (leave, TDY as part of military exercise/ deployment, or TDY for other reasons), branch of service, type of care provided, country/ place of care, and cost of care.

H. MONTHLY INTERNAL QUALITY MANAGEMENT/IMPROVEMENT PROGRAM. The contractor shall provide a report listing problems identified by the contractor's internal quality management/quality improvement program and the corrective actions planned/initiated to the Contracting Officer by the 10th of each month.

I. QUARTERLY MANAGEMENT REPORT. The contractor shall provide to the Regional Director and COR a quarterly management report no later than 15 days after the end of each quarter. Reports will include a statistical accounting of the number of calls from TRICARE Prime beneficiaries and measures of responsiveness by the contractor to these calls; the U.S. dollar amount of healthcare services provided, the number of pre-admission authorizations issued, the number of inpatient bed days consumed, the number and significant findings of utilization reviews conducted, and the number and status of patients under case management.

J. SEMI-ANNUAL BENEFICIARY SURVEY SUMMARY OF FINDINGS REPORT. The contractor shall perform semi-annual beneficiary surveys to determine the satisfaction of AD and ADFMs with the contractor's services. The contractor shall report its findings to the Contracting Officer no later than 30 calendar days following the completion of the survey.

- END -

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