



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY  
AURORA, COLORADO 80011-9066

TRICARE  
MANAGEMENT ACTIVITY

MB&RB

CHANGE 88  
6010.54-M  
SEPTEMBER 16, 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:** FOREIGN FEE SCHEDULE IMPLEMENTATION

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

**SUMMARY OF CHANGE(S):** This change includes clarification that the foreign fee schedules apply to retirees or their eligible family members or standard Active Duty Family Members (ADFM)s for services received in the Philippines or Panama that fall under the claims processing jurisdiction of the foreign claims processor; removal of March 1, 2009 Country Specific Index Factor 0.229; and, clarification that the primary or principal diagnosis (not the admitting diagnosis) for an admission will be used to determine the group for a payment rate. In addition, this change increases the inpatient per diem amounts by including an add-on to reimburse for hospital capital costs. It also provides that country specific index factor adjusted CMACs will not apply to ancillary services.

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

This change is made in conjunction with Aug 2002 TRM, Change No. 80.

Reta Michak  
Chief, Office of Medical Benefits  
and Reimbursement Branch

**ATTACHMENT(S):** 5 PAGE(S)  
**DISTRIBUTION:** 6010.54-M

**CHANGE 88**  
**6010.54-M**  
**SEPTEMBER 16, 2008**

**REMOVE PAGE(S)**

**CHAPTER 12**

Section 10.1, pages 1 through 3

Section 10.3, pages 1 and 2

**INSERT PAGE(S)**

Section 10.1, pages 1 through 3

Section 10.3, pages 1 and 2

## 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 [U.S. 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 [U.S. 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.

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), **TRICARE Management Activity (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.

F. TRICARE Global Remote Overseas (TGRO)/TRICARE Puerto Rico Contract (TPRC) healthcare contractor claims submitted for **Active Duty Family Members (ADFM)s** not enrolled in TOP Prime shall be paid following TOP Standard cost-sharing provisions. The overseas claims processing contractor's EOB shall advise the TGRO contractor/TPRC that the beneficiary was not enrolled in TOP Prime. Upon receipt of the EOB, the TGRO

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contractor/TPRC shall contact the appropriate overseas TAO Director for review of the enrollment problem. The beneficiary's enrollment will be corrected if the case warrants a retroactive enrollment per [Chapter 12, Section 3.2](#).

G. Overseas drug claims shall be paid following the guidelines outlined in the TRM, [Chapter 1, Section 15](#), and [Chapter 12, Section 11.1](#), TOP Prime and Standard cost share for pharmacy services are as outlined in [Chapter 12, Section 2.1](#).

H. Prior to payment, overseas ambulance service shall follow the CONUS medical necessity guidelines outlined in [Chapter 8, Section 1.1](#).

I. Payment may be made for TGRO contractor ambulance services provided by commercial transport (see [Chapter 12, Section 11.1, paragraph IV.A.5.b.\(2\)](#) for additional guidance on processing these claims).

- END -



## 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 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, [Section 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.

a. A percent factor may be applied or added to the allowed **amount** established by TRICARE under the TRM, Chapter 1, [Section 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.