Chapter 12
Section 11.1

Managed Care Support Contractor Responsibilities For Claims Processing

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I. GENERAL

A. The purpose of the following TOP claims processing procedures are to help ensure that all claims for care received by TOP eligible beneficiaries are processed in a timely and consistent manner and that government furnished funds are expended only for those services and supplies authorized under TRICARE while still allowing for the cultural differences unique to foreign countries and their health care systems.

B. With the exception of Puerto Rico, the TOP Managed Care Support Contractor (MCSC) shall to the extent possible maximize the use of the TRICARE Operations Manual, TRICARE Systems Manual, and the TRICARE Policy Manual, unless otherwise stated in this chapter, when processing TOP eligible beneficiary claims, including active duty service member and reserve/national guard member claims which fall under the jurisdictional responsibility of the MCS contractor responsible for the processing of TOP claims. However, the TRICARE provisions for claims processing are not intended to be strictly applied to claims for services received in foreign countries. The TOP MCS contractor shall exercise reasonable judgment to accommodate cultural differences relevant to the practices and delivery of health care services overseas.

C. Unless otherwise stated, the requirements provided in this chapter shall not apply to Stateside MCS contractor Regions.

II. TOP PROCESSING STANDARDS

A. Regardless of who submits the claim, TOP claims shall be processed using the standards outlined in the TRICARE Operations Manual, Chapter 1, except for:

1. Claims, the MCS contractor shall process eighty-five percent (85%) of all TOP claims to completion within twenty-one (21) days.

2. TRICARE Encounter Data (TED) data and required documents, the MCS contractor shall generate an initial submission claims processing cycle and transmit related TED data and required documents to TMA once every seven days for all TOP claims.

3. Overseas Drafts/checks and EOBs. Overseas drafts/checks and EOBs shall be first in each payment run. Drafts/checks that need to be converted to a foreign currency shall

be calculated based on the exchange rate in effect on the last date of service listed on the TEOB. Upon completion of the processing, drafts/checks shall be developed by the MCS contractor within forty-eight (48) hours, matched with the appropriate TEOBs, and mailed to the beneficiary/sponsor/host nation provider/POC.

4. Provider requests for Electronic Funds Transfer (EFT) payment. Upon host nation provider request the MCS contractor shall provide Electronic Funds Transfer payment to a U.S. or overseas bank. Bank charges incurred by the provider for EFT payment shall be the responsibility of the provider.

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

6. Authorization requests. Authorization requests timeliness standards/requirements do not apply to TOP.

7. Zip code file requirements do not apply to TOP.

8. Controls related to the operation of TOP Service Centers, HCFs, authorizations, referrals, and beneficiary/providers services are the responsibility of the overseas Regional Directors.

III. RECORDS MANAGEMENT

The Records Management requirements outlined in the TRICARE Operations Manual, Chapter 2 apply to the TOP.

IV. FINANCIAL ADMINISTRATION

1. The MCS contractor shall follow the Financial Administration Non-Financially Underwritten Funds requirements in the TRICARE Operations Manual, Chapter 3, with the following exceptions:

a. Draft/checks shall also reflect "TRICARE Overseas Program."

b. Drafts shall also reflect information that indicates the draft is valid for 190 days and if reissue is required/necessary, the draft must be returned to the MCS contractor with a request for reissuance.

c. The MCS contractor is responsible for following the requirements outlined in the TRICARE Operations Manual, Chapter 3, Section 3 related to voucher/batch preparation and integrity.

d. TED data for the overseas claims shall be reported on separate vouchers/batches according to the TRICARE Systems Manual, Chapter 2 and as follows:

(1) For remote site:

(a) ADFM & ADSM remote site claims, except health care claims for emergent/urgent care for Navy and Marine Corps ADSM who are either deployed and or deployed on liberty status in a remote site shall be submitted on vouchers instead of batches and shall be paid from the current not-at-risk bank account. They shall be submitted on the same voucher as all other claims currently processed from that account. Navy and Marine who are deployed and/or deployed on liberty status claims for emergent/urgent care will be sent by the remote site contractor to the line of the Navy or Marine Corps for payment of administrative fees and health care costs.

(b) Retirees and their dependents living in a remote site health care claims shall be submitted on vouchers instead of batches and shall be paid from the current not-at-risk bank account. They shall be submitted on the same voucher as all other claims currently processed from that account.

(c) ADSM, ADFM, retirees and their dependents living in a remote site stateside claims for health care shall be submitted on vouchers and shall be paid from the current not-at-risk bank account. They shall be submitted on the same voucher as all other claims currently processed from that account.

(d) Non-enrolled ADSM deployed or TDY to a remote site health care shall be paid by the overseas remote site contractor.

(2) For other than remote site claims:

(a) TRICARE Europe ADSM claims shall be submitted on batches and the 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 Landstuhl Finance and Accounting Office. Each bill shall include total monthly 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 moth of January $600,000 worth of claims were paid, of the $600,000, $300,000 were paid in Deutsch Marks, $200,000 were paid in Francs, etc.

(b) TOP eligible ADFM claims shall be submitted on vouchers and shall be paid from the current not-at-risk bank account. They shall be submitted on the same voucher as all other claims currently processed from that account.

(c) Retirees and their dependents living overseas claims shall be submitted on voucher and shall be paid from the current not-at-risk bank account. They shall be submitted on the same voucher as all other claims currently processed from that account.

(d) TOP Prime (ADSM & ADFM) and TOP Standard beneficiary stateside claims for health care shall be submitted on vouchers and shall be paid from the current not-at-risk bank account. They shall be submitted on the same voucher as all other claims currently processed from that account.

(e) ADSM enrolled in TRICARE Pacific and TRICARE Latin America and Canada, including the Caribbean Basin health care claims shall be paid by the military.

(f) Overseas health care claims determined to be the responsibility of the stateside managed care support contractor (i.e., beneficiaries enrolled or residing in a stateside MCSC region, who receive care while traveling or visiting abroad) shall be paid from the current at-risk bank account.

(g) TED data for the overseas claims shall be reported on separate vouchers according to the TRICARE Systems Manual, Chapter 2. To distinguish overseas ADSM/Remote Site, etc., vouchers from other TOP vouchers the MCS contractor shall utilize the specific voucher Branch of Service codes and the specific overseas region DMIS ID required in the TRICARE Systems Manual for reporting such claims.

2. The MCS 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.

3. The MCS contractor shall produce a separate report for ADSM one each for remote and non-remote and one report for all other TOP beneficiaries. The reports for net gains/losses shall be sent in a electronic format to TMA, Attn: Finance and Accounting Branch, 16401 East Centretech Parkway, Aurora, CO 80011-9066.

4. The MCS contractor shall calculate, TOP program currency gains and losses resulting from payments made to host nation providers and/or beneficiaries in foreign countries. The gains and losses shall be computed based on the exchange rate in effect on the "Ending Date of Care" and that shall be the rate used in the claims adjudication process. The difference between the cost of the foreign currency on the "Ending Date of Care" and the MCS contractor payment date shall be the gain or loss on the transaction. Payment shall be as follows for:

a. NET GAIN. For months that result in a net gain the MCS contractor shall forward the report along with their check payable to DoD, TMA, for the gain from currency conversion.

b. NET LOSS. TMA will reimburse the MCS contractor for any losses incurred from currency conversion. The TRICARE Overseas Currency report shall be accompanied by a letter (invoice) requesting reimbursement for the loss incurred. This payment will not be subject to the Prompt Payment Act (FAR 32.9) as amended, therefore, payment by TMA will usually be made within five (5) working days of receipt of the invoice and the TRICARE Overseas Currency Report.

V. CLAIMS PROCESSING PROCEDURES

A. Who May File A TOP Claim.

Claims may be filed by TOP eligible TRICARE beneficiaries, TOP host nation providers, and TRICARE authorized providers as allowed under TRICARE (see the TRICARE Operations Manual, Chapter 8).

B. TOP Claim Form.

1. Confidentiality requirements for TOP are identical to TRICARE requirements outlined in the TRICARE Operations Manual, Chapter 8.

2. The MCS contractor may accept any valid TRICARE approved claim form, current or obsolete.

C. TOP Claims Receipt And Control And Signature Requirements.

1. The MCS contractor shall follow the claims receipt and control, and signature requirements outlined in the TRICARE Operations Manual, Chapter 8, except when directed by TMA, Chief, Claims Operation Office. When directed by TMA, the MCS contractor may not use signature on file and may not accept facsimile signatures.

2. The MCS contractor shall waive beneficiary signature requirements for claims submitted for TOP remote site designated providers.

3. As a guideline, overseas claims shall be sent to the microfilm area, filmed and returned to the MCS contractor's overseas claims processing unit no later than the close of business the following working day of submission.

D. TOP Jurisdiction.

In the early stages of TOP claims review, the MCS contractor shall determine that claims received are within its contractual jurisdiction. TOP claims processing jurisdictions are identified within the MCS contractor's contract with TMA and includes all overseas locations except the 50 United States states. TOP jurisdiction requirements outlined are as follows:

1. Effective July 1, 1996, all care for Active Duty Family Members (ADFM) and retirees and their dependents living outside the U.S. (not enrolled in a managed care region) for care provided overseas and overseas care for ADSMs in TRICARE Europe (including routine and adjunctive dental).

2. Effective October 1, 1997, for all care outlined under paragraph V.D.1. above and for stateside care TOP ADFM enrolled in an overseas region except Puerto Rico and the Virgin Islands.

3. Effective October 1, 1999, for all care outlined under paragraph V.D.1. and 2. above and added stateside care received by overseas ADFMs from any overseas region including Puerto Rico and the Virgin Islands.

4. Effective September 1, 2001, for all care outlined under paragraph V.D.1., 2., and 3. above and added ADFM remote care from the TRICARE Pacific region.

5. Effective (TBD), for all care outlined in under paragraph V.D.1., 2., 3., and 4. above added, stateside care for non-enrollees residing outside the U.S. and ADSM/ADFM remote care from TRICARE Europe and TRICARE Latin America and Canada, including the Caribbean Basin and excluded claims processing responsibility for urgent/emergent care

claims for remote site Navy or Marine Corps ADSM deployed and/or deployed on liberty status; and excluded processing of retail network and non-network pharmacy service claims in Puerto Rico, Virgin Islands and Guam except claims for Virgin Island ADSM/ADFM TOP Prime enrollees prescriptions provided when they require inpatient and emergency room care which will be submitted under the overseas remote site contract.

6. ADSM not enrolled to a specific overseas region/DMIS ID who obtain care in an overseas remote location from an overseas remote site provider, the health care claims shall be processed by the claims processor responsible for foreign claims.

7. ADSM enrolled in TRICARE Pacific and TRICARE Latin America and Canada, including the Caribbean Basin overseas non-remote care shall be processed by the appropriate overseas military MTF.

8. Claims for durable medical equipment purchased/ordered by TOP eligible beneficiaries in an overseas area from a stateside provider (i.e., internet, etc.) shall be processed by the TOP MCS contractor.

9. Claims for a non-medical attendant to accompany a non-active duty TOP Prime patient's referred for medically necessary speciality care more than 100 miles from the patient's primary care manager locations shall be returned to the appropriate overseas Regional Director for action.

10. For inpatient claims paid under the DRG-based payment system, the MCS contractor with jurisdiction for the beneficiary's claim address, on the date of admission, shall process and pay the entire DRG claim, including cost outliers. For inpatient claims paid on a per diem basis, to include DRG transfers and short stay outlier cases, and for professional claims that are date-driven, the MCS contractor with jurisdiction for the beneficiary's claim address, on the date of service shall process and pay the claim.

11. Enrolled ADSM on a ship or at home port overseas care shall not be processed by the TOP MCS contractor but shall be processed by the member's unit.

12. ADSM (i.e., TDY/on leave) in an overseas region, claims for overseas care shall be processed by the MCS contractor responsible for where the ADSM is enrolled or if not enrolled where the ADSM resides. If care is provided in a remote site location by a remote site provider, the claim is processed by the remote site provider.

13. ADSM deployed to overseas remote sites, claims for the care shall be processed by the MCS contractor responsible for processing foreign claims.

14. TRICARE beneficiaries, enrolled or residing in a stateside MCS contractor region who, while traveling or visiting abroad and receive overseas health care, claims for the overseas care shall be processed by the stateside MCS contractor responsible for where the beneficiary resides or is enrolled. See paragraph P. of this section for MCS contractor processing and payment guidelines for these claims.

E. Host Nation Provider Requirements.

1. The MCS contractor shall use 32 CFR 199.6 and the TRICARE Operations Manual, Chapter 4 as a guideline for the types of host nation providers which may provide service to TOP/TRICARE beneficiaries. The MCS contractor is not required to follow the requirements outlined in the TRICARE Operations Manual, Chapter 5.

2. The MCS contractor is not required to certify host nation providers unless directed by TMA, Chief, Claims Operations Office. When the MCS contractor is directed by TMA to certify host nation providers the MCS contractor shall follow the requirements outlined in 32 CFR 199.6 and the Operations Manual, Chapter 4 to identify types of providers which are eligible to be authorized under TRICARE and the documentation required by the MCS contractor for certification of the host nation provider.

3. In some instances, TMA or designee may require host nation provider certification/confirmation in overseas countries. TMA or designee shall notify the MCS contractor of the providers that are certified/confirmed. Effective August 1, 2002 in areas where certification/confirmation is required by the government, the MCS contractor shall consider providers certified/confirmed by TMA or designee as TRICARE authorized providers and no other. The MCS contractor shall send host nation providers who are not TMA certified/confirmed to TMA for action. If the certifications action is not completed within 35 days, the contractor shall deny claims based on lack of provider credentialing. The TMA designee is required to send the results of the certification request (approval or non-approval) to the foreign claims processor, including copies of current licenses/credentials, the health care providers name and business/billing address and date of certification or denial. (See Figure 12-12.2-12 and Figure 12-12.2-13 for the forms that shall be used by TMA or designee for obtaining necessary licensure/credentialing information of overseas providers.)

4. The foreign claims processors and the Regional Director shall be provided via electronic, fax or e-mail, a current file of TMA designee certified providers. Upon receipt of the files, the foreign claims processor is required to ensure these providers are designated certified/authorized overseas host nation providers and shall assign each provider a unique number following current contract requirements and shall provide that number to the TMA designee and Regional Director. For those certified TMA designee non-network providers, the foreign claims processor shall assign these providers a separate unique provider ID number. Upon receipt of the new provider file update, the foreign claims processor shall provide the assigned provider number(s) to the TMA designee and the Regional Director by the next business day of receipt.

5. Updates/reconciliations to certified/credentialed or disapproved providers shall be provided by the TMA designee, Chief, Claims Operations Office for forwarding to the foreign claims processor and the Regional Director. The TMA designee, shall submit separate reports for network and non-network providers. For new non-network providers the TMA designee shall submit a cumulative report in an Excel format which includes those providers which are approved or denied, including copies of current licenses/credentials and the providers name, business address and billing address, if different than the business address, including Telephone and Fax numbers if available, date of certification/denial, and provider specialty if available. This report shall be submitted weekly. As this process is expanded to

other countries, the report shall include certified providers from these countries. For network providers the TMA designee shall follow the process for reporting outlined in paragraph 9. below, for remote site providers.

6. The foreign claims processor and the TMA designee shall use the following guidelines for prioritizing certification of providers as follows:

a. Reviewing new providers.

b. Reviewing the foreign claims processors current certified provider files.

c. Reviewing non-certified providers on claims which have been denied by the foreign claims processor and the beneficiary/provider has followed-up on why the claim was denied.

d. Reviewing non-certified providers on claims which have been denied by the foreign claims processor and the beneficiary/provider has NOT followed-up on why the claim was denied.

7. To assist in identifying the above provider priorities, the foreign claims processor is required to send to the TMA designee provider certification requests as outlined above. New provider requests will be sent by the foreign claims processor to the TMA designee and the Regional Director two (2) times per week on Mondays and Wednesdays.

8. Recertification/credentialing shall be performed by the TMA designee every three (3) years and shall follow the above process.

9. The MCS contractor shall be provided electronic provider files of designated remote site providers, including network provider and participating provider information and excluding dental provider files by the TMA designee. Upon receipt of the files, the MCS contractor is required to ensure these providers are designated authorized overseas host nation providers and/or remote site designated authorized providers and shall assign each provider a number following current contract requirements and provide that number to the TMA designated POC. A separate provider number will be assigned for the certified providers not in the remote site provider network. Also the MCS contractor shall be provided by the TMA designated POC, designated remote site electronic provider file updates as needed with a replacement provider file quarterly which shall arrive no later than the fifteenth (15th) of every month. Upon receipt of a new provider file update the MCS contractor shall provide the assigned provider number to the TMA designated contractor by the next business day of receipt.

10. Upon TOP Regional Director request, the MCS contractor shall provide copies of licensure/certification information for host nation providers, when available, from MCS contractor provider files.

11. The MCS contractor is required to assign provider numbers to host nation providers, identify providers as network or non-network, create and submit TEPRVs.

12. The MCS contractor shall accept Regional Director Network Provider designation notification letters that designate/undesignate overseas host nation providers/countries as TOP Network preferred providers. Upon receipt of the designation letters the MCS contractor is required to update their provider file accordingly and retain a copy of the letter in their provider file. The MCS contractor shall use the date on the notification letter as the effective begin/end date of TOP network designation. If the designation letter is undated, the MCS contractor shall contact the appropriate Regional Director for a begin/end date.

13. The MCS contractor shall receive an electronic Monthly Network Progress Report from the Regional Directors with updates for the previous sixty (60) days. The MCS contractor shall use this report to reconcile their provider files. The Monthly Network Progress Report shall arrive no later then the fifteenth (15th) of every month.

14. The MCS contractor shall also receive from the Regional Director, or their designee, provider file updates for TOP Remote Site designated providers. The electronic files will be sent to the MCS contractor for updates as needed. Upon receipt of a new TOP Remote Site designated provider update the MCS contractor shall provide the newly assigned provider number to the Regional Director, or their designee, by the next U.S. business day of receipt.

15. 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.

16. For the Philippines, Panama and Costa Rica, the MCS contractor shall, annually, review billings to determine if providers in these area have exceeded the $3,000 per year billing cap for pharmacy services. High volume providers (determined by total pharmacy services billings exceeding $3,000 in the previous twelve (12) months) identified shall be sent the provider notification letter (see Figure 12-12.2-8) advising them of the TOP National Drug Coding submission requirements and payment for drugs as required in TRICARE Reimbursement Manual, Chapter 1, Section 15 and this section. The electronic report shall arrive no later than the fifteenth (15th) of month in which it is due. As other countries are added, the report shall include these countries.

17. The MCS contractor shall provide an electronic report, annually, identifying all high volume overseas pharmacy providers that have exceeded the $3000, per year billing cap for pharmacy services to TMA, Chief, Claims Operation Office, 16401 East Centretech Parkway, Aurora, CO 80011-9066. The reports shall identify the provider, 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 MCS contractor to issue a provider notification letter (see Figure 12-12.2-8) to TMA identified overseas pharmacy providers 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 on the fifteenth (15th) of the month in which it is due. As other countries are added, the report shall include these countries.

18. For those provider identified annually as high volume providers (determined by total pharmacy services billings exceeding $3,000 in the previous twelve (12) months), the MCS 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 fifteenth (15th) of the month in which it is due. As other countries are added, the report shall include these countries.

19. The MCS contractor is not required to certify host nation providers for care received by stateside beneficiaries (Prime/Standard) who travel overseas and required/ received care.

F. Enrollment.

1. The MCS contractor is not responsible for enrollment requirements outlined in the TRICARE Operations Manual, Chapter 6, Section 1, for of TOP eligible beneficiaries.

2. When processing claims the MCS contractor shall consider the requirements for Enrollment Portability, Split Enrollment, Disenrollment and TRICARE Plus outlined in the TRICARE Operations Manual, Chapter 6 and related requirements outlined in this chapter.

G. Utilization Management/Authorizations.

1. The MCS 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 TRICARE Operations Manual, Chapter 7.

2. The MCS 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 Section 8.1 of this chapter). The MCS 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 MCS contractor shall follow the requirements outlined in the TRICARE Operations Manual, 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 DEERS.

5. The MCS contractor must maintain a preauthorization/authorization file.

6. The MCS contractor must be able to receive a paper authorization form that contains referral/preauthorization/authorization approval. The preauthorization/ authorization form must be approved by TMA, Chief Claims Operations Office. Subsequent changes to the authorization form require TMA approval.

7. The MCS contractor shall verify that the beneficiary, sponsor, provider and service or supply information submitted on the claim are consistent with that authorized and the care was accomplished within the authorized period.

8. When necessary, clarification of discrepancies between authorization data and data on the claims shall be made by the MCS contractor with the appropriate authorizing authority (see Chapter 12, Section 8.1).

9. The MCS contractor shall consider authorizations valid for ninety (90) days (i.e., date of service must be within ninety (90) days of issue date). The MCS contractor shall consider retrospective and chronic authorizations valid for the specific date/care authorized.

10. Procedures for preauthorizations/authorizations for stateside inpatient mental health care have been developed between the MCS contractor 's responsible for processing foreign claims and the overseas Regional Directors in coordination with TMA, Chief, Claims Operations Office. To perform this requirement, the MCS contractor shall at a minimum provide three twenty-four (24) hour telephone lines: one stateside 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 processor when care has been authorized. Additionally the MCS contractor responsible for foreign claims 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 stateside 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, PHP, etc. (Essentially, all admissions defined by the TRICARE/CHAMPUS Policy Manual, 6010.54-M, Chapter 1, Section 7.1, as requiring preauthorization). The MCSC 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 TRICARE Operations Manual, 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 Regional Director to discuss the case. The Overseas Regional Director will provide the schedule and contact information for all

overseas Regional Director mental health advisors. The final decision on whether or not to issue a denial will be made by the contractor.

(2) The 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 TRICARE Operations Manual, Chapter 13.

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

f. The MCSC responsible for processing foreign claims, shall notify the Regional Directors and TMA of any changes to phone and fax numbers.

11. If the MCS contractor has no record of referral/authorization, prior to denial/payment of the claim, the MCS contractor will follow the TOP Point of Service rules, assuming the service would otherwise be covered under TOP, as outlined in Chapter 12, Section 10.2.

12. For other than overseas remote site countries the MCS 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 MCS 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 Regional Director, 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 ICD9, 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 weekly for appropriate Regional Director action/authorization. (See Figure 12-12.2-2 and Figure 12-12.2-3.) The Regional Director shall review the file, designate authorization/denial/or payment under Point of Service and return the file to the MCS contractor within two weeks of its receipt at the Regional Director's office. Upon receipt of the signed Regional Director report directing appropriate action to the MCS contractor, the MCS contractor shall reprocess the claim as directed. When adjustments are required upon resubmission of the second family claim for the third time, by beneficiary or host nation provider, without Regional Director authorization or direction, the MCS contractor shall process the third claim following Point of Service payment procedures. The MCS contractor shall use specific Explanation of Benefits (EOB) messages advising the beneficiaries/host nation providers that authorizations or that care has not been received from a host nation network provider and are required on future claims to avoid Point of Service payment and to contact the appropriate Regional Director for assistance.

H. Claim Development.

1. General.

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

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

(1) Beneficiary/host nation provider signatures.

(2) Complete host nation provider name and address.

(3) A valid payable diagnosis, except when the claim is from Belgium. For claims missing a diagnosis, the MCS contractor shall research their history and apply the diagnosis from a related claim prior to returning the claim. For Belgium claims, the MCS contractor shall use dummy diagnosis codes since Belgium does not use diagnosis codes.

(4) Identification of the service/supply/DME ordered, performed or prescribed. The MCS contractor may use the date the claim form was signed as the specific date of service.

(5) Itemization of total charges. (Itemization of hospital room rates are not required on institutional claims).

c. Usual TRICARE Program itemization requirements are not required if the MCS contractor determines the service/supply/pharmacy/DME is determined to be a benefit of the TOP except for overseas pharmacy claims submitted by high volume overseas providers of pharmacy services. Overseas claims for pharmacy services submitted by TMA approved high volume overseas providers are required to follow the itemization requirements outlined in the TRICARE Operations Manual, Chapter 8, Section 7, including using National Drug Coding. The MCS contractor shall return all claims from overseas pharmacy services submitted by high volume overseas providers without NDC coding, unless the provider has been granted a waiver as outlined in paragraph V.H.1.e. below.

d. The MCS contractor shall use $3,000 as the overseas pharmacy service drug tolerance. A limited waiver to the NDC coding and payment requirements may be granted for overseas pharmacy services claims submitted from low volume/small overseas pharmacy providers or TRICARE eligible beneficiaries from the Philippines, Panama and Costa Rica and any other country designated by TMA, when it would create an undue hardship on a beneficiary. High volume overseas pharmacy providers from the Philippines, Panama and Costa Rica and any other country designated by TMA would not qualify for the limited waiver.

e. The MCS contractor shall use PFPWD claims processing procedures outlined in the TRICARE Policy Manual, Chapter 9 when processing PFPWD overseas claims.

f. The MCS contractor shall deny claims from non-certified or non-confirmed host nation providers when TMA directed MCS contractor certification/confirmation of the host nation provider prior to payment.

g. Requests for missing information shall be sent on the MCS contractor TRICARE/TOP letterhead and shall provide the information outlined in the TRICARE Operations Manual, Chapter 8, Section 7. When development is necessary in TRICARE Europe Region, the MCS contractor shall include a special insert in German, Italian and Spanish which indicates the MCS contractor address for returning requested information.

h. If the MCS contractor elects to develop for additional/missing information, and the requests for additional information are not received/returned within thirty-five (35) days the MCS contractor shall deny the claim.

I. Other TOP Claim Processing Requirements.

1. The MCS contractor must have an automated data system for eligibility, deductible and claims history data and must maintain on the automated data system all the necessary TOP data elements to ensure the ability to reproduce both TRICARE Encounter Data (TED) and Explanation of Benefits (EOBs) as outlined in the TRICARE Operations Manual, Chapter 8, Section 8, except for requiring overseas providers to use Health Care Procedure Coding System (HCPCS) to bill outpatient rehabilitation services, issue provider's the Form 1099 and suppression of checks/drafts for less than $1.00. The MCS contractor is allowed to split claims to accommodate multiple invoice numbers in order to reference invoice numbers on EOBs when necessary.

2. The MCS contractor shall not pay for pharmacy services obtained through the internet.

3. The MCS contractor shall pay all non-emergency and emergency claims for ADSM health care even when not a TRICARE benefit when the claim is:

a. Submitted by the Military Treatment Facility (MTF) or other military command personnel, or by a designated Point of Contact (POC); and

b. Accompanied by a completed and signed TRICARE claim form; and

c. Accompanied by either, a Standard Form 1034, a Standard Form 1035 continuation sheet, or a NAVMED 6320/10 (these forms shall be considered an authorization for payment); and

NOTE: The SF 1034, SF 1035 continuation sheet or NavMed 6320/10 must be signed by the submitting military command. If a patient signature is not present on the claim form, the military command must submit a letter of explanation with the unsigned claim form prior to payment.

d. DEERS verification indicates the active duty member was on active duty at the time the services were rendered.

4. Upon payment for TOP enrolled active duty member overseas/stateside claim, a copy of the EOB and, when applicable, the SF 1034 or SF 1035 or NAVMED 6320/1034, shall also be electronically submitted to the Military Treatment Facility (MTF), or MTF command personnel, or a designated Point of Contact (POC).

5. Emergency submitted active duty service member claims for health care received overseas/stateside and TOP Remote site enrolled ADSM claims, not meeting Chapter 2, Section 6.1 policy on emergency department services shall be denied explaining the reason of denial and advising resubmission with proper forms by the appropriate MTF, etc.

6. The MCS contractor shall deny all active duty service member claims for health care received overseas/stateside when any one of the administrative items outlined above in paragraph V.I.3.a. and b. are missing. Upon denial the MCS contractor shall instruct the active duty member/host nation provider to contact the local MTF or other military command personnel, for assistance in proper claim submission and in obtaining missing documentation. Copies of EOBs and claims denied as DEERS ineligible or not submitted by an MTF shall be electronically forwarded to the appropriate overseas Regional Director for further action.

7. The MCS contractor shall follow the additional specific processing procedures outlined in this chapter when processing claims for TRICARE Europe active duty members stationed in Germany.

8. The MCS contractor shall pay all TOP non-assigned ADSM stateside claims as outlined in Chapter 12, Section 10.1.

9. The MCS contractor shall process claims for TOP Remote site eligible enrolled beneficiaries following the guidelines outlined in this chapter and any additional guidelines/procedures agreed upon between TMA, the overseas Regional Directors and the MCS contractor(s) except for the requirements outlined in paragraph V.I.4. of this section.

10. The MCS contractor shall establish high dollar thresholds of $5,000 for non-institutional claims and $10,000 for institutional TOP claims.

J. Claims Auditing Software.

The Claims Auditing Software requirements outlined in the TRICARE Operations Manual, Chapter 8, Section 9 do not apply to TOP claims.

K. Application Of Deductible.

Application of TOP deductible procedures shall follow the guidelines outlined in the TRICARE Operations Manual, Chapter 8, Section 7 and Chapter 12, Section 2.3, except for the requirements related to claims with negotiated rates.

L. Explanation Of Benefits (EOB) Summary Vouchers.

1. The MCS contractor shall follow the EOB summary voucher requirements in TRICARE Operations Manual, Chapter 8, Section 8, where applicable, with the following exceptions and additional requirements:

a. The issuance of the TOP EOB is not optional for TOP Prime beneficiaries.

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

c. TOP EOBs shall provide a message indicating the exchange rate used to determine payment and shall clearly indicate that "This is not a bill."

d. TOP EOBs for overseas countries with toll-free service shall include the toll-free number for that country. Additionally, TOP EOBs for overseas enrolled active duty member military claims shall be annotated "ACTIVE DUTY."

e. For overseas pharmacy service claims, TOP EOBs must have the name of the provider of service on the claim.

f. EOBs shall be issued on all TOP Remote Site claims processed. Additionally EOB's shall be issued to the remote site contractor, the remote site rendering provider, and remote site beneficiaries when during claims processing the overseas claims processor determines Other Health Insurance (OHI) is available. The EOB should explain that prior to services being paid OHI information is required.

g. For remote site care invoice numbers shall be inserted in the patient account field on the EOB.

h. The following EOB message shall be used on overseas claims rendered by providers requiring TMA/Regional Director/their designee's certification and they have not been certified. "Your provider has not submitted documentation required to validate his/her training and/or licensure for designation as an authorized TRICARE provider."

M. Duplicate Payment Prevention.

The MCS contractor shall follow the duplicate payment prevention requirements outlined in the TRICARE Operations Manual, Chapter 8, Section 9 to include remote site claims.

N. Double Coverage.

1. TOP claims require double coverage review as outlined in the TRICARE Reimbursement Manual, Chapter 4.

2. TOP claims determined by the MCS contractor during processing to have OHI shall be returned for OHI information. Beneficiary/provider disagreements of the MCS

contractor determination shall be coordinated through the overseas Regional Director for resolution with the MCS contractor.

3. The MCS contractor shall consider Japanese National Insurance (JNI) as OHI. Claims involving JNI should include the Japanese insurance points. If the Japanese insurance points are not clearly indicated on the claim/bill, the MCS contractor shall contact the submitter or the appropriate TOP POC for assistance in determining the Japanese insurance points prior to processing the claim. When necessary the MCS contractor may contact the appropriate overseas Regional Director for assistance.

4. For remote site claims the contractor is required to check for OHI. WPS will notify the remote site contractor of required OHI information via the EOB. Upon receipt of the EOB requesting OHI, the remote site contractor will contact the appropriate overseas Regional Director for assistance in obtaining the needed beneficiary OHI information and resolving such claims. The appropriate overseas Regional Director shall notify the overseas claims processor of the needed OHI information to process the claim.

O. Third Party Liability.

1. The MCS contractor shall reimburse TOP claims suspected of Third Party Liability (TPL) and then develop for TPL information. Upon receipt of the information, the MCS contractor shall refer claims/documentation to the appropriate JAG office, as outlined in the TRICARE Operations Manual, Addendum B.

P. Reimbursement/Payment Of Overseas Claims.

1. When processing TOP claims the MCS contractor shall follow the reimbursement payment guidelines outlined in Chapter 12, Section 10.1 and the cost-sharing and deductible policies outlined in 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.

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 Other Health Insurance (OHI) and the MCS 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 above exchange rate methodology to determine deductible and co-payment amounts, if applicable, and to determine the amount to be paid in foreign currency.

e. The MCS contractor shall code lump sum payments instead of line items to minimize conversion problems.

f. Pay TOP host nation provider submitted claims to the host nation provider in foreign currency.

g. Pay TOP claims submitted by a beneficiary which indicates payment to the the beneficiary in foreign currency unless the beneficiary requests payment in U.S. dollars.

h. Shall prior to payment of remote site claims, verify that billed health care charges don't exceed the allowable CHAMPUS rates, Class A, basic rates for zip code 22041 (Washington, DC area). These rates may be found at website http://www.tricare.osd.mil under "Provider Resource" and then "CMAC Rates". Rates billed that exceed these maximums may be denied as unreasonable unless the contractor has been directed by TMA to allow payment at a higher rate. TMA shall notify the contractor of payment exceptions on an as needed basis. The contractor is required to maintain a list of TMA identified exceptions.

i. Pay overseas TOP Remote Site designated provider claims in U.S. dollars. Payment may be made by check or electronic funds transfer as requested.

j. Effective January 1, 2002, payment to Germany, Belgium, Finland, France, Greece, Ireland, Italy, Luxemburg, Netherlands, Austria, Portugal and Spain shall be made in Euro dollars. As other countries transition to Euro, the MCS contractor shall also switch to Euro dollars.

k. Partnership providers treating patients in a foreign country are authorized U.S. dollar payments based upon signed agreements.

l. Not honor any draft request for currency change, except when directed by TMA, Chief, Beneficiary and Provider Services office, once a foreign currency draft has been issued by the MCS contractor and the draft has been returned with the request.

m. 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 active duty member. If the host nation provider has been excluded by the Regional Director from the TRICARE Overseas host nation Preferred Provider Network no payment should be made. Drafts and TEOB shall be mailed using U.S. postage.

n. Shall process overseas eligible TRICARE for Life claims following TRICARE Standard requirement and shall pay overseas eligible TRICARE for Life claims as first payor applying a 25% cost-share.

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

TOP ELIGIBLE STANDARD BENEFICIARIES (EXCLUDING ADSM)

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 provider
All stateside/host nation providers.	No See below for stateside authorization exception.	TRICARE Standard	Directly to the host nation provider in TRICARE Europe unless claims indicate pay beneficiary. All other areas as noted on the claim.
Stateside Non-Emergency Inpatient Mental Health Care with authorization.	Yes	TRICARE Standard	Directly to stateside provider in TRICARE Europe unless claims indicate pay beneficiary. All other areas as noted on the claim.
Stateside Non-Emergency Inpatient Mental Health Care without authorization.	Yes	Deny claim.	No payment made.

ACTIVE DUTY FAMILY MEMBERS ENROLLED IN TRICARE PRIME (EXCLUDING ADSM):

IF THE CLAIM IS SUBMITTED:	AUTHORIZATION REQUIRED	PROCESSING ACTION:	AND PAYMENT IS MADE IN THE FOLLOWING MANNER:
Partnership	No	No deductible/cost-share.	Directly to host nation provider.
Mental Health Care Session 1-8 Fiscal year (dx 290-319) without authorization.	No	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.
Mental Health Care (dx 290-319) Session 9 and above/fiscal year with authorization.	Yes	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.

ACTIVE DUTY FAMILY MEMBERS ENROLLED IN TRICARE PRIME (EXCLUDING ADSM): (CONTINUED)

IF THE CLAIM IS SUBMITTED:	AUTHORIZATION REQUIRED	PROCESSING ACTION:	AND PAYMENT IS MADE IN THE FOLLOWING MANNER:
Mental Health Care (dx 290-319) Session 9 and above/fiscal year without authorization.	Yes	Point of Service.	No payment made.
Stateside except emergency/urgent with authorization.	Yes	TRICARE Prime.	Directly to stateside provider in TRICARE Europe unless claims indicate pay beneficiary. All other areas as noted on the claim.
Stateside except emergency/urgent without authorization.	Yes	TRICARE Point of Service.	Directly to stateside provider in TRICARE Europe unless claims indicate pay beneficiary. All other areas as noted on the claim.
Claims for Emergency care and ancillary services.	No	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.
Claims for TRICARE approved drugs.	No	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.
Program for Persons with Disabilities (PFPWD).	Yes	Deductible/cost-share as outlined in Chapter 9.	Directly to the host nation provider in TRICARE Europe unless claim indicates pay beneficiary. All other areas as noted on the claim.

ACTIVE DUTY FAMILY MEMBERS ENROLLED IN TRICARE PRIME (EXCLUDING ADSM): (CONTINUED)

IF THE CLAIM IS SUBMITTED:	AUTHORIZATION REQUIRED	PROCESSING ACTION:	AND PAYMENT IS MADE IN THE FOLLOWING MANNER:
All other care from Belgium, Germany, Guam, Iceland, Italy, Japan, Korea, Portugal (Azores), Spain, Turkey and the United Kingdom rendered by a host nation network or non-network provider with authorization.	Yes	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.
All care from Belgium, Germany, Guam, Iceland, Italy, Japan, Korea, Portugal (Azores), Spain, Turkey and the United Kingdom rendered by a non-network host nation provider without an authorization.	Yes	First family claim No deductible/cost-share. Second family claim No deductible/cost-share. Third family claim Point of Service cost-sharing and deductible apply.	Directly to the host nation provider in TRICARE Europe unless the claims indicate pay beneficiary. All other areas as noted on the claim.
TOP remote site care (see Figure 12-12.2-4 and Figure 12-12.2-5).	No	Deductible/cost-share waive.	Directly to submitter.

TOP ADSM (ENROLLED/NON-ENROLLED):

IF THE CLAIM IS SUBMITTED:	AUTHORIZATION REQUIRED	PROCESSING ACTION:	AND PAYMENT IS MADE IN THE FOLLOWING MANNER:
Overseas care, including dental, with SF 1034/1035 or NAVMED6320 and all required documentation, including Partnership Provider care.	Yes	No deductible/cost-share.	Directly to the host nation/stateside provider unless otherwise noted on the claim
Overseas care without SF 1034/1035 or NAVMED6320 and/or missing necessary required documentation.	Yes	Deny claim.	No payment made.

TOP ADSM (ENROLLED/NON-ENROLLED): (CONTINUED)

IF THE CLAIM IS SUBMITTED:	AUTHORIZATION REQUIRED	PROCESSING ACTION:	AND PAYMENT IS MADE IN THE FOLLOWING MANNER:
Overseas remote site location care (see Figure 12-12.2-4 and Figure 12-12.2-5).	No	No deductible/cost-share.	Directly to submitter.
Stateside care with authorization.	Yes	No deductible/cost-share.	Directly to provider.
Stateside care for non-emergent inpatient mental healthcare without authorization.	Yes	Deny claim.	No payment made.

3. MCS contractors shall allow TOP ADSM to use the MCS contractors stateside retail pharmacy network under the same contract requirements as other MHS eligible beneficiaries (see Chapter 8, Section 9.1).

4. MCS contractors responsible for processing TOP claims shall allow TOP enrolled ADFM beneficiaries to use their stateside retail pharmacy network under the same contract requirements as other MHS eligibles (see Chapter 8, Section 9.1).

5. Stateside MCS contractors shall process claims for overseas health care received by TRICARE beneficiaries enrolled to or residing in a stateside MCSC region following the guidelines outlined in this chapter, but shall apply the usual financial underwritten requirements specific to their region for referral/authorization, copays, cost shares and deductibles to determine final payment. Payment shall be made from the at-risk account and shall be based on the billed charges.

Q. Claims Adjustment And Recoupment.

1. The MCS contractor shall follow the adjustment requirements in the TRICARE Operations Manual, Chapter 11 except for the requirements related to financially underwritten funds.

2. The MCS contractor shall follow the recoupment requirements in the TRICARE Operations Manual, Chapter 11 except for the requirements related to providers. The MCS contractor shall use the following procedures for host nation provider recoupments. The MCS contractor shall:

(1) Send an initial demand letter.

(2) Send a second demand letter at sixty (60) days.

(3) Send a final demand letter at one hundred-twenty (120) days.

(4) Refer the case to TMA at one-hundred and eighty (180) days, if the case is over $600.00, and if under $600.00 the case shall remain open for an additional six (6) months and then shall be written off at three-hundred and sixty (360) days.

3. Recoupment letters (i.e., the initial letter, the sixty (60) day second request and the one hundred twenty (120) day final demand letter) shall be modified to delete references to U.S. law. Invoice numbers shall be provided on all recoupment letters. The MCS contractor shall include language in the recoupment letter requesting that refunds be returned/ provided in even dollars.

4. Recoupments letters sent to Germany, Italy and Spain, shall be written in the respective language

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

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

7. The MCS contractor shall have a TOP bank account capable of receiving/ accepting wire transfers from overseas for recoupment/overpayment returns. The MCS contractor shall accept the amount wired, together with the host nation provider's wiring fee, as total recoupment payment.

R. The MCS contractor Customer Service Responsibilities.

TOP customer support is to TOP/stateside Regional Directors, TOP host nation provider, TOP beneficiaries, designated Points of Contact, TOP HBAs, MCS contractors, and TMA and shall include the following:

1. The MCS contractor shall secure at a minimum one (1) dedicated post office box for the receipt of all claims and correspondence from foreign locations.

2. The MCS contractor shall identify a specific individual and an alternate as TRICARE Overseas Coordinator for the Regional Directors, TMA and stateside MCS contractors.

3. The MCS 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 MCS 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 MCS contractor's point of contact for TRICARE Overseas claims and related operational and support services. The MCS contractor's special department for TRICARE Overseas claims shall include at a minimum the following functions/ requirements:

5. The MCS 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 MCS 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.

6. The MCS 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.

7. The MCS contractor shall provide to each TOP Regional Director on-line read only access to their claims processing system. The MCS contractor shall refer beneficiary, provider, Health Benefit Advisors and Congressional inquires not related to claims status to TMA Chief, Beneficiary and Provider Services Office. The MCS contractor shall refer unresolved Regional Director issues to TMA, Chief Claims Operations Officer.

8. The MCS contractor shall provide an E-mail address for receipt of customer claims status inquiries.

9. The MCS contractor/Regional Directors shall work together when necessary to resolve beneficiary/provider overseas claims issues.

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

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

S. Appeal And Hearings.

The MCS contractor is required to follow the requirements outlined in 32 CFR 199.10 and the TRICARE Operations Manual, Chapter 13 related to appeals and hearing process except for remote site claims. For remote site claims the appeals and hearing process is as follows:

1. Pre-Authorization. The remote site contractor 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 remote site contractor and after initial denial determination by the remote site contractor, 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 remote site contractor after initial determination by remote site contractor, the ADSM or their appointed representative may appeal the denial of benefit/treatment to the appropriate regional

Director. The decision of the appropriate Regional Director is the final determination. The MCSC is required to maintain a log by Regional Director of overturned disputes.

4. Reconsiderations for remote site contractor initial denial determinations shall be appealed/directed to the overseas claims processor. The overseas claims processor shall perform the reconsideration review.

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

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

The MCS contractor shall comply with the HIPAA requirements related to foreign claims processing, in the TRICARE Operations Manual, Chapter 21.

U. Audits, Inspections And Reports.

1. The MCS contractor is required to follow the requirements outlined in the TRICARE Operations Manual, Chapter 15 related to Audits and Inspections.

2. TOP claims shall be included in the TMA quarterly claim audit.

3. The MCS contractor is required to submit the monthly reports as outlined in the TRICARE Operations Manual, Chapter 15, Sections 3 and 4 except for the:

a. MCS Contractor TRICARE Service Center Telephone Report.

b. Monthly Beneficiary Telephone Call Requesting Participating Provider Information Report.

4. The MCS contractor is required to follow the guidelines outlined in the TRICARE Operations Manual, Chapter 15, Section 5, related to Fraud & Abuse. In cases involving check fraud, the MCS contractor is not required to reissue checks until the investigation is finalized and the contractor has received the money back from the investigating bank.

5. The MCS contractor is not required to submit the Management Data Reporting outlined in the TRICARE Operations Manual, Chapter 15, Section 6, except for:

a. The Quality Management Activity Report.

b. The Staffing Level Report (required annually).

6. All reports shall be submitted electronically using Microsoft Office compatible software and must be sortable by all fields and by TOP Regional Director.

7. All reports, annual, monthly or quarterly, shall arrive no later than the fifteenth (15th) of the month. The reports shall be sent to the TRICARE Management Activity, Chief, Claims Operations Office, 16401East Centretech Parkway, Aurora, CO 80011-9066.

8. The MCS contractor shall submit the following TOP reports sorted by TOP Region/TOP Regional Director:

a. 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 Army National Guard), Fiscal Year in which services were provided, Country where services are provided, TOP Region, Active Duty Member's Name, Duty Station Address, SSN, begin and end Dates of Service, ICD9 Code, CPT-4 Code, Host Nation Provider Name, Host Nation Provider Address, Amount Billed, Amount Allowed, if available TED ICN Number. This report will also have a summary page showing current claim inventory and processing cycle time.

b. 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 Army National Guard), Fiscal Year in which services were provided, Country where services are provided, TOP Region, Active Duty Member's Name, Duty Station Address, SSN, begin and end Dates of Service, ICD9 Code, CPT-4 Code, Host Nation Provider Name, Host Nation Provider Address, Amount Billed, Amount Allowed, if available TED ICN Number. This report will also have a summary page showing current claim inventory and processing cycle time.

c. 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 Army National Guard), Fiscal Year in which services were provided, country where services are provided, TOP Region, Active Duty Member's Name, Duty Station Address, SSN, begin and end Dates of Service, ICD9 Code, CPT-4 Code, Host Nation Provider Name, Host Nation Provider Address, Amount Billed, Amount Allowed, if available HCSR ICN Number. This report will also have a summary page showing current claim inventory and processing cycle time.

d. Monthly PAID CLAIMS AND CURRENT INVENTORY TOP REMOTE SITE ACTIVE DUTY FAMILY MEMBER REPORT. The fields to be reported are: DMIS-ID, Branch of Service, (to include a breakout for Army National Guard), Fiscal Year in which services were provided, country where services are provided, TOP Region, Active Duty Member's Name, Duty Station Address, SSN, begin and end Dates of Service, ICD9 Code, CPT-4 Code, Host Nation Provider Name, Host Nation Provider Address, Amount Billed, Amount Allowed, if available HCSR ICN Number. This report will also have a summary page showing current claim inventory and processing cycle time.

e. Monthly PAID CLAIMS AND CURRENT INVENTORY RETIREES AND DEPENDENTS OF REITREES REPORT. The fields to be reported are: DMIS-ID, Branch of Service, (to include a breakout for Army National Guard), Fiscal Year in which services were provided, country where services are provided, TOP Region, Active Duty Member's Name, Duty Station Address, SSN, begin and end Dates of Service, ICD9 Code, CPT-4 Code, Host Nation Provider Name, Host Nation Provider Address, Amount Billed, Amount Allowed, if

available HCSR ICN Number. This report will also have a summary page showing current claim inventory and processing cycle time.

f. Monthly TOTAL CLAIMS BY COUNTRY FOR ACTIVE DUTY AND ACTIVE DUTY FAMILY MEMBERS RETIREES AND DEPENDENTS OF RETIREES REPORT. For each region the report shall include the following fields sorted by county, number of claims, amount billed, amount paid, 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 and institutional and non-institutional. There will be separate lines for Active Duty and Active Duty family members and a total run. This report shall be submit as 2 reports. One for institutional claims & one for non-institutional claims. The report shall be supplied on an Excel spreadsheet.

g. Monthly HOST NATION NETWORK PROGRSS 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 and amount allowed. This report shall be supplied on an Excel spreadsheet.

h. Monthly SUMMARY PROGRESS REPORT. The report shall summarize for the month, the percentage of claims provided by network, non-network and Partnership Providers.

i. Quarterly HOST NATION PROVIDER REPORT. This report shall list all providers who were network during the quarter. Data to be reported includes Country, Provider Tax ID, Provider Sub-ID, specialty, effective and expiration dates in the network, Provider Name and Address.

j. Monthly TRICARE EUROPE ACTIVE DUTY MEMBER AND OTHER ADSM CONUS/OCONUS CLAIMS REPORT. This is a one page summary report sent to TRICARE Europe Regional Directors showing current claims and adjustment inventory and processing cycle time.

k. 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 in an Excel spreadsheet.

l. Monthly TRICARE Europe Active Duty Member and other ADSM Stateside/Overseas claims to the following military offices:

(1) Director, TRICARE Europe Office/TEO
Unit 10310
APO AE 09136-0005

(2) Fleet Surgeons Office, U.S. Navy Europe
Fleet Medical Officer
CINCUSNAVEUR
PSC 802 Box 2
APO AE 09499-0151

(3) U.S. Air Force In Europe
HQ USAFE/SG
Unit 3050 Box 130
APO AE 09094-0130

(4) Commander, U.S. Army Europe ERMC
CMDR Europe Regional Medical Center
Attn: Managed Care Division
CMR 402
APO AE 09180

(5) U.S. Central Command
HQ USCENTCOM (CCSG)
715 South Boundary Blvd.
MacDill AFB, FL 33621-5101

(6) TPLA
MHCK-LA
1 Jarret and White Road
Tripler AMC, HI 96859-5000

NOTE: Each of the military services will establish a designated Point of Contact in each of the above listed military offices to work with the MCS contractor if additional information is needed.

- END -