CHAPTER 12
SECTION 10.1

PAYMENT POLICY

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I. POLICY

A. With the exception of Puerto Rico and prescription drugs, reimbursement of all TOP beneficiary claims for overseas health care shall be based upon the billed charges. (See Chapter 12, Section 11.1 for additional guidelines). Puerto Rico claims shall be reimbursed following stateside reimbursement guidelines.

B. Payment of Skilled Nursing Facility (SNF) claims from Puerto Rico and the U.S. Territories (Guam, the Virgin Islands and American Samoa) shall be 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 TRICARE Reimbursement Manual (TRM), Chapter 8):

a. Preauthorization for SNF care is not a requirement; it is discretionary. The review for the lower 18 RUGs for SNF care is required as provided in the TRM, Chapter 8, Section 2. The contractor is responsible for the reviews of the lower 18 RUGs and any discretionary preauthorization.

b. 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. For a failure to obtain other pre-authorizations/authorizations, the payment reduction policy in TRM, Chapter 1, Section 29 will apply.

c. The Managed Care Support Contractor (MCSC) will be responsible for collection of MDS assessment data. However, collection of the MDS assessment data is discretionary as provided in the TRICARE Reimbursement Manual, Chapter 8, Section 2.

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

e. The overseas MCSC, 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 Regional Directors

in obtaining/providing SNF data, for conducting any SNF PPS data analysis they deem necessary.

f. The overseas MCSC shall be required to submit the quarterly report to the government contractor as designated by TMA as required by the TRM, Chapter 8, Section 2.

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

D. For health care rendered in Puerto Rico and in the U.S., reimbursement or all TOP beneficiary care shall follow the TRICARE payment policies except as outlined in paragraph E. below.

E. Non-assigned provider claims for ADSM stateside health care shall be paid following normal TRICARE stateside 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% 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 Regional 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 Regional 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.

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.

In no case shall a uniformed service member be subjected to "balance billing" or ongoing collection action by a civilian provider or 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 Regional Director. The appropriate Regional Director will issue an authorization to the contractor for payments in excess of CMAC or other applicable TRICARE payment ceilings, provided the Regional Director has requested and has been granted a waiver from the Chief Operating Officer (COO), TRICARE Management Activity, or designee.

F. TGRO contractor claims submitted for ADFMs not enrolled in TOP Prime shall be paid following TOP standard cost-sharing provisions. The overseas MCSC's EOB shall advise the TGRO contractor that the beneficiary was not enrolled in TOP Prime and the claim was processed as a standard overseas beneficiary claim. Upon receipt of the EOB, the TGRO

contractor shall contact the appropriate overseas Regional Director for assistance in correcting the enrollment for the ADFM.

G. Overseas drug claims shall be paid following the guidelines outlined in the TRICARE Reimbursement Manual, 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 stateside medical necessity guidelines outlined in Chapter 8, Section 1.1.

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