Chapter 24 Section 3

Financial Administration

1.0 GENERAL

All TRICARE requirements regarding Financial Administration shall apply to the TRICARE Overseas Program (TOP) unless specifically changed, waived, or superseded by this section; the TRICARE Policy Manual (TPM), Chapter 12; or the TRICARE contract for health care support services outside the 50 United States and the District of Columbia (hereinafter referred to as the "TOP contract"). See Chapter 3 for additional instructions.

2.0 PAYMENT POLICY

2.1 Reimbursement of TOP beneficiary claims for overseas health care shall be based upon the lesser of billed charges, the negotiated reimbursement rate, or the government-established fee schedule. (See Section 9 and the TRICARE Reimbursement Manual (TRM), Chapter 1, Sections 34 and 35 for additional guidelines). Except for medical evacuations, claims for care in the U.S. commonwealths and territories shall be reimbursed following stateside reimbursement guidelines. Philippines and Panama claims shall be reimbursed following government-established fee schedules, unless the TOP contractor has negotiated a lesser rate with a purchased care sector provider.

2.2 Payment of Skilled Nursing Facility (SNF) claims from Puerto Rico and the U.S. territories (Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands) 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). SNF care is not available in other TOP locations.

2.2.1 TRICARE contractors, at their discretion, may conduct concurrent or retrospective review for Standard (through December 31, 2017) and TRICARE Select (starting January 1, 2018) and TRICARE for Life (TFL) patients when TRICARE is the primary payer. If Medicare requires reviews to be performed on low Patient Driven Payment Model (PDPM) categories, per the Medicare Policy Manual Chapter 8, the contractor will be responsible for all reviews for TRICARE Primary patients. There will be no review for Standard (through December 31, 2017) and TRICARE Select (starting January 1, 2018) or TFL patients where TRICARE is the secondary payer. The existing referral and authorization procedures for Prime beneficiaries will remain unaffected.

2.2.2 Beneficiaries in a low PDPM category depending on date of service may 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.

2.2.3 The TOP contractor, at their own discretion, may collect Minimum Data Set (MDS) assessment data per the TRM, Chapter 8, Section 2.

2.3 The TOP contractor shall be responsible for entering into participation agreements with SNFs in Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands.

2.3.1 The TOP 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 PDPM category. 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.

2.4 Balance billing provisions do not apply to TOP beneficiary claims for care rendered in a foreign country and paid as billed, since there is no unpaid balance on these claims. Purchased care sector network providers, participating providers, and providers in U.S. commonwealths and territories are prohibited from balance billing.

2.5 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 below.

2.5.1 TOP ADSMs who have been required by the provider to make "up front" payment at the time services are rendered may submit a claim for reimbursement directly to the contractor. Normal TRICARE claims processing requirements apply (including any authorization requirements and the use of TRICARE-approved claims forms). If the claim is payable, the contractor shall allow the billed amount and reimburse the ADSM for charges on the claim.

2.5.2 In no case shall an ADSM 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, Defense Health Agency (DHA), or designee.

2.5.3 Overseas drug claims shall be paid following the instructions in Section 9 and the TRM, Chapter 1, Section 15.

2.5.4 Overseas ambulance service claims shall be paid following the instructions in Section 7 and Chapter 8, Section 1; TPM, Chapter 8, Section 1.1, and TRM, Chapter 1, Section 14.

2.5.5 Payment may be made for ambulance services provided by commercial transport (see Section 7 for additional processing instructions for these claims).

2.5.6 The provisions of Chapter 3, Section 2, paragraph 2.1 are applicable to the TOP except for the optional provisions of Electronic Funds Transfer (EFT) payments to TOP beneficiaries. The TOP contractor is required to make EFT payments to all TOP beneficiaries (upon beneficiary request) when the beneficiary requests payment to a U.S. bank account or other U.S. financial institution.

2.5.7 The provisions of Chapter 3, Section 2, paragraph 2.2 are not applicable to the TOP. The TOP contractor may not require purchased care sector providers who submit claims electronically to accept an electronic remittance advice and to receive payment by Electronic Funds Transfer (EFT). These electronic processes are optional for purchased care sector providers since they may create a financial burden for the provider.

3.0 FINANCIAL ADMINISTRATION

3.1 The TOP contractor shall follow the Financial Administration non-financially underwritten funds requirements in Chapter 3 with the following exceptions:

3.1.1 Foreign overseas drafts (local currency) and checks (U.S. currency) shall also reflect "TRICARE Overseas Program".

3.1.2 Foreign overseas 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 TOP contractor with a request for reissuance. The contractor shall issue drafts/checks for Germany claims which look like local German drafts/checks.

3.2 The TRICARE Encounter Data (TED) for the overseas claims shall be reported on vouchers/batches according to the TRICARE Systems Manual (TSM), Chapter 2 and as follows for remote sites:

3.2.1 Active Duty Family Member (ADFM) and ADSM remote site claims, excluding 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 non-financially underwritten foreign bank account. They shall be submitted like all other claims currently processed from that account.

3.2.2 Navy deployed and/or deployed on liberty emergent or urgent care claims shall be submitted on a separate voucher. A separate bank account will be established for these beneficiaries. The Automated Standard Application for Payment (ASAP) account on the voucher header will identify the voucher as Navy.

3.2.3 Marine Corps deployed and/or deployed on liberty emergent or urgent care claims shall be submitted on a separate voucher. A separate bank account will be established for these beneficiaries. The ASAP account on the voucher header will identify the voucher as Marine Corps.

3.2.4 Claims for retirees and their eligible family members living in a remote site shall be submitted on vouchers instead of batches and shall be paid from the current non-financially underwritten bank account. They shall be submitted on the same voucher as all other claims currently processed from that account.

3.2.4.1 Claims for care rendered in the United States or the District of Columbia to TOP ADSM, ADFM, retirees and their dependents living in a remote overseas site shall be submitted on vouchers and shall be paid from the current non-financially underwritten bank account. They shall be submitted on the same voucher as all other claims currently processed from that account.

3.3 For other than remote site claims:

3.3.1 TOP eligible ADSM and ADFM claims shall be submitted on vouchers and shall be paid from the current non-financially underwritten bank account. They shall be submitted on the same voucher as all other claims currently processed from that account.

3.3.2 Claims for retirees and their eligible family members living overseas shall be submitted on vouchers and shall be paid from the current non-financially underwritten or TFL/accrual fund bank accounts. They shall be submitted on the same voucher as all other claims currently processed from that account.

3.3.3 TOP Prime (ADSM and ADFM) and TOP Standard (through December 31, 2017) and TOP Select (starting January 1, 2018) beneficiary stateside claims for health care shall be submitted on vouchers and shall be paid from the current non-financially underwritten bank account. They shall be submitted on the same voucher as all other claims currently processed from that account.

3.3.4 Overseas health care claims for stateside beneficiaries whose health care is normally provided under one of the three regional Managed Care Support Contracts (MCSCs) (i.e., beneficiaries enrolled or residing in the 50 United States or the District of Columbia, who receive care while traveling or visiting abroad) shall be processed by the TOP contractor. Claims for these beneficiaries shall be paid from the current non-financially underwritten bank account. This provision does not apply to beneficiaries who are enrolled to the Uniformed Services Family Health Plan (USFHP) or the Continued Health Care Benefit Program (CHCBP). Claims for these beneficiaries are processed by their respective contractor regardless of where the care is rendered.

3.4 The TOP contractor shall:

3.4.1 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. Reporting requirements for net gains/losses are identified by DD Form 1423, Contract Data Requirements List (CDRL), located in Section J of the applicable contract.

3.4.2 The TOP contractor shall calculate currency gains and losses resulting from payments made to host nations 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. The difference between the cost of the foreign currency on the ending date of care and the contractor payment date shall be the gain or loss on the transaction. Payment shall be as follows for:

3.4.2.1 Net Gain. For months that result in a net gain, the TOP contractor shall forward the report along with their check payable to the Department of Defense (DoD), DHA, for the gain from currency conversion.

3.4.2.2 Net Loss. DHA will reimburse the TOP 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 DHA will usually be made within five working days of receipt of the invoice and the TRICARE Overseas Currency report.

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