

## Pharmacy Claims Processing

Revision: C-76, October 5, 2020

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### 1.0 CLAIM TYPES

#### 1.1 Electronic Claims

**1.1.1** An electronic claim is a Health Insurance Portability and Accountability Act (HIPAA) compliant electronic transmission between the contractor and a mail order or network pharmacy which results in a dispensed pharmaceutical or authorized supply.

**1.1.2** A prescription order that does not result in a dispensed pharmaceutical is not a claim.

#### 1.2 Other Claim Types

**1.2.1** A Direct Member Reimbursement (DMR) claim is a beneficiary request for reimbursement of a dispensed pharmaceutical or covered medical supply. (See [Section 2](#) for information regarding what pharmaceutical claims are not covered by the Pharmacy contract.) DMRs constitute any of the following:

- Claims for beneficiaries who use non-network **pharmacies**; or
- Claims for beneficiaries who have Other Health Insurance (OHI) and are requesting TRICARE reimbursement as second **payer**; or
- Claims for covered pharmaceuticals and supplies purchased in a retail pharmacy that do not require a prescription.

**1.2.2** Claims may be submitted in other methods. Section B of the contract will determine whether these receive the electronic or paper transaction fee.

**1.2.3** A completed **DMR** claim can result in either benefit allowance or denial. However, **the contractor shall not deny** a claim for missing, incomplete or discrepant information. Rather, the contractor **shall** first use in-house methods (e.g., contractor files, telephone, Defense Enrollment Eligibility Reporting System (DEERS)) to obtain the missing or discrepant information. If this is unsuccessful, the contractor **shall** return the claim to the sender requesting all known missing information or required documentation (see [Chapter 8, Section 6](#)). **If the contractor returns a claim** for missing or discrepant information, **the contractor shall not process the claim** to completion and **deny** for this reason. **The contractor shall not submit a TRICARE Encounter Data (TED) record** for the returned claim. Otherwise, the contractor shall submit a TED record **for every claim processed to completion** to the Defense Health Agency (DHA) in accordance with the TRICARE Systems Manual (TSM).

**1.2.4** The contractor shall accept claims from State Medicaid agencies in accordance with TRICARE Reimbursement Manual (TRM), Chapter 1, Section 20.

**1.2.5** The contractor shall accept claims from a non-network pharmacy in a paper format, electronically through a claims clearinghouse, or on a tape/CD.

**1.2.6** The contractor shall accept claims from a network pharmacy in paper format for claims that could not be processed electronically due to a system issue.

## 2.0 OHI AND CLAIMS PROCESSING

**2.1** The contractor shall investigate all pharmacy claims for possible OHI coverage prior to a pharmaceutical being dispensed (for mail order and retail network claims) or prior to adjudication (for paper claims). (See TRM, Chapter 4, for double coverage review requirements.)

**2.2** If a beneficiary has OHI that includes pharmacy coverage (except for Medicaid), the other insurer shall be first payer except as described in TRM, Chapter 4.

**2.3** TRICARE cost-sharing of medications through a Medicare Part D prescription drug plan is subject to the double coverage provisions found in 32 CFR 199.8 and TRM, Chapter 4.

## 3.0 CATASTROPHIC CAP AND DEDUCTIBLE DATA (CCDD)

### 3.1 TRICARE Catastrophic Cap and Deductible (CC&D)

**3.1.1** The contractor shall update CC&D amounts on DEERS using the CCDD file application in accordance with the TSM.

**3.1.2** As part of a pharmacy transaction when the contractor initially queries DEERS for eligibility information using the "Claims Coverage" inquiry, the response will include CC&D totals.

**3.1.3** The contractor shall use this information to determine whether a beneficiary has met their catastrophic cap and apply necessary copayments or deductibles or both.

**3.1.3.1** If the query response shows that the catastrophic cap has been met, that contractor shall not apply or collect any copayment amount.

**3.1.3.2** If the query response shows the catastrophic cap has not been met, the contractor shall apply and collect the appropriate copayment amount (or portion thereof if application of the full copayment amount results in the catastrophic cap total being exceeded).

**3.1.4** After a copayment has been collected, the contractor shall submit a transaction to update the catastrophic cap amount on DEERS. If during this update, CCDD file shows that the cap is now met (due to an intervening transaction that occurred from the time between the initial eligibility inquiry and the update transaction), the contractor shall take the following actions:

**3.1.4.1** Proceed with the update transaction and apply the copayment amount to the CCDD file catastrophic cap totals (which shall result in the cap being exceeded).

**3.1.4.2** Initiate a refund of the copayment amount (or appropriate portion thereof which exceeds the cap amount) to the beneficiary. Once the refund has been sent, the contractor **shall** adjust (i.e., correct) the CCDD file totals to reflect the refunded copayment amount.

**3.1.4.3** Ensure this correction action **shall** result in the CCDD file total reflecting that the cap has been met, but not exceeded. (If the contractor previously submitted a TED record, the contractor **shall** submit an adjustment to the TED record to correct the copayment amount.)

## **3.2 Continued Health Care Benefits Program (CHCBP) CC&D**

**3.2.1** CHCBP CC&D totals are maintained by the CHCBP contractor.

**3.2.2** The CHCBP contractor and pharmacy contractor **shall** develop an automated exchange process for sharing current CHCBP CC&D totals **at least once a month**. This automated process allows both the CHCBP contractor and pharmacy contractor to reimburse beneficiaries for any overpayments after the date the CHCBP catastrophic cap or deductible is met and to prevent future overpayments from occurring during that fiscal year.

**3.2.3** The contractor **shall complete the corrections** prior to next automated file exchange. If the CHCBP CC&D totals change and the result is underpayments, the contractors **shall** also be responsible for recoupments.

## **4.0 PRIOR AUTHORIZATION AND MEDICAL NECESSITY**

### **4.1 Prior Authorization**

**4.1.1** Some medications require prior authorization before being dispensed. Medications requiring prior authorization include, but not limited to, those established by the Government such as brand name medications with a generic equivalent, medications with age limitations, and medications requiring a quantity limit override.

**4.1.2** Instructions on how to find information on drugs requiring prior authorization, prior authorization forms, and review criteria can be found at <https://tricare.mil/CoveredServices/Pharmacy/ManageScripts/PriorAuth>.

**4.1.3** Government review criteria are not available for all circumstances requiring prior authorization. If Government review criteria are not available, the contractor shall develop review criteria for these circumstances. For example, there is no Government-provided review criteria for quantity limit overrides.

### **4.2 Medical Necessity Reviews**

**4.2.1** Some medications may be designated as non-formulary agents, affecting the cost-share at retail and mail order points of service, as well as access at a Military Treatment Facility (MTF)/Enhanced Multi-Service Market (eMSM).

**4.2.2** If medical necessity is established, the prescription shall be dispensed with the formulary copayment amount applied.

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**4.2.3** Instructions on how to find information on non-formulary drugs, medical necessity forms, and review criteria can be found at <http://www.tricare.mil/CoveredServices/Pharmacy/Drugs/NonFormulary>.

**4.2.4** In general, in order to establish medical necessity for a pharmaceutical agent designated non-formulary under the Uniform Formulary Rule, one or more of the following criteria shall be met for available formulary alternatives, based on developed criteria:

**4.2.4.1** The use of the formulary alternative is contraindicated;

**4.2.4.2** The patient experiences, or is likely to experience, significant adverse effects from the formulary alternative, and the patient is reasonably expected to tolerate the non-formulary medication;

**4.2.4.3** The formulary alternative results in therapeutic failure, and the patient is reasonably expected to respond to the non-formulary medication;

**4.2.4.4** The patient previously responded to a non-formulary medication, and changing to a formulary alternative would incur unacceptable clinical risk; or

**4.2.4.5** There is no formulary alternative.

**4.3** Prior Authorization and Medical Necessity criteria are specified within the approved Department of Defense (DoD) Pharmacy and Therapeutics Committee (DoD P&T) minutes, available at <https://www.health.mil/formulary>.

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