

Chapter 16

Section 4

Contractor Responsibilities And Reimbursement

Revision: C-58, September 20, 2019

1.0 CONTRACTOR RECEIPT AND CONTROL OF CLAIMS

1.1 The contractor may establish a dedicated post office box to receive claims related to the TRICARE Prime Remote (TPR) Program. This dedicated post office box, if established, may also be the one used for handling Supplemental Health Care Program (SHCP) claims.

1.2 The contractor shall follow appropriate SHCP requirements for claims received for medical care furnished to Service members not enrolled in the TPR Program.

2.0 CLAIMS PROCESSING

2.1 Jurisdiction

2.1.1 The contractor shall process inpatient and outpatient medical claims for health care services provided worldwide to the contractor's TPR enrollees, except in the case of care provided overseas (i.e., outside of the 50 United States (U.S.) and the District of Columbia). Civilian health care while traveling or visiting overseas shall be processed by the TRICARE Overseas Program (TOP) contractor, regardless of where the beneficiary is enrolled. The contractor shall process claims for non-covered benefits in accordance with [Section 2, paragraph 5.3.2.2](#).

2.1.2 The contractor shall forward claims for Service members enrolled in TPR in other regions to the contractors for the regions in which the members are enrolled according to provisions in [Chapter 8, Section 2](#).

2.1.3 The contractor shall process claims received for Service members who receive care in their regions, but who are not enrolled in TPR, according to the instructions applicable to the SHCP.

2.1.4 The contractor shall forward Service member dental claims and inquiries to the Active Duty dental program contractor.

2.2 Claims for Care Provided Under the National DoD/DVA Memorandum of Agreement (MOA) for Spinal Cord Injury (SCI), Traumatic Brain Injury (TBI), and Blind Rehabilitation

2.2.1 Effective January 1, 2007, the contractor shall process claims for Service member care provided by the DVA/VHA for SCI, TBI, and Blind Rehabilitation. Claims shall be processed in accordance with this chapter and the following:

2.2.1.1 Claims received from a DVA/VHA health care facility for Service member care with any of the following diagnosis codes (principal or secondary) shall be processed as an MOA claim: V57.4; 049.9; 139.0; 310.2; 323.x; 324.0; 326; 344.0x; 344.1; 348.1; 367.9; 368.9; 369.01; 369.02; 369.05; 369.11; 369.15; 369.4; 430; 431; 432.x; 800.xx; 801.xx; 803.xx; 804.xx; 806.xx; 851.xx; 852.xx; 853.xx; 854.xx; 905.0; 907.0; 907.2; and 952.xx.

2.2.1.2 The contractor shall verify whether the MOA DVA/VHA-provided care has been authorized by the Defense Health Agency-Great Lakes (DHA-GL) Specified Authorization Staff (SAS). SAS will send authorizations to the contractor by fax. If an authorization is on file, the contractor shall process the claim to payment. The contractor shall not deny claims for lack of authorization. Rather, if a required authorization is not on file, the contractor shall place the claim in a pending status and will forward appropriate documentation to SAS for determination.

2.2.2 MOA claims shall be reimbursed as follows:

2.2.2.1 Claims for inpatient care shall be paid using DVA/VHA interagency rates. The interagency rate is a daily per diem to cover an inpatient stay and includes room and board, nursing, physician, and ancillary care. These rates will be provided to the contractor by the Defense Health Agency (DHA) (including periodic updates as needed). There are three different interagency rates to be paid for rehabilitation care under the MOA. The Rehabilitation Medicine rate will apply to TBI care. Blind rehabilitation and SCI care each have their own separate interagency rate. Additionally, it is possible that two or more separate rates may apply to one inpatient stay. If the DVA/VHA-submitted claim identifies more than one rate (with the appropriate number of days identified for each separate rate), the contractor shall pay the claim using the separate rates. (For example, a stay for SCI may include days paid with the SCI rate and days paid at a surgery rate.)

2.2.2.2 Claims for outpatient services shall be paid at the appropriate TRICARE allowable rate (e.g., CHAMPUS Maximum Allowable Charge (CMAC)) with a 10% discount applied.

2.2.2.3 Claims for the following care shall be paid at the interagency rate if one exists and, if not, then at billed charges: transportation; prosthetics; orthotics; Durable Medical Equipment (DME); adjunctive dental care; home care; personal care attendants; and extended care (e.g., nursing home care).

2.2.2.4 Since this is care for Service members, normal TRICARE coverage limitations do not apply to services rendered for MOA care. As long as a service has been authorized by SAS, it will be covered regardless of whether it would have ordinarily not been covered under TRICARE policy.

2.2.3 All TRICARE Encounter Data (TED) records for this care must include Special Processing Code 17 - DVA/VHA medical provider claim.

2.3 Time Limitations On Filing Service member Claims

The claims filing deadline outlined in [Chapter 8, Section 3, paragraph 1.1](#), does not apply to any Service member claims.

3.0 CLAIM REIMBURSEMENT

3.1 For network providers, the contractor shall pay TPR medical claims at the CHAMPUS allowable charge or at a lower negotiated rate.

3.2 No deductible, cost-sharing, or copayment amounts shall be applied to Service member claims.

3.3 If a non-participating provider requires a TPR enrollee to make an “up front” payment for health care services, in order for the enrollee to be reimbursed, the enrollee must submit a claim to the contractor with proof of payment and an explanation of the circumstances. The contractor shall process the claim according to the provisions in this chapter. If the claim is payable without SAS review, the contractor shall allow the billed amount and reimburse the enrollee for the charges on the claim. If the claim requires SAS review the contractor shall pend the claim to the SAS for determination. If the SAS authorizes the care, the contractor shall allow the billed amount and reimburse the enrollee for charges on the claim.

3.4 If the contractor becomes aware that a civilian provider is trying to collect “balance billing” amounts from a TPR enrollee or has initiated collection action for emergency or authorized care, the contractor shall follow contract procedures for notifying the provider that balance billing is prohibited. If the contractor is unable to resolve the situation, the contractor shall pend the file and forward the issue to the SAS for determination. The SAS will issue an authorization to the contractor for payments in excess of the applicable TRICARE payment ceilings provided the SAS has requested and has been granted a waiver from the Deputy Director, DHA, or designee.

3.5 If required services are not available from a network or participating provider within the medically appropriate time frame, the contractor shall arrange for care with a non-participating provider subject to the normal reimbursement rules.

3.5.1 The contractor initially shall make every effort to obtain the provider’s agreement to accept, as payment in full, a rate within the 100% of CMAC limitation. If this is not feasible, the contractor shall make every effort to obtain the provider’s agreement to accept, as payment in full, 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.

3.5.2 The contractor shall then request a waiver of CMAC limitation from the Director, TRICARE Regional Offices (TROs), as the designee of the Deputy Director, DHA, before patient referral is made to ensure the patient does not bear any out-of-pocket expense. The waiver request shall include the patient name, TPR location, services requested (Current Procedural Terminology, 4th Edition [CPT-4] codes), CMAC rate, billed charge, and anticipated negotiated rate. The contractor shall obtain approval from the RD before the negotiation can be concluded. The contractors shall ensure that the approved 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 Service member has personally paid the provider.

4.0 ADVANCED REHABILITATION CENTERS

See [Chapter 8, Section 5, paragraph 2.8](#).

5.0 THIRD PARTY LIABILITY (TPL)

TPL processing requirements ([Chapter 10](#)) apply to all claims covered by this chapter. However, the contractor shall not delay adjudication action on a claim while awaiting completion of the TPL questionnaire and compilation of documentation. Instead, the contractor shall process the claim(s) to completion. When the contractor receives a completed TPL questionnaire and/or other related documentation, the contractor shall forward the documentation as directed in [Chapter 10](#).

6.0 END OF PROCESSING

The contractor shall issue Explanations of Benefits (EOBs) and provider summary vouchers for TPR claims according to TRICARE Prime claims processing procedures.

7.0 TED VOUCHER SUBMITTAL

The contractor shall report the TPR Program claims on vouchers according to TRICARE Systems Manual (TSM), [Chapter 2, Section 2.3](#). The TED for each claim must reflect the appropriate data element values.

8.0 STANDARDS

All TRICARE Program claims processing standards apply to TPR claims, see [Chapter 1, Section 3](#).

- END -