

## Chapter 24

## Section 9

# Claims Processing Procedures

Revision: C-91, June 25, 2021

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### 1.0 GENERAL

**1.1** All TRICARE requirements regarding claims processing shall apply to the TRICARE Overseas Program (TOP) unless specifically changed, waived, or superseded by this section; the TRICARE Policy Manual (TPM), [Chapter 12](#); or the TRICARE contract for health care support services outside the 50 United States (U.S.) and the District of Columbia (hereinafter referred to as the "TOP Contract"). See [Chapter 8](#) for additional instructions.

**1.2** The provisions of [Chapter 8, Section 1, paragraph 1.0](#) are applicable to the TOP.

**1.3** The provisions of [Chapter 8, Section 1, paragraph 2.1](#) are applicable to the TOP. Additionally, a designated TOP Point of Contact (POC) may submit claims in accordance with [Section 12](#).

**1.4** The provisions of [Chapter 8, Section 1, paragraph 2.2](#) are not applicable to the TOP, except in U.S. territories where Medicaid is available.

**1.5** The provisions of [Chapter 8, Section 1, paragraph 2.3](#) are applicable the TOP; however, region or country-specific requirements regarding third party payments or payment addresses may be established by Defense Health Agency (DHA) at any time to prevent or reduce fraud.

**Note:** Benefit payment checks and Explanation Of Benefits (EOB) to Philippine providers (and other nation's providers as determined by the Government) shall be mailed to the place of service identified on the claim. This policy applies even if the provider uses a Third Party Administrator (TPA). No provider payments shall be sent to any other address. The Government may discontinue TPA payments to other countries or specific agencies if it is determined that significant fraud is occurring on a regular basis.

**1.6** Acceptable claim forms are identified in [Chapter 8, Section 1, paragraph 3.1](#), this may be any current or obsolete claim form (whether submitted by a beneficiary or a provider). Additionally the TOP contractor may accept any other claim form or alternative documentation as long as these methods provide sufficient data to facilitate claims processing and TRICARE Encounter Data (TED) submission.

**1.7** The provisions of [Chapter 8, Section 1, paragraph 4.0](#) are applicable to the TOP.

**1.8** The contractor's claims processing procedures shall integrate efforts to prevent and identify fraud/abuse.

## 2.0 JURISDICTION

**2.1** In the early stages of TOP claims review, the TOP contractor shall determine whether claims received are within its contractual jurisdiction using the criteria below.

**2.2** Services rendered onboard a commercial ship while outside U.S. territorial waters are the responsibility of the TOP contractor. Claims for services provided on a commercial ship that is outside the territorial waters of the U.S. shall be processed as foreign claims regardless of the provider's home address. If the provider is certified within the U.S., reimbursement for the claim is to be based on the provider's home address. If the provider is not certified within the U.S., reimbursement will follow the procedures for foreign claims. This does not include health care for enrolled Service members on a ship at sea or on a military ship at home port.

**2.3** The provisions of [Chapter 8, Section 2, paragraphs 1.0 and 2.0](#) are superseded as described in [paragraphs 2.3.1 through 2.3.9](#).

**2.3.1** When a beneficiary is enrolled in TOP Prime or TOP Prime Remote, the TOP contractor shall process all health care claims for the enrollee, regardless of where the enrollee receives services. Referral/authorization rules apply.

**2.3.2** Claims for Active Duty Family Members (ADFM) (including Reserve Component (RC) ADFMs whose sponsors have been activated for more than 30 days), retirees, and retiree family members whose care is normally provided under one of the regional contracts (i.e., beneficiaries enrolled or residing in the 50 U.S. and the District of Columbia) who receive Civilian Health Care (CHC) while traveling or visiting overseas shall be processed by the TOP contractor, regardless of where the beneficiary resides or is enrolled. Referral/authorization and Point Of Service (POS) rules apply for TRICARE Prime/TRICARE Prime Remote (TPR) enrollees.

**Note:** This provision does not apply to beneficiaries who are enrolled in 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.

**2.3.3** Claims for Service members residing in the 50 U.S. and the District of Columbia (including RC Service members activated for more than 30 days) who are on Temporary Additional Duty/ Temporary Duty (TAD/TDY), deployed, deployed on liberty, or in an authorized leave status in an overseas location shall be processed by the TOP contractor, regardless of where the Service members resides or is enrolled. **Claims for Active Duty Service Members (ADSMs) shall be processed in accordance with Section 26.**

**2.3.4** Claims for TOP-enrolled Service members (including RC Service members activated for more than 30 days) on a military ship or with an overseas home port shall not be processed by the member's military unit. These claims shall be processed by the TOP contractor.

**2.3.5** Initial and follow-on Line Of Duty (LOD) claims for RC Service members on orders for 30 consecutive days or less, who are injured while traveling to or from annual training or while performing their annual training who receive civilian medical care overseas, shall have their claims processed by the TOP contractor upon verification of LOD status. Defense Health Agency-Great Lakes (DHA-GL) will validate LOD status for RC Service members in the U.S. Virgin Islands.

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**2.3.6** The TOP contractor shall process claims for Durable Equipment (DE) and Durable Medical Equipment (DME) (otherwise coverable by TRICARE) that is purchased/ordered by TOP-eligible beneficiaries in an overseas area from a stateside provider (i.e., Internet, etc.).

**2.3.7** For inpatient claims that are paid under the Diagnosis Related Group (DRG)-based payment system, the TOP contractor, 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 contractor shall process and pay the claims.

**2.3.8** When a beneficiary's enrollment changes from one TRICARE region to another during a hospital stay that will be paid under the DRG-based payment system, the contractor with jurisdiction on the date of admission shall process and pay the entire DRG claim, including cost outliers.

**2.3.9** For information on portability claims for relocating TOP Prime/TOP Prime Remote enrollees, refer to [Chapter 6, Section 2](#).

**2.4** The provisions of [Chapter 8, Section 2, paragraphs 6.0, 6.1, 6.2, and 6.3](#) are applicable to the TOP.

**2.5** The provisions of [Chapter 8, Section 2, paragraph 6.4](#) and [Chapter 19, Section 4](#) are applicable to the TOP for U.S. citizens who are practicing outside the U.S.

**2.6** The provisions of [Chapter 8, Section 2, paragraphs 6.5, 6.6, 6.7, 7.1, 7.2, 8.1, 8.2, and 8.3](#) are applicable to the TOP.

**2.7** Refer to the TRICARE Reimbursement Manual (TRM), [Chapter 4, Section 4, paragraph 5.0](#) for jurisdictional guidance regarding health care claims for work-related illness or injury which is covered under a Worker's Compensation Program.

**2.8** The provisions of [Chapter 8, Section 2, paragraph 5.0](#) are applicable to the TOP in those locations where the TRICARE Pharmacy (TPharm) contractor has established services (the U.S. territories of Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands). The TOP contractor cannot process pharmacy claims from these locations except for pharmacy that is part of an emergency room visit or inpatient treatment. Any prescriptions from this care that are **not** provided at time of treatment for inpatient/emergency care, shall be required to be submitted through the TPharm contractor. Copays will apply.

**2.9** The TOP contractor shall forward all retail pharmacy claims to the TPharm contractor within 72 hours of identifying them as being out-of-jurisdiction. In all other overseas locations, the contractor shall process claims from purchased care sector retail pharmacies and providers.

**2.10** ADFMs with TRICARE Select and retirees or their family members residing overseas obtaining prescription from an overseas purchased care sector pharmacy shall submit their claims to the TOP contractor. For cost-share/deductible provisions, see TRM, [Chapter 2](#) regarding the mandatory collection of pharmacy copayment amounts at the time of service are waived for foreign providers.

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### 3.0 CLAIMS FILING DEADLINE

The provisions of [Chapter 8, Section 3](#) are applicable to the TOP except that claims for services provided outside the 50 U.S. or the District of Columbia, the Commonwealth of Puerto Rico, or the possessions of the U.S. are considered to be filed in a timely manner if they are filed no later than three years after the date the services were provided or three years from the date of discharge for an inpatient admission. All other claims must be filed within one year according to the requirements listed in [Chapter 8, Section 3](#), unless an exception to the filing deadline has been granted. See [Chapter 1, Section 2, paragraph 5.0](#) for the timely filing waiver process.

### 4.0 SIGNATURE REQUIREMENTS

**4.1** The provisions of [Chapter 8, Section 4](#) are applicable to the TOP unless a different process has been directed by the DHA Contracting Officer (CO).

**4.2** The TOP contractor may, at its discretion, accept a thumb print in lieu of a signature on a claim form, unless otherwise directed by the Government. When directed by the DHA CO, the TOP contractor shall not use signature on file and may not accept facsimile or thumb print signatures on claims.

### 5.0 REFERRALS/PREAUTHORIZATIONS/AUTHORIZATIONS

The provisions of [Chapter 8, Section 5](#) are altered for the TOP by the requirements listed below.

#### 5.1 Referral/Preauthorization/Authorization Requirements for TOP Prime and TOP Prime Remote Enrollees

**5.1.1** Unless otherwise directed by the Government, referrals/preauthorizations/authorizations are not required for emergency care, clinical preventive services, ancillary services, radiological diagnostics (excluding Magnetic Resonance Imaging (MRI) and Positron Emission Tomography (PET) scans), drugs, and services provided by a TOP Partnership Provider. Additionally, TOP Prime/TOP Prime Remote ADFMs will require a referral for all mental health and Substance Use Disorder (SUD) services except outpatient office-based visits. TOP Prime/TOP Prime Remote ADFMs will also require preauthorization for treatment of SUDs as outlined in the TPM, [Chapter 7, Section 3.5, paragraph 4.0](#) and for the treatment of mental disorders as outlined in the TPM, [Chapter 7, Section 3.8, paragraph 6.0](#). All other care that is provided to a TOP Prime/TOP Prime Remote-enrolled Service member or ADFM by anyone other than their Primary Care Manager (PCM) requires authorization, regardless of where the care is rendered.

**5.1.2** Claims for ADSMs shall be processed in accordance with [Section 26](#). While authorizations are required for ADSM care, for administrative reasons, the contractor shall process and pay such claims without an authorization for TRICARE covered services (to include services, supplies and equipment waived under a Supplemental Health Care Program (SHCP)), as if there were a authorization on file. If the care is retroactively authorized by the Government (including submission of an approved SHCP waiver for a non-covered service), then the contractor shall enter the authorization and process the claim for payment. If the contractor determines that the care was not authorized, the contractor shall deny the claim. Refer to [Section 26](#) for additional information.

**5.1.3** Claims for self-referred, non-emergency, and non-urgent care for TOP Prime and TPR enrolled ADFMs shall process with POS deductibles and cost-shares unless the appropriate TRICARE

Area Office (TAO) or TRICARE Overseas Program Office (TOPO) has approved a retroactive authorization.

**5.1.4** TRICARE-eligible beneficiaries residing in an overseas location who are not enrolled in TOP Prime/TOP Prime Remote typically do not need to obtain preauthorization/authorization for care. However, preauthorization reviews shall be performed for all care and procedures listed in [Chapter 7, Section 2](#). The TOP contractor may propose additional authorization reviews for non-enrolled TOP beneficiaries to the government.

**5.1.5** TRICARE beneficiaries whose health care is normally provided under one of the two regional Managed Care Support Contractors (MCSCs) who require care while traveling in an overseas location shall request any necessary preauthorizations/authorizations through the TOP contractor, regardless of where the beneficiary resides or is enrolled. Denial of requested services should be visible to the claims processing contractor to ensure claims are denied or processed as POS as appropriate.

**Note:** This process does not apply to beneficiaries enrolled to the USFHP or the CHCBP.

## **5.2 Point of Service (POS) Provisions**

**5.2.1** Unless specifically excluded by this section, all self-referred, non-emergency care provided to TOP Prime/TOP Prime Remote-enrolled ADFMs which is not either provided/referred by the beneficiary's PCM or specifically authorized shall be reimbursed under the POS option. This provision applies regardless of where the care is rendered. POS provisions also apply to the following stateside beneficiaries when traveling overseas: ADFMs, retirees, and retiree family members who are enrolled in TRICARE Prime, and ADFMs enrolled in TPR for ADFMs.

**5.2.2** POS cost-sharing only applies to TRICARE-covered services. Claims for services that are not a covered TRICARE benefit shall be denied.

**5.2.3** The TOP contractor shall adjust POS deductibles and cost-shares when TOP PCMs or Health Care Finders (HCFs) do not follow established referral/authorization procedures. For example, if the contractor processes a claim under the POS option because there was no evidence of a referral and/or an authorization, and the contractor later verifies that the PCM or other appropriate provider referred the beneficiary for the care, the contractor shall adjust the claim and reverse the POS charges. The contractor need not identify past claims that may be eligible for POS adjustment; however, the contractor shall adjust these claims as they are brought to their attention.

**5.2.4** On a case-by-case basis, following stabilization of the patient, the TAO Director or MTF Commander may require an enrolled beneficiary to transfer to a TOP network facility or an MTF. The TAO Director or MTF Commander shall provide written notice to the beneficiary (or responsible party) advising them of the impending transfer to a TOP network facility/MTF. If a beneficiary who is subject to TOP POS provisions elects to remain in the non-network facility after such notification, POS cost-sharing provisions will apply beginning 24 hours following the receipt of the written notice. Neither the TOP Director nor the MTF Commander will require a transfer until such time as the transfer is deemed medically safe.

**5.2.5** The following deductible and cost-sharing amounts apply to all TOP POS claims for health care support services:

- Enrollment year deductible for outpatient claims: \$300 per individual; \$600 per family. No deductible applies to inpatient services.
- Beneficiary cost-share for inpatient and outpatient claims: 50% of the allowable charge after the deductible has been met (deductible only applies to outpatient claims).
- POS deductible and cost-share amounts are not creditable to the enrollment/Fiscal Year (FY) catastrophic cap and they are not limited by the cap.
- POS deductible and cost-share amounts do not apply to claims for care received by newborns and newly adopted children who are deemed enrolled in TOP Prime or TOP Prime Remote.

**5.2.6** POS deductible and cost-share amounts do not apply if a TOP enrollee has Other Health Insurance (OHI) that provides primary coverage (i.e., the OHI must be primary under the provisions of the TRM, [Chapter 4, Section 1](#)). Evidence of OHI claims processing (including the exact amount paid on the claim) must be submitted with the TOP claim.

**5.2.7** EOB shall clearly indicate that a claim has been processed under the POS Option.

**5.2.8** POS is not applicable to Service members or to TRICARE Select.

**5.3** Extended Care Health Option (ECHO) benefits in overseas locations must be authorized by the TOP contractor. Refer to [Section 23](#) and the TPM, [Chapter 9](#) for additional guidance.

**5.4** Refer to [Section 10](#) for referral/preauthorization/authorization requirements for Service member dental care in remote overseas locations.

## **6.0 CLAIM DEVELOPMENT**

**6.1** Development of missing information shall be kept to a minimum. The TOP contractor shall use available in-house methods, contractor files, telephone, Defense Enrollment Eligibility Reporting System (DEERS), etc., to obtain incomplete or discrepant information. If this is unsuccessful, the 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 contractor's system shall identify the claim as returned, not denied. The Government reserves the right to audit returned claims as required, therefore the contractor shall retain sufficient information on returned claims to permit such audits. The contractor shall review all claims to ensure TOP required information is provided prior to payment. For the Philippines, claims requiring development of missing or discrepant information, or those being developed for medical documentation, shall be pending for 90 days and are excluded from the claims processing standard.

**6.2** Claims may be filed by eligible TRICARE beneficiaries, purchased care sector providers, TOP POCs, and TRICARE authorized providers in the 50 U.S. and the District of Columbia as allowed under TRICARE (see [Chapter 8, Section 1](#)).

**6.3** Confidentiality requirements for TOP are identical to TRICARE requirements outlined in [Chapter 8](#).

**6.4** The provisions of [Chapter 8, Section 9](#) are applicable to TOP.

**6.5** The following minimal information is required on each overseas claim prior to payment:

**6.5.1 Signatures**

Beneficiary and purchased care sector provider signatures (signature on file is acceptable unless specifically prohibited by the Government).

**6.5.2 Name and Address**

**6.5.2.1** Complete beneficiary and purchased care sector provider name and address.

**6.5.2.2** If an address is not available on the claim, obtain the address either from previously submitted claims, directly from the beneficiary/purchased care sector provider via phone, fax, or e-mail, DEERS per [paragraph 6.1](#).

**Note:** The TOP contractor shall accept APO/FPO for the beneficiary address.

**6.5.3 Diagnosis(es)**

**6.5.3.1** Prior to returning a claim that is missing a diagnosis, the TOP contractor shall research the patient's history and determine whether a diagnosis from a related claim can be applied. The diagnosis should be reflective of the services rendered.

**6.5.3.2** Claims received for dates of service for outpatient services or dates of discharge for inpatient services before the mandated date, as directed by Health and Human Services (HHS), for International Classification of Diseases, 10th Revision (ICD-10) implementation, with ICD-10 codes shall be converted to International Classification of Diseases, 9th Revision, Clinical Modifications (ICD-9-CM) codes by the TOP contractor. Claims received for dates of service for outpatient services or dates of discharge for inpatient services on or after the mandated date, as directed by HHS, for ICD-10 implementation, with ICD-9 or ICD-9-CM codes shall be converted to ICD-10-CM codes by the TOP contractor. Refer to [Chapter 8, Section 6, paragraphs 4.0 and 5.0](#) regarding the use of ICD-9-CM **V** codes (factors influencing health status and contact with health services) and ICD-10-CM **Z** codes (factors influencing health status and contact with health services).

**6.5.4 Procedures/Services/Supply/DME**

The TOP contractor shall identify the procedure(s)/service(s)/supply/DME ordered, performed or prescribed, including the date ordered performed or prescribed. The TOP contractor may use the date the claim form was signed as the specific date of service, if the service/purchase date/order date is not on the bill.

**6.5.5** Claims received with a narrative description of services provided shall be coded by the TOP contractor with as accurate-coding as possible based upon the level of detail provided in the narrative description or as directed by the TOPO. Services which contain sufficient detail to identify an accurate procedure code shall be used. All surgical procedures must be coded accurately based on the level of detailed description. Outpatient professional services shall be coded accurately. Office visits which include multiple services shall be coded accurately and not bundled when the description of services



are available. The provisions of [paragraph 6.1](#) apply for narrative claims that cannot be accurately coded due to insufficient or vague information. Claims received for dates of service for outpatient services or dates of discharge for inpatient services before the mandated date, as directed by HHS, for ICD-10 implementation, with ICD-10 codes shall be converted to ICD-9 codes by the TOP contractor. Claims received for dates of discharge for inpatient services on or after the mandated date, as directed by HHS, for ICD-10 implementation, with ICD-9 codes shall be converted to ICD-10 codes by the TOP contractor. Refer to [Chapter 8, Section 6, paragraph 4.0](#) regarding the use of **V** and **Z** codes.

#### **6.5.5.1 Inpatient Institutional Procedures**

Inpatient institutional (i.e., hospital) claims received for dates of discharge for inpatient services before the mandated date, as directed by HHS, for ICD-10 implementation, shall have the procedure narratives coded by the TOP contractor using ICD-9-CM, Volume 3 procedure codes. Inpatient institutional (i.e., hospital) claims received for dates of discharge on or after the mandated date, as directed by HHS, for ICD-10 implementation, shall have the procedure narratives coded by the TOP contractor using ICD-10-Procedure Classification System (ICD-10-PCS) procedure codes.

#### **6.5.5.2 Outpatient Institutional Procedures and Professional Services**

Claims received for outpatient institutional (e.g., ambulance services, laboratory, Ambulatory Surgery Centers (ASCs), partial hospitalizations, outpatient hospital services) services and professional services shall be coded using Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT).

#### **6.5.6 Care authorizations (when required).**

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

**6.5.8** Proof of payment is required for all beneficiary submitted claims if the claim indicates that the beneficiary made payment to the provider or facility. Due to cultural differences, there may be significant variation in provider processes for issuing receipts to the beneficiaries. Therefore, the overseas claims processor shall use best business practices when determining if the documentation provided is acceptable for the country where the services were rendered.

#### **6.5.8.1 Examples of ACCEPTABLE Beneficiary Proof of Payment:**

- Cancelled checks (made payable to the provider)
- Credit or bank card statements or receipts
- Bank account statements (with documentation of payment to the provider)
- Receipt, itemized bill, or statement issued by the provider's office stamped "PAID" on all pages
- Proof of Electronic Funds Transfer (EFT) from the beneficiary to the provider
- Invoice for pharmaceuticals dispensed on an outpatient basis (overseas pharmacies will



not dispense drugs without payment; therefore, an invoice represents proof of payment)

- Invoice for health care from providers in Turkey (Turkish providers will not provide an invoice to the patient until payment has been made; therefore, an invoice represents proof of payment)

**6.5.8.2** Examples of UNACCEPTABLE Beneficiary Proof of Payment:

- Cancelled check made payable to "Cash" or to the beneficiary or sponsor
- Bank account statements showing cash withdrawal (without additional documentation of payment to the provider)
- Letter signed by patient saying s/he has paid the bills
- Paid amount shown only on the claim or itemized bill
- Handwritten statements (e.g., "Paid in Full," "Paid by Patient," "Paid in Cash")
- Paid in cash (without additional documentation of payment to the provider)

**6.6** Non-prescription (Over-The-Counter (OTC)) drugs are to be denied. This includes drugs that are considered OTC by U.S. standards, even when they require a prescription in a foreign country.

**6.7** The TOP contractor shall use a schedule of allowable charges based on the Average Wholesale Price (AWP) as a reference source for processing drug related TRICARE overseas claims.

**6.8** Claims for medications prescribed by a host-nation physician, and commonly used in the host-nation country, shall be cost-shared unless they are considered OTC by U.S. standards.

**6.9** For the Philippines, prescription drugs may only be cost-shared when dispensed by a certified retail pharmacy or hospital-based pharmacy. The TOP contractor shall deny claims for prescription drugs dispensed by a physician's office. Certification requirements outlined in [Section 29](#) apply.

**Note:** This does not apply to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS).

**6.10** Claims for DME involving lease/purchase shall always be developed for missing information.

**6.11** The TOP contractor shall use ECHO claims processing procedures outlined in TPM, [Chapter 9, Section 18.1](#), when processing ECHO overseas claims.

**6.12** The TOP contractor shall deny claims from non-certified or non-confirmed purchased care sector providers when the DHA CO has directed contractor certification/confirmation of the purchased care sector provider prior to payment.

**6.13** Requests for missing information shall be sent on the TOP contractor's TRICARE/TOP letterhead. When development is necessary, the contractor shall include a special insert in German, Italian,

Spanish, Tagalog, Japanese, and Korean which indicates what missing information is required to process the claim and includes the contractor's address for returning requested information.

**6.14** If the TOP contractor elects to develop for additional/missing information, and the request for additional information is not received/returned within 45 days, the contractor shall deny the claim.

**6.15** If the TOP contractor has no record of referral/authorization prior to denial/payment of the claim, the contractor shall follow the TOP POS rules, if the service would otherwise be covered under TOP.

**6.16** The TOP contractor shall develop procedures for the identification and tracking of TOP enrollee claims submitted by either a purchased care sector designated or non-designated overseas purchased care sector provider without preauthorization/authorization. Upon receipt of a claim for a TOP-enrolled ADFM submitted by a purchased care sector designated or non-designated overseas purchased care sector provider without preauthorization/authorization, the contractor shall process the claims following POS payment procedures. For Service member claims submitted by a purchased care sector provider without preauthorization/authorization, the contractor shall **process the claim if services are covered by TRICARE. If services are non-covered services and no authorization is on file, the claim shall be denied.** Refer to [Section 26](#) for more information on ADSM pended claims.

**6.17** The TOP 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 TED and EOBs as outlined in [Chapter 8, Section 8](#), except for requiring overseas providers to use HCPCS to bill outpatient rehabilitation services, issue provider's the Form 1099 and suppression of checks/drafts for \$.99 or less. The contractor may split claims to accommodate multiple invoice numbers in order to reference invoice numbers on EOBs when necessary. Refer to [Chapter 8, Section 6](#) for additional requirements related to claims splitting.

**6.18** The TOP contractor shall not pay for pharmacy services obtained through the Internet.

**6.19** The TOP contractor shall pay all TOP Service member stateside claims as outlined in [Section 26](#).

**6.20** All claims shall be submitted in a Health Insurance Portability and Accountability Act (HIPAA) compliant format. Refer to [Section 28](#) for more information on HIPAA requirements.

**6.21** Electronic claims not accepted by the TOP contractor's Electronic Data Information (EDI) system/program shall be rejected.

**6.22** For all overseas claims, the TOP contractor shall create and submit TEDs following current guidelines in the TSM for TED development and submission. Claim information will be able to be accessed through the TRICARE Patient Encounter Processing and Reporting (PEPR) Purchased Care Detail Information System (PCDIS).

**6.23** The TOP contractor shall establish Utilization Management (UM) high dollar/frequency thresholds in accordance with [Section 6](#).

**6.24** Claims either denied as "beneficiary not eligible" or "found to be not eligible on DEERS" may be processed as a "good faith payment" when received from the Defense Health Agency (DHA) Communications Office. The TAO Director shall work with the TOP contractor on claims issues related to

good faith payment documentation (e.g., a completed claim form and other documentation as required by [Chapter 10, Sections 3 and 4](#)).

**6.25** The provisions of [Chapter 8, Section 6, paragraph 11.0](#) shall apply to the TOP.

**6.26** The Claims Auditing Software requirements outlined in the TRM, [Chapter 1, Section 3](#) do not apply to TOP claims; however, the TOP contractor shall implement an internal process for identifying upcoding, unbundling, etc. on coded claims.

## **7.0 APPLICATION OF DEDUCTIBLE AND COST-SHARING**

Application of TOP deductible and cost-sharing procedures shall follow the guidelines outlined in [Chapter 8, Section 7](#).

## **8.0 EOB VOUCHERS**

The TOP contractor shall follow the EOB voucher requirements in [Chapter 8, Section 8](#), where applicable, with the following exceptions and additional requirements:

**8.1** The letterhead on all TOP EOBs shall also reflect "TRICARE Overseas Program" and shall be annotated Prime or TRICARE Select.

**8.2** TOP EOBs may be issued on regular stock, shall provide a message indicating the exchange rate used to determine payment and shall clearly indicate that "This is not a bill".

**8.3** TOP EOBs shall include the toll-free number for beneficiary and provider assistance.

**8.4** TOP EOBs for overseas enrolled Service member claims shall be annotated "ACTIVE DUTY."

**8.5** For Point of Sale or Vendor pharmacy overseas claims, TOP EOBs shall have the name of the provider of service on the claim.

**8.6** For beneficiary submitted pharmacy claims, TOP EOBs shall contain the name of the provider of service, if the information is available. If the information is not available, the EOBs shall contain "your pharmacy" as the provider of service.

**8.7** The TOP contractor shall insert the provider's payment invoice numbers in the patient's account field on all provider EOBs, if available.

**8.8** The TOP contractor shall designate an EOB message for overseas claims rendered by non-network purchased care sector providers who are required to be certified, but have not been certified by the TOP contractor, "Your provider has not submitted documentation required to validate his/her training and/or licensure for designation as an authorized TRICARE provider". Refer to [Section 4](#) for more information regarding certification of providers in designated locations.

**8.9** When a provider's/beneficiary's EOB, EOB and check, or letter is returned as undeliverable, the check shall be voided.

**8.10** The TOP contractor may utilize secure electronic EOB delivery to beneficiaries unless mail delivery has been requested by the beneficiary or has not signed up for electronic delivery.

**8.11** The contractor may issue monthly summary EOBs to beneficiaries on claims when there is no beneficiary liability. The processing date of the oldest claim for the summary EOB shall not be greater than 31 calendar days.

## **9.0 DUPLICATE PAYMENT PREVENTION**

**9.1** The TOP contractor shall follow the duplicate payment prevention requirements outlined in [Chapter 8, Section 9](#).

**9.2** The TOP contractor shall ensure that business processes are established which require appropriate system and/or supervisory controls to prevent erroneous manual overrides when reviewing potential duplicate payments.

## **10.0 DOUBLE COVERAGE**

**10.1** TOP claims require double coverage review as outlined in the TRM, [Chapter 4](#).

**10.2** Beneficiary/provider disagreements regarding the contractor's determination shall be coordinated through the overseas TOPO for resolution with the contractor.

**10.3** Overseas insurance plans such as German Statutory Health Insurance, Japanese National Insurance (JNI), and Australian Medicare, etc., are considered OHI. National Health Insurance (NHI) plans do not always provide EOBs to assist in the adjudication of TRICARE claims. If a beneficiary has attempted unsuccessfully to obtain an EOB from their NHI plan, they may submit a beneficiary attestation and an itemized claim checklist (approved by DHA) with their claim. The TOP contractor shall waive the requirement for an EOB from the NHI plan when accompanied by the DHA-approved document. If the TOP contractor has validated and documented the NHI does not provide coverage for something that is a TRICARE benefit (e.g., breast pumps), the TOP contractor shall waive the requirement for an EOB from the NHI plan.

**Note:** If the Japanese insurance points are not clearly indicated on the claim/bill, the TOP contractor shall contact the submitter or the appropriate TOP POC for assistance in determining the Japanese insurance points prior to processing the claim.

## **11.0 THIRD PARTY LIABILITY (TPL)**

The TOP contractor shall reimburse TOP claims suspected of TPL and then develop for TPL information. Upon receipt of the information, the contractor shall refer claims/documentation to the appropriate Judge Advocate General (JAG) office, as outlined in the [Chapter 10](#).

## **12.0 REIMBURSEMENT/PAYMENT OF OVERSEAS CLAIMS**

When processing TOP claims, the TOP contractor shall follow the reimbursement payment guidelines outlined in the TRM, [Chapter 1, Section 34](#) and the cost-sharing and deductible policies outlined in the TRM, [Chapter 2, Section 1](#), and shall:

**12.1** Reimburse claims for purchased care sector services/charges for care rendered to TOP eligible beneficiaries which is generally considered purchased care sector practice and incidental to covered services, but which would not typically be covered under TRICARE. An example of such services may be, charges from purchased care sector ambulance companies for driving purchased care sector physicians to accidents or private residences, or the manner in which services are rendered and considered the standard of care in a purchased care sector country, such as rehabilitation services received in an inpatient setting.

**12.2** Reimburse claims at the lesser of the billed amount, the negotiated reimbursement rate, the CHAMPUS Maximum Allowable Charge (CMAC), or the Government established fee schedules (when applicable) (TRM, [Chapter 1, Sections 34 and 35](#)), unless a different reimbursement rate has been established as described in TPM, [Chapter 12, Section 1.3](#).

**Note:** Government established fee schedules (per TRM, [Chapter 1, Sections 34 and 35](#)) are only applicable to retirees or their eligible family members or TRICARE Select ADFMs.

**12.3** Not reimburse for purchased care sector care/services specifically excluded under TRICARE.

**12.4** Not reimburse for purchased care sector care/services provided in the Philippines unless all of the certification requirements listed in [Section 14](#) have been met.

**12.5** Not reimburse for administrative charges billed separately on claims, except for individual administrative charges as determined by the Government. The contractor shall reimburse these charges only in instances when the fee is billed concurrently with the corresponding health care services. If a bill is received for these charges without a corresponding health care service, the charges shall be denied.

**12.6** Determine exchange rates as follows:

**12.6.1** Use the exchange rate in effect on the ending date that services were received unless evidence of OHI and then the TOP 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;

**12.6.2** Use the ending dates of the last service to determine exchange rates for multiple services.

**12.6.3** Use the exchange rate in [paragraph 12.6.1](#) to determine deductible and copayment amounts, if applicable, and to determine the amount to be paid in foreign currency.

**12.6.4** Overseas drafts/checks and EOBs. Upon completion of processing, the contractor shall create checks (payable in U.S. dollars). The TOP contractor shall do this within 48 hours after approval by DHA Contract Resource Management (CRM). Drafts (payable in foreign currency units) shall be created by the TOP contractor within 96 hours following CRM approval, unless a different process has been authorized by DHA. Payments 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 EOB. Drafts/checks shall be matched with the appropriate EOB, and mailed to the beneficiary/sponsor/purchased care sector provider/POC as applicable.

**Note:** Drafts for certain foreign currency units may require purchase from a bank location other than the one normally used by the TOP contractor (out of state or out of country). Currency units that

must be purchased from an alternate bank (out of state or out of country) may take up to 10 business days for the draft to be returned and matched up with the EOB.

**12.7** Convert lump sum payments, instead of line items, to minimize conversion problems.

**12.8** Pay provider claims for all overseas locations in the country's local currency as identified on the claim for the specific country by foreign currency/drafts. Drafts may not be changed to a U.S. dollar check after the contractor has issued a foreign draft.

**12.9** Know that foreign overseas drafts (in local currency) are good for 190 days and may be cashed at any time, unless a different process has been established by DHA. U.S. dollar checks are good for 120 days unless a different process has been established by DHA. The provisions of [Chapter 3, Section 4](#) regarding staledated, voided, or returned checks/Electronic Funds Transfers (EFTs) are applicable to the TOP.

**12.10** Pay TOP claims submitted by a beneficiary in U.S. dollars, unless there is a beneficiary request on the claim at the time of submission for payment in a foreign currency. The TOP contractor may reissue the payment in U.S. dollars if a request is subsequently received from the beneficiary and the foreign draft is included in the request or the payment has staledated, or if directed by the appropriate DHA COR.

**12.11** Payment shall be made in local currency.

**12.12** Issue drafts/checks for German claims which look like German drafts/checks.

**Note:** In order for TRICARE drafts/checks to look like German drafts/checks, a German address must be used. The TOP contractor may use a corporate address in Germany or the TAO Eurasia-Africa address for this purpose.

**12.13** The contractor shall pay all beneficiary-submitted claims for TRICARE covered drugs dispensed by a U.S. embassy health clinic to the beneficiary. The contractor is not to make payments directly to the embassy health clinic.

**12.14** Know that professional services rendered by a U.S. embassy health clinic are not covered by TRICARE/TOP. These services are covered under International Cooperative Administrative Support Services (ICASS) agreements. Embassy providers (acting as PCMs) may refer TOP enrollees to purchased care sector providers, these claims shall be processed per TOP policy and procedures.

**12.15** Reimburse claims for drugs or diagnostic/ancillary services purchased overseas following applicable deductible/cost-share policies.

**12.16** In emergency situations, the requirement for Medicare certification for facilities in U.S. commonwealths and territories may be waived. After a review of the facts, the contractor may cost-share otherwise covered services or supplies rendered in an emergency situation by an unauthorized provider to the beneficiary, or on behalf of the beneficiary, to the beneficiary's appointed payee, guardian, or parent in accordance with TPM, [Chapter 11, Section 4.2](#) and TRM, [Chapter 1, Section 29](#).

**12.17** The contractor shall mail the drafts/checks and EOBs to purchased care sector providers unless the claim indicates payment should be made to the beneficiary. In conformity with banking

requirements, the drafts/checks shall contain the contractor's address. Drafts and EOBs shall be mailed using U.S. postage. Additionally, payments/checks may be made to network providers, with an Embassy address.

**12.18** Mail benefit payment checks and EOBs to Philippine providers, and other nations' providers as directed by the DHA CO, to the place of service identified on the claim. No provider checks or EOBs for Philippine providers, and other nations' providers as directed by the DHA CO may be sent to any other address.

**12.19** Process/pay inpatient and outpatient claims for TRICARE overseas eligible beneficiaries, including Service member claims, as indicated below:

**12.19.1** The TPharm contractor shall allow TOP Service members to use the TPharm retail pharmacy network under the same contract requirements as other Military Health System (MHS) eligible beneficiaries (see TPM, [Chapter 8, Section 9.1](#)).

**12.19.2** The TPharm contractor shall allow TOP enrolled ADFM beneficiaries to use their stateside retail pharmacy network under the same contract requirements as other MHS eligibles (see TPM, [Chapter 8, Section 9.1](#)).

**12.19.3** The TOP contractor shall process claims for overseas health care received by TRICARE beneficiaries enrolled to or residing in a stateside contractor's region following the guidelines outlined in this chapter. Payment shall be made from applicable bank accounts and shall be based on billed charges unless a lower reimbursement rate has been established by the Government or the contractor.

**12.20** EFT payments. Upon purchased care sector provider request, the TRICARE Overseas health care support contractor shall provide EFT payment to a U.S. or overseas bank on a weekly basis. Bank charges incurred by the provider for EFT payment shall be the responsibility of the provider. Upon beneficiary request, EFT payments to a U.S. bank may be provided. Bank charges associated with beneficiary EFT payments shall be the responsibility of the beneficiary.

**12.21** The TOP contractor shall process 90% of all retained and adjustment TOP claims to completion within 30 calendar days from the date of receipt. Claims pending per Government direction are excluded from this standard. However, the number of excluded claims shall be reported on the designated DD Form 1423, Contract Data Requirements List (CDRL), located in Section J of the applicable contract. One hundred percent (100%) of all claims (both retained and excluded, including adjustments) shall be processed to completion within 90 calendar days from the date of receipt, unless the CO specifically directs the contractor to continue pending a claim or group of claims.

**12.22** Exclude correspondence pending due to stop payment orders, check tracers on foreign banks, and conversion on currency from the routine 45 calendar day correspondence standard and the priority 10 calendar day correspondence standard. However, the number of excluded routine and priority correspondence must be reported on the designated DD Form 1423, CDRL, located in Section J of the applicable contract.

**12.23** The TOP contractor shall pay Value Added Tax (VAT) included on German health care claims for all beneficiary categories.



**12.24** Reimburse fees for transplant donor searches in Germany on a global flat fee basis since the German Government does not permit health care facilities to itemize such charges.

**12.25** Reimburse itemized fees for supplies that are related or incidental to inpatient treatment (e.g., hospital gowns) if similar supplies would be covered under reimbursement methodologies used within the U.S. The TOP contractor shall implement internal management controls to ensure that payments are reasonable and customary for the location.

### **13.0 CLAIMS ADJUSTMENT AND RECOUPMENT**

**13.1** The TOP contractor shall follow the adjustment requirements in [Chapter 10](#) except for the requirements related to financially underwritten funds.

**13.2** The TOP contractor shall follow the recoupment requirements in [Chapter 10](#) for non-financially underwritten funds, except for providers. The contractor shall use the following procedures for purchased care sector provider recoupments. Recoupment actions shall be conducted in a manner that is considered culturally appropriate for the purchased care sector provider's country. The contractor shall:

- Send an initial demand letter;
- Send a second demand letter at 90 days;
- Send a final demand letter at 120 days; and
- Refer the case to DHA at 240 days, if the case is over \$600, and if under \$600 the case shall remain open for an additional four months and then shall be written off at 360 days.

**13.3** Recoupment letters (i.e., the initial letter, the 90 day second request and the 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 TOP contractor shall include language in the recoupment letter requesting that refunds be returned/provided in the exact amount requested.

**13.4** Provider recoupment letters sent to Germany, Italy, Spain, Japan, and Korea, shall be written in the respective language.

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

**13.6** The TOP contractor shall have a TOP bank account capable of receiving/accepting wire transfers for purchased care sector provider recoupment/overpayment returns. The TOP contractor shall accept the amount received as payment against the amount owed. Any fees associated with the wire transfer are the responsibility of the payer/provider.

### **14.0 DUPLICATE PAYMENT PREVENTION**

The provisions of [Chapter 8, Section 9](#) are applicable to the TOP.

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