



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY  
AURORA, COLORADO 80011-9066

TRICARE  
MANAGEMENT ACTIVITY

OD

CHANGE 144  
6010.51-M  
AUGUST 13, 2012

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL  
FOR  
TRICARE OPERATIONS MANUAL (TOM), AUGUST 2002**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

**CHANGE TITLE:** TRICARE LOGO

**CONREQ:** 15376

**PAGE CHANGE(S):** See pages 2 and 3.

**SUMMARY OF CHANGE(S):** This change to the TOM provides instructions on the use and reproduction of the TRICARE® trademark. This change will ensure any reproduction of the mark must be in full compliance with the requirements set forth in the TRICARE® Brand Style Guide. This change also updates the division name for the Beneficiary Education and Support Division (BE&SD).

**EFFECTIVE DATE:** Upon direction of the Contracting Officer.

**IMPLEMENTATION DATE:** Upon direction of the Contracting Officer.

  
for Reta M. Michak  
Director, Operations Division

**ATTACHMENT(S):** 73 PAGES  
**DISTRIBUTION:** 6010.51-M

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT.

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**AUGUST 13, 2012**

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# TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002

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- Requests for information on potential fraud or abuse cases.
- Information concerning scheduled on-site reviews.
- Communications regarding litigation cases.
- Provider authorization questions.
- Questions or requests for comment on press releases and related materials published by TMA. Copies of releases shall be sent to all contractors to keep them informed of TRICARE information activities.
- Information concerning the creation and transmission of health care data.

## **6.0. TMA-REQUIRED MEETINGS**

**6.1.** A 14 calendar day notice will be provided by the Contracting Officer for all meetings hosted by TMA. The contractor shall provide annual representation at two contractor conferences (senior management level) at TMA, two regional contractor and two regional provider conferences, and one Provider Representative meeting at TMA. The contractor shall provide up to four Provider Representatives at up to four additional meetings at the direction of the Contracting Officer per contract year. The cost of attendance at these meetings shall be included in the contractor's cost for Administrative Support Services.

## **7.0. TMA DELEGATION OF AUTHORITY**

Authority has been delegated to the Director, TMA, Beneficiary *Education and Support Division (BE&SD)* to perform the following:

- Grant exceptions to the claims filing deadline,
- Grant "good faith payments",
- Waive the signature requirements on TRICARE claims,
- Adjudicate and process unique claims requiring special handling, and claims for emergency care provided by a Department of Veterans Affairs (DVA) facility or a facility under the Bureau of Indian Affairs,
- Authorize benefits for which the authority has not otherwise been delegated to other TRICARE officials or contractors,
- Authorize an "override" of information contained on DEERS, pending a system update, based on appropriate documentation regarding eligibility under the law, regulation and policy.



## 2.4. Execution Of Memoranda Of Understanding (MOU)

### 2.4.1. MOU With MTF Commanders

Sixty calendar days prior to the start of health care delivery, the contractor shall have executed an MOU with all MTF Commanders in the Region. The MOU shall include, but not be limited to, MTF Optimization, Resource Sharing, TSC location and Government furnished services, surveillance and reporting, use of facilities, Medical Management. The contractor shall provide two copies of each executed MOU to the CO and the COR within 10 calendar days following the execution of the MOU.

### 2.4.2. MOU With TMA *Beneficiary Education and Support Division (BE&SD)*

The contractor shall meet with the TMA *BE&SD* within 60 calendar days after health care contract award to develop a MOU, including deliverables and schedules. The MOU shall be executed within 30 days of the MOU meeting with the *BE&SD*. The contractor shall provide two copies of the executed MOU to the CO and the COR within 10 calendar days following the execution of the MOU.

## 2.5. Phase-In Of TRICARE Prime Enrollment

The contractor shall begin the enrollment process for the TRICARE Prime Program no later than 60 calendar days prior to the scheduled start of health care delivery, with actual enrollment processing to begin 40 days prior to the start of health care delivery, subject to TMA approval of systems under the contract.

**NOTE:** MTFs have the responsibility for reassigning all enrollees assigned Resource Sharing PCMs under the current managed care support contracts to other MTF PCMs or "Pseudo" PCMs using CHCS. These reassignments must be completed not later than 14 days prior to the start of health care delivery. If instructed by the MTF commander, the incoming contractor will be required to reassign such enrollees to new PCMs using DOES/DEERS. The MTF's instructions to accomplish this task will be in writing and will include sufficient information to reasonably identify the beneficiary, as well as the PCM currently assigned and the PCM to be assigned. These PCM reassignments should not cross DMISs, CHCS platforms or regions. They should be initiated by the MTF within 15 days of the start of health care delivery and will be completed by the contractor within 30 days of receipt.

### 2.5.1. Enrollment Actions During 45-Day Transition Period

**2.5.1.1.** For enrollments in the Region with an effective date prior to the start of health care delivery (e.g., AD enrollment, mid-month enrollment; transfer-in, etc.), the incoming contractor must effect an enrollment to begin on the start of health care delivery once notified by the outgoing contractor of the new enrollment. The end date of the enrollment should follow the Enrollment Year to Fiscal Year realignment process. (DMDC may run a report at the end of the transition period that reflects new additions.)

**2.5.1.2.** When a current enrollment in the Region requires deletion with an effective date prior to the start of health care delivery (e.g., transfers out; disenrollments for failure to pay fees; cancellations, etc.), when requested by the outgoing contractor, the incoming contractor

must cancel the future enrollment segment and notify the outgoing contractor when this action has been completed.

**2.5.1.3.** For all other enrollment actions with an effective date prior to start of health care delivery (e.g., PCM changes; DMIS ID changes; enrollment begin date changes; etc.), when requested by the outgoing contractor, the incoming contractor must cancel the future enrollment segment and notify the outgoing contractor when this action has been completed. When notified by the outgoing contractor that their change has been effected, the incoming contractor must reinstate the future enrollment segment.

**2.5.1.4.** Once health care delivery begins, all enrollment actions will be accomplished by the incoming contractor. If the outgoing contractor requires a retroactive change, they must submit their request to the incoming contractor who will perform the change and notify the outgoing contractor when it is complete.

**2.5.2.** In addition to other contractually required enrollment reports, the contractor, within 30 calendar days following the start of health care delivery, and within 10 calendar days following the close of each calendar month through the seventh month following the start of health care delivery, shall provide a report to the TMA CO and the COR on progress made in implementing TMA approved enrollment plan. The report shall identify those areas in the contractor's approved start-up plan to be serviced by TRICARE Prime in which enrollment significantly exceeds or falls short of the targets established by the contractor in the approved enrollment plan, and outline corrective action plans for any deficiencies in the contractor's enrollment process which are significant deviations from the approved enrollment plan.

## **2.6. Transfer Of Enrollment Files**

**2.6.1.** The incoming contractor shall obtain enrollment policy information from DEERS through an initial enrollment load file. DMDC will provide the incoming contractor with an incremental enrollment load file for each contract transition. The incoming contractor shall process each enrollment load file within 24 hours or less from receipt of the file. The following procedures apply to outgoing contracts that are being combined to form the new TNEX region/contract until TNEX is fully implemented.

**NOTE:** Each TNEX contract transition shall require a three-day freeze of enrollment and claim processing. This freeze will occur beginning the first weekend that precedes the 60 day window prior to the start of health care delivery. The actual calendar dates will be determined during the transition meeting.

**2.6.2.** Split enrollments occur when all family members are covered under the same type of coverage but do not reside in the same contract-area, causing the enrollments to be administered by multiple contracts. A policy for the family will exist for each MCSC contract. However, as MCSCs migrate to TNEX, DEERS will consolidate all split policies that are within the new MCSC contract-area and communicate this information to the incoming MCSC via an initial load file. If needed, the incoming TNEX contractor shall communicate with beneficiaries whose policies have been consolidated and apply any overage of fees to the next fee obligation. The fee overage must be applied first to the existing policy period. If

beneficiaries on the list who are within its region. Claims received for those beneficiaries, for which no authorization is on file, are to be suspended and the contractor shall notify the TMA, Beneficiary *Education* and *Support* Division (*BE&SD*). Refer to [32 CFR 199.4](#).

**7.0. INTERIM REFERRAL AND AUTHORIZATION PROCESS**

**7.1.** The interim referral and authorization management process shall be implemented and operated until such time as the government issues a change order directing the implementation of an alternate authorization and referral management system. Following implementation of this interim process, MTFs and Managed Care Support Contractors (MCSCs) may elect to work together to develop alternative means of accomplishing referrals and authorizations, with approval of the contracting officer. Any such development and the subsequent implementation of any alternative shall be without cost to the government.

**7.2.** The contractor shall process referrals in accordance with the following:

**7.2.1. Referrals From The MTF To The Contractor**

Referrals from the MTF shall include all of the following information, at a minimum, unless otherwise specified. Contractors shall receive the MTF referral via fax (or by other electronic means agreed upon by the MTF and the MCSC). The MTF is not required to provide diagnosis or procedure codes. The MCSC shall translate the narrative descriptions into standard diagnosis and procedure codes.

REQUIRED DATA ELEMENT*	DESCRIPTION/PURPOSE/USE
Request Date/Time	DD MMM YY hhmm
Request Priority	STAT/24-hour/ASAP/Today/72-hour/Routine
Requester	
Referring Provider Name	Name of PCM/MTF individual provider making request
Referring Provider NPI	HIPAA National Provider Identifier (NPI) - Type 1 (Individual)
Referring MTF	Name of Military Treatment Facility (MTF)
Referring MT NPI	HIPAA National Provider Identifier - Type 2 (Organizational)
PATIENT INFO	
Sponsor SSN	
Patient ID	EDI_PN (from DEERS) if available
Patient Name	Full Name of Patient (if no EDI_PN available)
Patient DOB	Date of Birth (required if patient not on DEERS)
Patient Gender	
Patient Address	Full Address of Beneficiary (including zip)
Patient Telephone Number	If available - Telephone Number (including area code)

**TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002**

CHAPTER 8, SECTION 5

REFERRALS/PREAUTHORIZATIONS/AUTHORIZATIONS

REQUIRED DATA ELEMENT*	DESCRIPTION/PURPOSE/USE
<b>CLINICAL INFO</b>	
Patient Primary Provisional Diagnosis	Description
Reason for Request	Sufficient Clinical Info to Perform MNR
<b>SERVICE</b>	
Service 1 - Provider	Specialty of Service Provider
Service 1 - Provider Sub-Specialty	Additional Sub-Specialist Info if Needed (Free Text Clarifying Info Entered with Reason for Request) e.g., Pediatric Nephrologist
<b>SERVICE (CONTINUED)</b>	
Service 1 - By Name Provider Request if Applicable - First and Last Name	Optional Info Regarding Preferred Specialist Provider (Free Text)
Service 1 - Service Type	Inpatient, Specialty Referral, DME Purchase/Rental, Other Health Service, et al DME Provider to do CMN.
Service 1 - Service Quantity (optional)	Number of Visits, Units, etc.
CHCS Generated Order Number (DMIS-YYMMDD-XXXXX)	Unique Identifier Number (UIN). The UIN is the DMIS (of the referring facility identified in the "Referring MTF" field on this request) -- Date in format indicated -- Consult Order Number from CHCS.

**Special Instructions:**

**NOTE 1:** \*Above data elements are required unless otherwise noted as "Optional."

**NOTE 2:** Use of the NPI is required in accordance with the HHS NPI Final Rule by May 23, 2007 or upon Service direction and/or direction of the Contracting Officer (CO). Implementation requirements may be found at [Chapter 21, Section 4](#).

**NOTE 3:** When issuing a preauthorization for an ADSM while in terminal leave status to obtain medical care from the Department of Veterans Affairs (DVA), as required by [Chapter 18, Section 1, paragraph 4.6.](#), the MTF shall make special entries for data elements as follows:

Patient Primary Provisional Diagnosis	Condition of a routine or urgent nature as specified by the patient at a future date.
Reason for Request	Provide preauthorization for outpatient treatment by the DVA for routine or urgent conditions while the active duty patient is in a terminal leave status.
Service 1 - Provider	Any DVA provider
Service 1 - By Name Provider Request if Applicable - First and Last Name	DVA provider only

**4.5.** The TRICARE payment was made to the beneficiary instead of the non-network participating provider. The contractor shall immediately issue payment to the non-network participating provider and concurrently take recoupment action against the beneficiary.

**4.6.** Any other instance in which the erroneous payment was made directly to the beneficiary, except [paragraph 3.9](#).

#### **5.0. OVERPAID PARTY IS DECEASED**

If the contractor determines that liability for an overpayment rests with a beneficiary or provider who is deceased, the contractor shall seek recoupment of the overpayment from the estate of the deceased person under state laws. The procedures described in this section shall be followed.

#### **6.0. GOOD FAITH PAYMENT**

**6.1.** With prior approval from TMA, a contractor may make a good faith payment to a participating provider, or allow a previous payment to stand, for care provided to a patient, but only in the following situations.

- An ineligible patient holds an ID card showing TRICARE eligibility and the provider exercised reasonable care in accepting the apparently valid ID card as evidence of eligibility;
- An ineligible patient sees a Resource Sharing provider and there is evidence from DEERS indicating the patient had been shown as eligible at the time of service; or
- An ineligible beneficiary enrolls in Prime, claims are filed and denied as TRICARE ineligible, and the contractor can document via evidence from DEERS that the individual had in fact been shown on DEERS as eligible on the date of Prime enrollment and for the period covering the dates of medical care.

**6.2.** Whether the claim is initially paid or denied, the provider is expected to make reasonable efforts to collect payment from the ineligible patient prior to requesting approval of a good faith payment. Documentation of the unsuccessful effort is to be submitted to the Beneficiary *Education* and *Support Division (BE&SD)*, TMA, Aurora, Colorado, Attn: Good Faith Payment Considerations with the request. Immediately prior to submitting a request for approval of a good faith payment, the contractor shall recheck the current DEERS records to confirm that the person is not eligible and include the documentation of the results. The contractor is not financially responsible for making good faith payments. The contractor's costs will be separately reimbursed by the government.

**6.3.** If the contractor made payment to the participating provider, the contractor shall advise the participating provider and the patient of the patient's ineligibility and then follow recoupment procedures. If, during the recoupment process, the participating provider alleges that he or she relied on the information on the patient's ID card showing TRICARE eligibility, the contractor shall forward the file to *BE&SD*, TMA for consideration of a good faith

payment and advise the participating provider of the action taken. The file shall include documentation of all contact with the participating provider and patient.

**6.4.** If the contractor has not made payment to the participating provider, the contractor shall deny the claim based upon ineligibility of the patient. If the participating provider alleges that he/she/it relied on the information on the patient's ID card showing TRICARE eligibility, the contractor shall forward the file to *BE&SD*, TMA and advise the participating provider of the action taken. The file shall include documentation of all contacts with the participating provider and patient.

**6.5.** A provider who erroneously furnishes services and/or supplies to an ineligible beneficiary as a result of careless identification procedures is not entitled to a good faith payment. DMDC is responsible for providing beneficiaries with accurate and appropriate means of identification.

#### **7.0. OVERPAYMENTS RESULTING FROM ALLEGED MISINFORMATION**

An allegation by a patient or provider that information obtained from a health benefits advisor, contractor, or other party caused the overpayment does not alter the liability for the overpayment, or is it grounds for termination of recoupment activity.

#### **8.0. DENIAL OF BENEFITS PREVIOUSLY PROVIDED**

In those instances in which clarification, interpretation or a change in the TRICARE Regulation would result in denial of services or supplies previously covered, no action should be taken to recover payments expended for those benefits paid prior to the date of such clarification or change, unless specifically directed by TMA.

#### **9.0. DOUBLE COVERAGE SITUATIONS - PRIMARY HEALTH INSURANCE PLAN LIABLE**

A "Primary Plan," under TRICARE Law and Regulation is any other health insurance coverage the patient has, except Medicaid (Title XIX) or a supplement plan which is specifically designed to pay only TRICARE deductibles, coinsurance and other cost-shares. (See the TRICARE Reimbursement Manual, [Chapter 4](#).) The liability for refunding overpayments in all double coverage situations shall rest with the primary health insurance plan. When that plan has not already made its benefit payment to the beneficiary or provider, the contractor shall attempt recoupment directly from the primary plan in such cases. If the other plan has made payment, then the TRICARE payment shall normally be recouped from the party to whom the TRICARE payment was made.

#### **10.0. THIRD PARTY RECOVERIES**

When potential recovery from or actual payment by a liable third party is discovered, the contractor shall take recoupment action under the provisions of [Chapter 11, Section 5](#).

**4.4.** The TRICARE payment was made to the beneficiary instead of the participating provider. The contractor shall immediately issue payment to the participating provider and concurrently take recoupment action against the beneficiary.

**4.5.** Any instance where the erroneous payment was made directly to the beneficiary, except [paragraph 3.9](#).

**5.0. OVERPAID PARTY IS DECEASED**

If the contractor determines that liability for an overpayment rests with a beneficiary or provider who is deceased, the contractor shall seek recoupment of the overpayment from the estate of the deceased person. The procedures described in this section shall be followed.

**6.0. GOOD FAITH PAYMENT**

**6.1.** Participating providers who exercise reasonable care and precaution in identifying persons claiming to be eligible TRICARE beneficiaries and furnish otherwise-covered services and supplies to such persons in good faith, may be granted a good faith payment, although the person receiving the services and supplies is subsequently determined to be ineligible for benefits. In order to meet the requirements for a good faith payment, the participating provider must have:

- Exercised reasonable care and precaution in identifying the patient as TRICARE eligible.
- Made reasonable efforts to collect payment for the services provided from the person who erroneously claimed to be a TRICARE beneficiary.

**6.2.** In order to qualify for a good faith payment, the provider must submit documentation to substantiate that he/she has met BOTH requirements. The usual evidence that a provider has exercised reasonable care and precaution in identifying the patient as TRICARE-eligible is a copy of the patient's ID card which indicates that he/she was eligible for civilian medical care at the time services were provided. Generally, the provider must have obtained the copy of the ID card when the services were provided. If the provider did not obtain a copy of the ID card, he/she will submit to Beneficiary *Education and Support Division (BE&SD)*, TMA an explanation of why a copy was not obtained and the reason(s) for his/her determination that the patient was eligible for TRICARE benefits.

**6.3.** The documentation required to establish that a provider has made reasonable efforts to collect will vary, depending upon the facts of each case. Such documentation may include, but is not limited to, invoices or demand letters sent to the patient, and memoranda of telephone calls to the patient demanding payment. If the TRICARE beneficiary has moved and left no forwarding address, the provider must supply copies of returned letters or memoranda of unsuccessful attempts to reach the patient by telephone.

**6.4.** The contractor is not authorized to determine whether a provider exercised "reasonable care" which may qualify the provider for a good faith payment; nor are they authorized to seek, invite, or encourage good faith payment requests from providers. However, should a provider initiate an inquiry regarding denial of a claim due to the

patient's ineligibility, or a recoupment action in which the patient's eligibility is the issue, the contractor may advise the provider of the procedures for requesting a good faith payment.

**6.5.** If the contractor has NOT paid the participating provider (i.e., the claim is denied), the contractor shall advise the provider and the patient by EOB that the claim has been denied due to the patient's ineligibility so that the provider may attempt collection from the patient in a timely manner. Occasionally, the patient may need only to update his DEERS record, so that the denied claim may be processed and paid. Upon notification of the patient's ineligibility, the provider must attempt collection from the patient. If the provider alleges that he/she exercised reasonable care and caution in identifying the patient as TRICARE-eligible and requests a good faith payment, the contractor is responsible for advising the provider in writing within 30 days of the date of the request that documentation of his/her efforts to collect from that patient is required. The file shall be referred to **BE&SD**, TMA, for consideration of the request for a good faith payment and shall include:

- Pertinent claim form(s) and EOB(s)
- Evidence of the patient's ineligibility
- The provider's request for a good faith payment
- Documentation of all contractor contacts with the provider and the patient
- Documentation of efforts made by the provider to identify the patient as TRICARE-eligible prior to rendering service
- Documentation of efforts to collect from the ineligible patient.

**6.6.** The contractor shall notify the provider that his request has been referred to **BE&SD**, TMA. If TMA grants the request for a good faith payment, the contractor shall then reprocess and pay the previously denied assigned claim and initiate recoupment action against the beneficiary.

**6.7.** If an assigned claim was paid before the contractor discovered the patient's ineligibility, the contractor shall initiate recoupment action against the participating provider, and concurrently, advise the patient of his/her ineligibility for TRICARE benefits and his/her liability for payment to the provider. If the provider alleges that he/she exercised reasonable care and precaution in identifying the patient as TRICARE-eligible, and requests a good faith payment, the file shall be referred to **BE&SD**, TMA, for consideration of the request. The provider is required to supply all of the documentation outlined in [paragraph 6.2](#). If the provider's good faith payment request does not include documentation to substantiate the provider's efforts to collect from the patient, the contractor shall notify the provider in writing within 30 days of the date of the provider's request of the requirement to provide the information. Upon receipt of the requested information, the contractor shall notify the provider that his/her request has been referred to **BE&SD**, TMA. The contractor shall suspend recoupment action until a response to the good faith payment request has been received from **BE&SD**, TMA. If no response is received within 60 days, the contractor shall contact the Recoupment Division, TMA, to determine whether continued suspension of recoupment action is appropriate. If **BE&SD**, TMA notifies the contractor that a good faith

payment has been granted, the contractor shall terminate collection action against the provider, refund any monies collected from the provider, and initiate recoupment action against the ineligible beneficiary.

#### **7.0. OVERPAYMENTS RESULTING FROM ALLEGED MISINFORMATION**

An allegation by a patient or provider that information obtained from a health benefits advisor, contractor, or other party caused the overpayment does not alter the liability for the overpayment nor is it grounds for termination of recoupment activity.

#### **8.0. DENIAL OF BENEFITS PREVIOUSLY PROVIDED**

In those instances where TMA clarification, interpretation, or a change in the TRICARE Regulation results in denial of services or supplies previously covered, no action need be taken to recover payments expended for these benefits prior to the date of such clarification or change, unless specifically directed by TMA.

#### **9.0. DOUBLE COVERAGE SITUATIONS - PRIMARY HEALTH INSURANCE PLAN LIABLE**

A "Primary Plan," under TRICARE Law and Regulation is any other health insurance (OHI) coverage the patient has, except Medicaid (Title XIX) or a supplement plan which is specifically designed to pay only TRICARE deductibles, coinsurance and other cost-shares. (See the TRICARE Reimbursement Manual, [Chapter 4](#).) The liability for refunding overpayments in all double coverage situations shall rest with the primary health insurance plan. Where that plan has not already made its benefit payment to the beneficiary or provider, the contractor shall attempt recoupment directly from the primary plan in such cases. If the other plan has made payment, then the TRICARE payment shall normally be recouped from the party to whom payment was made by TRICARE.

#### **10.0. THIRD PARTY RECOVERIES**

When potential recovery from or actual payment by a liable third party is discovered, the contractor shall refer the matter to the designated Uniformed Service legal officer for recoupment as set forth in [Chapter 11, Section 5](#).

#### **11.0. PROCEDURES FOR RECOUPMENT OF OVERPAYMENTS**

For the purpose of determining the amount of the overpayment in a particular case, the contractor shall include all claims overpaid for the same reason/case/episode of care. All research required to establish the existence of a debt shall be accomplished and the initial demand letter shall be issued within 30 days from the date that a potential recoupment action is identified or notification is received that an erroneous payment has been made. (See sample letters [Chapter 11, Addendum A, Figure 11-A-5](#) and [Figure 11-A-6](#).) The contractor shall ensure that all demand letters are sent to the correct debtor at the most current address on file, i.e., enrollment file, provider file, claims history, etc. When letters are returned by the post office the forwarding address shall be obtained and letters that are returned shall be reissued to the new address. For any recoupment case involving a large number of claims having low dollar overpayments, the contractor may request a waiver to the claim

adjustment requirements on a case by case basis. Such requests are to be sent to the Chief, Recoupment Division, TMA.

**12.0. ERRONEOUS PAYMENTS RESULTING FROM INCORRECT ASSESSMENT OF THE DEDUCTIBLE**

**12.1.** If a contractor erroneously calculates the deductible and the error is discovered within the same fiscal year as the one in which the error was made, the error shall be corrected by properly assessing the deductible on the next claim or claims. No recoupment notice needs to be given if the deductible can be collected within the fiscal year in which the error was made.

**12.2.** If the deductible cannot be collected in the same fiscal year in which the error was made, the contractor shall initiate recoupment action in accordance with this chapter, regardless of the amount owed by the beneficiary, as a result of the erroneous calculation of the deductible.

**13.0. OVERPAYMENTS TOTALING LESS THAN \$110**

The contractor shall take no recovery action when the overpayment to a single payee is less than \$110.

**14.0. OVERPAYMENTS TOTALING \$110 OR MORE**

The contractor shall take the following recovery actions when the overpayment resulted from reasons other than failure to properly assess the deductible and the overpayment totals \$110 or more.

**15.0. OTHER THAN PARTICIPATING PROVIDER**

**15.1.** When an initial request for refund is sent, flag the record of the overpaid party for possible future offset action and suspend payment on a sufficient number of current claims to satisfy the amount of the debt.

**15.2.** Such claims may be processed to the point of payment to expedite finalizing when the refund payment is received. If the debtor on the claim in question is other than a participating provider, a system flag shall be set for future offset action.

**15.3.** If the refund request is unsuccessful after 30 days from the date of the request, offset against any claims suspended during the 30 days as required in this section. Offset can be made against any claim or claims on which payment(s) would be made to the previously overpaid party, irrespective of who is the patient on the claim from which offset is taken. For example, where benefit payments have been made to either parent on behalf of a minor child; i.e., under 18 years of age, unless one parent has been named the custodial parent in a divorce decree, both parents are responsible for those debts and offset may be taken against claims of either parent. However, an offset may not be taken against a sponsor for debts of the spouse or against a spouse for debts of the sponsor. If the overpayment is offset, prepare a EOB for each claim against which offset was made and send a notice to the overpaid party explaining the overpayment and the offset action (see sample letter, [Figure 11-A-7](#)).

## **16.0. PARTICIPATING PROVIDER**

Within 30 days of identifying an overpayment, send a written request for refund to the overpaid party. At the same time, the beneficiary shall be notified in writing, that a recoupment action has been initiated against the rendering provider. This letter shall identify the beneficiary's specific claims included in the recoupment action. The letter shall advise the beneficiary that no response is required and refer the beneficiary to the Beneficiary Service Representative (BSR) if they have further questions. (See sample letter, [Figure 11-A-8](#).) No offset flag is set at this point in the recoupment process (see [paragraph 16.2.2](#)).

### **16.1. Account Balance \$110 To Less Than \$600**

If the initial refund request is unsuccessful and there are insufficient funds available for a full offset send a follow-up letter 30 calendar days from the date of the initial letter. All follow-up requests shall include a copy of the original refund request and will notify the overpaid party that unless arrangements for refund are made with the contractor within 30 days from the date of the follow-up request, an attempt shall be made to offset against future claims. (See instructions in [paragraph 16.2.2](#) and the sample letters, [Figure 11-A-9](#) and [Figure 11-A-11](#).) When one year has passed and the debt has not been collected, the contractor shall ascertain whether there are any other active recoupment cases against the same debtor. If there are none, the contractor shall follow the instructions in [Chapter 3](#). If there are one or more additional active recoupment cases against the same debtor and the total outstanding debt for all active recoupment cases is \$600 or more, all cases shall be consolidated and referred to the Recoupment Division, TMA, regardless of the age of the cases. A credit adjustment will be submitted to include all amounts recouped up to the point of referral. The offset flag shall be removed when the cases are transferred. Documentation shall be included in the recoupment case file that the offset flag has been removed. The documentation may be a copy of the contractor's internal form designed to direct removal of the offset flag. All cases shall be referred to TMA within five working days after the offset flag has been removed.

### **16.2. Account Balance \$600 Or More**

**16.2.1.** If the initial refund request is unsuccessful and there are insufficient funds available for a full offset (see [paragraph 15.0](#), for suspended claims) send a follow-up letter 30 calendar days following the date of the initial letter. All follow-up requests shall include a copy of the original refund request and will notify the overpaid party that unless arrangements for refund are made with the contractor within 30 calendar days from the date of the follow-up request, an attempt shall be made to offset against future claims, and the matter shall be referred to TMA for further action (see sample letters, [Figure 11-A-10](#) and [Figure 11-A-12](#)).

**16.2.2.** If the initial and follow-up refund requests and the offset attempt, if any, are unsuccessful for a period of 60 days from the date of the initial demand letter, set an offset flag on the file of the overpaid party (including a participating provider and other debtors) until the file is transferred to TMA in accordance with [paragraph 19.0](#). In those cases which are not transferred to TMA (i.e., cases below \$600 in which the debtor has not requested relief from the indebtedness), the offset flag shall remain on the file of the overpaid party for the term of the TRICARE contract for potential future offset. In the event of a contractor transition, only offset accounts which have been on offset for less than 12 months will be

transferred to the new contractor. Any offset account received by the new contractor as a result of a transition shall be kept in effect for the life of its contract. When all or part of an overpayment is offset, prepare a EOB for each claim against which offset was made and send a notice to the overpaid party explaining the overpayment and the offset. (See the sample letter at [Figure 11-A-7](#).) If the offset is against the provider, the provider shall be advised that reimbursement for the claim against which the offset was made may not be sought from the patient on whose behalf the services were provided. Additionally, a letter (see [Figure 11-A-19](#)) shall be sent to the TRICARE beneficiary against whose claim the offset was taken. The contractor shall remove the offset flag on an account when it is referred to the Office of General Counsel, TRICARE, or when the contractor is advised to do so by that office. Documentation shall be included in the recoupment case file that the offset flag has been removed. The documentation may be a copy of the contractor's internal form designed to direct removal of the offset flag. All cases shall be referred to TRICARE within five working days after the offset flag has been removed.

**16.2.3.** If the debt has not been collected in full and there has been no positive response to the demand for payment such as a request for installment repayment agreement within 90 days from the date of the initial demand letter, and the balance remaining on the refund request is \$600 or more, the contractor shall send a final demand letter to the debtor (see [Figure 11-A-17](#)). The final demand letter shall be sent regardless of whether the debtor is a beneficiary or a provider and shall be accompanied by a completed Promissory Note (see [Figure 11-A-13](#)).

**16.2.4.** If offsets have not resulted in collection of at least 50% of the amount of the debt, and there has been no positive response to the demands for payment within 150 days from the date of the initial demand letter and the balance remaining on the account is \$600 or more, the case shall be referred to the Recoupment Division, TMA. When a case is transferred to TMA, the contractor shall advise the debtor of the referral and the debtor shall be notified that future payments should be sent to the Resource Management Division, TMA, 16401 East Centretch parkway, Aurora, CO 80011-9066 (see [Figure 11-A-26](#)). The offset flag will be removed when the cases are transferred. A credit adjustment will be submitted to include all amounts recouped up to the point of referral.

**16.2.5.** If, on the 150th day, the contractor has been successful in collecting 50% or more of the total amount of the debt, the offset flag shall remain in place, and the contractor shall hold the case an additional 150 days. Those cases that are held 300 days because collection by offset during the first 150 days was largely successful, shall be transferred to the Recoupment Division, TMA, on the 301st day, if the balance remaining on the account is \$600 or more. (See [Chapter 3, Addendum A, Figure 3-A-4](#), Instructions for the Accounts Receivable Report, for instructions on recoupments under \$600 and over 300 days.) When the case is transferred to the Recoupment Division, TMA, the offset flag shall be removed. Documentation shall be included in the recoupment case file that the offset flag has been removed. The documentation may be a copy of the contractor's internal form designed to direct removal of the offset flag. All cases shall be referred to TRICARE within five working days after the offset flag has been removed. When a case is transferred to TMA, the contractor shall advise the debtor of the referral and the debtor shall be notified that future payments should be sent to the Resource Management Division, TMA, 16401 East Centretch Parkway, Aurora, CO 80011-9066. A credit adjustment shall be submitted to include all amounts recouped up to the point of referral.

**16.2.6.** For further guidance on recoupments under \$600 and over 300 days, see the [Chapter 3, Addendum A, Figure 3-A-4](#), Instructions for Accounts Receivable Report.

**16.2.7.** Any case, with an account balance of \$600 or more in which a debtor unequivocally refuses to repay and no possibility of offset exists, shall be referred immediately to the Recoupment Division, TMA. Any case in which a debtor seeks relief from the indebtedness due to financial hardship, or seeks other equitable relief shall be handled in accordance with [paragraph 28.0](#).

## **17.0. BANKRUPTCY**

**17.1.** All Notices of Bankruptcy, and letters from petitioners, attorneys for petitioners, and trustees of the bankrupt estate shall be forwarded to the Recoupment Division, TMA, within three work days of receipt. Each Notice of Bankruptcy forwarded to TMA shall include: the debtor's full name; the debtor's full and complete social security number/tax identification number; the name of the bankruptcy court wherein bankruptcy was filed; and the bankruptcy case number. (See sample coversheet, [Figure 11-A-33](#)). The contractor shall verify that the only bankruptcy cases forwarded to TMA are for debts which were paid with non-financially underwritten funds. Additionally, the contractor shall take the following actions:

**17.2.** If the petitioner in bankruptcy is indebted to TRICARE, all recoupment actions shall cease. If the debtor is on offset, the contractor shall terminate the offset immediately. If the recoupment case(s) against the bankrupt petitioner has not already been transferred to the Recoupment Division, TMA, the complete case file(s), regardless of dollar value, shall be transferred with the Notice of Bankruptcy within three work days of receipt. Each case file shall contain all the documentation required by [paragraph 19.0](#), below. However, the contractor shall not hold the Notice of Bankruptcy while they attempt to obtain all of the required documentation. A note will be placed in the case file to indicate when the missing documentation will be forwarded. If any amounts have been collected by offset or voluntary repayment by the debtor, the case file must contain the dates and amounts of each offset and/or payment. In addition, at the time the case file is forwarded to the Recoupment Division, TMA, a check for the total amount collected shall be forwarded to the Finance and Accounting Office, TMA. The following information shall accompany the check:

- The Debtor's Full Name
- The Sponsor's Social Security Number on the overpaid claim
- The Claim Number (ICN) of the overpaid claim
- The Dates and Amounts of each offset and/or payment

**17.3.** If there is no ongoing recoupment case against the petitioner in bankruptcy and the petitioner is a provider, contractor shall ascertain whether any assigned claims are pending for the petitioner provider. If there are claims pending, payment on those claims shall be suspended, and the Notice of Bankruptcy will be forwarded within three work days of receipt to the Recoupment Division, TMA, with advice as to the number of claims suspended and their value. The Recoupment Division will advise the contractor when the pended claims may be processed and to whom payment should be issued. (See [Figure 11-A-32](#) for a sample report of claims pended for provider bankruptcy.)

**17.4.** The contractor shall identify individuals and providers who have, during the term of their TMA contract, filed a Petition in Bankruptcy, regardless of whether the petitioner is or has been indebted to TRICARE. The contractor shall initiate no recoupment action, either on their own initiative or upon the request of another TMA component, against a debtor who has filed a petition in bankruptcy, without prior approval by the Recoupment Division, TMA.

**18.0. PROCESSING CLAIMS WHEN THE PRIMARY INSURER IS BANKRUPT OR IN RECEIVERSHIP**

**18.1.** Increasingly, insurance companies which have been primary to TRICARE are filing petitions in bankruptcy or have been placed in receivership, and are refusing to honor claims. This situation is to be distinguished from that in which an employer or labor union stops paying premiums to an insurance company. In the latter case, insurance coverage ceases for the employee or member of the labor union when premiums have not been paid; the TRICARE claims should be processed in the same manner as any other claim on which the beneficiary has no other health insurance. Although the TRICARE beneficiary who was formerly covered by the bankrupt insurer may have a claim against the bankrupt estate, the beneficiary may have to wait years for distribution of assets, if any. Since TRICARE is, by federal statute and regulation, secondary to all health benefit and insurance plans, extraordinary measures must be taken to allow TRICARE to pay claims as primary payer pending any distribution of assets from the bankrupt estate.

**18.2.** The contractor shall have documentation to prove that a claim was filed with the primary insurer or a Proof of Claim was filed with the bankruptcy court. This information may be requested using [Figure 11-A-28](#). When a TRICARE beneficiary or participating provider provides evidence that the beneficiary's primary insurer is in bankruptcy and is no longer honoring claims, the contractor may issue payment on a claim-by-claim basis, after the following steps have been taken:

**18.3.** Determine the time period that the TRICARE beneficiary was covered by the bankrupt insurer.

**18.4.** For each claim, ascertain whether the medical care claimed was received during the period of coverage by the bankrupt insurer.

**18.5.** If the medical care was received after the petition in bankruptcy was filed by the primary insurer, determine whether the TRICARE beneficiary has obtained alternative insurance which is primary to TRICARE. If alternative insurance has been obtained, process the claim under the double coverage provisions of the TRICARE Reimbursement Manual.

**18.6.** If the medical care was received prior to the filing of a petition in bankruptcy by the primary insurer, determine whether the primary insurer has issued payment on the claimed services.

**18.7.** If the bankrupt primary insurer has not issued payment on the claimed services, and the medical care was received during the period of coverage by the bankrupt insurer, determine who the payee on the TRICARE check will be. Normally, if the claim is assigned, payment is issued to the provider of medical services. If the claim is not assigned, payment is

issued to the TRICARE beneficiary, or, if the TRICARE beneficiary is a minor, or incompetent, to a parent, guardian, or conservator.

**18.8.** If the TRICARE payment is to be issued to a provider, complete the Power of Attorney and Agreement ([Figure 11-A-27](#)) and mail it to the provider. The date line on page 2 of the form is to be completed by the provider. Use the letter at [Figure 11-A-28](#).

**18.9.** If the TRICARE payment is to be issued to the TRICARE beneficiary, or his or her parent or guardian, complete the Power of Attorney and Agreement ([Figure 11-A-29](#)) and mail it to the beneficiary. The date line on page 2 is to be completed by the beneficiary. Use the sample letter at [Figure 11-A-30](#).

**18.10.** If the signed Power of Attorney and Agreement has not been returned within 35 days from the date of the contractor's letter ([Figure 11-A-28](#) or [Figure 11-A-30](#)), the claim is to be denied.

**18.11.** When the signed Power of Attorney and Agreement has been received, the contractor shall process the claim. The Power of Attorney and Agreement must have an original signature; facsimile signatures (i.e., signature stamps) are not acceptable. An authorized agent of a participating provider may sign the Power of Attorney and Agreement; however, no special designation of appointment is required. Only one signed Power of Attorney and Agreement is required from each potential recipient of a TRICARE payment for medical care claimed during the period of coverage by the bankrupt insurer. A separate Power of Attorney and Agreement is not needed for each claim. Each potential recipient of a TRICARE payment (i.e., beneficiary or participating provider) who signs a Power of Attorney and Agreement may file more than one claim for services provided or received during the period the TRICARE beneficiary was covered by the bankrupt insurer.

**18.12.** The contractor shall maintain a record of all signed Powers of Attorney and Agreement and all claims on which TRICARE payment has been issued as the primary payor. The contractor shall perform the required follow-up and complete the required report. Claim forms and EOBs shall be filed in the usual manner.

**18.13.** Biannually, the contractor shall follow-up with each beneficiary for whom claims have been paid by TRICARE as primary payor as a result of the filing of a petition in bankruptcy by the primary insurer. If any assets were distributed from the bankrupt estate to the TRICARE beneficiary for medical care, the amount received either by the TRICARE beneficiary or the participating provider will be treated as a payment made by the primary insurer, and benefits shall be coordinated in the usual manner. If the contractor determines that an overpayment has been made, recoupment action shall be initiated from the recipient of the TRICARE overpayment. No later than January 15 and July 15 of each year, the contractor shall submit the report located at [Figure 11-A-31](#) to the Recoupment Division, TMA.

**18.14.** If, during a biannual follow-up, the contractor learns that the bankruptcy case has been closed, and no assets have been distributed, no further follow-up is required.

**18.15.** If a transition occurs before the contractor determined that the bankruptcy case has been closed, with or without distribution of assets, the Power of Attorney and Agreement forms, with copies of claims and EOBs will be sent to the Recoupment Division, TMA for follow-up.

## **19.0. CASE REFERRALS**

**19.1.** Cases referred to the Office of General Counsel, TMA, as required in [paragraphs 16.2.4.](#) and [17.0.](#), above, shall include the documentation listed below. All documentation shall be placed in the file in the order listed, with [paragraph 19.2.](#) on the bottom and [paragraph 19.8.](#) on top.

**19.2.** Legible copies of all claims involved in the recoupment. If copies of all claims cannot, with good reason, be provided, a copy of the automated claims history may be substituted. However, if a claims history is substituted for copies of the actual claims, a detailed explanation of each field on the claims history shall be provided.

**19.3.** Documentary evidence, i.e., workpapers, calculations reflecting how the amount of the overpayment was determined, establishing how the overpayment was identified and the basis for the erroneous TRICARE payment, including copies of checks and EOBs for both the erroneous payment and the correct payment, and documentation such as proof of Medicare eligibility, proof of other health insurance, (EOBs from the other health insurance reflecting what the other health insurance paid for, the relevant care and the name of the other health insurance, policy number and the effective dates of coverage), signed promissory note, etc. When a check copy cannot be obtained the contractor shall document efforts to obtain it and include the documentation in the file. Normally cases shall not be forwarded without check copies and EOBs. When a contractor has determined that a check copy or EOB cannot be obtained, the contractor shall document efforts made to obtain it and include it in the file. The contractor shall also notify the TMA Recoupment Office by facsimile within 5 days of the date it determined that the documentation could not be obtained and provide the Recoupment Case Number (RCN), claim number, check date, provider name, patient name, Sponsor SSN and date(s) of service. If the Recoupment Office cannot obtain the required check copies of EOBs, they will advise the contractor to forward the file without them.

**19.4.** Copies of checks and EOBs showing payment made to correct the erroneous payment, if any. When the recoupment is the result of a duplicate payment, copies of the check and EOB for the original payment and the copies of the check and the EOB for the duplicate payment shall be included in the file.

**19.5.** Copies of all demand letters sent to the debtor, which must provide a full explanation of the circumstances surrounding the erroneous payment.

**19.6.** Copies of all correspondence received from the overpaid party or their representative relating to the recoupment case and the contractor response.

**19.7.** Copies of all EOBs reflecting collections by offset and copies of all payment acknowledgment letters issued to debtors. Also, the contractor shall maintain a tally sheet reflecting the original amount of the debt, each offset taken, and the balance remaining after each offset. Documentation shall be included in the recoupment case file that the offset flag

BENEFICIARY *EDUCATION* AND *SUPPORT DIVISION (BE&SD)*

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<b>ADDENDUM A</b>	<b>TRICARE LOGO</b> FIGURE 12-A-1 <i>Requirements</i> And Guidelines For The Use Of The TRICARE Logo

## MARKETING AND EDUCATION REQUIREMENTS

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The marketing and education of TRICARE beneficiaries, TRICARE providers and Military Health System (MHS) staff and providers will be accomplished through a collaborative effort between the TRICARE Management Activity (TMA) *Beneficiary Education and Support Division (BE&SD)*, the Managed Care Support (MCS) and other TRICARE contractors. This collaboration will ensure information and education about the TRICARE Program, policies, health care delivery requirements and changes and/or addition to benefits is effectively provided. Marketing and education activities include the provision of marketing and education materials, and training programs and briefings in accordance with the TRICARE Operations Manual (TOM), [Chapter 12, Section 2](#). The Government will furnish all printed marketing and educational materials. The MCS and/or other TRICARE contractors will be responsible for the individual distribution of Government furnished materials.

### 1.0. MARKETING AND EDUCATION PLAN

1.1. The Managed Care Support Contractor (MCSC) shall prepare and submit to TMA *BE&SD* an annual marketing and education plan to inform and educate TRICARE beneficiaries, TRICARE and MHS staff and providers on all aspects of TRICARE programs. The plan shall identify any desired marketing and education materials required from the Government to support the accomplishment of plan goals for marketing and education.

1.2. The MCSC shall submit the plan to TMA *BE&SD* by the 180th calendar day prior to the start of health care delivery and 90 calendar days prior to the beginning of each option period thereafter. The Contracting Officer will provide the MCSC with written approval within 30 calendar days of receipt of the plan.

### 2.0. INTERFACE REQUIREMENTS

2.1. TMA *BE&SD* will meet with each MCS and TRICARE contractor within 60 calendar days after health care contract award to develop and establish a Memorandum of Understanding (MOU). The MOU will establish the review and approval process for annual marketing and education plans and identify desired marketing and education materials. The MOU will identify the process for requesting additional marketing and education material beyond those requested in the annual plan submitted. The MOU shall also address the ordering and bulk shipment of materials, inclusion of health promotion, health care delivery and geographic specific information in marketing and educational materials. The MOU shall be effective within 30 days of the meeting between TMA *BE&SD* and the contractor.

2.2. The MCSC shall participate in monthly TRICARE beneficiary and provider education work group meetings comprised of the TRICARE Regional Offices (TROs) marketing representatives, Services marketing representative, OCONUS marketing representative and the TRICARE Beneficiary Publications Office/*BE&SD*. As advisors, the

contractors shall provide unique perspectives, ideas and recommendations regarding the development and maintenance of TRICARE educational materials to the group. The goal of the monthly meetings is to present status updates on production, address issues and provide new information and propose new ideas for products and/or initiatives. All requests for marketing and education materials shall be submitted by the contractor via the appropriate TRO for review and consideration. Approval shall be based on justification that supports a uniform image and consistency in the provision of TRICARE Program information and available funding. The contractor shall provide a primary and alternate representative for attendance and participation in the monthly meetings, to be held approximately 12 times per contract year in the Washington, DC area. Meetings may be attended via teleconference, video telecommunications or in person, as directed by the government.

### 3.0. REQUIRED EDUCATIONAL MATERIALS

The Government will furnish all beneficiary educational materials which may include printed and electronic media. Materials developed by the Government and distributed in support of the TRICARE program will be selected on the basis of recommendations by contractors, program managers, the Services, TMA leadership and others with interest and concerns about the information being provided to TRICARE beneficiaries and other stakeholders. *BE&SD* and the TROs will review all recommendations and will prioritize products in accordance with funding availability. TMA/*BE&SD* will have final approval authority. The MCS and/or other TRICARE contractors will be responsible for the distribution of Government-furnished materials to MHS beneficiaries. The government will provide all enrollment materials for distribution by the MCSC.

### 4.0. DISSEMINATION OF INFORMATION

4.1. The MCSC shall distribute TRICARE information using effective methods that ensure timely delivery and receipt to all MHS beneficiary households in the region based on Defense Enrollment Eligibility Reporting System (DEERS) data. The MCSCs annual Marketing and Education Plan (see [paragraph 1.0.](#)) shall indicate frequency and methods of information distribution. In addition, the MCSC shall be required to do a mailing pertaining to a benefit update, within the contract period, to all eligible beneficiary households. The MCSC shall also furnish enrollment information and forms, network provider information, Health Care Finder (HCF) information, claim forms, claim completion instructions, the TRICARE Handbook, DEERS information and other informational materials upon request to beneficiaries, providers, and congressional offices. The MCSC shall establish and maintain effective communications with all beneficiaries. (See [Chapter 12, Section 4.](#))

4.2. Annually, the MCSC shall be responsible for all provider education, which may include producing and distributing an annual Provider Handbook, newsletters, and/or bulletins. The MCSC may use any method of distribution that ensures timely receipt by all providers. Copies of TRICARE educational materials distributed to providers will be provided to the TMA Regional Director (RD), TMA *BE&SD*, and congressional offices. The Government reserves the right to evaluate the success of the MCSC provider relations effort via scientific surveys and other data collection efforts with the network providers.

4.3. The MCSC shall distribute a quarterly newsletter to all TRICARE Prime enrollees, including active duty personnel, dual-eligible beneficiaries, congressional offices, and Health

Benefits Advisors (HBAs). The MCSC shall also distribute an annual TRICARE Standard newsletter to beneficiaries not enrolled in Prime using information contained in DEERS or provided by beneficiaries. The newsletters will generally be no more than six double-sided pages in length (8 1/2" x 11"). The MCSC shall not modify the content and length of the beneficiary newsletter prior to distribution. The MCSC shall use any method of distribution that ensures timely delivery and receipt to all recipients.

**4.4.** The TDEFIC contractor shall maintain a supply of TRICARE For Life (TFL) beneficiary educational materials. The TDEFIC contractor shall provide a copy of the most recent TFL information upon request.

#### **5.0. ORDERING MARKETING AND EDUCATION MATERIALS**

Initial requests for desired marketing and education materials shall be submitted to TMA *BE&SD* during the development of the MOU after initial award of the MCS contract. Requests for additionally desired marketing and education materials, not included in the annual submission of the marketing and education plan shall be submitted to TMA *BE&SD* in accordance with the established MOU. For each contract year, initial requests for marketing and education materials shall be included with the submission of the annual marketing and education plan. Requests for materials shall include the date and numbers required. The contractors shall provide TMA *BE&SD* with a single point of contact and address(es) for delivery of marketing materials.

#### **6.0. MEDICAL MANAGEMENT TRAINING**

The contractor shall participate in Health Affairs sponsored Medical Management Training as requested, to include coordination of training schedules and the development of the agenda and training materials. Each contractor will participate in two four-day training sessions per year in their respective Region. The location of the training will be designated by Health Affairs.



## BENEFICIARY EDUCATION

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In addition to its responsibility to provide information to beneficiaries concerning the TRICARE Standard Program, the MCS contractor shall develop a beneficiary education program to inform beneficiaries about the TRICARE Prime and TRICARE Extra programs. This program shall include the distribution of education materials to all enrollee households, supplying educational materials at every TRICARE Service Center and at every Health Benefits Advisor's office, participation in all "newcomer orientations" at all bases, and conducting general information sessions for all demographic categories (for example, active duty personnel, active duty family members, new retirees and their dependents, dual-eligible beneficiaries, et cetera) at each MTF at least every six months.

### 1.0. EDUCATION REQUIREMENTS

**1.1.** The MCS contractor shall conduct one three-day TRICARE training course each quarter covering all aspects of the program including, but not limited to, TRICARE, overseas, dual-eligibles, et cetera. The location of the course shall be within the region; however, the exact location will change each quarter to allow maximum participation by Uniformed Services personnel who require an in-depth understanding of TRICARE to successfully accomplish their assigned duties. The contractor shall follow the Government provided training material (slides, notes, etc.) in delivering the course. The Government will provide all handouts for the course. Government furnished facilities will not be provided.

**1.2.** The MCS contractor shall conduct three one-hour training sessions, followed by a question and answer session, for clinical personnel at each MTF/DTF monthly. Training sessions will be at the date and time specified by the MTF/DTF Commander and may correspond with the hours personnel work at the facility. The contractor shall also conduct one one-hour training session, followed by a question and answer session, for administrative personnel at each MTF/DTF monthly. The contractor shall follow the Government provided training material (slides, notes, etc.) in delivering the course which will cover all aspects of TRICARE including, but not limited to, TRICARE Prime, Extra, and Standard, financial impact of MTF decisions on both the beneficiary and the MHS, dual-eligibles, et cetera. The Government will provide all handouts for the course. Government-furnished facilities will be provided for the course location.

**1.3.** The MCS contractor shall provide one one-hour briefing, followed by a question and answer session, weekly to an audience specified by the MTF/DTF Commander. Examples of audiences are Ombudsmen, support groups, obstetrical patients, retiree groups, parent groups, dual-eligibles, etc. The contractor shall follow the Government provided training material (slides, notes, etc.) in delivering the course. Government-furnished facilities will be provided for the course location. The MCS contractor shall actively announce each briefing time, location, and audience through base publications, local fraternal organizations, and flyers posted throughout the base.

**1.4.** The MCS contractor shall conduct three one-hour briefings, followed by a question and answer session, for military recruiters in the region, annually. The briefings shall occur during the recruiters' annual regional/district conference and cover all aspects of TRICARE. The contractor shall use the Government provided training materials (slides, notes, etc.) in delivering the course. The Government will provide all handouts for the course. Government-furnished facilities will be provided for the course location.

**1.5.** The MCS contractor shall provide one one-hour briefing covering all aspects of TRICARE, followed by a question and answer session, annually, at each Reserve/National Guard unit listed in the websites below. The Regional Director will provide the date and time of each briefing annually. The MCS contractor shall use the Government provided training materials (slides, notes, etc.). Government furnished facilities will be provided at the course location. The Government will provide all handouts for the course.

- Air National Guard: [http://www.goang.com/about/aboutang\\_locations.aspx](http://www.goang.com/about/aboutang_locations.aspx)
- Army National Guard: <http://www.arng.army.mil/tools/unit.asp>
- Navy Reserve: <http://www.navalreserve.com>
- Marine Reserves: <http://www.marforres.usmc.mil/Units>
- Air Force Reserves: <http://www.afrc.af.mil/units.htm>
- Army Reserves: <http://www.army.mil/organization/reserveunits.html>
- *Coast Guard Reserves:* <http://www.uscg.mil/hq/reserve/reshmpg.html>

## **2.0. BENEFICIARY SURVEYS**

In accordance with DoD Instruction 1100.13, and Health Affairs Policy Memorandum 9700012, surveys of military members, retirees and their families must be approved and licensed through issuance of a Report Control Symbol (RCS). Contractors shall not conduct written or telephonic beneficiary surveys without the approval of the TRICARE Management Activity (TMA) Program Analysis and Evaluation Directorate. TMA has an ongoing survey research and analysis program which includes a periodic survey of DoD beneficiaries. The survey addresses health status, use of care, satisfaction with military and civilian care, and attitudes toward TRICARE. The data are collected at the Prime service area level and can be aggregated to the regional level. Regional reports containing Prime service area data are available through the Regional Director. Contractors shall work with the Regional Directors to define both their ongoing and special purpose requirements for survey data. Contractors with special needs not met by an existing instrument may submit surveys, sampling plans, and cost estimates to the TMA, Program Analysis and Evaluation Directorate, through the Regional Director, if applicable, for approval and licensing.

## TRICARE SERVICE CENTERS

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### 1.0. LOCATION AND OPERATIONS

TRICARE Service Centers (TSCs) shall be established at each Military Treatment Facility (MTF) and within each Base Realignment and Closure (BRAC) site. If space provided at an MTF is not sufficient, the contractor shall be responsible for obtaining the additional space. The contractor shall sufficiently staff the TSC and is responsible for its operations. TSCs located in an MTF shall be operated, at a minimum, Monday through Friday (except Federal holidays) during the administrative hours of the facility. The contractor shall staff all TSCs on a full-time basis with qualified personnel capable of performing all functions of the TSC. The TSC shall meet the standards in [Chapter 1, Section 3](#), as applicable. The contractor shall provide all furniture, equipment, supplies, telephone services, etc., required at each TSC regardless of where it is located. If requested by the MTF Commander, the contractor shall place a suggestion box in the TSC at a location recommended by the MTF Commander. Copies of the suggestions or comments received in the suggestion box shall be furnished to the MTF Commander when requested.

### 2.0. TRICARE SERVICE CENTER FUNCTIONS

The contractor shall be responsible for establishing TSCs which provide beneficiary enrollment, access to and referral for care, information on the Point of Service (POS) option, information (including on-line access to the claims processing system for information about the status of a claim), assist beneficiaries with claim problems when the Managed Care Support Contractor (MCSC) is responsible for processing the claim, and continuity of care services to all Military Health System (MHS) beneficiaries including, but not limited to, active duty personnel, dependents of active duty personnel, retirees and their dependents, survivors, Medicare eligible beneficiaries and all other categories of individuals eligible to receive MHS services. Based on the Memorandum of Understanding (MOU) provisions between the MTF and the contractor, the contractor shall ensure effective operation of the TSCs to reflect the provisions in [Chapter 16, Section 1, paragraph 1.0](#). TSCs shall maintain up-to-date lists of the providers in the contractor's network. MTF commanders, Regional Directors (RDs), and MHS beneficiaries shall be granted access to these lists on an as needed basis. The contractor shall ensure eligibility for care and enrollment status of beneficiaries before making any arrangements for medical services. TSCs shall have an interface with the automated claims processing and enrollment systems to support the functions of the TSC not later than 30 calendar days prior to the start of the health care delivery. The activities of the TSC shall include:

#### 2.1. MHS Beneficiary Information

TSCs shall provide personal assistance to all MHS beneficiaries seeking information about TRICARE Prime, TRICARE Extra, and TRICARE Standard. The contractor shall ensure

that the TSCs are supplied with enrollment and marketing information for TRICARE Prime, Extra, and Standard, dual-eligible program and claims submission information, CHAMPVA TRICARE dental programs, and all other relevant materials. Through the TSCs, the contractor shall establish mechanisms to advise beneficiaries of care options and services offered.

## 2.2. Continuity Of Care

TSCs shall act as the focal point for providing information, referral, and assistance to beneficiaries seeking access to TRICARE services. The TSCs shall maintain day-to-day liaison with MTF officials to promote MTF Optimization and ensure effective performance of the access, referral, information and continuity of care functions.

## 2.3. Enrollment

TSCs shall provide personal assistance to eligible beneficiaries electing to enroll or disenroll and permanently assigned active duty personnel enrolling in TRICARE Prime. The TSC shall provide assistance to all MHS beneficiaries (including active duty, Medicare eligibles and others) in understanding program requirements, answering questions, adhering to MTF Commanders' and RDs' determinations for *Primary Care Management (PCM)* assignment, and following grievance and inquiry procedures in accordance with [Section 10](#).

## 2.4. TRICARE Dental Program Information

2.4.1. TSCs shall provide information on eligibility for the TRICARE Dental Program (TDP) and on how to obtain dental information from the TDP contractor. Active duty members and their families shall be informed of their possible eligibility, handed a TDP brochure containing enrollment and coverage details, and provided the following:

**THE TRICARE DENTAL PROGRAM IS FOR ACTIVE DUTY  
FAMILIES, SELECTED RESERVE AND INDIVIDUAL  
READY RESERVE MEMBERS, AND THEIR FAMILY MEMBERS**

If you are interested in enrolling your dependents in the TRICARE Dental Program, please contact United Concordia Companies, Inc., to receive information on what dental benefits are covered, procedures for enrolling your family, and the amount of the enrollment fees. The HBA can also assist you with information about your coverage and with choosing a dentist. Enrolling in the dental program is voluntary, and enrollments will be accomplished by United Concordia Companies Inc.

You may write to United Concordia Companies, Inc.

United Concordia  
TDP Customer Service  
P.O. Box 69410  
Harrisburg, PA 17106-9410

## BENEFICIARY, CONGRESSIONAL, AND HEALTH BENEFIT ADVISOR RELATIONS

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### 1.0. GENERAL

In a service relations program, the contractor's primary responsibilities are to the beneficiaries and the providers. However, in meeting these responsibilities, it is frequently necessary to respond to Congressional Offices or to Health Benefit Advisors (HBAs) who are intervening on behalf of a beneficiary or provider. To facilitate handling of these contacts, the contractor should establish a working relationship with the Congressional delegations in each state and with the HBAs in the service area. These individuals can often assist in resolving questions/problems of the beneficiary and provider population.

### 2.0. BENEFICIARY RELATIONS

The contractor will be invited to attend and participate in beneficiary meetings, such as The Retired Military Associations. These meetings provide opportunity for the contractor to make presentations and distribute educational material to the beneficiaries.

### 3.0. CONGRESSIONAL AND HBA RELATIONS

The contractor is responsible for performance of the following minimum functions in carrying out a Congressional and HBA relations programs within the service area of the contract.

#### 3.1. Establish Communications

**3.1.1.** The contractor shall establish and maintain effective communication with the Congressional office staffs and HBAs in the service area(s) of the contract(s). To do this, the contractor shall establish procedures and provide staffing to perform all necessary functions.

**3.1.2.** The contractor shall provide written notification of the contractor's point(s) of contact [name(s), address(es), and phone number(s)] to all congressional offices and HBAs serving the states covered by the contract. The contractor shall provide separate telephone numbers (lines) reserved exclusively for congressional offices and HBAs. This service is not required to be toll-free; however, the contractor shall provide sufficient telephone lines and TRICARE staff to meet the requirements in [Chapter 1, Section 3](#). In addition, when it is appropriate because of the volume of Congressional office inquiries received, a contractor representative may need to make a visit to resolve problems and/or educate the staff about TRICARE operations and requirements. In most MTF Prime service areas, it is expected that the contractor's TRICARE Service Center staff will have regular if not daily, interface with the HBAs. In other areas, the contractor shall develop a program of regular HBA contact which includes a contractor representative meeting with the HBA at least semi-annually. When serious problems or other needs arise, more frequent contact will be required.

**3.2. Reporting**

By the 30th day following the close of each contract quarter, the contractor shall submit a summary report only, with the number and the types of contacts (Congressional, HBA, etc.) actually completed. The report shall show, for example, 100 visits, 50 HBA contacts, etc. The actual visit or contact reports, plus the internal contractor management monitoring reports shall remain a requirement. This report shall be available for TMA review at the contractor's office but shall not routinely be sent to the TMA. A special report shall be sent to the TMA when there is any special accomplishment achieved, special problems encountered or when the contractor's representative receives a recommendation or request from a provider which needs special attention at TMA.

**4.0. SPECIAL HBA MEETINGS**

TMA conducts workshops with HBAs in various locations throughout the year. The contractor shall provide representation to participate in the workshops where HBAs from the contractor's service area will be present in significant numbers. TMA will provide at least 30 calendar days notice of such a requirement. TMA will also outline the expected nature of contractor's participation. If a contractor has a specific problem or issue which should be addressed at an HBA meeting, TMA should be notified at least 21 days prior to the scheduled meeting.

## INQUIRY SERVICES DEPARTMENT - GENERAL

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### 1.0. INQUIRY SERVICE DEPARTMENT OBJECTIVES

Contractors shall implement an inquiry processing service which ensures that all inquiries about TRICARE received from TRICARE beneficiaries, providers, and other interested parties are processed in a timely and consistent manner and that information delivered about the program is accurate. The services department shall be able to assist in settling TRICARE claims and provide program information whether the inquiry is by telephone, letter, electronic media, or walk-in. For inquiries regarding Active Duty Claims, contractors shall follow the procedures as outlined in [Chapter 18](#).

### 2.0. WRITTEN INQUIRIES

The contractor shall process both routine and priority correspondence meeting the standards and requirements set forth in [Chapter 1, Section 3](#).

### 3.0. TELEPHONES

The contractor shall provide the availability of telephone contact as a service to all TRICARE inquiries [beneficiaries, Regional Directors, providers, ASD(HA), TMA, HBAs, and congressional offices]. TRICARE has established a 1-800-TRICARE telephone number. This number will route incoming calls to the appropriate contractor for action. The MCSC and TDEFIC shall provide the Contracting Officer with the single telephone number to which these calls shall be routed no later than 150 calendar days prior to the start of services.

### 4.0. WALK-IN INQUIRIES

The contractor shall provide facilities and trained personnel to process walk-in inquiries promptly and accurately. The contractor shall provide for appropriate space and trained staff to enable it to handle walk-in inquiries, including a reception area to accommodate persons visiting its offices about TRICARE matters. This area shall provide sufficient privacy to preclude violation of the Privacy Act. The contractor staff shall be trained to meet with, and properly respond to, all visitors giving prompt, accurate answers to their concerns. Because personal interviews are difficult to monitor for quality of the contact, only the most skilled persons should be assigned.

### 5.0. TRAINING OF SERVICE REPRESENTATIVES

All representatives must be knowledgeable people with a high level of communications skills. Access to claims history and all other necessary information is essential. Service representatives must be thoroughly trained in the areas outlined in [Chapter 1, Administration](#). Special emphasis should be placed on medical terminology, all pertinent

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instructions and program benefit policies (including both standard TRICARE and TRICARE Prime) and how they are applied in processing, Privacy Act and information requirements, Freedom of Information Act, contractor claims processing system capabilities, and communication skills, and training in the identification and reporting of potential fraud and abuse situations. In addition, the telephone representatives need special training in telephone procedures, including any special instructions on the telephone system, listening for content, customer contact and courtesy, and time management, and training in the identification and reporting of potential fraud and abuse situations.

## CORRESPONDENCE CONTROL, PROCESSING AND APPRAISAL

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### 1.0. GENERAL

The contractor shall make timely, accurate answers to all TRICARE inquiries [written, telephone, electronic, walk-in, ASD(HA), TRICARE Management Activity (TMA), Regional Director, HBA, and congressional]. Written inquiries received shall be sorted and categorized as defined in [paragraph 3.0](#) below. For standards refer to [Chapter 1, Section 3](#). On all outgoing correspondence from the contractor to the beneficiary, if the SSN is used it shall be limited to the last four digits due to security and privacy concerns.

#### 1.1. Correspondence Receipt And Control

The contractor shall establish and maintain an automated control system for routine and priority correspondence, appeals, and grievances which meets the requirements of [Chapter 1, Section 3](#); Chapter 12; and [Chapter 13](#). The contractor shall capture and retain needed data for input to workload and cycle time aging reports.

#### 1.2. Availability Of information

Information required for appropriate responses to inquiries, including but not limited to TRICARE claim files, appeal files, previous correspondence, and canceled checks must be retrievable within five workdays following a request for the information.

### 2.0. CONTROL

Correspondence shall be controlled and stamped with the actual date of receipt in the contractor's custody. The control system shall be automated unless the contractor receives approval for another system which will produce comparable results. Information required for appropriate responses to inquiries shall be retrievable not less than five days following a request for the information. When appropriate, contractor must be able to associate incoming correspondence with prior inquiries. All correspondence or other documents received or generated in the services department shall be filed within five workdays following processing to completion. If correspondence is answered by telephone, a record of the conversation shall be filed with the inquiry.

### 3.0. CATEGORIES OF CORRESPONDENCE

All incoming correspondence shall be separated into the following categories for reporting purposes:

- Appeals
- Grievances

- Priority correspondence
- Routine inquiries, including allowable charge complaints
- Allowable Charge Complaints

#### **4.0. ROUTINE CORRESPONDENCE**

**4.1.** Responses may be provided by telephone, form letter, preprinted information, or individual letter. A copy of the response shall be filed with the inquiry. The text of written responses shall be typed. On form letters or preprinted information, the address may be neatly handwritten, if the contractor chooses. In situations of potential fraud or abuse, a referral to the contractor's Program Integrity Unit shall be completed and a copy of the referral filed with the correspondence. For standards see [Chapter 1, Section 3](#).

**4.2.** If correspondence is received which does not contain enough information to identify the specific concern, the contractor should develop incomplete inquiries by using the quickest and most cost effective method for acquiring the information. Telephone contact is recommended. When a reasonable effort has been made to acquire the missing information, notify the correspondent that a response is not possible until receipt of the requested information. The contractor may then close the item for reporting purposes.

**4.3.** Correspondence status inquiries, such as "tracer" claims from providers or beneficiaries and provider and beneficiary letters inquiring about the status of a claim, may be closed without a written response if the claim was processed within five calendar days prior to receipt of the inquiry. The day that the determination was made that the inquiry may be closed without a written response is the day the inquiry is to be closed for correspondence cycle time purposes. Otherwise, "tracer" claims, usually submitted by providers, are to be researched to determine whether the initial claim was received. If the initial claim was received and processed to completion, the contractor is to advise the provider of the date processed and the amount of payment, if any, or reason for denial. If the initial claim was not received, the contractor shall indicate this on the claim and submit the claim for normal processing, advising the provider of this action.

#### **5.0. PRIORITY CORRESPONDENCE**

Priority written correspondence is correspondence received from members of the U.S. Congress, the Office of the Assistant Secretary of Defense (Health Affairs), TMA, Regional Director's Offices and such other classes as may be designated as "priority" by contractor management. Inquiries from the Surgeons General, Flag Officers, and state officials, such as insurance commissioners, are considered priority correspondence. The contractor shall forward all Congressional inquiries involving DEERS to the DEERS Research and Analysis Section, DMDC/DEERS, 400 Gigling Road, Seaside, CA 93955-6771, including any claim information required for them to respond to the inquiry. A notification shall be sent to the Congressional office informing them that the letter has been forwarded to the DMDC Support Office (DSO). For standards refer to [Chapter 1, Section 3](#).

## TELEPHONE INQUIRIES

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### 1.0. TELEPHONE SYSTEM

The contractor shall provide an incoming telephone inquiry system. The telephone system shall be fully staffed, at a minimum, between 8 a.m. and 6 p.m. of the time zone(s) in the region. All telephones must be staffed and able to respond throughout the entire period. A recorded message indicating normal business hours shall be used on the telephone lines after hours. Calls will be handled in the order they are received. The phone number(s) shall be published on the Explanation of Benefits (EOB) and otherwise be made known to beneficiaries, providers, Health Benefits Advisors (HBAs), and Congressional offices.

### 2.0. RESPONSIVENESS

Telephone inquiries shall be answered according to the standards in [Chapter 1, Section 3, paragraph 3.4](#). Contractors may respond to telephone inquiries by letter if written response provides better service. For example, it may be difficult to reestablish telephone contact with the calling party, a written response may provide the caller with needed documentation, or a situation may call for a complex explanation which is clearer if written. The contractor staff shall be trained to respond in the most appropriate, accurate manner. Telephone inquiries reporting a potential fraud or abuse situation shall be documented and referred to the contractor's Program Integrity Unit.

### 3.0. REQUIREMENTS

The requirements and standards established below apply to all telephone calls. There should be no differentiation in the service provided whether the call originates locally or through the toll-free lines. The contractor shall provide the availability of telephone contact as a service to all TRICARE inquiries [active duty personnel, TRICARE beneficiaries, dual-eligible beneficiaries, Regional Directors (RDs), providers, Assistant Secretary of Defense (Health Affairs) (ASD(HA)), TRICARE Management Activity (TMA), HBAs, and congressional offices]. At a minimum the service shall be continuous during normal business hours which are defined as 8:00 A.M. through 6:00 P.M. (except weekends and holidays) in all time zones within the contract area. This service is intended to assist the public in securing answers to various TRICARE questions including, but not limited to:

**3.1.** General program information;

**3.2.** Specific information regarding claims in process and claims completed, e.g., explanations of the methods and specific facts employed in making reasonable charge and medical necessity determinations, information regarding types of medical services submitted (The contractor shall transfer out-of-jurisdiction calls requiring the assistance of another contractor. The contractor shall answer program information and network provider

availability/assistance calls without regard to jurisdiction, *to include identifying behavioral health providers willing to accept TRICARE.*);

**3.3.** When the individual beneficiaries ask questions about *Defense Enrollment Eligibility Reporting System (DEERS)* or DEERS eligibility, the contractor shall refer the beneficiary to the *Defense Manpower Data Center (DMDC) Beneficiary Telephone Center*, 6:00 A.M. to 3:30 P.M. Pacific Time, toll-free 1-800-538-9552, TTY/TDD 1-866-363-2883. These numbers cannot be used by the *TRICARE Service Center (TSC)* or other service provider; they are only for the beneficiary's use.

**3.4.** Additional information needed to have a claim processed;

**3.5.** Information about review and appeal rights and the actions required by the beneficiary or provider to use these rights.

**3.6.** Information about and procedures for the TRICARE Program.

**3.7.** Information concerning benefit authorization requirements and procedures for obtaining authorizations. Provisions must be included to allow the transfer of calls to the authorizing organization (within the contractor's organization, to include subcontractor) without disconnecting the call.

### **3.8. Telephone Standards**

Refer to [Chapter 1, Section 3](#).

### **3.9. Toll-Free Telephone Service**

Toll-free service can be provided by a number of means available from local telephone companies. These include, but are not limited to: Wide Area Telephone Service (WATS), Foreign Exchange lines (FX), etc. The contractor is not restricted to the use of any long distance carrier and may change companies at its discretion to improve the efficiency and cost effectiveness of the toll-free service. Should changes in long distance carriers occur, these changes must be transparent to *Military Health System (MHS)* beneficiaries and providers. The Contracting Officer (CO) shall be notified of any proposed change in companies at least 30 calendar days prior to the actual change of companies. The contractor shall advertise the toll-free service using all available media including the EOB; newsletters; telephone directories published by the contractor, military organizations, etc. and other appropriate sources.

### **3.10. Telephone Monitoring Equipment**

The contractor or telephone company with which the contractor does business shall have telephone equipment that is programmed to measure and record response time and ensure standards are always met. The equipment shall:

**3.10.1. Measure busy signal level.** Busy signal level is defined as the percentage of time a caller receives a busy signal. The equipment must produce busy signal data. The busy signal rate shall be expressed as a percentage, which is to be determined as follows: divide

## ALLOWABLE CHARGE REVIEWS (INCLUDES DRGs)

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### 1.0. GENERAL

Beneficiaries and providers have the right to question the amount allowed for services received or rendered for non-network care. (Network providers should have complaint procedures included in their contracts or the administrative procedures established with the TRICARE contractor.) The amount of the allowance is not an appealable issue under the appeals procedures and regulations of the program. When a complaint is received, the accuracy of the application of the reimbursement methodology, including the procedure code and the profile development must be verified. The rights of the beneficiaries and providers must be protected by careful review of each case. For allowable charge complaints related to reimbursement based on the TRICARE National Allowable Charge System, see [paragraph 4.0.](#), below.

### 2.0. ALLOWABLE CHARGE REVIEW CRITERIA

#### 2.1. Requirements

The allowable charge inquiry must be received or postmarked within 90 days from the date of the EOB or it may be denied for lack of timeliness. If the inquiry is in writing and the issue is not clearly a question of allowable charge, any doubt must be resolved in favor of handling the case as an appeal. Allowable charge complaints shall be reported on the workload report as required by [Chapter 15, Section 4](#). The contractor shall respond only to a person entitled to the information; i.e., beneficiary, parent/guardian, participating provider, other TRICARE contractors, or to TMA.

#### 2.2. Allowable Charge Complaint Procedures

An allowable charge complaint need not be submitted in writing. Oral inquiries (complaints) shall be documented on a contact report, by contractor staff. The handling requirements for timeliness of contractor processing are the same as for routine or priority correspondence. Upon receipt of an allowable charge complaint, the contractor shall recover the claim and related documents, including the "Beneficiary History and Deductible File", to completely review the case and establish accuracy of processing. The following checklist is suggested:

2.2.1. Was the correct procedure code used?

2.2.2. Were there other clerical errors, such as wrong type of service code, which may have caused the difference?

2.2.3. Did the case go to medical review?

**2.2.4.** Was all needed medical documentation present to make a completely accurate determination?

**2.2.5.** Should the case be further documented and referred to medical review?

**2.2.6.** Was the profiled fee calculated correctly?

**NOTE:** Contractors need not routinely validate the fee calculation; however, if the difference between billed and allowed is 20% or more, the dollar value of the difference is significant and all other factors appear to be correct, there is reason to question the validity of the fee.

### **2.3. Responses To Allowable Charge Complaints**

A written response to allowable charge complaints is preferred, but the inquiry can be handled by documented telephone call, as may other correspondence. The beneficiary or provider must be offered a written response. If the complaining party indicates dissatisfaction with the contractor's oral explanation of an adverse determination, the contractor will send a detailed letter advising of the results. Occasionally the allowable charge complaint or inquiry will be sent directly to the TMA instead of the contractor. When this occurs, the complaint/inquiry will be forwarded to the contractor for response.

#### **2.3.1. Adverse Determination**

If the processing and payment were correct, the inquirer shall be told of the outcome and advised of the methodology for determining allowable charges. The explanation should clearly indicate that the determination was based on the information presented and, if more complex procedures were involved or if the case was unusually complex, whether additional information could change the determination. If such information is available to the inquirer, it should be submitted to the contractor for further review. If, after the contractor's review, it is determined that the original amount is still correct, the inquirer shall be informed that this is the final determination.

#### **2.3.2. Additional Payment Due**

If it is found that an error has occurred, or if added information is secured which changes the determination, an adjustment shall be made. The notice of the determination shall explain the reason for the adjustment, e.g., correction of clerical error, added claim information provided, correction of information provided on the claim, etc. Adjustments shall be prepared in accordance with instructions in [Chapter 11](#).

### **3.0. EXCESS CHARGES BILLED IN PARTICIPATING PROVIDER CLAIM CASES**

If an allowable charge inquiry/complaint indicates a participating provider is improperly billing for more than the allowable charge, refer to [Chapter 14](#).

## GRIEVANCES AND GRIEVANCE PROCESSING

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### 1.0. GRIEVANCE PROCESSING JURISDICTION

The regional contractor with claims processing jurisdiction for the beneficiary's claim is responsible for processing grievances filed by or in behalf of the beneficiary. Should a grievance pertain to an issue that is the responsibility of another contractor, the other contractor will assist the contractor with jurisdiction in resolving the issue.

### 2.0. GRIEVANCE SYSTEM

The contractor shall develop and implement a grievance system, separate and apart from the appeal process. The grievance system shall allow full opportunity for aggrieved parties to seek and obtain an explanation for and/or correction of any perceived failure of a network provider, the health care finder service, or other contractor or subcontractor personnel to furnish the level or quality of care and/or service to which the beneficiary may believe he/she is entitled. Any TRICARE beneficiary, sponsor, parent, guardian, or other representative who is aggrieved by any failure or perceived failure of the contractor, subcontractor or contracted providers of service or care to meet the obligations for timely, quality care and service at appropriate levels may file a grievance. All grievances must be submitted in writing. The subjects of grievances may be, but are not limited to, such issues as the refusal of a PCM to provide services or to refer a beneficiary to a specialist, the length of the waiting period to obtain an appointment, undue delays at an office when an appointment has been made, improper level of care, poor quality of care, or other factors which reflect upon the quality of the care provided or the quality and/or timeliness of the service. If the written complaint reveals an appealable issue, the correspondence shall be forwarded to the contractor's appeals unit for a reconsideration review.

### 3.0. CONTRACTOR RESPONSIBILITIES

It is the contractor's responsibility to conduct an investigation and, if possible, resolve the aggrieved party's problem or concern. In this responsibility the contractor shall:

**3.1.** Ensure that information for filing of grievances is readily available to all MHS beneficiaries within the service area.

**3.2.** Maintain a system of receipt, identification, and control which will enable accurate and timely handling. All grievances shall be stamped with the actual date of receipt within three workdays of receipt in the contractor's custody. The date of receipt shall be counted as the first day.

- 3.3.** Investigate the grievance and document the results within 60 days of receipt of the grievance. The contractor shall notify the Contracting Officer of all grievances not reviewed within 60 days of receipt.
- 3.4.** Provide interim written responses by the 30th calendar day after receipt for all grievances not processed to completion by that date.
- 3.5.** Take positive steps to resolve any problem identified within 60 days of the problem identification. If the problem cannot be resolved within that period of time, the Contracting Officer or Contracting Officer's Representative shall be informed of the nature of the problem and the expected date of resolution. If there is no resolution to the problem, the contractor should acknowledge receipt of the grievance and explain to the grievant why the problem cannot be resolved.
- 3.6.** Written notification of the results of the review shall be submitted to the beneficiary within 60 days of the original receipt of the grievance. The letter will indicate who the grievant may contact to obtain more information and provide an opportunity for the grievant, if not satisfied with the resolution, to request a second review by a different individual.
- 3.7.** Ensure the involvement in the grievance review process of appropriate medical personnel, including personnel responsible for the contractor's quality assurance program in any case where the grievance is related to the quality of medical care or impacts on utilization review activities.
- 3.8.** Maintain records for all grievances, including copies of the correspondence, the results of the review/investigation and the action taken to resolve any problems which are identified through the grievance.

## COLLECTION ACTIONS AGAINST BENEFICIARIES

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### 1.0. GENERAL

1.1. It is the intent of the Department of Defense that no patient, family member or sponsor shall be subjected to ongoing collection action undertaken by or on behalf of a provider of services or supplies, as a result of the inappropriate non-payment, partial payment or denial of claims for services which should have been covered under TRICARE.

1.2. When the Department becomes aware that such collection action has been initiated, it will intervene on behalf of the party against whom the collection action has been taken, acting through a Debt Collection Assistance Officer (DCAO). There will be a DCAO designated at each MTF as well as at each Regional Director.

1.3. While the Department will assist in the resolution of collection matters, the ultimate responsibility for resolving collection matters lies with the patient, family member or sponsor. The Department will not provide legal representation to resolve these issues. TRICARE can only assume responsibility for collection assistance for medically necessary supplies and services as authorized for coverage under TRICARE regulation. There is no authority for the government to pay attorneys' fees, court costs, collection agency fees, accrued interest, late charges, etc.

1.4. Historically, many collection actions have resulted from the provider's violation of the participation agreement or balance billing in violation of applicable statute. When it has been determined that balance billing or violation of the participation agreement is at issue, the matter will continue to be handled in accordance with the existing program integrity guidelines contained in [Chapter 14, Section 6](#).

### 2.0. DEBT COLLECTION ASSISTANCE PROGRAM INTERVENTION ACTIONS

Upon notification of a problem DoD will assume responsibility to investigate and, when appropriate, resolve and/or assist in the clarification of collection issues for TRICARE beneficiaries. The most frequent sequence of events anticipated is:

- Beneficiary calls or is referred to DCAO.
- DCAO assumes responsibility for coordinating investigation and case conclusion.

2.1. Possible actions leading to case conclusions could include:

2.1.1. DCAO requests/encourages collection agency suspension of collection action pending investigation,

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**2.1.2.** Expedited payment by MCSC or MTF. All requests for expedited payment shall be coordinated through the prime TRICARE contractor for the Region. When research reveals a processing error by the contractor or subcontractor, any additional payment due shall be processed on an expedited basis, and the MCSC's report to the DCAO shall reflect an expected date of payment.

**2.1.3.** Beneficiary liability identified on investigative reports from MCSC (DCAO assists beneficiary with understanding payment issues),

**2.1.4.** Referral of the debtor to military legal assistance officers for assistance under authority of 10 U.S.C. Section 1044.

**2.1.5.** Additional review at TMA of issues unresolved by DCAO or MCSC,

**2.1.6.** Referral to Program Integrity, TMA, for balance billing violations,

**2.1.7.** Provider education, and/or

**2.1.8.** The DCAO will report back in writing to the beneficiary the result of the actions undertaken to address his/her collection case.

**2.1.9.** The DCAO will provide the beneficiary with a letter taking responsibility for the investigation and resolution/clarification of claims collection problems.

**2.1.10.** The DCAO cannot provide legal advice. If such advice is required, the individual should seek the assistance of an attorney. Military legal assistance officers provide assistance with collection matters on a regular basis.

**3.0. RESPONSIBILITIES**

**3.1. MTF/Regional Director/MMSO**

- Provide a DCAO to handle collection concerns for beneficiaries.
- DCAO issues case resolution letters to the beneficiary.
- Publicize DCAO e-mail addresses, mailing addresses, fax numbers and phone numbers to beneficiaries, both CONUS and OCONUS.
- DCAO obtains required Privacy Act releases from the beneficiary to permit research and disclosure to the DCAO by all parties.
- DCAO maintains and provides records and statistics on collection activity.
- DCAO refers all unresolved collections actions cases to TMA (Office of Collection Claims Evaluation, Aurora) if case is not resolved after 30 days of initial receipt of case at MCSC.

## TRICARE LOGO

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FIGURE 12-A-1 **REQUIREMENTS AND GUIDELINES FOR THE USE OF THE TRICARE LOGO**



*TRICARE Brand. TRICARE® is a registered trademark of the Department of Defense (DoD). Any reproduction of its trademarks and/or service mark must be in full compliance with the requirements set forth in the TRICARE® Brand Style Guide, a copy of which is available on the TMA web site at <http://www.tricare.mil/styleguide>, and all applicable statutes and DoD regulations. The TRICARE Brand includes all TMA marks using the word TRICARE, with or without a design element like the one shown above. The TRICARE Brand also includes, but is not limited to, TRICARE University, the names of TMA programs such as "TRICARE For Life" and "TRICARE Prime," and all internet domain names used by TMA or its contractors that contain the word TRICARE.*



concisely state the rationale for the decision; i.e., fully state the reasons that were the basis for the approval or denial of TRICARE benefits. If applicable TRICARE criteria must be met, the patient's medical condition must be related to each criterion and a finding made concerning whether each criterion is met. The contractor and the NQMC shall state the amount in dispute remaining as a result of the decision and how the amount in dispute was determined (calculated). Also state whether payments are to be recouped.

#### **6.5. Waiver Of Liability**

Waiver of Liability provisions are only applicable to denials as described in [Chapter 13, Section 4](#). For applicable cases, the contractor and the NQMC shall include a statement explaining waiver of liability determination as applied to the beneficiary and to each provider, including the rationale for each decision. A beneficiary found not to be liable for the entire episode of care will not be offered further appeal rights. Refer to the TRICARE Policy Manual, [Chapter 1, Section 4.1](#) for information relating to waiver of liability.

#### **6.6. Hold Harmless**

Hold harmless provisions are applied only to care provided by a network provider. In applicable cases, the contractor and the NQMC shall include a statement explaining hold harmless, including how the provision is waived, the beneficiary's right to a refund, the method by which a beneficiary can request a refund, and must provide information regarding from what entity a refund can be requested. (See [Chapter 5, Section 1, paragraph 2.5](#).)

**6.6.1.** Suggested wording for inclusion in a reconsideration determination in which a provider is a network provider is:

"If you decide to proceed with the service or it has already been provided, and the service is provided by a network provider who was aware of your TRICARE eligibility, you may be held harmless from financial liability despite the service having been determined to be non-covered by TRICARE. A network provider cannot bill you for non-covered care unless you are informed in advance that the care will not be covered by TRICARE and you waive your right to be held harmless by agreeing in advance (which agreement is evidenced in writing) to pay for the specific non-covered care. If the service has already been provided when you receive this letter and it was provided by a network provider who was aware of your TRICARE eligibility, and if there was no such agreement and you have paid for the care, you may seek a refund for the amount you paid. This can be done by requesting a refund from [insert contractor name and address].

Include documentation of your payment for the care, by writing to the above address. If you have not paid for the care and have not signed such an agreement, and a network provider is seeking payment for the care, please notify the TRICARE Management Activity, Beneficiary

*Education and Support Division (BE&SD), 7700 Arlington Boulevard, Suite 5101, Falls Church, Virginia 22042-5101.*

Under hold harmless provisions, the beneficiary has no financial liability and, therefore, has no further appeal rights. If, however, you agree(d) in advance to waive your right to be held harmless, you will be financially liable and the appeal rights outlined below would apply. Similarly, the appeal rights outlined below apply if you have not yet received the care or if you received the care from a non-network provider and there is \$50.00 or more in dispute.”

## **6.7. Point Of Service (POS)**

The *POS* option is available to TRICARE Prime beneficiaries who seek or receive non-emergency specialty or inpatient care, either within or outside the network which is neither provided by the beneficiary’s Primary Care Manager or referred by the Primary Care Manager, nor authorized by the contractor. The contractor and the NQMC shall provide beneficiaries who enroll in TRICARE Prime full and fair disclosure of any restrictions on freedom of choice that may be applicable to enrollees, including the Point-of-Service (POS) option. Therefore, the contractor and the NQMC must explain the right of the beneficiary to exercise the POS option and its effect on the payment of benefits for services determined to be medically necessary (Additional information about the POS option can be found in the TRICARE Reimbursement Manual, [Chapter 2, Section 3](#)).

**6.7.1.** Suggested language to be included in a reconsideration determination where the beneficiary has been identified as a TRICARE Prime enrollee is:

“Should you, as a TRICARE Prime enrollee, elect to proceed with this service and the service is provided by a non-network provider, and provided the service is found upon appeal to have been medically necessary, benefits will be payable under the deductible and cost-share amounts for Point-of-Service claims and your out-of-pocket expenses will be higher than they would be had you received the service from a network provider. No more than 50% of the allowable charge can be paid by the government for care provided under the Point-of-Service option.”

## **6.8. Appeal Rights**

The contractor and the NQMC shall state whether further appeal rights are available if the determination is less than fully favorable.

### **6.8.1. Medical Necessity Contractor Reconsideration Determinations**

If the contractor reconsideration determination is less than fully favorable, the contractor shall include a statement explaining the right of the beneficiary (or representative) and the non-network participating provider to request an appeal to the NQMC for a second reconsideration. Timeframes to file an appeal of the contractor reconsideration determination are as follows:

**2.6.2.3.** The medical condition requires treatment and can be resolved within 180 days, as determined by a DoD physician, from the date the condition is validated by the DoD physician.

**2.6.2.3.1.** The period of coverage for the TCSRC shall be no more than 180 days from the date the diagnosed condition is validated by a DoD physician. If a medical condition is identified during the TAMP coverage period, but not validated by a DoD physician until a date after the TAMP coverage period, the start date will be the date that the condition was validated by a DoD physician.

**2.6.2.3.2.** Service members who are discovered to have a service-related condition, which can not be resolved within the 180 day transitional care period, should be referred by MMSO to the former member's service or to the Veterans Administration (VA) for a determination of eligibility for government provided care.

**2.6.2.3.3.** Care is authorized for the service-related condition for 180 days from the date the DoD physician validates the service-related condition. For example a service-related condition validated on day 90 of TAMP will result in the following timelines: Care under TAMP for other than the service-related condition terminates on day 180 after the beginning of TAMP coverage. Care for the service-related condition terminates on day 270 in this example (180 days from the day the service-related condition is validated by a DOD physician).

### **2.6.3. Eligibility**

**2.6.3.1.** The eligible pool of beneficiaries are former ADSMs who are within their 180 day TAMP coverage period, regardless of where they currently reside.

**2.6.3.2.** A DoD physician must determine that the condition meets the criteria in [paragraph 2.6.2](#). Final validation of the condition must be made by the DoD Physician associated with MMSO. If the determination is made that the member is eligible for this program, the former member shall be entitled to receive medical and adjunctive dental care for that condition, and that condition only, as if they were still on active duty. Enrollment into this program does not affect the eligibility requirements for any other TRICARE program for the former service member or their family members.

**2.6.3.3.** Enrollment in the TCSRC includes limited eligibility for MTF Pharmacy, Retail Pharmacy, and TRICARE Mail Order Pharmacy (TMOP) benefits.

### **2.6.4. Implementation Steps, Processing For MMSO, And Contractor Requirements And Responsibilities**

The processes and requirements for a member with a possible Section 1637 condition are spelled out in [paragraphs 2.6.4.1.](#) through [2.6.4.7.](#) These steps, requirements, and responsibilities are applicable to MMSO, the MCSCs, TRICARE civilian providers, and the Armed Forces, and are provided to make each aware of the steps, processes, and responsibilities/requirements of each organization.

**2.6.4.1.** TMA *Beneficiary Education and Support Division (BE&SD)* will educate beneficiaries on the Section 1637 benefit. Contractors will collaborate with *BE&SD* in the development of materials that support both beneficiary and provider education.

**2.6.4.2.** A former ADSM on TAMP that believes he/she has a service-related condition which may qualify them for the TCSRC program is to be referred to MMSO for instructions on how to apply for the benefit.

**2.6.4.3.** MMSO will determine if further clinical evaluation/testing of the former ADSM is needed to validate that the member has a qualifying condition for enrollment into the Section 1637 program. If further clinical evaluation/testing is needed, MMSO will follow existing "defer to network" referral processes and the MCSC will execute a referral and authorization to support healthcare delivery for the area in which the member resides. Based on the member's residential address, the MCSC will locate the proper healthcare delivery site. If a DoD MTF is within the one hour drive time Access To Care (ATC) standards and the MTF has the capabilities, the MTF is to receive the referral request for consideration. If there is no MTF or the MTF does not have the capabilities, then the MCSC should ascertain if a Department of Veterans Affairs (DVA) medical facility (as a network provider) is within ATC standards and the facility has the capabilities. If neither of the above are available, then the MCSC shall locate a civilian provider that has both the capability and capacity to accept this referral request within the prescribed ATC standards. The MCSC will execute an active provider locator process (Health Care Finder (HCF)) to support the member's need for this referral request. MMSO's "defer to network" request will be acted on by the MCSC under the normal "urgent/72 hour" requirement. The MCSC will inform the member of the appropriate delivery site and provider contact information for the member to make the appointment. If this care is obtained in the civilian sector or a VA medical facility, the contractor shall pay these claims in the same manner as other active duty claims. The MCSC will instruct the accepting provider to return the results of the encounter to MMSO within 48 hours of the encounter. Once any additional information is received, the DoD physician associated with MMSO will make the determination of eligibility for the Section 1637 program. The eligibility determination for coverage under the Section 1637 benefit will be made within 30 calendar days of receiving the member's request, inclusive of the time required to obtain additional information. If the condition does not meet the criteria for enrollment into the Section 1637 program, but the former ADSM is otherwise eligible for TRICARE benefits, they may continue to receive care for the condition, following existing TRICARE guidelines. The former ADSM may appeal the decision of the DoD Physician in writing to MMSO within 30 calendar days of receipt of the denial by the DoD physician. MMSO will issue a final determination within 30 calendar days of receipt of the appeal. If MMSO determines the condition should be covered under the Section 1637 benefit, coverage will begin on the date MMSO renders the final determination.

**2.6.4.4.** If the DoD physician determines the individual is eligible for the Section 1637 program, MMSO will provide the enrollment information (Enrollment Start date and condition authorized for treatment) to the member and the contractor responsible for enrollments in the region where the former service member resides. This notice will clearly identify it is for the Section 1637 program. The contractor shall enroll the former service member into the Section 1637 program on DEERS using DEERS Online Enrollment System (DOES) within four business days of receiving the notification from MMSO. This entry will include the Start Date (date condition validated by the DoD physician), an EOC Code, and an

EOC Description. The contractor will enter the validated condition covered by the Section 1637 program (received from MMSO) into the contractor's referral and authorization system within eight business days of receipt of the notification from MMSO. The MCSC shall actively assist the member using the HCF program in determining the location of final restorative healthcare for the identified Section 1637 condition. The location of service shall be determined as defined in [paragraph 2.6.4.3](#). The MCSC shall instruct the accepting provider on the terms of this final "eval and treat" referral from MMSO and when and where to send clinical results/findings to close out MMSO's files on the Section 1637 eligible member. DEERS shall store the secondary Health Care Delivery Plan (HCDP) code, the date the condition was validated by the DoD physician, the EOC Code, and the EOC Description. DEERS shall return the HCDP code, the start and end dates for the coverage plan, the EOC Code, and the EOC Description with every eligibility query. This program is portable across all contractors.

**2.6.4.5.** The member in the TCSRC program will obtain the appropriate care for the service-related condition close to their residence, as defined in [paragraphs 2.6.4.3](#) and [2.6.4.4](#). Civilian and VA claims for the specific condition will be processed as if the member were still on active duty, with no copayments required. If the "eval" or "eval and treat" referrals sent to the MCSC from MMSO are presented to an MTF for execution, and the MTF accepts, any subsequent MTF generated "defer to network" requests will be accepted, recorded, and claim adjudicated; and this process may be outside the MCSC's EOC coding/criteria. The MCSC may request clarifications from the MTF on a subsequent "defer to network" request if the referral is for healthcare delivery that is not apparently related to the Section 1637 determined condition.

**2.6.4.6.** The Section 1637 benefit shall be terminated 180 days after the validated diagnosis is made by the DoD physician, no matter the status of the service-related condition. Following the termination of the Transitional Care period, further care for this service-related condition may be provided by the Department of Veterans Affairs (DVA).

**2.6.4.7.** Personnel on active duty for longer than 30 calendar days will have their Section 1637 coverage terminated by DEERS. Personnel scheduled to report for active duty (Early Alert Status), may have both the Section 1637 HCDP and HCDP 001 (for Active Duty). Once the active duty period actually begins, Section 1637 coverage will be terminated. If active duty orders are cancelled prior to entry on active duty, Section 1637 coverage will continue until the original end date. There is no reinstatement of the terminated Section 1637 coverage.

## **2.6.5. Claims Processing And Payment**

**2.6.5.1.** The Section 1637 HCDP code can be present with any other HCDP code. During claims processing, if the TCSRC HCDP is received from DEERS, the contractor must first determine if the claim being processed is for the Section 1637 condition. If the claim is for the specific service-related condition, the claim shall be processed and paid as if the member were an ADSM. The MCSC shall determine if the claim is for an MTF directed "defer to network" request for the Section 1637 condition. The MCSC shall determine if the MTF "defer to network" request is related to the Section 1637 condition; which may not relate to the EOC codes determined by the MCSC. If the claim is not for the covered condition, the claim shall be processed following the standard TRICARE procedures. If the claim includes

services for the Section 1637 covered condition, and additional services, the contractor must assess the claim's status and take one of the following actions:

**2.6.5.1.1.** Contractor Splits Claim. If a contractor receives a claim for a member eligible for Section 1637 coverage and the claim includes services not covered by the Section 1637 diagnosis, and the contractor can determine which services are covered under the Section 1637 condition, then the contractor will split the claim into separate claims.

**2.6.5.1.2.** Contractor Returns Claim to Provider. If the claim does not meet the conditions described above, then the contractor will return the claim to the submitter with an explanation that indicates the claim must be split in order to be paid.

**2.6.5.2.** Where a beneficiary has had clinical evaluation(s)/tests performed to determine eligibility for Section 1637 coverage and has paid for those clinical evaluation(s)/tests out-of-pocket, the contractor shall process any claim received for such clinical evaluation(s)/tests and shall pay any such claim as if the member were an ADSM.

**2.6.5.3.** Members with multiple service-related conditions will have multiple Section 1637 enrollments. Each condition may have the same or different begin and end dates.

**2.6.5.4.** Jurisdiction rules for Section 1637 coverage shall be in accordance with [Chapter 8, Section 2](#).

**2.6.5.5.** The contractors shall pay all claims submitted for the specific service-related condition in the same manner as other Active Duty claims. There shall be no application of catastrophic cap, deductibles, cost-shares, copayments or coordination of benefits for these claims. Claims paid for the specific service-related condition under this change should be paid from non-financially underwritten funds.

**2.6.5.6.** Claims paid for medical care under the 180 day TAMP program, for other than the service-related condition, shall continue to be paid as an ADFM beneficiary under TRICARE with application of appropriate cost-shares and deductibles for these claims. The Section 1637 benefit does not extend the duration of the TAMP period beyond 180 days.

**2.6.5.7.** If the contractor is unable to determine the care received is covered by the Section 1637 diagnosis, the claim is to be pended while the contractor obtains further clarification from MMSO.

**2.6.5.8.** Pharmacy transactions at retail network pharmacies are processed on-line using the HIPAA data transaction standard of the National Council for Prescription Drug Programs (NCPDP). Under this standard, claims are adjudicated real time for eligibility along with clinical and administrative edits at the point of service which includes cost-share determinations based on the member's primary HCDP code.

**2.6.5.8.1.** Enrolled members determined to be eligible for pharmacy services based on their primary HCDP code will pay appropriate cost-shares as determined by their primary HCDP code and will submit a paper claim to the pharmacy contractor to seek reimbursement of these costs shares. Enrollment documentation that includes the specific condition for Section 1637 enrollment shall be submitted with their claim. The pharmacy contractor will

verify eligibility in DEERS and determine coverage of the prescription based on the specific condition detailed in the supporting documentation.

**2.6.5.8.2.** Enrolled members determined to not be eligible for pharmacy services based on their primary HCDP code will pay out-of-pocket for the total cost of the prescription and then submit a paper claim to the pharmacy contractor for reimbursement. The pharmacy contractor shall verify eligibility in DEERS and determine coverage of the prescription based on the specific condition detailed in the supporting documentation.

**2.6.5.8.3.** Enrolled members may submit prescriptions related to their specific coverage to the TMOP. Enrollment documentation that includes the specific condition for enrollment shall be submitted with their claim. The pharmacy contractor shall verify eligibility in DEERS and determine coverage of the prescription based on the specific condition detailed in the supporting documentation. Prescriptions determined not to be related to the covered condition shall be processed based on the members primary HCDP code, or returned to the member unfilled if ineligible for coverage both under the program and their primary HCDP code.

**2.6.5.8.4.** In situations where the supporting document submitted by the member to the pharmacy contractor does not provide sufficient detail of their covered condition, the pharmacy contractor will contact MMSO to obtain appropriate documentation of their covered condition needed to make a coverage determination and process the claim.

## **2.6.6. Definitions**

**2.6.6.1.** Validated Date and Diagnosis. The date a DoD physician (Military or Civil Service) validates the diagnosis of a service-related condition and validates that the condition can be resolved within 180 days.

**2.6.6.2.** MMSO. The centralized government office which will be the overall government organization to provide government services to TAMP members that have a service-related condition.

## **3.0. ENROLLMENT STATUS EFFECT ON CLAIMS PROCESSING**

**3.1.** Active duty claims shall be processed without application of a cost-share, copayment, or deductible. These are SHCP claims.

**3.2.** Claims for TRICARE Prime enrollees who are in MTF inpatient status shall be processed without application of a cost-share, copayment, or deductible. These are SHCP claims.

**3.3.** Claims for TRICARE Prime enrollees who are not in MTF inpatient status shall be processed with the application of the appropriate TRICARE copays. These are TRICARE claims and not SHCP claims.

**3.4.** Claims for TRICARE eligibles, who are not enrolled in Prime, and who are not in MTF inpatient status, shall be processed in accordance with TRICARE Extra or Standard procedures. These are TRICARE claims and not SHCP claims.

**3.5.** Claims for services provided under the current Memoranda of Understanding (MOU) between the DoD (including Army, Air Force, and Navy/Marine Corps facilities) and the DHHS (including the Indian Health Service (IHS), Public Health Service (PHS), etc.) are not covered. These are not SHCP claims.

**3.6.** Claims for services not included in the current MOU between the DoD (including the Army, Air Force and Navy/Marine Corps facilities) and the DHHS shall be processed in accordance with the requirements in this chapter. These are SHCP claims.

**3.7.** Claims for services provided under any local MOU between the DoD (including the Army, Air Force and Navy/Marine Corps facilities) and the DVA are not covered. These are not SHCP claims. (Claims for services provided under the current national MOA for Spinal Cord Injury, Traumatic Brain Injury and Blind Rehabilitation are covered, see [Chapter 18, Section 2, paragraph 3.1.](#))

**3.8.** Claims for services not included in the current MOU between the DoD (including the Army, Air Force and Navy/Marine Corps facilities) and the DVA, including TDRL claims, shall be processed in accordance with the requirements in this chapter. These are SHCP claims.

**3.9.** Claims for participants in the CCEP shall be processed for payment solely on the basis of MTF authorization. There will not be a cost-share, copayment, or deductible applied to these claims. These are SHCP claims.

**3.10.** Claims for non-TRICARE eligibles shall be processed for payment solely on the basis of MTF authorization. There will not be a cost-share, copayment, or deductible applied to these claims. These are SHCP claims.

**3.11.** Outpatient claims for non-TRICARE Medicare eligibles will be returned to the submitting party for filing with the Medicare claims processor. These are not SHCP or TRICARE claims.

**3.12.** Claims for TDRL participants shall be processed for payment in accordance with DoD/HA Policy Letter dated March 30, 2009, Subject: Policy Guidance for Use of Supplemental Health Care Program Funds to Pay for Required Physical Examinations for Members on the Temporary Disability Retirement List. There will not be a cost-share, copayment, or deductible applied to these claims. These are SHCP claims. SHCP funds will only be applied to the exam. SHCP funds shall not be used to treat the condition which caused member to be placed on the TDRL or for conditions discovered during the exam.

**3.13.** Claims from members enrolled in the FRCP shall be processed without application of a cost-share, copayment, or deductible. These are SHCP claims.

#### **4.0. MEDICAL RECORDS**

The current contract requirements for medical records shall also apply to ADSMs in this program. Narrative summaries and other documentation of care rendered (including laboratory reports and X-rays) shall be given to the ADSM for delivery to his/her PCM and inclusion in his/her military health record. The contractor shall be responsible for all

administrative/copying costs. Under no circumstances will the ADSM be charged for this documentation. Network providers shall be reimbursed for medical records photocopying and postage costs incurred at the rates established in their network provider participation agreements. Participating and non-participating providers shall be reimbursed for medical records photocopying and postage costs on the basis of billed charges. ADSMs who have paid for copied records and applicable postage costs shall be reimbursed for the full amount paid to ensure they have no out of pocket expenses. All providers and/or patients must submit a claim form, with the charges clearly identified, to the contractor for reimbursement. ADSM's claim forms should be accompanied by a receipt showing the amount paid.

## **5.0. REIMBURSEMENT**

**5.1.** Allowable amounts are to be determined based upon the TRICARE payment reimbursement methodology applicable to the services reflected on the claim, (e.g., DRGs, mental health per diem, CMAC, Outpatient Prospective Payment System (OPPS), or TRICARE network provider discount). Reimbursement for services not ordinarily covered by TRICARE and/or rendered by a provider who cannot be a TRICARE authorized provider shall be at billed amounts.

**5.2.** Claims with codes on the TRICARE inpatient only list performed in an outpatient setting will be denied, except in those situations where the beneficiary dies in an emergency room prior to admission. Reference the TRM, [Chapter 13, Section 2, paragraph III.D](#). Professional providers may submit with modifier CA. No bypass authority is authorized for inpatient only procedure editing. Bypass authority is authorized for codes contained on the Government No Pay List when the service is authorized by the MTF.

**5.3.** Cost-sharing and deductibles shall not be applied to supplemental health care claims for MTF referred services rendered to uniformed service members, to other MTF referred patients who are not TRICARE eligible, to TDRL participants, to members enrolled in the FRCP, or to patients who receive referred civilian services while remaining in an MTF inpatient status.

**5.4.** Pending development and implementation of recently enacted legislative authority to waive CMACs under TRICARE, the following interim procedures shall be followed when necessary to assure adequate availability of health care to ADSMs under SHCP. 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. 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 and communicate the same to the referring MTF. A waiver of CMAC limitation must be obtained by the MTF from the Regional Director (RD), as the designee of the Chief Operating Officer (COO), TMA, before patient referral is made to ensure that the patient does not bear any out-of-pocket expense. Upon approval of a CMAC waiver by the RD, the MTF will notify the contractor who shall then conclude rate negotiations, and notify the MTF when an agreement with the provider has been reached. The contractor 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 ADSM has personally paid the provider.

**5.5.** Referred patients 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.

**5.5.1.** Supplemental health care claims for uniformed service members, members enrolled in the FRCP, and all MTF inpatients receiving referred civilian care while remaining in an MTF inpatient status shall be promptly reimbursed and the patient shall not be required to bear any out of pocket expense. If such payment exceeds normally allowable amounts, the contractor shall allow the billed amount and reimburse the patient for charges on the claim. As a goal, no such claim should remain unpaid after 30 calendar days.

**5.5.2.** All other claims shall be subject to the appropriate TRICARE copayment and deductible requirements, and to TRICARE payment maximums. Claims for non-enrolled Medicare eligibles shall be returned to the submitting party for filing with the Medicare claims processor.

**5.6.** In no case shall a uniformed service member who has acted in apparent good faith be required to incur out-of-pocket expenses or be subjected to ongoing collection action initiated by a civilian provider who has refused to abide by TRICARE requirements. (The determination whether a member has acted in good faith rests with the Uniformed Services.) For example, a provider might continue to pursue the service member by “balance billing” for amounts which are clearly in excess of the amount which he had previously agreed to accept as payment in full. When the contractor becomes aware of such situations, they shall initiate contact with the Uniformed SPOC ([Chapter 18, Addendum A](#)) so that action appropriate to the particular situation can be undertaken. On an exception basis, such action might include specific authorization by the Uniformed Service to pay additional amounts to the provider. In this instance, a waiver from the COO, TMA, or a designee, must be initiated by the Uniformed Service for authority to make payment in excess of CMAC or other applicable TRICARE payment ceilings. The contractor and the Government shall act in concert as promptly as possible to issue appropriate payment.

## **6.0. END OF PROCESSING**

### **6.1. Explanation Of Benefits**

An EOB shall be prepared for each supplemental health care claim processed, and copies sent to the provider and the patient in accordance with normal claims processing procedures. For all claims pertaining to civilian services rendered to an MTF inpatient and for all other claims for which the MTF has authorized supplemental health care payment, the EOB will include the following statement, “This is a supplemental health care claim, not a TRICARE claim. Questions concerning the processing of this claim must be addressed to the TRICARE Service Center.” Any standard TRICARE EOB messages which are applicable to the claim are also to be utilized, e.g., “No authorization on file.”

## **6.2. Appeal Rights**

For supplemental health care claims, the appeals process in [Chapter 13](#), applies, as limited herein. If the care is still denied after completion of a review to verify that no miscoding or other clerical error took place and the MTF will not authorize the care in question, then the notification of the denial shall include the following statement: "If you disagree with this decision, please contact (insert MTF name here)." TRICARE appeal rights shall pertain to outpatient claims for treatment of TRICARE eligible patients.

## **7.0. CLAIMS PAYMENTS AND CONTRACTOR REIMBURSEMENT**

### **7.1. Referred Care For MTF Inpatients**

Providers, patients or Services (e.g., MTF) shall forward medical claims to the contractor for reimbursement. The contractor shall forward a single consolidated invoice, with accompanying claims data (only accepted or provisionally accepted by TED) on a monthly basis to the enrolling MTF and its paying office (Defense Finance and Accounting Service [DFAS]). MTFs will forward receiving reports after approval to the DFAS for payment to the contractor.

### **7.2. MTF Referred Outpatient Care**

Providers, patients or Services (e.g., MTF) shall forward medical claims to the contractor for reimbursement. The contractor shall forward a single consolidated invoice with accompanying claims data (only accepted or provisionally accepted by TED), on a monthly basis to the enrolling MTF and its paying office (DFAS). The invoice shall contain claims for uniformed service members and non-TRICARE eligibles with an MTF authorization for payment under supplemental health care. DFAS shall pay the contractor based on approved invoices. Claims for Medicare eligibles will be returned to the submitting party for filing with the Medicare claims processor.

## **8.0. TED SUBMITTAL**

The TED for each claim must reflect the appropriate data element values. The appropriate codes published in the TSM are to be used for supplemental health care claims.

## **9.0. REQUIRED REPORTS**

Summary reports reflecting government dollars paid for supplemental health care claims shall be prepared and submitted to each Service Headquarters every month. Separate reports shall be produced for services rendered to Army National Guard members. All reports described below shall be submitted in electronic media in an Excel format. Payments for CCEP claims, TDRL claims, and for members enrolled in the FRCP shall each be reported separately. A separate report of payments on behalf of non-DoD patients shall also be prepared and forwarded to TMA, Managed Care Support Operations Branch. Summary and detailed reports (also reflecting government dollars paid) for each month will be prepared and submitted to each referring MTF. These reports will be submitted no later than the 15th calendar day of the month following the reporting period. SHCP and CCEP reports will reflect total care paid, and the total dollar amount contained in data elements ([paragraphs](#)

9.1.1. through 9.1.3.), will equal the total amount requested for reimbursement from TMA, Office of Contract Resource Management for each report. For those data elements in items (paragraphs 9.1.1. through 9.1.3.), which require a count, the contractor must ensure that no workload is double counted. Data elements to include in the reports are:

**9.1. Summary Reports By Branch Of Service To Service HQ And TMA (COO)**

9.1.1. Defense Medical Information System Identification (DMIS-ID) Code (PCM Location DMIS-ID (Enrollment) Code)

9.1.2. Total Number and Dollar Amount of Claims Paid

9.1.3. Inpatient Dollars Paid - Institutional

9.1.4. Inpatient Dollars Paid - Professional Services

9.1.5. Outpatient Dollars Paid - Clinic Visits (Professional and Ancillary Services)

9.1.6. Outpatient Dollars Paid - Ambulatory Surgeries/Procedures - Professional

9.1.7. Outpatient Dollars Paid - Ambulatory Surgeries/Procedures - Institutional

9.1.8. Total Admissions/Dispositions

9.1.9. Total Bed Days/Length of Stay (LOS)

9.1.10. Total Ambulatory Surgeries/Procedures, including all Ancillary

9.1.11. Total Outpatient Visits, excluding Ambulatory Surgeries but including all Ancillary related to the outpatient visits

9.1.12. CPT Codes/DRG/ICD-9 Codes

9.1.13. Other items paid

**9.2. Detailed Reports For Each MTF**

9.2.1. Patient DMIS-ID Code (enrollment DMIS)

9.2.2. Referring MTF's DMIS-ID code

9.2.3. Patient Name/Social Security Number (SSN)

9.2.4. Sponsor SSN

9.2.5. Age/Sex/Beneficiary Category (ADSM, ADFM, NADSM, NADFM, TFL, TRICARE ineligible)

9.2.6. MTF PCM (if available)

- 9.2.7. Referring provider (if available)
- 9.2.8. Civilian Provider's Name/Provider ID#
- 9.2.9. Dates of Care (Outpatient or Inpatient Admission)
- 9.2.10. Care End Date (FY - Month)
- 9.2.11. Admitting Diagnoses (Primary/Secondary)
- 9.2.12. Dispositioning Diagnoses (Primary/Secondary)
- 9.2.13. CPT Codes/DRG/ICD-9 Codes Related to Inpatient Claim
- 9.2.14. Total Bed Days/LOS (Inpatient)
- 9.2.15. Inpatient Institutional \$ Paid
- 9.2.16. Inpatient Professional \$ Paid
- 9.2.17. CPT Codes/ICD-9 Codes Related to Outpatient Claim (including Professional and Ancillary Services)
- 9.2.18. Outpatient Clinic \$ Paid (Including Professional and Ancillary Services)
- 9.2.19. CPT Codes/ICD-9 Codes Related to Ambulatory Surgery/Procedure Claim (including Professional and Ancillary Services)
- 9.2.20. Ambulatory Surgery/Procedure \$ Paid (Professional)
- 9.2.21. Ambulatory Surgery/Procedure \$ Paid (Institutional)

### 9.3. Additional Reports

9.3.1. The contractor shall produce monthly workload and timeliness reports for the SHCP. The reports shall cover the period beginning on the first day of the month and closing on the last day of the month. The reports are due on the 15th calendar day of the month following the month being reported.

9.3.2. The contractor shall prepare a cover letter when forwarding reports, which identifies the reports being forwarded, the period being reported, the date the cover letter is prepared by the contractor, and a contractor POC should there be any questions regarding the reports.

### 9.3.3. Workload Reports

9.3.3.1. The contractor shall prepare and submit a monthly SHCP claims workload report for each branch of service (to include Army National Guard separately), as well as one workload report which shows the cumulative totals for all services. The branch of service

shall be determined by the service affiliation of the referring MTF and not by the branch of service of the active duty member. The following data shall be included in the workload reports:

- Beginning Inventory of Uncompleted Claims
- Total Number of New Claims Received
- Total Number of Claims Returned
- Total Number of Claims Processed to Completion
- Ending Inventory of Uncompleted Claims

**NOTE:** Ending inventory of uncompleted claims must equal the beginning inventory of uncompleted claims plus total number of new claims received minus total number of claims returned minus total number of claims processed to completion.

**9.3.3.2.** The contractor shall send a copy of the monthly Workload Reports to the TMA, Chief, Claims Operations Office and to the RD. The contractor shall also send a copy of each Service's monthly report to the respective Service Project Officer identified in [Chapter 18, Addendum A](#).

#### **9.3.4. Timeliness Reports**

**9.3.4.1.** The contractor shall prepare and submit a separate monthly cycle time and aging report for SHCP claims, containing the same elements and timeliness breakouts as submitted for other TRICARE claims.

**9.3.4.2.** The contractor shall send a copy of the SHCP Timeliness Reports to the RD; Chief Financial Officer, TMA; and to the Chief, Special Contracts and Operations Office, TMA.

#### **9.4. SHCP Claims Listing**

Throughout the period of the contract, the contractor shall have the ability to produce, when requested by TMA, a hardcopy listing of all SHCP claims processed to completion for any given month(s) to substantiate the contractor's SHCP vouchers to TMA (see [Chapter 18, Section 4](#)). The listing shall include the following data elements: referring DMIS-ID code, Internal Control Number (ICN), patient's SSN, and the date the claim was processed to completion. This list shall be presented in ascending DMIS code order.

### **10.0. CONTRACTOR'S RESPONSIBILITY TO RESPOND TO INQUIRIES**

#### **10.1. Telephonic Inquiries**

Inquiries relating to the SHCP need not be tracked nor reported separately from other inquiries received by the contractor. All inquiries to the contractor should come from MTFs/claims offices, the Service Project Officers or the TMA. In some instances, inquiries may come from Congressional offices, patients or providers. To facilitate this process, the contractor shall provide a specific telephone number, different from the public toll-free number, for inquiries related to the SHCP Claims Program. The line shall be operational and continuously staffed according to the hours and schedule specified in the contractor's TRICARE contract for toll-free and other service phone lines. It may be the same line as

required in support of TPR under [Chapter 17](#) and may be the same line required under [Chapter 19](#). The telephone response standards of [Chapter 1, Section 3, paragraph 3.4](#). shall apply to SHCP telephonic inquiries.

#### **10.1.1. Congressional Telephonic Inquiries**

The contractor shall refer any congressional telephonic inquiries to the referring MTF if the inquiry is related to the authorization or non-authorization of a specific claim. If it is a general congressional inquiry regarding the SHCP claims program, the contractor shall respond or refer the caller as appropriate.

#### **10.1.2. Provider And Other Telephonic Inquiries**

The contractor shall refer any other telephonic inquiries it receives, including calls from the provider, service member or the MTF patient, to the referring MTF if the inquiry pertains to the authorization or non-authorization of a specific claim. The contractor shall respond as appropriate to general inquiries regarding the SHCP.

### **10.2. Written Inquiries**

#### **10.2.1. Congressional Written Inquiries**

The contractor shall refer written congressional inquiries to the Service Project Officer of the referring MTF's branch of service if the inquiry is related to the authorization or non-authorization of a specific claim. When referring the inquiry to the Service Project Officer, the contractor shall attach a copy of all supporting documentation related to the inquiry. If it is a general congressional inquiry regarding the SHCP, the contractor shall refer the inquiry to the TMA. The contractor shall refer all congressional written inquiries within 72 hours of identifying the inquiry as relating to the SHCP. When referring the inquiry, the contractor shall also send a letter to the congressional office informing them of the action taken and providing them with the name, address and telephone number of the individual or entity to which the congressional correspondence was transferred.

#### **10.2.2. Provider And Service Member (Or MTF Patient) Written Inquiries**

The contractor shall refer provider and service member or MTF patient written inquiries to the referring MTF if the inquiry pertains to the authorization or non-authorization of a specific claim, or to the caller's Service Project Officer if it is a general inquiry regarding the SHCP.

#### **10.2.3. MTF Written Inquiries**

The contractor shall provide a final written response to all written inquiries from the MTF within ten work days of the receipt of the inquiry.

## **11.0. DEDICATED SHCP UNIT**

The contractor may at their discretion establish a dedicated unit for all contractor responsibilities related to processing SHCP claims and responding to inquiries about the SHCP. Regardless of the existence of a dedicated unit, the contractor shall designate a POC for Government inquiries related to the SHCP.

## **6.0. END OF PROCESSING**

### **6.1. Beneficiary Cost-Shares**

Beneficiary costs shares shall be based on the network status of the provider. Where TRICARE is primary payer, cost-shares for services received from network providers shall be TRICARE Extra cost-shares. Services received from non-network providers shall be TRICARE Standard cost-shares.

### **6.2. Application Of Catastrophic Cap**

Only the actual beneficiary out-of-pocket liability remaining after TRICARE payments will be counted for purposes of the annual catastrophic loss protection.

### **6.3. Appeals And Grievances**

#### **6.3.1. TRICARE For Life (TFL) Initial Determinations**

Services and supplies denied payment by Medicare will not be considered for coverage by TRICARE if the Medicare denial of payment is appealable under the Medicare appeal process. If, however, a Medicare appeal results in some payment by Medicare, the services and supplies covered by Medicare will be considered for coverage by TRICARE. Services and supplies denied payment by Medicare will be considered for coverage by TRICARE, if the Medicare denial of payment is not appealable under the Medicare appeal process. The appeal procedures set forth in [Chapter 13](#) are applicable to initial denial determinations by TRICARE under TDEFIC.

#### **6.3.2. Grievance System**

The contractor shall develop and implement a grievance system, separate and apart from the appeal process. The grievance system shall allow full opportunity for aggrieved parties to seek and obtain an explanation for and/or correction of any perceived failure of contractor or subcontractor personnel to furnish the level or quality of service to which the beneficiary may believe he/she is entitled. Any TRICARE beneficiary, sponsor, parent, guardian, or other representative who is aggrieved by any failure or perceived failure of the contractor or subcontractor to meet the obligations for timely, quality service may file a grievance. All grievances must be submitted in writing. If the written complaint reveals a TRICARE appealable issue, the correspondence shall be forwarded to the contractor's appeals unit for a reconsideration review. If the complaint reveals a Medicare appealable issuer or regards care for which Medicare was the primary payer and the issue does not involve any actions by a TRICARE contractor, the complaint shall be forwarded to Medicare for resolution. The beneficiary shall be notified that the complaint was forwarded to Medicare and the address and phone number of where the complaint was forwarded.

## **7.0. TED SUBMISSION**

For every claim processed to completion, the TDEFIC contractor shall submit a TRICARE Encounter Data (TED) record to TMA in accordance with the requirements of the TRICARE Systems Manual ([TSM](#)) 7950.1-M.

**8.0. CONTINUED TRICARE COVERAGE FOR DUAL ELIGIBLE BENEFICIARIES UNDER AGE 65**

**8.1.** The Fiscal Year (FY) 2005 National Defense Authorization Act (NDAA) has extended TRICARE coverage to those individuals who, because of disability or End Stage Renal Disease (ESRD), are eligible for Medicare Part A but did not obtain Part B. The new legislation provides the authority to waive collection of prior payments and to continue TRICARE coverage of benefits for these individuals for a period of July 1, 1999 and ending on December 31, 2004. In a future Centers for Medicare and Medicaid Services (CMS) Special Enrollment Period, these individuals without Part B will automatically be enrolled in Part B unless they specifically opt out. If an individual does disenroll from Medicare Part B, he or she will lose all TRICARE coverage effective with the date of disenrollment. However, individuals will be given an opportunity to change the effective date of Medicare Part B enrollment to any month in 2004. Effective January 1, 2005, any TRICARE beneficiary under the age of 65, except for dependents of active duty members, who are or become eligible for Medicare and do not purchase Part B, will lose TRICARE coverage.

**8.2.** On a date to be announced, Defense Manpower Data Center (DMDC) will load the most current Medicare status for all beneficiaries under age 65. The Defense Enrollment Eligibility Reporting System (DEERS) query response for Other Government Programs (OGPs) will list the Medicare entitlement and reflect either Part A or both Part A and Part B effective dates. DMDC has temporarily modified the "benefits rules" within DEERS during this waiver period to show these beneficiaries with Part A or gaps in effective dates between Part A and Part B as TRICARE eligible. Treat these individuals as fully TRICARE dual eligible even if there is a gap in effective dates between Part A and Part B and accept the Health Care Delivery Plan (HCDP) returned from DEERS.

**8.3.** The following direction applies:

**8.3.1.** Pay the allowable amount on all claims and reprocess any claims denied for lack of Medicare Part B since April 1, 2004 until December 31, 2004. Pay if otherwise allowable. TRICARE will be secondary to Medicare Part A coverage unless the beneficiary has exhausted his/her Medicare benefits. Pay as primary for all non-institutional claims for any coverage period without Part B until December 31, 2004 unless the individual has private other health insurance. Timely filing requirements apply.

**8.3.2.** Contractors are not required to search their claim systems and reprocess any claims processed and paid prior to April 1, 2004. An exception will be made on a case-by-case basis if authorized by the Beneficiary *Education* and *Support Division (BE&SD)*, TMA-Aurora.

**8.3.3.** The Department of Defense (DoD) determines health care eligibility/benefits and DEERS is the eligibility system of record for DoD. The eligibility/benefit response returned by DEERS will be accepted, used by the contractors to process each claim, and not be modified by proprietary system edits. Discrepancies will continue to be reported to DMDC.

**8.3.4.** Contractors will be notified when Medicare automatically enrolls these individuals in Part B, and DEERS receives and loads these enrollments. At that point, TRICARE will revert to paying secondary to Medicare. If an individual disenrolls from Medicare Part B, coverage will continue until December 31, 2004 at which time no further

## TRICARE ALASKA

SECTION	SUBJECT
<b>1</b>	<b>TRICARE ALASKA</b>
1.0.	General
2.0.	Optimization
3.0.	Beneficiary Satisfaction
4.0.	Best Value Health Care
5.0.	Transitions
6.0.	Access To Data
7.0.	Administration
8.0.	Records Management
9.0.	Financial Administration
10.0.	Provider Certification And Credentialing
11.0.	Support Of TRICARE Providers
12.0.	Enrollment
13.0.	Utilization And Quality Management
14.0.	Claims Processing
15.0.	Duplicate Claims
16.0.	Claims Adjustments And Recoupments
17.0.	Beneficiary <i>Education</i> And <i>Support division (BE&amp;SD)</i>
18.0.	TRICARE Service Centers (TSCs)
19.0.	Appeals And Hearings
20.0.	Program Integrity
21.0.	Audits, Inspections, And Reports
22.0.	RD/MTF Contractor Interfaces
23.0.	TRICARE Prime Remote (TPR) Program
24.0.	Civilian Care Referred By MHS Facilities
25.0.	Civilian Health Care (CHC) Of Uniformed Service Members
26.0.	Demonstrations
27.0.	Health Insurance Portability And Accountability Act Of 1996 (HIPAA)
28.0.	TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC)



of Alaska based on the Government's ultimate decision regarding the underwriting of health care performed in Alaska.

## 10.0. PROVIDER CERTIFICATION AND CREDENTIALING

The contractor shall comply with the provisions of Chapter 4, for providers rendering care in the state of Alaska.

## 11.0. SUPPORT OF TRICARE PROVIDERS

*11.1. The contractor is required to provide assistance to the Government in servicing participating and non-participating providers. This assistance shall include certifying and credentialing providers according to paragraph 10.0. The contractor shall provide the appropriate level and number of provider representatives to service the participating and non-participating providers throughout the state of Alaska. The provider representative shall be located in contractor furnished facilities in close proximity to the MTF. The provider representative shall assist in establishing provider networks. The contractor's provider representatives shall also assist providers with TRICARE questions/problems as necessary. In this role, the provider representative shall be supported by all appropriate contractor staff and systems. For example, if a provider wishes to determine the status of a claim, he can call the contractor's claims information toll-free telephone number or check the status via an electronic means. However, if a provider requests the assistance of an individual on-site at the provider's office to resolve problems, the provider representative shall provide the assistance.*

*11.2. Alaskan providers shall not be required to submit claims electronically. As such, Alaskan claims shall be removed from both the numerator and the denominator when computing the percentage of claims submitted electronically.*

## 12.0. ENROLLMENT

**12.1.** The contractor is responsible for all enrollment activity in the state of Alaska in accordance with the provisions of Chapter 6. Enrollments within the state of Alaska shall all be to PCMs located within a MTF or in PSAs around a limited number of MTFs, to PCMs in the TRICARE network.

**12.2.** *Where enrollment to private sector PCMs is permitted, the contractor shall coordinate with the MTF Commander to ensure the combined total of MTF and private sector enrollees does not exceed the number for which compliance with TRICARE Prime access to care standards can be assured, considering MTF and preferred provider network resources together. Enrollment will be to the MTF first and then to the private sector at the discretion of the MTF Commander in coordination with the contractor.*

## 13.0. UTILIZATION AND QUALITY MANAGEMENT

The contractor shall comply with the provisions of Chapter 7, regarding utilization and quality management. In doing so, the contractor shall establish a separate utilization management plan for care received in the state of Alaska. This plan shall recognize that the MTF PCM is responsible for services rendered to his/her TRICARE Prime enrollees. As such, the MTF is responsible for issuing all authorizations for its Prime enrollees. The contractor is

responsible for ensuring that MTF issued authorizations are entered into all applicable contractor systems to ensure accurate, timely customer service and claims adjudication.

**13.1.** Cases for care rendered in the state of Alaska shall be included in the selection of cases for review by the National Quality Monitoring Contractor (NQMC) per [Chapter 7, Section 3](#). If the NQMC identifies an aberrant provider from the state of Alaska, and the provider is a network provider, the MCSC shall advise the TRO-W Alaska Branch of the findings.

**13.2.** The contractor shall comply with and include care rendered in the state of Alaska in its Clinical Quality Management Program (CQMP) per [Chapter 7, Section 4](#). The Clinical Quality Management Program Annual Report (CQMP AR) shall include a separate section specifically addressing Alaska.

**13.3.** All potential quality issues and unusual provider findings by the NQMC during their case reviews shall be processed and investigated by the MCSC per existing Clinical Quality Management (CQM) policies.

#### **14.0. CLAIMS PROCESSING**

The contractor shall process claims in accordance with [Chapter 8](#).

#### **15.0. DUPLICATE CLAIMS**

The contractor shall comply with [Chapters 9](#) and/or [10](#), as appropriate, for the identification, correction and resolution of duplicate and potentially duplicate claims.

#### **16.0. CLAIMS ADJUSTMENTS AND RECOUPMENTS**

The contractor shall comply with the provisions of [Chapter 11](#), regarding claims adjustments and recoupments.

#### **17.0. BENEFICIARY *EDUCATION* AND *SUPPORT DIVISION (BE&SD)***

**17.1.** The contractor shall comply with the provisions of [Chapter 12, Section 1](#) relating to the provision of marketing and education materials in the state of Alaska.

**17.2.** The contractor shall comply with the provisions of [Chapter 12, Section 2](#) and the TRICARE MCS contract, Section C-7.17 regarding briefings within the state of Alaska.

#### **18.0. TRICARE SERVICE CENTERS (TSCS)**

The contractor shall operate TSCs at every MTF in the state of Alaska. These TSCs shall be the primary source of customer service for TRICARE beneficiaries requesting on-site information and/or assistance. The functions of the TSC shall be as specified in [Chapter 12, Section 3](#). In providing assistance with referrals, the MCSC shall first direct all beneficiaries to the MTF (beneficiaries referred out of the MTF for specialty services shall not be referred back to the MTF) and then to the network. The MCSC shall maintain an up-to-date list of network providers.

## RESERVE COMPONENT HEALTH COVERAGE PLANS

SECTION	SUBJECT
<b>1</b>	<b>TRICARE RESERVE SELECT</b>
1.0.	General
2.0.	TRS Premiums
3.0.	Qualifying To Purchase TRS Coverage
4.0.	Coverage-Related Procedures
5.0.	Premium Billing And Collection
6.0.	Claims Processing
7.0.	<i>Beneficiary Education And Support Division (BE&amp;SD)</i>
8.0.	Analysis And Reporting
9.0.	Payments For Contractor Services Rendered
10.0.	Delinquent Premiums
<b>2</b>	<b>TRICARE RETIRED RESERVE</b>
1.0.	General
2.0.	TRR Premiums
3.0.	Qualifying To Purchase TRR Coverage
4.0.	Coverage-Related Procedures
5.0.	Premium Billing And Collection
6.0.	Claims Processing
7.0.	<i>Beneficiary Education And Support Division (BE&amp;SD)</i>
8.0.	Analysis And Reporting
9.0.	Payments For Contractor Services Rendered
<b>ADDENDUM A</b>	<b>FIGURES</b>
	FIGURE 24-A-1 Contractor Closure Letter



**5.3.4.** Premium payments shall be made payable to the contractor servicing the member's/survivor's coverage as specified in [paragraph 5.1.](#)

#### **5.4. Annual Premium Adjustment**

**5.4.1.** Contractors shall include advance notification of annual premium adjustments on the October, November and December monthly bills. (The October notification may not include the actual premium rates for the new year). The notification shall include the new amount for member only and member and family coverage. For those members/survivors not receiving a monthly bill, the contractor shall issue a notice advising the member/survivor of the adjusted premium amount at the same time the October, November and December bills are mailed and shall initiate all actions required to allow the continuation of the EFT transaction or RCC payment with the adjusted premium amount.

**5.4.2.** For premium adjustments that go into effect at any time other than January the first, the government will provide instructions about notification of members/survivors.

#### **5.5. Premium Adjustments from Changes Associated with QLEs**

**5.5.1.** When a QLE is processed that changes the premium, the effective date of the premium change shall be the date of the QLE.

**5.5.2.** If the change from a QLE results in an increase in the premium, the contractor shall adjust the next bill or electronic payment, to include any underpaid amount (prorated to the day as specified in [paragraph 5.3.](#)), to the effective date of the change.

**5.5.3.** If the change from a QLE results in a decrease in the premium, the contractor shall retain any overpaid amount and apply it to subsequent bills or electronic payment until all of the overpayment is exhausted.

#### **5.6. Terminations and Premium Adjustments**

The contractor shall initiate the process to refund any premium amounts applied for coverage after the date of termination as specified in [paragraph 4.4.](#)

#### **5.7. Online Transactions**

In addition to requirements specified in [paragraph 5.0.](#) and its subordinate paragraphs, the contractor may provide online capability for TRS members/survivors to conduct business related to premium collection and other applicable administrative services through secure access to the contractor's web site.

### **6.0. CLAIMS PROCESSING**

**6.1.** The contractor shall process TRS claims under established TRICARE Standard and TRICARE Extra ADFM cost-sharing rules and guidance. Normal TRICARE Other Health Insurance (OHI) processing rules apply to TRS.

**6.2.** The contractor shall pend all claims for health care provided to a newborn/new child of a TRS member until the member completes the process specified in [paragraph 4.2.3.1](#). If the contractor becomes aware that a TRS member has an unregistered newborn/new child the contractor shall notify the TRS member of the requirement to enroll the newborn/new child in DEERS and submit a request form for the newborn/new child NLT 60 days after birth/custody. When the member completes the process specified in [paragraph 4.2.3.2](#), the contractor shall process any claims associated with the newborn/new child's health care. If the member fails to complete the process as specified in [paragraph 4.2.3.2](#), the contractor shall deny any claims associated with the newborn/new child's health care.

**6.3.** Premium payments made for TRS shall not be applied to the fiscal year deductible or catastrophic cap limit.

**6.4.** Non-Availability Statements (NASs) requirements shall apply to TRS members, family members, and survivors in the same manner as for ADFMs under TRICARE Standard/Extra.

**6.5.** Medicare is the primary payer for TRICARE beneficiaries who have Medicare eligibility. Claims under the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) will be adjudicated under the rules set forth in [Chapter 20, Section 3](#). The MCSCs shall follow procedures established in the TRICARE Reimbursement Manual (TRM), [Chapter 4, Section 4](#) regarding dual-eligibles' claims processing.

**6.6.** If the contractor receives a PNT notifying them of a retroactive TRS disenrollment the contractor shall initiate recoupment of claims paid, if appropriate, as specified in [Chapter 11](#).

**6.7.** If at anytime the contractor discovers that the Selected Reserve member may be eligible for or enrolled in the FEHBP, the contractor shall report the discovery to the appropriate TRICARE RD or their designee or TAO Director NLT one business day after discovery. As applicable, the contractor shall follow [paragraph 4.4.1](#) and its subordinate paragraphs for loss of TRS eligibility. If any other actions are to be taken by the contractor as a result of this discovery, the TRICARE RD or their designee or TAO Director will send instructions to the contractor.

## **7.0. *BENEFICIARY EDUCATION AND SUPPORT DIVISION (BE&SD)***

In addition to communications and customer service functions specified throughout this chapter, the contractor shall perform communications and customer service functions to the same extent as they do for TRICARE Standard and TRICARE Extra.

### **7.1. Customer Education**

**7.1.1.** Information materials (i.e., public notices, flyers, informational brochures, etc.) will be developed and printed centrally by Department of Defense (DoD), TRICARE Management Activity (TMA), *BE&SD*. The contractor shall distribute all documents associated with the TRS Program to the same extent and through the same means as TRICARE Standard materials are distributed. Copies of the TRS Handbook and other information materials may be ordered through the usual TMA *BE&SD* ordering process.

**5.5.3.** If the change from a QLE results in a decrease in the premium, the contractor shall retain any overpaid amount and apply it to subsequent bills or electronic payments until all of the overpayment is exhausted.

## **5.6. Terminations**

The contractor shall initiate the process to refund any premium amounts applied for coverage after the date of termination as specified in [paragraph 4.4](#).

## **5.7. Online Transactions**

In addition to requirements specified in [paragraph 5.0](#) and its subordinate paragraphs, the contractor may provide online capability for TRR members/survivors to conduct business related to premium collection and other applicable administrative services through secure access to the contractor's web site.

## **6.0. CLAIMS PROCESSING**

**6.1.** The contractor shall process TRR claims under established TRICARE Standard and TRICARE Extra retiree cost-sharing rules and guidance. Normal TRICARE Other Health Insurance (OHI) processing rules apply to TRR.

**6.2.** The contractor shall pend all claims for health care provided to a newborn/new child of a TRR member until the member completes the process specified in [paragraph 4.2.3.1](#). If the contractor becomes aware that a TRR member has an unregistered newborn/new child, the contractor shall notify the TRR member of the requirement to register the new child in DEERS and submit a request form for the newborn/new child NLT 60 days after birth/custody. When the member completes the process specified in [paragraph 4.2.3.1](#), the contractor shall process any claims associated with the child's health care. If the member fails to complete the process as specified in [paragraph 4.2.3.1](#), the contractor shall deny any claims associated with the child's health care.

**6.3.** Premium payments made for TRR shall not be applied to the fiscal year deductible or catastrophic cap limit.

**6.4.** Non-Availability Statement (NAS) requirements shall apply to TRR members, family members, and survivors in the same manner as for retirees under TRICARE Standard/Extra.

**6.5.** If a Retired Reserve member purchases TRR during the same calendar year that the member had a TRICARE Reserve Select plan in effect, the catastrophic cap, deductibles and cost shares shall not be recalculated.

**6.6.** Medicare is the primary payer for TRICARE beneficiaries who have Medicare eligibility. Claims under the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) will be adjudicated under the rules set forth in [Chapter 22, Section 3](#). The MCSCs shall follow procedures established in the TRICARE Reimbursement Manual (TRM), ([Chapter 4, Section 4](#)) regarding dual-eligibles' claims processing.

**6.7.** If the contractor receives a PNT notifying them of a retroactive TRR disenrollment the contractor shall initiate recoupment of claims paid if appropriate as specified in [Chapter 11](#).

**6.8.** If at anytime the contractor discovers that the Retired Reserve member may be eligible for or enrolled in the FEHBP, the contractor shall report the discovery to the appropriate TRICARE RD or their designee or TAO Director NLT one business day after discovery. As applicable, the contractor shall follow [paragraph 4.4.1](#) and its subordinate paragraphs for loss of TRR eligibility. If any other actions are to be taken by the contractor as a result of this discovery, the TRICARE RD or their designee or TAO Director will send instructions to the contractor.

## **7.0. *BENEFICIARY EDUCATION AND SUPPORT DIVISION (BE&SD)***

In addition to *BE&SD* functions specified throughout this chapter, the contractor shall perform *BE&SD* functions to the same extent as they do for TRICARE Standard and TRICARE Extra.

### **7.1. Customer Education**

**7.1.1.** Materials (i.e., public notices, flyers, informational brochures, web site etc.) will be developed and distributed centrally by Department of Defense (DoD), TRICARE Management Activity (TMA), Office of *BE&SD*. The contractor shall distribute all informational materials associated with the TRR program to the same extent and through the same means as TRICARE Standard materials are distributed. Copies of the TRR handbook and other information materials may be obtained through the usual TMA *BE&SD* process.

**7.1.2.** Upon start of coverage under TRR each contractor shall mail one copy of the TRR handbook to each TRR member/survivor with TRR member-only coverage and one copy to the household of each TRR member/survivor with TRR member-and-family coverage. The member/survivor's servicing contractor shall send additional handbooks upon request, such as when covered family members live in different locations (split locations).

### **7.2. Customer Service**

The contractor shall provide all customer service support in a manner equivalent to that provided TRICARE Standard beneficiaries. When the contractor receives an inquiry involving TRR eligibility or qualifications, the contractor shall refer the individual to the appropriate RC.

## **8.0. ANALYSIS AND REPORTING**

TRR workload shall be included, but not separately identified, in all reports.

## TRICARE YOUNG ADULT (TYA)

SECTION	SUBJECT
<b>1</b>	<b>TRICARE YOUNG ADULT (TYA)</b>
	1.0. General
	2.0. TYA Coverage
	3.0. Qualifying To Purchase TYA Coverage
	4.0. Coverage-Related Procedures
	5.0. Premium Collection
	6.0. Claims Processing
	7.0. <i>Beneficiary Education And Support Division (BE&amp;SD)</i>
	8.0. Analysis And Reporting
	9.0. Payments For Contractor Services Rendered
	10.0. CHCBP To TYA Procedures
	11.0. Coding Of TED Records



- 6.2.** Non-Availability Statement (NAS) requirements shall apply to young adult dependents in the same manner as under the corresponding TRICARE plan.
- 6.3.** If a young adult dependent purchases TYA coverage during the same fiscal year that he or she had another TRICARE health plan in effect, the individual cost-shares, contributions to the individual and family deductibles, and contributions to the family catastrophic cap from the other TRICARE health plan still apply in that fiscal year and shall not be recalculated. If retroactive TYA coverage is purchased and replaces previously purchased CHCBP coverage, cost-shares, contributions to deductibles, or contributions to the catastrophic cap amounts previously paid under CHCBP shall be carried over to a TYA plan. Otherwise, any cost-shares, contributions to deductibles, or contributions to the catastrophic cap amounts previously paid under CHCBP shall not be carried over to a TYA plan.
- 6.4.** Medicare is the primary payer for TRICARE beneficiaries who are eligible for Medicare. Claims under the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) will be adjudicated under the rules set forth in [Chapter 22, Section 3](#). The contractors shall follow procedures established in the TRICARE Reimbursement Manual (TRM), [Chapter 4, Section 4](#), regarding dual eligible claims processing. Payment of Medicare Part B premiums do not provide a basis to waive TYA premiums.
- 6.5.** If the contractor receives a PNT notifying them of a retroactive TYA disenrollment the contractor shall initiate recoupment of claims paid if appropriate as specified in [Chapter 11](#).
- 6.6.** If at any time the contractor discovers that the young adult dependent may be eligible or is enrolled in an eligible employer-sponsored health plan from their employer, the contractor shall report the discovery to the appropriate waiver approval authority NLT one business day after discovery. Claims may be pended or held until a final decision is reached. As applicable, the contractor shall follow [paragraph 4.3](#) and its subordinate paragraphs for loss of TYA eligibility.

**7.0. *BENEFICIARY EDUCATION AND SUPPORT DIVISION (BE&SD)***

In addition to *BE&SD* functions specified throughout this chapter, the contractor shall perform *BE&SD* functions to the same extent as they do for other TRICARE plans.

**7.1. Customer Education**

**7.1.1.** Materials (i.e., public notices, flyers, informational brochures, web site, etc.) will be developed and distributed centrally by Department of Defense (DoD), TRICARE Management Activity (TMA), Office of *BE&SD*. The contractor shall distribute all informational materials associated with the TYA program to the same extent and through the same means as other TRICARE materials are distributed. Copies of TYA informational materials may be obtained through the usual TMA *BE&SD* process.

**7.1.2.** Upon start of coverage under TYA, the DMDC-generated enrollment letter will include information on how purchasers can obtain TYA and other TRICARE plan materials over the internet or how to request fulfillment materials from the contractor. The servicing contractor shall send fulfillment materials only upon request.

## **7.2. Customer Service**

The contractor shall provide all customer service support to young adult dependents in a manner equivalent to that provided to other TRICARE beneficiaries.

## **8.0. ANALYSIS AND REPORTING**

TYA workload shall be included, but not separately identified, in all reports.

## **9.0. PAYMENTS FOR CONTRACTOR SERVICES RENDERED**

### **9.1. Claims Reporting**

The contractor shall report TYA program claims according to [Chapter 3](#). The contractor shall process payments on a non-financially underwritten basis for the health care costs incurred for each TYA claim processed to completion according to the provisions of [Chapter 3](#).

### **9.2. Fiduciary Responsibilities**

**9.2.1.** The contractor shall act as a fiduciary for all funds acquired from TYA premium collections, which are government property. The contractor shall develop strict funds control processes for its collection, retention and transfer of premium funds to the government. All premium collections received by the contractor shall be maintained in accordance with these procedures.

**9.2.2.** Premiums shall be deposited into a non-interest bearing account to collect and disburse TYA premiums. The contractor shall deposit TYA premium collections to the established account within one business day of receipt. A separate bank account is not required; however, individual line item reporting for the TYA program is required.

**9.2.3.** The contractor shall wire-transfer the premium collections, net of refund payments, monthly to a specified government account as directed by the TMA Contract Resource Management (CRM) Finance And Accounting Office (F&AO). The government will provide the contractor with information for this government account. The contractor shall notify the TMA CRM F&AO, by e-mail, within one business day of the deposit, specifying the date and amount of the deposit as well as its purpose (i.e., TYA premiums).

**9.2.4.** The contractor shall maintain a system for tracking and reporting premiums, collections, and starts of coverage. The system is subject to government review and approval.

**9.2.5.** The contractor shall electronically submit monthly reports of premium activity supporting the wire transfer of dollars to the [CO](#).

### **3.11. Coverage and Renewals**

**3.11.1.** *The contractor shall mail initial premium renewal notices to beneficiaries no later than 30 days before the expiration of the coverage. The beneficiary's coverage in CHCBP is based on the documentation that the applicant submits to verify eligibility, therefore, the contractor shall not routinely query DEERS for renewal coverages and quarterly billings. Absent information or evidence to the contrary, the contractor shall assume that the individual continues to meet the requirements for CHCBP. Renewal notices shall clearly specify the premium amount due, the date by which the premium must be received, and the mailing address to which the premium payment must be sent. Renewal notices shall specify that failure to submit the premium due will result in denial of continued coverage and termination from the program.*

**3.11.2.** *The contractor shall provide a 30 calendar day grace period following the premium due date in which the beneficiary may submit his/her premium and continue benefits with no break in coverage. If the premium is not received following the initial renewal notice to the beneficiary requesting premium for the next quarter, the contractor shall issue a second renewal notice to the beneficiary within 10 business days of the start of the grace period. The second renewal notice shall indicate that this is the second and final billing notice and that if payment is not received by the due date specified in the notice, that CHCBP coverage will be terminated as of that date. The notice shall also advise the beneficiary that if coverage is terminated due to nonpayment of premium, that he/she will be permanently locked-out of CHCBP.*

**3.11.3.** *If the premium is not received by the end of the grace period, the contractor shall terminate the beneficiary's coverage in CHCBP and mail a letter to the beneficiary confirming the termination within 10 business days, to include the effective date and basis for the termination. The contractor shall enter all CHCBP terminations into DEERS.*

**3.11.4.** *Beneficiaries who desire to voluntarily withdraw from the CHCBP prior to the end of their paid up period shall send a written request to the contractor. Beneficiaries who voluntarily disenroll from the CHCBP are not permitted to re-enroll until they gain and then once again lose TRICARE eligibility. Refund of unused premiums is only allowed for items covered in [paragraph 3.8](#).*

**3.11.5.** *Following a beneficiary's termination from the CHCBP, except for those who have re-established TRICARE coverage, the contractor shall issue a Certificate of Creditable Coverage (CoCC) to the beneficiary within 10 business days from the termination date and upon request up to 24 months after the termination date. No later than four months prior to the start work date of the contract, the government will furnish the contractor with a sample of the format for the CoCCs.*

**3.11.6.** *In preparing and mailing all written notices and correspondence to applicants and beneficiaries, the contractor shall use the most current address on file or available.*

### **3.12. CHCBP Coverage Data and Report**

*The contractor shall maintain systems and databases to collect, track and process applications and to report monthly coverage information to the government as well as any ad hoc reports that may be requested regarding CHCBP coverage. The contractor shall have the capability to retroactively retrieve pertinent coverage information on any individual who has been accepted or denied coverage in the program, to include the basis for such denials.*

#### **4.0. PROGRAM MATERIALS**

All informational materials, booklets, brochures, and other public material are subject to review and approval by the TMA *Beneficiary Education and Support (BE&SD)* prior to finalizing the material, and all must contain the contractor's name, mailing address, toll-free telephone number and web site.

#### **5.0. INQUIRIES AND CUSTOMER SERVICE FUNCTIONS**

The contractor shall respond to CHCBP inquiries from any geographic area, to include locations outside the 50 United States and the District of Columbia. The contractor shall provide timely, accurate and thorough responses to the inquiries it receives from any source, e.g., prospective applicants, beneficiaries, providers, other contractors, government officials, etc. in accordance with [Chapter 1, Section 3, paragraph 3.0](#).

#### **6.0. FIDUCIARY RESPONSIBILITIES**

**6.1.** The contractor shall act as a fiduciary for all funds acquired from CHCBP premium collections, which are government property. The contractor shall develop strict funds control processes for its collection, retention and transfer of CHCBP premiums to the government. The contractor shall follow the requirements in [Chapter 3](#).

**6.2.** The contractor shall maintain a system for tracking and reporting premiums and beneficiaries/policy holders. The system is subject to government review and approval.

**6.3.** By the 10th calendar day of the month following the activity, the contractor shall submit the following reports: CHCBP Workload Report, CHCBP Monthly Enrollee Premiums Report, CHCBP Adjusted Premiums Report, CHCBP Enrollment Data Report, and CHCBP Premiums Summary Report.

#### **7.0. DEERS**

Refer to the DEERS instructions in the TSM for additional DEERS requirements related to CHCBP.

#### **8.0. REPORTING RESPONSIBILITIES**

In addition to the written monthly reports, the CHCBP contractor may be required to produce CHCBP ad hoc reports as requested by the government. The data elements or information for such reports would be limited to that information that the CHCBP contractor has collected or should reasonably have collected in the performance of CHCBP work. Some manipulation and formatting of the data and information may be required to meet the requirements of the ad hoc reports. The government estimates that the CHCBP contractor would not receive more than three such requests per contract year and that the level of effort for the CHCBP contractor to produce the ad hoc reports is not expected to be significant.