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TRICARE
MANAGEMENT ACTIVITY

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CHANGE 46
6010.51-M
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PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE OPERATIONS MANUAL (TOM)

The TRICARE Management Activity has authorized the following addition(s)/
revision(s) to 6010.51-M, reissued August 2002.

CHANGE TITLE: AD SM REFERRALS/AUTHORIZATIONS

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change to the TOM streamlines the referral and
authorization process for active duty service members while providing sufficient
administrative and clinical controls to ensure maintenance of required fitness-for-
duty oversight.

EFFECTIVE AND IMPLEMENTATION DATE: Upon direction of the Contracting
Officer.

A handwritten signature in cursive script that reads "Evie Lammle".

Evie Lammle
Director, Program Requirements Division

ATTACHMENT(S): 19 PAGES
DISTRIBUTION: 6010.51-M

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

CHANGE 46
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REMOVE PAGE(S)

INSERT PAGE(S)

CHAPTER 17

Section 2, pages 3 through 6

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CHAPTER 18

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CHAPTER 19

Section 2, pages 1 and 2

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5.3. Non-Emergency Specialty Care, All Inpatient Care, Mental Health Care, And Other Care

The following care requires SPOC review to determine its impact on the ADSM's fitness for duty and/or to determine whether the ADSM must use a military source of care or may use a civilian source: non-emergency specialty care, claims for prescriptions for controlled substances (network pharmacies shall fill the prescription and the contractor shall forward claim information to the SPOC on the monthly report for a retrospective review), all inpatient hospitalization, mental health care, and invasive medical and surgical procedures (with the exception of laboratory services) furnished in ambulatory settings. The contractor shall not, however, delay claim processing for a SPOC review determination.

5.3.1. Referred Care

5.3.1.1. *The requesting provider shall follow the contractor's referral procedures and shall contact the contractor for an authorization. If an authorization is required, the contractor shall enter the information in Chapter 17, Addendum D, required by the Service Point of Contact (SPOC) for a fitness-for-duty review. The SPOC will respond to the contractor within two working days. When a SPOC referral directs evaluation or treatment of a condition, as opposed to directing a specific service(s), the Managed Care Support Contractor (MCSC) shall use its best business practices in determining the services encompassed within the Episode Of Care (EOC), indicated by the referral. The services may include laboratory tests, radiology tests, echocardiograms, holter monitors, pulmonary function tests, and routine treadmills associated with the EOC. A separate SPOC authorization for these services is not required. If a civilian provider requests additional treatment outside the original EOC, the MCSC shall contact the SPOC for approval. The contractor shall not communicate to the provider or patient that the care has been authorized until the SPOC review process has been completed.*

5.3.1.2. If the SPOC determines that the ADSM may receive the care from a civilian source, the SPOC will enter the appropriate code into the authorization/referral system. The contractor shall notify the ADSM of approved referrals. The ADSM may receive the specialty care from an MTF, a network provider, or a non-network provider according to TRICARE access standards, where possible. In areas where providers are not available within TRICARE access standards, community norms shall apply. (An ADSM may always choose to receive care at an MTF even when the SPOC has authorized a civilian source of care and even if the care at the MTF cannot be arranged within the Prime access standards subject to the member's unit commander [or supervisor] approval.) If the appointment is with a non-network provider, the contractor shall instruct the provider on payment requirements for ADSMs (e.g., no deductible or cost-share) and on other issues affecting claim payment (e.g., the balance billing prohibition).

5.3.1.3. If the contractor does not receive the SPOC's response or request for an extension within two (2) work days, the contractor shall, within one work day after the end of the two work day waiting period, enter the contractor's authorization code into the contractor's claims processing system. The contractor shall document in the contractor's system each step of the effort to obtain a review decision from the SPOC. The first choice for civilian care is with a network provider; if a network provider is not available within Prime access standards, the contractor may authorize the care with a TRICARE-authorized provider. The contractor shall help the ADSM locate an authorized provider.

5.3.1.4. If the SPOC directs the care to a military source, the SPOC will manage the episode of care. If the ADSM disagrees with a SPOC determination that the care must be provided by a military source, the ADSM may appeal only through the SPOC who will coordinate the appeal with the Regional Director; the contractor shall refer all appeals and inquiries concerning the SPOC's fitness-for-duty determination to the SPOC.

5.3.1.5. If the ADSM's PCM determines that a specialty referral or test is required on an emergency or urgent basis (less than 48 hours from the time of the PCM office visit) the PCM shall contact the contractor for a referral and send required information to the SPOC for a fitness for duty review. The ADSM shall receive the care as needed without waiting for the SPOC determination, and the contractor shall adjudicate the claim according to TRICARE Prime provisions. If further specialty care is warranted, the PCM shall request a referral to specialty care. The contractor shall contact the SPOC with a request for an additional SPOC review for the specialty care.

5.3.2. Care Received With No Authorization or Referral

5.3.2.1. The contractor may receive claims for care that require referral, authorization, and SPOC review, that have not been authorized or reviewed. If the claim involves care covered under TPR, the contractor shall pend the claim and supply the required information (Chapter 17, Addendum D) to the SPOC for review. If the SPOC does not notify the contractor of the review determination or ask for an extension for further review within two workdays after submitting the request for coverage determination, the contractor shall then authorize the care. The contractor shall then release the claim for payment, and apply any overrides necessary to ensure that the claim is paid with no fees assessed to the active duty member. However, the contractor shall not make claims payments to sanctioned or suspended providers (see Chapter 14, Section 6).

5.3.2.2. If the contractor determines that the services on the claim are not covered under TRICARE Prime and/or that the provider of care is not TRICARE-authorized, or is not certified, the contractor shall pend the claim and supply required information (Chapter 17, Addendum D) to the SPOC for a coverage determination as well as for a fitness-for-duty screening (refer to Chapter 17, Addendum B) for information and examples of covered services). If the SPOC does not notify the contractor of the review determination or ask for an extension for further review within two workdays after submitting the request for a coverage determination, the contractor shall then authorize the care. The contractor shall then release the claim for payment and apply any overrides necessary to ensure that the claim is paid. However, the contractor shall not make claims payments to sanctioned or suspended providers (see Chapter 14, Section 6).

NOTE: If the SPOC retroactively determines that the payment should not have been made, the contractor shall initiate recoupment actions according to Chapter 11, Section 4.

6.0. ADDITIONAL INSTRUCTIONS

6.1. Wellness Examinations

The contractor shall reimburse charges for wellness examinations covered under TRICARE Prime (see the TRICARE Policy Manual, Chapter 7, Section 2.2) without SPOC

review. The contractor shall supply information related to requests for follow-up or additional GYN care that requires SPOC review (paragraph 5.2., above) to the SPOC for a fitness-for-duty determination (see Chapter 17, Addendum B).

6.2. Optometry And Hearing Examinations

The ADSM may directly contact the contractor for assistance in arranging for optometry and hearing examinations. The contractor shall refer ADSMs to SPOCs for information on how to obtain eyeglasses, hearing aids, and examinations for, and contact lenses from the Military Health System (MHS) (see Chapter 17, Addendum B).

6.3. No PCM Assigned

ADSMs who work and reside in areas where a PCM is not available may directly access the contractor for assistance in arranging for routine primary care and for urgent specialty or inpatient care with a TRICARE-authorized provider. Since a non-network provider is not required to know the fitness-for-duty review process, it is important that the ADSM coordinate all requests for specialty and inpatient care through the contractor. The contractor shall contact the SPOC as required for reviews and other assistance as needed.

6.4. Emergency Care

For emergency care, refer to the TRICARE Policy Manual for guidelines.

6.5. Dental Care

The military services will continue to process and reimburse claims for all dental services, including adjunctive dental care. Chapter 17, Addendum C provides guidelines for dental claims and inquiries. (See Chapter 17, Section 4, paragraph 2.4. for adjunctive dental care provided under the National DoD/VA MOA.)

6.6. Immunizations

The contractor shall reimburse immunizations as primary care under the guidelines in the TRICARE Reimbursement Manual.

6.7. Ancillary Services

A SPOC authorization for health care includes authorization for any ancillary services related to the health care authorized.

7.0. ACTIVE DUTY SERVICE MEMBER MEDICAL RECORDS

7.1. For TPR-enrolled ADSMs with assigned PCMs, the contractor shall follow contract requirements for maintaining medical records.

7.2. ADSMs will be instructed by their commands to sign annual medical release forms with their PCMs to allow information to be forwarded as necessary to civilian and military providers. The contractor may use the current "signature on file" procedures to fulfill this

requirement (Chapter 8, Section 5, paragraph 6.0.). When an ADSM leaves an assignment as a result of a Permanent Change of Station (PCS) or other service-related change of duty status, the PCM shall provide a complete copy of medical records, to include copies of specialty and ancillary care documentation, to ADSMs within 30 calendar days of the ADSM's request for the records. The ADSM may also request copies of medical care documentation on an ongoing, episode of care basis. The contractor shall be responsible for all administrative/copying costs. 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.

NOTE: The purpose of the copying of medical records is to assist the ADSM in maintaining accurate and current medical documentation. The contractor shall not make payment to the provider who photocopies medical records to support the adjudication of a claim.

7.3. ADSMs without assigned PCMs are responsible for maintaining their medical records when receiving care from civilian providers.

8.0. PROVIDER EDUCATION

The contractor shall familiarize network providers and, when appropriate, other providers with the TRICARE Prime Remote Program, special requirements for ADSM health care, and billing procedures (e.g., no cost-share or deductible amounts, balance billing prohibition, etc.). On an ongoing basis, the contractor shall include information on ADSM specialty care procedures and billing instructions in routine information and educational programs according to contractual requirements.

CONTRACTOR RESPONSIBILITIES

1.0. CONTRACTOR RECEIPT AND CONTROL OF SHCP CLAIMS

1.1. Post Office Box

The contractor may establish a dedicated post office box to receive claims and correspondence related to the Supplemental Health Care Program (SHCP). This dedicated box, if established, may be the same post office box which may be established for handling TRICARE Prime Remote and Non-Referred Care claims, as discussed in Chapter 17 and Chapter 19.

1.2. Claims Processing

1.2.1. Claims Processing And Reporting

Regardless of who submits the claim, SHCP claims shall be processed using the same standards in Chapter 1, unless otherwise stated in this chapter. The contractor for the region in which the patient is enrolled shall process the claim to completion. The claims tracking and retrieval requirements of Chapter 1, Section 3, paragraph 2.1. apply equally to SHCP claims. Reports on the timeliness of processing supplemental health care claims, as required under paragraph 9.0., are due to each *Military Treatment Facility* (MTF) no later than the 15th calendar day of the month following the reporting period.

1.2.2. Civilian Services Rendered To MTF Inpatients

Claims for MTF inpatients referred to a civilian facility or internal resource sharing provider for medical care (test, procedure, or consult) shall be processed to completion without application of a cost-share, co-payment, or deductible. Nonavailability statements shall not be required. Costs for transportation of current MTF inpatients by ambulance to or from a civilian provider shall be considered medical costs and shall be reimbursed, as shall costs for inpatient care in civilian facilities. Additionally, claims for inpatients who are not TRICARE eligible (e.g. Service Secretary Designee, parents, etc.), will be paid based on MTF authorization despite the lack of any DEERS indication of eligibility. These are SHCP claims. SHCP shall not be used for TRICARE For Life beneficiaries referred from an MTF as an inpatient. Such civilian claims shall be processed with Medicare first without consideration of SHCP.

1.2.3. Outpatient Care

Outpatient civilian care claims are to be processed according to the patient's enrollment status (see paragraph 3.0.). If the patient is TRICARE eligible, normal TRICARE processing requirements will apply. Additionally, for service determined eligible patients

other than active duty, (e.g., ROTC, Reserve Component, National Guard, Foreign military, etc.) claims will be paid based on an MTF authorization despite the lack of any DEERS indication of eligibility.

1.2.4. Emergency Civilian Hospitalization

If an emergency civilian hospitalization becomes necessary during the test or procedure referred by the MTF and comes to the attention of the contractor, it will be reported to the Patient Administration Department of the referring MTF. The MTF will have primary case management responsibility, including authorization of care and patient movement for all civilian hospitalizations.

1.2.5. Comprehensive Clinical Evaluation Program (CCEP)

Claims for participants in the Comprehensive Clinical Evaluation Program (CCEP) will be processed based on the MTF authorization. These claims are SHCP claims, but will be maintained and tracked separately from other SHCP claims. It is the responsibility of the MTF to identify such referrals as CCEP referrals to the contractor at the time of authorization.

1.2.6. Foreign Claims Processing

1.2.6.1. Process claims received by the contractor for patients covered by reciprocal host nation health care agreements in accordance with the current requirements of the TRICARE Operations Manual and the TRICARE Policy Manual.

1.2.6.2. Forward claims received for personnel permanently assigned to an overseas location to the appropriate overseas claims processor for processing in accordance with the TRICARE Policy Manual, Chapter 12, TRICARE Overseas Program.

1.2.7. Claims Received With Both MTF-Referred And Non-Referred Lines

The contractor shall use the same *best business practices* as used for other Prime enrollees in determining *Episode Of Care (EOC)* when the claims are received with lines of care that contain both MTF -Referred and non-referred lines. *Claims received which contain services outside the originally referred EOC on an Active Duty Service Member (ADSM) must come back to the Primary Care Manager (PCM) for approval. Laboratory tests, radiology tests, echocardiogram, holter monitors, pulmonary function tests, and routine treadmills associated with that EOC may be considered part of the originally requested services and do not need to come back to the PCM for approval.*

1.3. Authorization Verification

1.3.1. The contractor shall verify that care provided was authorized by the MTF.

1.3.1.1. *When a MTF referral directs evaluation or treatment of a condition, as opposed to directing a specific service(s), the Managed Care Support Contractor (MCSC) shall use its best business practices in determining the services encompassed within the EOC, indicated by the referral. The services may include laboratory tests, radiology tests, echocardiogram, holter monitors,*

pulmonary function tests, and routine treadmills associated with that EOC. A separate MTF authorization for these services is not required. If a civilian provider requests additional treatment outside of the original EOC, the MCSC shall contact the referring or enrolling MTF for approval.

1.3.1.2. *If an authorization is not on file, then the contractor shall place the claim in a pending file and verify authorization with the MTF to which the ADSM is enrolled. The contractor shall contact the MTF within one working day. If the MTF retroactively authorizes the care, then the contractor shall enter the authorization and notify the claims processor to process the claim for payment. If the MTF determines that the care was not authorized, the contractor shall notify the claims processor and an Explanation of Benefits (EOB) denying the claim shall be initiated. If the contractor does not receive the MTF's response within four working days, the contractor shall, within one working day, enter the contractor's authorization code into the contractor's claims processing system. Claims authorized due to a lack of response from the MTF shall be considered as "Referred Care".*

1.3.2. For outpatient active duty and non-TRICARE eligible patients, and for all SHCP inpatients, there will be no application by the contractor of the DEERS Catastrophic Cap and Deductible Data (CCDD), Third Party Liability (TPL), or Other Health Insurance (OHI) processing procedures, for supplemental health care claims. Normal TRICARE rules will apply for all TRICARE eligible outpatients' claims. Outpatient claims for non-enrolled Medicare eligibles will be returned to the submitting party for filing with the Medicare claims processor.

2.0. COVERAGE

2.1. Normal TRICARE coverage limitations will not apply to services rendered to supplemental health care patients. Services that have been authorized will be covered regardless of whether they would have ordinarily been covered under TRICARE policy. On occasion a referral may be made for services from a provider of a type which is not TRICARE authorized. The contractor shall not make claims payments to sanctioned or suspended providers. (See Chapter 14, Section 6.) The claim shall be denied if a sanctioned or suspended provider bills for services. MTFs do not have the authority to overturn TMA or Department of Health and Human Services provider exclusions. TRICARE utilization review and utilization management requirements will not apply.

2.2. Unlike a normal TRICARE authorization, an MTF authorization shall be deemed to constitute referral, authorization, eligibility verification, and direction to bypass provider certification and NAS rules. The contractor shall take measures as appropriate to enable them to distinguish between the two authorization types.

2.3. Within the category of SHCP, the contractor shall identify referrals by the MTF for the Comprehensive Clinical Evaluation Program (CCEP). The contractor shall take measures as appropriate to distinguish these claims from other SHCP claims.

2.4. Ancillary Services

An MTF authorization for care includes any ancillary services related to the health care authorized.

3.0. ENROLLMENT STATUS EFFECT ON CLAIMS PROCESSING

- 3.1.** Active duty claims shall be processed without application of a cost-share, co-payment, 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, co-payment, 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 between the Department of Defense (including Army, Air Force, and Navy/Marine Corps facilities) and the Department of Health and Human Services (including the Indian Health Service, Public Health Service, etc.) are not covered. These are not SHCP claims.
- 3.6.** Claims for services not included in the current Memoranda of Understanding between the Department of Defense (including the Army, Air Force and Navy/Marine Corps facilities) and the Department of Health and Human Services shall be processed in accordance with the requirements in this chapter. These are SHCP claims.
- 3.7.** Claims for services provided under any local Memoranda of Understanding between the Department of Defense (including the Army, Air Force and Navy/Marine Corps facilities) and the Department of Veterans' Affairs (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 Memoranda of Understanding between the Department of Defense (including the Army, Air Force and Navy/Marine Corps facilities) and the Department of Veterans' Affairs shall be processed in accordance with the requirements in this chapter. These are SHCP claims.
- 3.9.** Claims for participants in the Comprehensive Clinical Evaluation Program (CCEP) shall be processed for payment solely on the basis of MTF authorization. There will not be a cost-share, co-pay 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, co-pay 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.

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, 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. 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, or to patients who receive referred civilian services while remaining in an MTF inpatient status.

5.3. 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, as the designee of the Chief Operating Officer (COO), TRICARE Management Activity (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 Regional Director, 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.

5.4. 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.

5.4.1. Supplemental health care claims for uniformed service members 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.

5.4.2. 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.

5.5. 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 Service point of contact (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 Chief Operating Officer (COO), TRICARE Management Activity, 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 Explanation of Benefits (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 Manual 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 shall be reported separately. A separate report of payments on behalf of non-DoD patients shall also be prepared and forwarded to TRICARE Management Activity, 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

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CONTRACTOR RESPONSIBILITIES

total dollar amount contained in data elements (paragraphs 9.1.1. through 9.1.3. below), 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. below), 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. 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/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/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/Length of Stay (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 point of contact 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 Regional Director. 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 Regional Director; 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, 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 TRICARE Prime Remote 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 point of contact for Government inquiries related to the SHCP.

PROVIDERS OF CARE

1.0. GENERAL

1.1. The SHCP payment structure applies to inpatient and outpatient medical claims submitted from civilian institutions, individual professional providers, and uniformed service members for civilian health care received within the 50 United States and the District of Columbia. Most patients covered by this chapter will have undergone medical care prior to any contact with the *Service Point of Contact* (SPOC) (Chapter 19, Addendum A) or the MCS contractor. However, when the patient initiates contact prior to treatment and the SPOC has authorized the care being sought, the Managed Care Support Contractor (MCSC) will make referrals to network providers; if a network provider is not available, the referral will be made to a TRICARE authorized provider. *When a SPOC referral directs evaluation or treatment of a condition, as opposed to directing a specific service(s), the MCSC shall use its best business practices in determining the services encompassed within the Episode of Care (EOC), indicated by the referral. The services may include laboratory tests, radiology tests, echocardiograms, holter monitors, pulmonary function tests, and routine treadmills associated with that EOC. A separate SPOC authorization for these services is not required. If a civilian provider requests additional treatment outside the original EOC, the MCSC shall contact the SPOC for approval. The contractor shall not communicate to the provider or patient that the care has been authorized until the SPOC review process has been completed.*

1.2. For service determined eligible patients other than active duty (e.g., ROTC, Reserve Component, foreign military, etc.), the contractor, upon receiving an authorization from the SPOC, will document the authorization with a network provider or TRICARE-authorized provider (if available).

2.0. DEPARTMENT OF VETERAN'S AFFAIRS

In addition to receiving claims from civilian providers, the contractors may also receive SHCP claims from the Department of Veteran's Affairs (DVA). The provisions of the SHCP will not apply to services provided under any local Memoranda of Understanding between the Department of Defense (including the Army, Air Force and Navy/Marine Corps facilities) and the Department of Veteran's Affairs. Claims for these services will continue to be processed by the Services or MTF as outlined in the MOU. However, any services not included in the MOU shall be paid by the MCSC in accordance with the requirements in this chapter.

2.1. Claims for Care Provided Under the National DoD/VA MOA for Spinal Cord Injury (SCI), Traumatic Brain Injury (TBI), and Blind Rehabilitation

2.1.1. The contractor shall reimburse for services under the current national DoD/VA MOA for "Referral of Active Duty Military Personnel Who Sustain Spinal Cord Injury,

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Traumatic Brain Injury, or Blindness to Veterans Affairs Medical Facilities for Health Care and Rehabilitative Services." The contractor shall begin processing these claims effective January 1, 2007. Previously these claims were processed/paid for by either MMSO (for Army and Navy care) or by the Air Force. MOA claims shall be processed in accordance with this chapter and the following.

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

2.1.3. The contractor shall verify whether the MOA VA-provided care has been authorized by MMSO. MMSO will send authorizations to the contractor by fax. If an authorization is on file, the contractor shall process the claim to payment. The contractor shall not deny claims for lack of authorization. Rather, if a required authorization is not on file, the contractor will place the claim in a pending status and will forward appropriate documentation to MMSO for determination (following the procedures in Chapter 19, Addendum B for MMSO SPOC referral and review procedures).

2.1.4. MOA claims shall be reimbursed as follows:

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

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

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

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

2.1.5. On January 1, 2007, the contractor will begin processing claims for care provided on and after this date. Claims for care provided prior to this date, will continue to be

reimbursed by either MMSO or the Air Force. After 90 days, all claims -- regardless of dates of service -- will be processed by the contractor. All TED records for this care must include Special Processing Code 17 - VA medical provider claim.

2.1.6. Sixty to ninety days prior to the effective date, the contractor shall meet with MMSO to discuss the transition of claims processing responsibility (this meeting can be by telephone). Items to be discussed include: points of contact (including fax numbers) for authorizations; coordination of a process to forward claims received at the wrong location during the dual processing period; establish points of contact for transition issues; other items deemed necessary to facilitate a successful transition of these claims. The contractor will not be responsible for processing adjustments for any claim previously paid by MMSO or the Services.

