



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
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TRICARE
MANAGEMENT ACTIVITY

PRD

CHANGE 56
6010.51-M
NOVEMBER 6, 2007

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: FINAL IMPLEMENTING INSTRUCTIONS FOR PHASE I
(DEVELOPMENT AND IMPLEMENTATION) TO THE
OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS)

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): Ongoing changes/clarifications to TRICARE
Hospital OPPS.

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

This change is made in conjunction with Aug 2002 TPM, Change No. 63, Aug 2002
TRM, Change No. 69, and Aug 2002 TSM, Change No. 52.

Evie Lammle
Director, Program Requirements Division

ATTACHMENT(S): 17 PAGES
DISTRIBUTION: 6010.51-M

CHANGE 56
6010.51-M
NOVEMBER 6, 2007

REMOVE PAGE(S)

INSERT PAGE(S)

CHAPTER 18

Section 3, pages 3 through 12

Section 3, pages 3 through 12

CHAPTER 19

Section 3, pages 3 through 9

Section 3, pages 3 through 9

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. *In no case shall a payment be made for outpatient institutional services listed on the inpatient only procedure list except for inpatient procedures performed in an emergency room on a beneficiary who dies prior to admission. Reference the TRICARE Reimbursement Manual (TRM), Chapter 13, Section 2, paragraph III.D.* 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 *the TRICARE Management Activity (TMA)* or Department of Health and Human Services (*DHHS*) 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 *Non-Availability Statement (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 *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, 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 Department of Defense (*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 Memoranda of Understanding 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 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 *DoD* (including the Army, Air Force and Navy/Marine Corps facilities) and the *DVA* 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.

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, *CHAMPUS Maximum Allowable Charge (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, 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, 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 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.

5.5. 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 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 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 **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 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 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. 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.), 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 ineligibles)
- 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.

area of the MTF to which he/she is enrolled, the care shall be authorized in accordance with the MCSC-MTF MOU established between the contractor and the local MTF. If the caller is traveling away from his/her duty station, the care shall be authorized if a prudent person would consider the care to be urgent or emergent. Callers seeking authorization for routine care shall be referred back to their MTF for instructions. Overseas enrollees shall be referred to the SPOC. The contractor shall send daily notifications to the ADSMs' enrolled MTF for all care authorized after hours according to locally established business rules.

5.1. Emergency Care (As Defined In The TRICARE Policy Manual)

Subsequent to the eligibility verification process described in [paragraph 5.0.](#) above, the contractor shall pay all emergency claims for eligible uniformed Service members. If an emergency civilian hospitalization comes to the attention of the contractor, it shall be reported to the SPOC. The SPOC will have primary case management responsibility, including authorization of care and patient movement for all civilian hospitalizations.

5.2. Non-Emergent Care

Subsequent to eligibility verification as described in [paragraph 5.0.](#) above, the contractor shall verify whether the non-emergent medical civilian health care provided was already authorized by the SPOC or the contractor. If there is an authorization on file, the contractor shall process the claim to payment. If a required authorization is not on file for a non-enrollee, then the contractor will place the claim in a pending status and will forward copies of appropriate documentation to SPOC for determination. See [Chapter 19, Addendum B](#) for SPOC referral and review procedures.

5.2.1. If the SPOC authorizes care, the claim shall be processed for payment.

5.2.2. If the SPOC determines that the civilian health care was not authorized, the contractor shall follow normal TRICARE requirements for issuing *Explanations of Benefits* (EOBs) and summary vouchers.

5.3. Ancillary Services

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

6.0. COVERAGE

6.1. Normal TRICARE coverage limitations will not apply to services rendered to SHCP eligible uniformed service members covered by this chapter. Services that have been authorized by the SPOC will be covered regardless of whether they would have ordinarily been covered under TRICARE policy. *In no case shall a payment be made for outpatient services listed on the inpatient only procedures list except for inpatient procedures performed in an emergency room on a beneficiary who dies prior to admission. Reference the TRICARE Reimbursement Manual (TRM), Chapter 13, Section 2, paragraph III.D.* Occasionally, care may be authorized which was not rendered by a TRICARE authorized provider. Contractors 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. SPOCs do not have the

authority to overturn *the TRICARE Management Activity (TMA)* or Department of Health and Human Services (*DHHS*) provider exclusions. Customary TRICARE utilization review and utilization management requirements will not apply.

6.2. Unlike a normal TRICARE authorization, a SPOC authorization shall be deemed to constitute referral, authorization, eligibility verification, and direction to bypass provider certification and *Non-Availability Statement (NAS)* rules. Contractors shall take measures as appropriate to enable them to distinguish between the two authorization types.

7.0. 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 shall 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 will 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 will 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.

8.0. REIMBURSEMENT

8.1. 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, *CHAMPUS Maximum Allowable Charge (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. Cost sharing and deductibles shall not be applied to SHCP claims.

8.2. *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.*

8.3. 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 one

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. The contractor shall then request a waiver of CMAC limitation from the Regional Director, 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. The waiver request shall include the patient name, ADSM's location, services requested (CPT-4) codes, CMAC rate, billed charge, and anticipated negotiated rate. The contractor must obtain approval from the Regional Director before the negotiation can be concluded. The contractors shall ensure that the approved payment is annotated in the authorization/claims processing system, and that payment is issued directly to the provider, unless there is information presented that the ADSM has personally paid the provider.

8.4. Eligible uniformed service members 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. If the claim is payable without SPOC review the contractor shall allow the billed amount and reimburse the ADSM for charges on the claim. If the claim requires SPOC review the contractor shall pend the claim to the SPOC for determination. If the SPOC authorizes the care the contractor shall allow the billed amount and reimburse the ADSM for charges on the claim.

8.5. In no case shall a uniformed service member be subjected to "balance billing" or ongoing collection action by a civilian provider for emergency or authorized care. If the contractor becomes aware of such situations that they cannot resolve they shall pend the file and forward the issue to the SPOC for determination. The SPOC will issue an authorization to the contractor for payments in excess of CMAC or other applicable TRICARE payment ceilings, provided the SPOC has requested and has been granted a waiver from the COO, TMA, or designee.

9.0. END OF PROCESSING

9.1. EOB

An appropriate EOB shall be prepared for each supplemental health care claim processed, and copies sent to the provider and the patient (uniformed service member) in accordance with normal claims processing procedures. The EOB will also 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 SPOC." Any standard TRICARE EOB messages which are applicable to the claim are also to be utilized, e.g., "No authorization on file."

9.2. Appeal Process

9.2.1. If the contractor, at the direction of the Service Point of Contact (SPOC), denies authorization of, or authorization for reimbursement, for an ADSM's health care services, the contractor shall, on the EOB or other appropriate document, furnish the ADSM with clear guidance for requesting a reconsideration from or filing an appeal with the SPOC. The SPOC will handle only those issues that involve SPOC denials of authorization or authorization for reimbursement. The contractor shall handle allowable charge issues, grievances, etc.

9.2.2. An ADSM will appeal SPOC denials of authorization or authorization for reimbursement through the SPOC--not through the contractor. If the ADSM disagrees with a denial, the first level of appeal will be through the **SPOC** who will coordinate the appeal with the appropriate Regional Director. The ADSM may initiate the appeal by contacting his/her **SPOC** or by calling the Military Medical Support Office (MMSO) at 1-888-647-6676. If the SPOC upholds the denial, the SPOC will notify the ADSM of further appeal rights with the appropriate Surgeon General's office. If the denial is overturned at any level, the SPOC will notify the contractor and the ADSM.

9.2.3. The contractor shall forward all written inquiries and correspondence related to SPOC denials of authorization or authorization for reimbursement to the appropriate SPOC. The contractor shall refer telephonic inquiries related to SPOC denials to 1-888-MHS-MMSO.

10.0. TED VOUCHER SUBMITTAL

The contractor shall report the SHCP claims on TED vouchers according to the provisions in [Chapter 3, Section 3](#).

11.0. REPORTS FOR SHCP

11.1. Required Reports

11.1.1. Reports reflecting government dollars paid for all SHCP claims will be prepared and submitted to the SPOC and each Regional Director every month by branch of service. The contractor shall produce separate reports for services furnished to members of the Army National Guard and a separate report for services rendered to members of the Air Force National Guard. Contractors shall submit all reports described below in electronic media in an Excel format. The contractor shall also prepare a separate report of payment on behalf of non-DoD patients. The contractor shall forward this report to **TMA**, Managed Care Support Operations Branch. The contractor shall submit these reports no later than the 15th calendar day of the month following the reporting period. These reports will reflect total care paid, and the total dollar amount contained in data elements [paragraphs 11.1.3.1. through 11.1.3.13.](#), and will equal the total amount submitted to **TMA**, Contract Resource Management Directorate as vouchers and approved for check release. For those data elements in items [paragraphs 11.1.3.1. through 11.1.3.13.](#), which require a count, the MCS contractor must ensure that no workload is double-counted.

11.1.2. Aggregated quarterly reports will be prepared and submitted to each Service Headquarters. These reports will be submitted no later than the 15th calendar day of the month following the close of each fiscal quarter.

11.1.3. Data elements to include in the reports are:

11.1.3.1. DMIS ID Code - enrollment MTF

11.1.3.2. Total Number and Dollar Amount of Claims Paid

11.1.3.3. Inpatient Dollars Paid - Institutional

- 11.1.3.4. Inpatient Dollars Paid - Professional Services
- 11.1.3.5. Outpatient Dollars Paid - Clinic Visits (Professional and Ancillary Services)
- 11.1.3.6. Outpatient Dollars Paid - Ambulatory Surgeries/ Procedures - Professional Services
- 11.1.3.7. Outpatient Dollars Paid - Ambulatory Surgeries/ Procedures - Institutional
- 11.1.3.8. Total Admissions/Dispositions
- 11.1.3.9. Total Bed Days/LOS
- 11.1.3.10. Total Ambulatory Surgeries/Procedures, including all Ancillary
- 11.1.3.11. Total Outpatient Visits, Excluding Ambulatory Surgeries but including all Ancillary related to the outpatient visits
- 11.1.3.12. CPT Codes/DRG/ICD-9 Codes
- 11.1.3.13. Other Items Paid

11.2. Additional Reports

The contractor shall produce monthly workload and timeliness reports for the SHCP. The reports 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. The contractor shall prepare a cover letter when forwarding reports, which shall identify 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.

11.2.1. Workload Reports

The contractor shall prepare and submit a monthly SHCP claims workload report for each branch of service (to include Army National Guard, and Air Force National Guard separately), as well as one workload report which shows the cumulative totals for all services. The contractor shall send a copy of the Workload Reports to the TMA, Chief, Special Contracts and Operations Office. The contractor shall also send a copy of each Service's monthly report to the respective Service Project Officer identified in [Chapter 19, Addendum A](#) and to the SPOC. 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.

11.2.2. Timeliness Reports

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

11.2.3. Aging Claims Report

The government intends to take action on all referrals to the SPOC as quickly as possible. To support this objective, the SPOC must be kept apprised of those claims on which the contractor cannot take further action until the SPOC has completed its reviews and approvals. Therefore, no less frequently than once per week, the contractor shall forward to the SPOC a report listing those claims which have been pended awaiting SPOC action, and the age of those claims. The age breakouts reported in that report may be based upon the same categories as reported in the monthly cycle time and aging reports sent to TMA ([Chapter 15, Addendum A, Figure 15-A-2](#)). In the alternative, they may be configured based upon existing workload management reports used internally by the contractor or its subcontractor. The weekly report to the SPOC may consist simply of a copy of the relevant portion of such an internal report if the contractor or its subcontractor currently utilizes one.

11.2.4. 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 contractors SHCP vouchers to TMA. 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.

12.0. CONTRACTOR'S RESPONSIBILITY TO RESPOND TO INQUIRIES

12.1. Telephonic Inquiries

Inquiries relating to the SHCP need not be tracked nor reported separately from other inquiries received by the MCS contractor. All inquiries to the contractor should come from the MTFs/claims offices, the Service Project Officers, the TMA, or SPOC. However, inquiries may be received from congressional representatives, providers and/or patients. 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 18](#). The telephone response standards of [Chapter 1, Section 3, paragraph 3.4](#). shall apply to SHCP telephonic inquiries.

12.1.1. Congressional Telephonic Inquiries

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

12.1.2. Provider And Other Telephonic Inquiries

The contractor shall refer provider and any other telephonic inquiries it receives, including calls from the Service member to the SPOC if the inquiry is related to the authorization or non-authorization of a specific claim. The contractor shall respond as appropriate to general inquiries regarding the SHCP.

12.2. Written Inquiries

12.2.1. Congressional Written Inquiries

The contractor shall refer written congressional inquiries to the SPOC if the inquiry is related to the authorization or non-authorization of a specific claim or episode of treatment. When referring the inquiry, 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.

12.2.2. Provider And Service Member (Or MTF Patient) Written Inquiries

The contractor shall refer provider and service member written inquiries to the SPOC.

12.2.3. MTF Written Inquiries

The contractor shall refer all written inquiries from the MTF to the SPOC upon receipt of the inquiry.

13.0. 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.

