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TRICARE
MANAGEMENT ACTIVITY

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SEPTEMBER 18, 2008

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: RESPITE CARE BENEFIT

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change includes the requirements necessary to
extend respite care benefits and other extended care benefits to members of the
Uniformed Services who incur a serious injury or illness while on active duty.

EFFECTIVE DATE: January 1, 2008.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Aug 2002 TPM, Change No. 89 and Aug
2002 TSM, Change No. 65.

for Laura Sells
Laura Sells

Chief, Purchased Care Procurement Branch

ATTACHMENT(S): 16 PAGES
DISTRIBUTION: 6010.51-M

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

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6010.51-M
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REMOVE PAGE(S)

CHAPTER 18

Table of Contents, page i

Section 3, pages 1 through 12

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INSERT PAGE(S)

Table of Contents, page i

Section 3, pages 1 through 13

Addendum C, pages 1 and 2

CIVILIAN CARE REFERRED BY MHS FACILITIES

SECTION	SUBJECT
1	GENERAL
	1.0. Introduction
	2.0. Military Service Participation In The SHCP
	3.0. Contractor Responsibilities
	4.0. Supplemental Health Care Program Differences
2	PROVIDERS OF CARE
	1.0. Civilian Providers
	2.0. Uniformed Services Family Health Plan (USFHP) (Formerly Uniformed Services Treatment Facilities [USTFs])
	3.0. Veteran's Affairs
3	CONTRACTOR RESPONSIBILITIES
	1.0. Contractor Receipt And Control Of SHCP Claims
	2.0. Coverage
	3.0. Enrollment Status Effect On Claims Processing
	4.0. Medical Records
	5.0. Reimbursement
	6.0. End Of Processing
	7.0. Claims Payments And Contractor Reimbursement
	8.0. TED Submittal
	9.0. Required Reports
	10.0. Contractor's Responsibility To Respond To Inquiries
	11.0. Dedicated SHCP Unit
4	PAYMENT FOR CONTRACTOR SERVICES RENDERED
	1.0. Voucher Submissions
	2.0. Audits And Inspection Of The Contractor's Records
5	POINTS OF CONTACT
	1.0. Service Project Officers
ADDENDUM A	POINTS OF CONTACT
	1.0. Service Project Officers
ADDENDUM B	DENTAL COVERAGE FOR ACTIVE DUTY SERVICE MEMBERS (ADSMS)
	2.0. Service Points Of Contact (SPOCs)
ADDENDUM C	DEFINITIONS, TERMS, AND LIMITATIONS AS APPLIED TO THE RESPITE BENEFIT UNDER THIS SECTION
	1.0. <i>Qualifying Condition For Receipt Of Respite Benefits</i>
	2.0. <i>Limitations On Respite Benefits</i>

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 (*TPR*) 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, copayment, 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 *Defense Enrollment Eligibility Reporting System* (DEERS) indication of eligibility. These are SHCP claims. SHCP shall not be used for TRICARE For Life (*TFL*) 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 (*RC*), 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 (*TOM*) and the TRICARE Policy Manual (*TPM*).

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 *TPM*, Chapter 12, TRICARE Overseas Program (*TOP*).

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. 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.

2.5. *Provision Of Respite Care For The Benefit Of Seriously Ill Or Injured Active Duty Members*

2.5.1. *The National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2008 established respite care and other extended care benefits for members of the Uniformed Services (including RC members) who incur a serious injury or illness while on active duty. The eligibility rules and exclusions contained in 32 CFR 199.5(e)(3) and (5) do not apply to the provision of respite benefits for an ADSM. See Addendum C for definitions, terms, and limitations applicable to the respite care benefit.*

2.5.2. *ADSMs may qualify for respite care benefits regardless of their enrollment status. ADSMs in the 50 United States and the District of Columbia may qualify if they are enrolled in TRICARE Prime, TPR, or not enrolled and receiving services in accordance with the non-enrolled/non-referred provisions for the use of SHCP funds. ADSMs outside the 50 United States and the District of Columbia may qualify if they are enrolled to TOP Prime (with enrollment to an MTF), TRICARE Global Remote Overseas (TGRO), TRICARE Puerto Rico, or not enrolled and receiving services in accordance with the non-enrolled/non-referred provisions for ADSM care overseas (see the TPM, Chapter 12).*

NOTE: *Respite care benefits must be performed by a TRICARE-authorized Home Health Agency (HHA), regardless of the ADSM's location (see 32 CFR 199.6(b)(4)(xv) for HHA definition).*

2.5.3. *There are no cost-shares or copays for ADSM respite benefits when those services are approved by the member's Direct Care System (DCS) case manager or other appropriate DCS authority (i.e., Military Medical Support Office (MMSO) Service Point of Contact (SPOC), the enrolled or referring MTF, TRICARE Area Office (TAO), or Community-Based Health Care Organization (CBHCO)).*

2.5.4. *All SHCP requirements and provisions of Chapters 17, 18, and 19 apply to this benefit unless changed or modified by this paragraph. The appropriate chapter for the status of the ADSM shall apply. Contractors shall follow the requirements and provisions of these chapters, to include MTF or MMSO referrals and authorizations, receipt and control of claims, authorization verification, reimbursement and payment mechanisms to providers, reimbursement specifying no cost-share, copay, or deductible to be paid by the ADSM, use of CHAMPUS Maximum Allowable Charges (CMACs)/ Diagnosis Related Groups (DRGs) when applicable, and TRICARE Encounter Data (TED) submittal.*

2.5.5. *Contractors shall follow the provisions of the TRICARE Systems Manual (TSM), Chapter 2, Sections 2.8 and 6.4 regarding the TED special processing code for the ADSM respite benefit. Claims should indicate an appropriate procedure code for respite care (CPT¹ 99600 or HCPCS S9122-S9124) and shall be reimbursed based upon the allowable charge or the negotiated rate.*

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2.5.6. *Respite care services and requirements are as follows:*

2.5.6.1. *Respite care is authorized for a member of the Uniformed Services on active duty and has a qualifying condition as defined in [Addendum C](#).*

2.5.6.2. *Respite care is available if an ADSM's plan of care includes frequent interventions by the primary caregiver(s).*

2.5.6.3. *ADSMs receiving respite care are eligible to receive a maximum of 40 respite hours in a calendar week, no more than five days per calendar week and no more than eight hours per calendar day. No additional benefit caps apply.*

2.5.6.4. *Respite benefits shall be provided by a TRICARE-authorized HHA and are intended to mirror the benefits under the TRICARE ECHO Home Health Care (EHHC) program described in the TPM, [Chapter 9, Section 15.1](#).*

NOTE: *Contractors are not required to enroll ADSMs in the ECHO program (or a comparable program) for this respite benefit.*

2.5.6.5. *Authorized respite care does not cover care for other dependents or others who may reside in or be visiting the ADSM's residence.*

2.5.6.6. *In addition, consistent with the requirement that respite care services shall be provided by a TRICARE-authorized HHA, services or items provided or prescribed by a member of the patient's family or a person living in the same household are excluded from respite care benefit coverage.*

2.5.6.7. *The contractor shall follow the reimbursement methodology for the similar respite care benefit found in the TPM, [Chapter 9](#), as modified by ADSM SHCP reimbursement methodology contained in [Chapters 17, 18, and 19](#) (for ADSMs located in the 50 United States and the District of Columbia) or TOP reimbursement methodology contained in the TPM, [Chapter 12](#) (for ADSMs located outside the 50 United States and the District of Columbia).*

2.5.7. *Should other services or supplies not outlined above, or otherwise available under the TRICARE program, be considered necessary for the care or treatment of an ADSM, a request may be submitted to the MMSO, MTF, or TAO for authorization of payment.*

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 *MOU* between the DoD (including the Army, Air Force and Navy/Marine Corps facilities) and the DHHS shall be processed in accordance with the requirements in this chapter. These are SHCP claims.

3.7. Claims for services provided under any local MOU between the DoD (including the Army, Air Force and Navy/Marine Corps facilities) and the 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 *MOU* 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, 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 **EOB** shall be prepared for each supplemental health care claim processed, and copies sent to the provider and the patient in accordance with normal claims processing procedures. For all claims pertaining to civilian services rendered to an MTF inpatient and for all other claims for which the MTF has authorized supplemental health care payment, the EOB will include the following statement, "This is a supplemental health care claim, not a TRICARE claim. Questions concerning the processing of this claim must be addressed to the TRICARE Service Center." Any standard TRICARE EOB messages which are applicable to the claim are also to be utilized, e.g., "No authorization on file."

6.2. Appeal Rights

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

7.0. CLAIMS PAYMENTS AND CONTRACTOR REIMBURSEMENT

7.1. Referred Care For MTF Inpatients

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

7.2. MTF Referred Outpatient Care

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

8.0. TED SUBMITTAL

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

9.0. REQUIRED REPORTS

Summary reports reflecting government dollars paid for supplemental health care claims shall be prepared and submitted to each Service Headquarters every month. Separate reports shall be produced for services rendered to Army National Guard members. All reports described below shall be submitted in electronic media in an Excel format. Payments for CCEP claims 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.](#)), will equal the total amount requested for reimbursement from TMA, Office of Contract Resource Management for each report. For those data elements in items ([paragraphs 9.1.1. through 9.1.3.](#)), which require a count, the contractor must ensure that no workload is double counted. Data elements to include in the reports are:

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

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

TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002

CHAPTER 18, SECTION 3

CONTRACTOR RESPONSIBILITIES

- 9.1.2. Total Number and Dollar Amount of Claims Paid
- 9.1.3. Inpatient Dollars Paid - Institutional
- 9.1.4. Inpatient Dollars Paid - Professional Services
- 9.1.5. Outpatient Dollars Paid - Clinic Visits (Professional and Ancillary Services)
- 9.1.6. Outpatient Dollars Paid - Ambulatory Surgeries/Procedures - Professional
- 9.1.7. Outpatient Dollars Paid - Ambulatory Surgeries/Procedures - Institutional
- 9.1.8. Total Admissions/Dispositions
- 9.1.9. Total Bed Days/*Length of Stay* (LOS)
- 9.1.10. Total Ambulatory Surgeries/Procedures, including all Ancillary
- 9.1.11. Total Outpatient Visits, excluding Ambulatory Surgeries but including all Ancillary related to the outpatient visits
- 9.1.12. CPT Codes/DRG/ICD-9 Codes
- 9.1.13. Other items paid
- 9.2. **Detailed Reports For Each MTF**
 - 9.2.1. Patient DMIS-ID Code (enrollment DMIS)
 - 9.2.2. Referring MTF's DMIS-ID code
 - 9.2.3. Patient Name/*Social Security Number* (SSN)
 - 9.2.4. Sponsor SSN
 - 9.2.5. Age/Sex/Beneficiary Category (ADSM, ADFM, NADSM, NADFM, TFL, TRICARE ineligible)
 - 9.2.6. MTF PCM (if available)
 - 9.2.7. Referring provider (if available)
 - 9.2.8. Civilian Provider's Name/Provider ID#
 - 9.2.9. Dates of Care (Outpatient or Inpatient Admission)
 - 9.2.10. Care End Date (FY - Month)
 - 9.2.11. Admitting Diagnoses (Primary/Secondary)

- 9.2.12. Dispositioning Diagnoses (Primary/Secondary)
- 9.2.13. CPT Codes/DRG/ICD-9 Codes Related to Inpatient Claim
- 9.2.14. Total Bed Days/*LOS* (Inpatient)
- 9.2.15. Inpatient Institutional \$ Paid
- 9.2.16. Inpatient Professional \$ Paid
- 9.2.17. CPT Codes/ICD-9 Codes Related to Outpatient Claim (including Professional and Ancillary Services)
- 9.2.18. Outpatient Clinic \$ Paid (Including Professional and Ancillary Services)
- 9.2.19. CPT Codes/ICD-9 Codes Related to Ambulatory Surgery/Procedure Claim (including Professional and Ancillary Services)
- 9.2.20. Ambulatory Surgery/Procedure \$ Paid (Professional)
- 9.2.21. Ambulatory Surgery/Procedure \$ Paid (Institutional)

9.3. Additional Reports

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

9.3.2. The contractor shall prepare a cover letter when forwarding reports, which identifies the reports being forwarded, the period being reported, the date the cover letter is prepared by the contractor, and a contractor 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, *Internal Control Number (ICN)*, patient's SSN, and the date the claim was processed to completion. This list shall be presented in ascending DMIS code order.

10.0. CONTRACTOR'S RESPONSIBILITY TO RESPOND TO INQUIRIES

10.1. Telephonic Inquiries

Inquiries relating to the SHCP need not be tracked nor reported separately from other inquiries received by the contractor. All inquiries to the contractor should come from MTFs/claims offices, the Service Project Officers or the TMA. In some instances, inquiries may come from Congressional offices, patients or providers. To facilitate this process, the contractor shall provide a specific telephone number, different from the public toll-free number, for inquiries related to the SHCP Claims Program. The line shall be operational and continuously staffed according to the hours and schedule specified in the contractor's TRICARE contract for toll-free and other service phone lines. It may be the same line as required in support of *TPR* under [Chapter 17](#) and may be the same line required under [Chapter 19](#). The telephone response standards of [Chapter 1, Section 3, paragraph 3.4](#) shall apply to SHCP telephonic inquiries.

10.1.1. Congressional Telephonic Inquiries

The contractor shall refer any congressional telephonic inquiries to the referring MTF if the inquiry is related to the authorization or non-authorization of a specific claim. If it

is a general congressional inquiry regarding the SHCP claims program, the contractor shall respond or refer the caller as appropriate.

10.1.2. Provider And Other Telephonic Inquiries

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

10.2. Written Inquiries

10.2.1. Congressional Written Inquiries

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

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

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

10.2.3. MTF Written Inquiries

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

11.0. DEDICATED SHCP UNIT

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

DEFINITIONS, TERMS, AND LIMITATIONS AS APPLIED TO THE RESPITE BENEFIT UNDER THIS SECTION

1.0. QUALIFYING CONDITION FOR RECEIPT OF RESPITE BENEFITS

For the purposes of receiving respite benefits, a qualifying condition is defined as a serious injury or illness resulting in, or based on the clinical assessment of the member's provider or case management team that will result in a physical disability, or an extraordinary physical or psychological condition.

1.1. Extraordinary Physical Or Psychological Condition

A complex physical or psychological clinical condition of such severity which results in the active duty beneficiary being homebound.

1.2. Homebound

A beneficiary's condition is such that there exists a normal inability to leave home and, consequently, leaving home would require considerable and taxing effort. Any absence of an individual from the home attributable to the need to receive health care treatment--including regular absences for the purpose of participating in rehabilitative, therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a state, or accredited to furnish adult day-care services in the state shall not disqualify an individual from being considered to be confined to home. Any other absence of an individual from the home shall not disqualify an individual if the absence is infrequent or of relatively short duration. Any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. Also, absences from the home for non-medical purposes, such as an occasional trip to the barber, a walk around the block or a drive, would not necessarily negate the beneficiary's homebound status if the absences are undertaken on an infrequent basis and are of relatively short duration. Absences, whether regular or infrequent, from the beneficiary's primary home for the purpose of attending an educational program in a public or private school that is licensed and/or certified by a state, shall not negate the beneficiary's homebound status.

1.3. Primary Caregiver

An individual who provides services to a beneficiary to support Activities of Daily Living (ADL) and specific services essential to the safe management of the beneficiary's condition.

1.4. ADL

Care that consists of providing food (including special diets), clothing and shelter; personal hygiene services; observation and general monitoring; bowel training or management (unless abnormalities in bowel function are of a severity to result in a need for medical or surgical intervention in the absence of skilled services); safety precautions; general preventive procedures (such as turning to prevent bedsores); passive exercise; companionship; recreation; transportation; and other such

elements of personal care that can reasonably be performed by an untrained adult with minimal instruction or supervision. ADL may also be referred to as "essentials of daily living".

1.5. Respite Care

Respite care is short-term care for a patient in order to provide rest and change for the primary caregivers who have been caring for the patient at home. Although this is usually the patient's family, it may be a relative or friend who assists the member with their ADL. Respite care consists of providing skilled and non-skilled services to a beneficiary such that in the absence of the primary caregiver, management of the beneficiary's qualifying condition and safety are provided. Respite care services are provided exclusively to the Active Duty Service Member (ADSM) beneficiary.

2.0. LIMITATIONS ON RESPITE BENEFITS

2.1. *Respite care is available for the member of the uniformed services with a qualifying condition. Respite care is available if an ADSM's plan of care includes frequent interventions by the primary caregiver(s).*

2.1.1. *The term "frequent" means "more than two interventions during the eight-hour period per day that the primary caregiver would normally be sleeping."*

2.2. *The services performed by the primary caregiver are those that can be performed safely and effectively by the average non-medical person without direct supervision of a health care provider after the primary caregiver has been trained by appropriate medical personnel.*

2.3. *Respite care services are limited to a maximum of eight hours per calendar day, five days per calendar week.*