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TRICARE
MANAGEMENT ACTIVITY

PCPB

CHANGE 72
6010.51-M
SEPTEMBER 29, 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: MAY 2007 CONSOLIDATED CHANGE

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

SUMMARY OF CHANGE(S): This change consists primarily of administrative changes and clarifications. Also included are the following: removal of requirement to send annual renewal letters to Active Duty Service Members (ADSMs) without dependents; revises DD2642 claim form; adds language regarding NASA Astronauts; extends Noble Eagle/Enduring Freedom Reserve Family Demonstration to 2009; excludes the use of the sponsor's Social Security Number (SSN) on the Monthly Health Insurance Portability and Accountability Act (HIPAA) Complaint Report; and clarifies preauthorized requirements for TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) claims

EFFECTIVE AND IMPLEMENTATION DATE: October 1, 2008.

This change is made in conjunction with Aug 2002 TPM, Change No. 90, Aug 2002 TRM, Change No. 83, and Aug 2002 TSM, Change No. 67.

for 
Laura Sells

Chief, Purchased Care Procurement Branch

ATTACHMENT(S): 85 PAGES
DISTRIBUTION: 6010.51-M

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

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CHAPTER 24

Section 1, pages 11 and 12

Section 1, pages 11 through 13

SUMMARY OF CHANGES

CHAPTER 1

1. Section 8, page 6. In paragraph 2.10.1, removed the words "Next Generation" from the reference to MHS Systems.

CHAPTER 6

2. Section 1, page 4. Paragraph 6.0 corrected the website where the enrollment applications are provided. Paragraph 7.1 added Active Duty Service Members before acronym (ADSMs). Paragraph 7.2 revised language to state "... there is no action required if an ADSM does not have enrolled family members".

CHAPTER 7

3. Section 1, page 5. Paragraph 7.5 clarified language regarding when acknowledgement must be completed by physician.

CHAPTER 8

4. Section 8, page 2. Paragraph 5.1 changed exceptions to include HIV, pregnancy and changed Venereal Disease to Sexually Transmitted Diseases. Paragraph 6.0 added TRICARE Management Activity before acronym (TMA).
5. Addendum A, pages 1 and 2. Added revised claim form; DD2642.

CHAPTER 11

6. Section 4, page 21. Paragraph 31.0 added note referencing Figure 3-A-4 requiring that cases 300 days delinquent with balances less than \$600 be written off and reported on line A.5.
7. Section 5, page 9. Changed the date of reporting requirements in paragraph 8.1 from January 31 to November 1.
8. Addendum B, page 19. Regarding State of New York - deleted Army references to offices other than U.S. Military Academy at West Point.

SUMMARY OF CHANGES (Continued)

CHAPTER 12

9. Section 1, pages 1 and 2. Deleted existing paragraph 2.2 and inserted new paragraph with language indicating TRICARE Beneficiary Publication Committee has replaced the MEC.

CHAPTER 13

10. Section 2, page 6. Revised sentence in paragraph 4.0 to reflect that the MCSC reconsideration determination is final if less than \$50 remains in dispute.
11. Addendum A, page 7. Revised Figure 13-A-5 to include fields stating that the MCSC reconsideration determination is final if less than \$50 remains in dispute.

CHAPTER 14

12. Section 6, page 7. Corrects cross-reference.

CHAPTER 16

13. Section 2, page 1. Deleted statement in paragraph 1.0 referring to the contractor making cash payments.
14. Section 2, page 3. Added language "completed credentialing packet" to requirement for resource sharing agreement in paragraph 3.1.

CHAPTER 17

15. Section 1, page 2. Inserted new paragraph 2.5, "Active Duty Service Member Astronauts assigned to the Johnson Space Center in Houston, Texas must and shall be enrolled in TPR."
16. Section 3, page 1. Added two new sentences regarding NASA Astronauts.

CHAPTER 18

17. Section 1, page 2. Deleted language that excluded SHCP claims in the quarterly claims audit and corrected cross-reference. Made corrections to acronyms.

SUMMARY OF CHANGES (Continued)

CHAPTER 19

18. Section 4, page 1. Deleted language that excludes SHCP claims in the TMA claims audit. Spelled out acronyms.

CHAPTER 20

19. Section 4, page 3. Extends the Noble Eagle/Enduring Freedom Reserve Family Demo to 2009.

CHAPTER 21

20. Section 3, page 6. Deleted language to exclude the use of the sponsor's SSN on the monthly HIPAA Complaint Report.

21. Section 3, page 11. Deleted language to exclude the use of the sponsor's SSN on the monthly HIPAA Complaint Report.

22. Addendum C, page 1. Deleted column in Figure 21-C-1, to exclude the use of the sponsor's SSN on the monthly HIPAA Complaint Report.

CHAPTER 22

23. Section 3, page 2. Reworded paragraph 4.3 regarding Preauthorization Requirements for TDEFIC claims.

24. Section 4, page 1. Paragraph 1.1 provided definition for acronyms. Paragraph 3.0 deleted text and inserted new text referencing the requirements in Chapter 14.

CHAPTER 24

25. Section 1, page 12. In paragraph 9.2.3., added language to reflect that collections for delinquency cases that have been transferred to TMA OGC-AC, shall be wire-transferred separately.

there is additional overage, the overage shall be applied to the next policy period when the policy is established on DEERS (i.e., 45 days prior to the expiration of the current policy).

2.6.3. When all contracts have transitioned to TNEX, DEERS will perform a final consolidation of all split families. DEERS will provide the incoming contractors with reports of the beneficiaries who have been consolidated. If needed, the incoming MCSC shall communicate to beneficiaries whose policies have been consolidated and apply any overage of fees to the next fee obligation. The fee overage must be applied first to the existing policy period. If there is additional overage, the overage shall be applied to the next policy period when the policy is established on DEERS (i.e., 45 days prior to the expiration of the current policy).

2.6.4. The incoming contractor shall send enrollment renewal notices for all enrollees whose current enrollment period expires *on or* after the start of health care delivery. The incoming contractor shall send billing statements where the enrollment fee payment would be due *on or* after the start of health care delivery. The incoming contractor shall start sending billing notices and process renewals 45 days prior to the start of health care.

2.6.5. *Outstanding enrollment record discrepancies and issues reported to the DEERS Support Office (DSO) by the outgoing contractor will be transferred to the incoming contractor for reconciliation. Records will be reconciled in accordance with TRICARE Systems Manual, Chapter 3, Section 1.6.*

2.7. Enrollment Fees

The incoming contractor shall obtain the cumulative total of enrollment fees and paid through dates for the policies from *the outgoing MCSCs* with the enrollment transition information. The contractor who collects the enrollment fee will retain the enrollment fee *based on the start date of the enrollment*. The incoming contractor shall resolve any discrepancies of cumulative enrollment fees and paid through dates with the outgoing contractor within 90 days of start of health care on policies inherited during the transition. The incoming contractor shall send the corrected fee information to DEERS using *DOES or* the batch fee interface outlined in the TRICARE Systems Manual, [Chapter 3](#).

2.8. Phase-In Requirements Related To The Health Care Finder Function

The hiring and training of Health Care Finder staff shall be completed no later than 40 calendar days prior to the start of health care delivery for TRICARE Prime in each Prime service area. Health Care Finder space will be occupied and all equipment and supplies in place not later than 40 calendar days prior to the start of health care delivery. The provider/beneficiary community shall be advised of the procedures for accessing the health care finder function no later than 40 calendar days prior to the start of health care delivery.

2.9. Phase-In Requirements Of The TRICARE Service Centers (TSCs)

2.9.1. In the event the incoming contractor will utilize the existing TSCs of the outgoing contractor, the outgoing contractor shall allow reasonable access to the incoming contractor throughout the Transition Period to install communication lines, equipment and other essential work to fully manage and operate the TSCs.

2.9.2. The final schedule for access to and occupancy of the TSCs will be determined at the Transition Specification Meeting. The approved schedule must allow the outgoing contractor to fulfill all contract requirements through the last day of health care delivery, and must provide the incoming contractor sufficient access to install equipment and train staff to undertake all required functions on the first day of health care delivery.

2.9.3. Acquisition Of Resources

All TRICARE Service Center and Field Representatives shall be fully trained and available for all duties no less than 40 calendar days prior to initiation of health care services.

2.10. Claims Processing System And Operations

During the period between the date of award and the start of health care delivery, the incoming contractor shall, pursuant to an implementation schedule approved by TMA, meet the following requirements:

2.10.1. Contractor File Conversions and Testing

The incoming contractor shall perform initial conversion and testing of all ADP files (e.g., provider files, pricing files, and beneficiary history) not later than 30 calendar days following receipt of the files from the outgoing contractor(s). All ADP file conversions shall be fully tested and operational for the Benchmark (see [paragraph 3.0.](#)). Integration testing will be conducted to validate the contractor's internal interfaces to each of the TRICARE MHS Systems. This testing will verify the contractor's system integration, functionality, and implementation process. The incoming contractor shall be responsible for the preparation and completion of Integration Testing prior to the start of Benchmark Testing.

TMA Test Managers will work with the contractor to plan, execute and evaluate the Integration Testing efforts. The contractor shall identify a primary and a back-up Testing Coordinator to work with the TMA Test Managers. The Testing Coordinator is responsible for contractor testing preparations, coordination of tests, identification of issues and their resolution, and verification of test results. A web application will be available for use by contractor Test Coordinators to report and track issues and problems identified during integration testing.

2.10.2. Receipt Of Outgoing Contractor's Weekly Shipment Of History Updates And Dual Operations

2.10.2.1. Beginning with the 120th calendar day prior to the start of health care delivery and continuing for 180 calendar days after the start of health care delivery, the incoming contractor shall convert the weekly shipments of the beneficiary history updates from the outgoing contractor(s) within two work days following receipt. The incoming contractor shall load enrollment year catastrophic cap totals from the outgoing contractor within two working days following receipt. These files shall be validated by the incoming contractor before use. Tests for claims, update of catastrophic cap, and duplicate claims shall be performed within two workdays following conversion. Following the start of health care delivery, these files shall be loaded to history and used for claims processing on the first processing cycle following the check for duplicate deductibles.

- Sponsor SSN (for family moves)
- Name of beneficiary

The contractor will perform direct care PCM reassignment moves within three working days of the effective date of the PCM's reassignment.

4.0. ENROLLMENT BY INDIVIDUAL OR FAMILY UNIT

Enrollment shall be on an individual or family basis. *For newborns and adoptees see the TRICARE Policy Manual, Chapter 10, Section 3.1.*

5.0. ENROLLMENT PROCESSING

In accordance with the agreement with the MTF Commander and the appropriate Regional Director and the provisions in the Regional Director Requirements, the contractor shall be responsible for enrollment processing and for coordinating enrollment processing with the MTF, the appropriate Regional Director, and DEERS. The contractor shall enter enrollments into DEERS using the government-furnished systems application. The contractor shall perform the following specific functions related to enrollment processing:

5.1. The contractor shall collect Prime service area enrollment applications at the TRICARE Service Centers or other sites mutually agreed to by the contractor, Regional Director, and the MTF Commander, or by mail. The contractor shall collect non-Prime service area enrollment applications by mail or other means determined by the contractor.

5.2. Family members of active duty E-1 through E-4 who reside within the Prime service area of a military medical treatment facility and who are not already enrolled in TRICARE Prime shall be encouraged to enroll upon in-processing or when otherwise identified as a candidate for enrollment in accordance with the provisions of [paragraph 10.0.](#), below.

5.3. At the time of enrollment processing, the contractor shall access DEERS to verify eligibility of enrollees and shall update the residential mailing address and any other fields for which they have update capability on DEERS. If the enrollment form does not contain a mailing address, the enrollment form should be developed for a mailing address. Enrollees may submit a temporary address (i.e., Post Office Box, Unit address, etc.), until a permanent address is established. Temporary addresses must be updated with the permanent address when provided to the contractor by the enrollee in accordance with the TRICARE Systems Manual, [Chapter 3, Section 1.5](#). Contractor shall not input temporary addresses **not** provided by the enrollee. If the DEERS record does not contain an address, or if the application contains information different from that contained on DEERS in fields for which the contractor does not have update capability, the contractor shall contact the beneficiary by telephone within five calendar days outlining the discrepant information and requesting that the beneficiary contact their military personnel information office.

5.4. The contractor shall electronically submit to DEERS updated records of enrollees and disenrollees using the government-furnished systems application DOES. MCSCs shall utilize DOES to correct system level Primary Care Information Transfer (PIT) enrollment data discrepancies (i.e., missing data), when PIT data discrepancies are communicated to the MCSC.

6.0. ENROLLMENT APPLICATIONS

The TRICARE Prime Enrollment Application and PCM Change Form (one combined form) and the TRICARE Prime Disenrollment Form will be provided by the government to the contractor via the *DoD* web site. The government will review and consider recommended changes and modifications to these forms from the contractors annually during a designated review cycle. The government will provide notification to the contractors at least 30 days prior to the beginning of the review period.

7.0. ENROLLMENT PERIOD

7.1. Effective Date Of Enrollment

Enrollment may occur any time during the contract period; however, all new enrollment periods shall coincide with the fiscal year. The incoming contractor shall inherit enrollments at transition that were established based on an enrollment year period. The incoming contractor shall align these enrollments to the fiscal year upon renewal of the enrollment period. The effective date of enrollment for *Active Duty Service Members (ADSMs)* shall be the date the contractor receives the signed enrollment application. All other enrollment periods shall begin on the first day of the month following the month in which the enrollment application and enrollment fee payment are received by the contractor. If an application and fee are received after the 20th day of the month, enrollment will be on the first day of the second month after the month in which the contractor received the application. Enrollees who transfer enrollment continue with the same enrollment period. The enrollment transfer, however, is effective the date the gaining contractor receives a signed enrollment application or transfer application. See TRICARE Policy Manual [Chapter 10, Sections 2.1 and 5.1](#) for information on TAMP and other changes in status.

7.2. Enrollment Expiration

No later than 30 calendar days before the expiration date of an enrollment, the contractor shall send the appropriate individual (sponsor, custodial parent, retiree, retiree family member, survivor or eligible former spouse, etc.) a written notification of the pending expiration and renewal of the TRICARE Prime enrollment, and a bill for the enrollment fee, if applicable (*since ADSMs must be enrolled but their family members need not be, there is no action required if an ADSM does not have enrolled family members*). The bill shall offer the various payment options: annual, quarterly or monthly. The contractor shall issue a delinquency notice to the appropriate individual 15 calendar days after the expiration date. The contractor shall automatically renew enrollments upon expiration unless the enrollee declines renewal, is no longer eligible for Prime enrollment, or fails to pay the enrollment fee on a timely basis, including any grace period allowed. The contractor shall allow a 30 calendar day grace period beginning the first day following the last day of the enrollment period. If the enrollee requests disenrollment during this grace period, the contractor shall disenroll the beneficiary effective retroactive to the enrollment period expiration date. The contractor may pend claims during the grace period to avoid the need to recoup overpayments. If an enrollee does not respond to the re-enrollment notification and fails to make an enrollment fee payment by the end of the grace period, the contractor is to assume that the enrollee has declined re-enrollment. The contractor shall disenroll the beneficiary retroactive to the enrollment

expiration date. DMDC sends written notification to the beneficiary of the disenrollment and the reason for the disenrollment within five business days of the disenrollment transaction.

7.3. Disenrollment

The contractor shall automatically disenroll beneficiaries when an enrollment fee payment, either the entire annual amount or an installment payment, is not received by the 30th calendar day following the annual expiration date or the due date for the installment payment. After the 30th calendar day, the contractor shall disenroll the beneficiaries with a disenrollment effective date retroactive to the annual renewal date or the payment due date, whichever applies. Prior to processing a disenrollment with a reason of "non-payment of fees," the MCSC or USFHP provider must reconcile their fee payment system against the fee totals in DEERS. Once the MCSC confirms that the payment amounts match, the disenrollment may be entered in DOES. The disenrolled beneficiary will be responsible for the deductible and cost-shares applicable under TRICARE Extra or Standard (depending on the provider's status) for any health care received during the 30 day grace period. In addition, the beneficiary shall be responsible for the cost of any services received during the 30 day grace period that may have been covered under TRICARE Prime but are not a benefit under TRICARE Extra or Standard, e.g., preventive care.

8.0. ENROLLMENT FEES

8.1. General

The contractor shall collect the enrollment fee payment from the TRICARE Prime enrollee, and report enrollment fees to DEERS (see the TRICARE Systems Manual, [Chapter 3](#)). The Prime enrollee shall select one of the three payment fee options on the Prime Enrollment Application Form:

- Annual Payment Fee Option. Annual installment will be collected in one lump sum. For initial enrollments and re-enrollments that are not yet aligned to the fiscal year, the contractor shall prorate the fee from the enrollment date to September 30. The contractor shall accept payment of the annual enrollment fee by personal check, cashier's check, traveler's check, money order or credit card (e.g., Visa/Master card).
- Quarterly Payment Fee Option. Quarterly installments are equal to one-fourth ($\frac{1}{4}$) of the total annual fee amount. For initial enrollments and re-enrollments that are not yet aligned to the fiscal year, the contractor shall prorate the quarterly fee to covering the period until the next fiscal year quarter (e.g., January 1, April 1, July 1, October 1) and collect quarterly fees thereafter through September 30. The contractor shall accept payment of the quarterly enrollment fee by personal check, cashier's check, traveler's check, money order or credit card (e.g., Visa/Master card).
- Monthly Payment Fee Option. Monthly installments are equal to one-twelfth ($\frac{1}{12}$) of the total annual fee amount. Monthly enrollment fees must be paid through an allotment from retirement pay or through electronic funds transfer (EFTs) from the enrollee's designated financial institution. Enrollees who elect the

monthly fee payment option must pay the first quarter installment (first 3 months) at the time the enrollment application is submitted to allow time for the allotment or EFT to be established. The contractor shall accept payment of the first quarterly installment by personal check, cashier's check, traveler's check, money order or credit card (e.g., Visa/Master card). The contractor shall be responsible for verifying the information necessary to initiate monthly allotments and EFTs. The contractor shall direct bill the beneficiary only when a problem occurs in initially setting up the allotment or EFT. In the event that there are insufficient funds to process a monthly EFT, the contractor may assess the account holder a fee of up to 20 U.S. dollars.

NOTE: During the enrollment year to fiscal year alignment process, (which occurs upon an initial enrollment or upon the first re-enrollment performed by the MCSC) enrollment fees will be prorated to the end of the current fiscal year (September 30th). The next enrollment period will begin on October 1st. At that point, the enrollment year is considered aligned with the fiscal year.

8.2. Member Category

The sponsor's member category on the effective date of the initial enrollment, as displayed in DOES, shall determine the requirement for an enrollment fee.

NOTE: Unremarried former spouses became sponsors in their own right as of October 1, 2003. However, although sponsors in their own right, they cannot "sponsor" any family members, including children. Enrolled unremarried former spouses must pay an annual individual enrollment fee. Children of unremarried former spouses residing with the unremarried former spouse, and whose eligibility for benefits is based on the ex-spouse (former sponsor) are identified under the ex-spouse's (former sponsor's) on DEERS and the enrollment record for the ex-spouse. A family enrollment fee must be collected and applied under the ex-spouse (former sponsor's) enrollment, in addition to the individual enrollment fee collected for the unremarried former spouse's enrollment fee. For example, a contractor will collect the annual enrollment fee for an unremarried former spouse, now a sponsor in their own right. The contractor will also collect an annual family enrollment fee for the eligible (as determined by the status of the ex-spouse [former and original sponsor] and not the unremarried former spouse) children living with the unremarried former spouse.

8.3. Overpayment Of Enrollment Fees

If enrollment fees are overpaid during the payment of installments during an enrollment year, MCS contractors can maintain a credit of those fees and apply the credit to any outstanding payments due. If credits of the overpayment of enrollment fees are not maintained, MCS contractors are required to refund any overpayments of \$1 or more. When TRICARE Prime enrollment changes from an individual to a family prior to annual renewal, the unused portion of the enrollment fee will be prorated on a monthly basis and shall be applied toward a new enrollment period.

8.4. Medicare Part B - Fee Waiver

Each Prime enrolled beneficiary under age 65, who maintains enrollment in Medicare Part B, is entitled to a \$230 waiver of their TRICARE Prime enrollment fee.

8.4.1. Each Prime enrolled beneficiary under age 65, who maintains enrollment in Medicare Part B, with a single enrollment will have no enrollment fee.

8.4.2. For a family enrollment in TRICARE Prime, where one family member is under age 65 and maintains enrollment in Medicare Part B, \$230 of the \$460 family enrollment fee is waived and the remaining \$230 must be paid. The \$230 enrollment fee shall be collected in accordance with the payment method selected on the enrollment form.

For a family enrollment in TRICARE Prime, where two or more family members are under age 65 and maintain enrollment in Medicare Part B, the \$460 family enrollment fee is waived regardless of the number of family members that are not entitled to Medicare Part B.

8.5. Mid-Month Enrollees

The contractor shall collect any applicable enrollment fee from the mid-month enrollee at the time of enrollment; however there will be no additional enrollment fee collected for the days between the effective enrollment date and the determined enrollment date. The determined enrollment date shall be determined using the existing 20th day of the month rule (e.g., A member submits a request to remain in Prime prior to his retirement date which is May 15th. The effective enrollment date will be May 15th and the determined enrollment date will be June 1st. If the retirement date is May 27th, the effective enrollment date will be May 27th and the determined enrollment date will be July 1st). Reference the TRICARE Policy Manual, [Chapter 10, Section 3.1](#).

9.0. ENROLLMENT/NETWORK PROVIDER TYPE ASSIGNMENT DURING IN-PROCESSING

9.1. The Managed Care Support Contractors (MCSCs) shall provide a process to enroll eligible beneficiaries into TRICARE programs using the TRICARE enrollment form. All TRICARE enrollments shall be performed through the government furnished DEERS application. Enrollment will include designation of a Primary Care Location in accordance with MTF MOUs. The Network Provider Type assignment shall be accomplished based on utilizing a Memorandum of Understanding (MOU), to be developed between each MTF within their region, appropriate Regional Director and the MCSC, to prescribe the Primary Care Location assignment business rules. Family members of active duty E-1 through E-4 who reside within the Prime service area of a military medical treatment facility and who are not already enrolled in TRICARE Prime should be encouraged to enroll upon in-processing or when otherwise identified as a candidate for enrollment in accordance with the provisions of [paragraph 10.0.](#), below.

9.2. The MCSCs shall administer the TRICARE enrollment form, verify accuracy of information and initiate the enrollment process through the DEERS enrollment application.

9.2.1. The equipment needed to run the DEERS desktop enrollment application shall be furnished by the MCSC and shall meet technical specifications in the TRICARE Systems Manual, [Chapter 3](#).

9.3. The MCSC representative will provide a current Primary Care Location listing to the enrollee during enrollment processing, and will provide guidance to the enrollee related to Primary Care Location selection. The MCSC representative will assign enrollees to Primary Care Locations until maximum capacity is reached. In accordance with approved MTF MOUs, the MTF will provide a listing of Primary Care Locations with associated groups.

9.4. The Defense Manpower Data Center (DMDC) will centrally print the Universal TRICARE Beneficiary Card generated from DMDC/DEERS enrollment data on a regular basis at the intervals and events required under current contract requirements. DMDC will centrally mail all Universal TRICARE Beneficiary Cards directly to the enrollee at the residential mailing address specified on the enrollment application. The return address on the envelope mailed by DMDC will be that of the respective MCS contractor. In the case of receiving returned mail, the MCSC shall develop a process to fulfill the delivery of the Universal TRICARE Beneficiary Card to the enrollee.

10.0. ENROLLMENT OF FAMILY MEMBERS OF E-1 THROUGH E-4

10.1. Section 712 of the National Defense Authorization Act for Fiscal Year 1999 modified Chapter 55 of Title 10, United States Code by adding a new section 1079a which provides for TRICARE Prime enrollment for active duty families of E-1 through E-4 in certain circumstances.

10.2. When family members of E-1 through E-4 reside in a Prime service area of a military medical treatment facility offering TRICARE Prime, the family members will be encouraged to enroll in TRICARE Prime. Upon enrollment, they will choose or be assigned a Primary Care Manager located in the military medical treatment facility. Such family members may, however, specifically decline such enrollment without adverse consequences. The choice of whether to enroll in TRICARE Prime, or to decline enrollment is completely voluntary. Family members of E-1 through E-4 who decline enrollment or who enroll in Prime and subsequently disenroll may re-enroll at any time.

10.3. Enrollment processing and allowance of civilian PCM assignments will be in accordance with the Memorandum of Understanding between the contractor and the MTF. The completion of an enrollment application is a prerequisite for enrollment of such family members.

10.4. The primary means of identification and subsequent referral for enrollment will occur during in-processing. These non-enrolled families may also be referred to the local TRICARE Service Center by the MTF, Commanders, First Sergeants/Sergeants Major, supervisors, Family Support Centers et. al.

10.5. The local TRICARE Service Center will provide enrollment information and support the family member in making an enrollment decision (i.e., to enroll in TRICARE Prime or to decline enrollment). The contractor shall inform the family members of the benefits and opportunities that accompany Prime enrollment and will give them the opportunity to select

or be assigned an MTF primary care manager, select a civilian PCM if permitted by applicable MOU, or to decline enrollment in TRICARE Prime. The effective date of enrollment shall be determined by the actual date of the enrollment application and consistent with current TRICARE rules (i.e., the “20th of the month” rule, as applied under the current contract arrangements).

10.6. The education of such potential enrollees shall specifically address the advantages of TRICARE Prime enrollment (e.g., guaranteed access, the support of a Primary Care Manager, etc.), shall reinforce that enrollment is at no cost for family members of E-1 through E-4, and shall discuss the potential effective date of the enrollment, explaining that the actual effective date will depend upon the date the enrollment application is received, consistent with current TRICARE rules (i.e., the “20th of the month” rule, as applied under the current contract arrangements).

10.7. Eligibility effective dates will be assigned consistently with all other TRICARE Prime enrollment policies, i.e., enrollments received on or before the 20th day of the month will become effective on the first day of the following month, etc. These enrollments and enrollment refusals should not be tracked, or the enrollees identified differently than enrollments initiated through any other process, such as the MCSC’s own marketing efforts.

10.8. Enrollment may be terminated at any time upon request of the enrollee, sponsor or other party as appropriate under existing enrollment/disenrollment procedures.

10.9. Contractors are not required to screen every TRICARE claim on an automated basis to determine whether it may be for treatment of a non-enrolled active duty family member of E-1 through E-4, living in a Prime service area. Rather, they are to support the prompt and informed enrollment of such individuals when they have been identified by DoD in the course of such a person’s interaction with the military health care system or personnel community, and have been referred to the contractor for enrollment.

11.0. TRICARE ELIGIBILITY CHANGES

11.1. Refer to the TRICARE Policy Manual, [Chapter 10, Section 3.1](#) for information on changes in eligibility. The contractor shall allow a TRICARE-eligible beneficiary who has less than 12 months of eligibility remaining (for example, a retiree or a family member who is 64 years of age, a TAMP beneficiary, etc.) to enroll in TRICARE Prime until such time as the enrollee loses his/her TRICARE eligibility. The enrollment transaction to DEERS shall reflect the end date of enrollment to be the same as the end date of eligibility on DEERS. The beneficiary shall have the choice of paying the entire enrollment fee or paying the fees on a more frequent basis (e.g., monthly or quarterly), as allowable under current instructions. If the enrollee chooses to pay by installments, the contractor shall collect only those installments required to cover the period of eligibility.

11.2. Contractors shall reimburse the unused portion of the TRICARE Prime enrollment fee to retired TRICARE Prime enrollees (and their families) who have been recalled to active duty and report such credits to DEERS. Contractors shall calculate the reimbursement using monthly pro-rating as defined in [Appendix A](#). If the reactivated member’s family chooses continued enrollment in TRICARE Prime, the family shall begin a new enrollment period and shall be offered the opportunity to keep its primary care manager, if possible. Any

enrollment/fiscal year catastrophic cap accumulations shall be applied to the new enrollment period.

11.3. The contractor shall reimburse enrollment fees when a written request with a copy of the death certificate have been received. Reimbursements shall be prorated on a monthly basis. This applies to an individual enrollment and to family enrollments that become individual plans upon the death of one or more family members. For individual enrollments, the contractor will refund remaining enrollment fees when the executor of the estate request reimbursement. For family enrollments, the contractor will make the necessary adjustments to convert the family enrollment to an individual enrollment when notified of the death of one of the two family enrollees. Enrollment fees for family enrollments of three or more members are not impacted upon the death of only one member. The contractor shall record reimbursements of fees in DEERS.

11.4. The MCSCs shall refund the unused portion of the TRICARE Prime enrollment fee to TRICARE Prime enrollees who become eligible for Medicare Part A based on disability, End Stage Renal Disease (ESRD), or upon attaining age 65 and have Medicare Part B coverage. The contractor shall calculate the refund using monthly pro-rating as defined in [Appendix A](#).

11.4.1. For Prime enrollees who become Medicare eligible upon attaining age 65 and maintain their Medicare Part B coverage, refunds are required for overpayments occurring on and after the start of health care delivery of all MCS contracts whose health care delivery began after March 31, 2004. The contractor shall utilize its files to substantiate any claim of overpayment.

11.4.2. For Prime enrollees who are under 65 years of age and become Medicare eligible due to disability or ESRD and have maintained their Medicare Part B coverage, refunds are required for overpayments starting on the date the enrollee has Medicare Part B, but no earlier than March 26, 1998. Beneficiaries must provide sufficient documentation to support the overpayment for a refund. The contractor shall supplement the beneficiaries' documentation using DEERS and any available internal files, both from the current and prior contracts.

11.4.3. The contractor is not required to research their files to identify these individuals. If the contractor receives a refund request, then the contractor shall refund the unused portion of the enrollment fee determined to be an overpayment in accordance with policy. Beneficiaries age 65 and over who are not entitled to premium free Medicare Part A remain eligible for TRICARE Prime.

NOTE: Medicare eligibles age 65 and over are not eligible to either enroll or remain in TRICARE Prime. Each Prime enrolled beneficiary under age 65 who is indicated on DEERS as having Medicare Parts A and B or who provides a copy of his/her Medicare card as proof of entitlement to Medicare Parts A and B, shall receive a \$230 waiver of their TRICARE Prime enrollment fee (see [paragraph 8.4](#)).

11.5. The contractor shall include full and complete information about the effects of changes in eligibility and rank in all beneficiary education materials and briefings.

12.0. WOUNDED, ILL, AND INJURED (WII) ENROLLMENT CLASSIFICATION

The WII program provides a continuum of integrated care from the point of injury to the return to duty or transition to active citizenship for the Active Component (AC) or the Reserve Component (RC) service members who have been activated for more than 30 days. These AC/RC service members, referred to as ADSMs, have been injured or become ill while on active duty and will remain in an active duty status while receiving medical care or undergoing physical disability processing. WII programs vary in name according to Service. The Service shall determine member eligibility for enrollment into a WII program, as well as whether or not to utilize these enrollments.

To better manage this population, a secondary enrollment classification of Health Care Delivery Program (HCDP) Plan Coverage Codes, WII 415 and WII 416 were developed. The primary rules apply to the WII HCDP codes:

- ADSMs must be enrolled to a TRICARE Prime program prior to, or at the same time, as being enrolled into a WII 415 or WII 416 program.
- A member cannot be enrolled in WII 415 and WII 416 programs at the same time.
- WII 415 and WII 416 enrollments will terminate at the end of the member's active duty eligibility, when members transfer enrollment to another MTF, change of a plan code, or at the direction of the Service-specific WII entity.
- Any claims processed for WII 415/416 enrollees shall follow the rules associated with the primary HCDP Plan Coverage Code, such as TRICARE Prime, TRICARE Prime Remote (TPR), TRICARE Overseas Program (TOP) Prime, or TRICARE Puerto Rico Contract (TPRC). All claims will process and pay under Supplemental Health Care Program (SHCP) rules. DEERS will not produce specific enrollment cards or letters for WII 415/416 enrollment.

WII 415/416 TRICARE Encounter Data (TED) records shall be coded with the WII 415/416 HCDP Plan Coverage Code; however, the Enrollment/Health Plan Code data element on the TED record shall reflect the appropriate value for the primary HCDP Plan Coverage Code. For example, a TED record for a WII 416 enrollee with primary enrollment to TPR would reflect the HCDP Plan Coverage Code of "416" but the Enrollment/Health Plan Code would be coded "W TPR Active Duty Service Member".

12.1. WII 415 - Wounded, Ill, And Injured (e.g., Warrior Transition/MEDHOLD Unit (WTU))

12.1.1. Service defined eligible ADSMs assigned to a WII 415 Program such as a MEDHOLD or WTU shall be enrolled to TRICARE Prime or TOP Prime prior to, or at the same time, as being enrolled into the WII 415. Members cannot be enrolled to the WII 415 without a concurrent TRICARE Prime or TOP Prime enrollment. Service appointed WII case managers as determined by the Services, will coordinate with the MTF to facilitate TRICARE Prime PCM assignments for WII 415 members. The contractor shall then assign a PCM in accordance with the MTF MOU and in coordination with the WII case manager. WII 415 enrollment will not run in conjunction with Transitional Assistance Management Program

(TAMP) and members enrolled in TPR, TRICARE Global Remote Overseas (TGRO), or TPRC are not eligible to enroll in the WII 415.

12.1.2. The Service-specific WII entity will stamp the front page of the DD Form 2876, enrollment application form, with WII 415 for new enrollments that begin after the DEERS implementation date. The enrollment form will then be sent to the appropriate contractor or TRICARE Area Office (TAO) who shall perform the enrollment in the Defense Online Enrollment System (DOES) and include the following information:

- WII 415 HCDP Plan Coverage Code
- WII 415 Enrollment Start Date (Contractors may change the DOES defaulted start date, which may or may not coincide with the Prime Enrollment start date. The start date can be changed up to 289 days in the past or 90 days into the future.)

12.1.3. WII 415 enrollments will be in conjunction with an MTF enrollment only, not to civilian network PCMs under TPR enrollment rules. DEERS will end WII 415 enrollments upon loss of member's active duty eligibility. WII 415 program enrollments will not be portable across programs or regions. TAOs will enter WII 415 enrollments through DOES for Outside the Continental United States (OCONUS) regions.

12.1.4. The contractors shall accomplish the following functions based on receipt of notification from the Service-specific WII program entities:

- Enrollment
- Disenrollment
- Cancel enrollment
- Cancel disenrollment
- Address update
- MCSC can request Policy Notification Transaction (PNT) resend
- Modify begin date
- Modify end date

12.1.5. Service WII entities will provide contractors/TAOs a list by name and Social Security Number (SSN) of those ADSMs currently assigned to their WII program at the time the program is implemented by DEERS. The contractors/TAOs shall enter these ADSMs into DOES as enrolled in WII 415 with a start date of the date of implementation, unless another date, up to 289 days in the past, is provided by the WII entity.

12.2. WII 416 - Wounded, Ill, And Injured - Community-Based (e.g., Community-Based Health Care Organization (CBHCO))

12.2.1. Service defined eligible ADSMs may be assigned to a WII 416 Program such as the Army's CBHCO and receive required medical care near the member's home. The service member shall be enrolled to TRICARE Prime, TPR, TGRO, or TPRC prior to or at the same time as being enrolled into WII 416. Members cannot be enrolled to the WII 416 program without a concurrent Prime, TPR, TGRO, or TPRC enrollment. Service appointed case managers will coordinate with the contractor or MTF to facilitate TRICARE Prime or TPR

PCM assignments for eligible beneficiaries. The contractor shall then assign a PCM based on the MTF MOU and in coordination with the WII entity (e.g., CBHCO). WII 416 enrollments will not run in conjunction with TAMP.

12.2.2. The Service-specific WII Program will stamp the front page of the DD Form 2876, enrollment application form, with WII 416 for all new enrollments. The begin date will be the date the contractors receive the signed enrollment form. The enrollment form will then be sent to the appropriate contractor or TAO who shall perform the enrollment in the DOES and include the following information:

- WII 416 HCDP Plan Coverage Code
- WII 416 Enrollment Start Date (Date received by the contractor or the date indicated by the Service-specific WII Program which can be up to 289 days in the past, or 90 days in the future.)

12.2.3. WII 416 enrollments can be in conjunction with an MTF, TPR, TGRO, or TPRC enrollment. DEERS will end WII 416 enrollments upon loss of member's active duty eligibility. WII 416 program enrollments will not be portable across programs or regions. TAOs will enter WII 416 enrollments through DOES for OCONUS regions.

12.2.4. The contractors shall accomplish the following functions based on receipt of notification from Service-specific WII program entities:

- Enrollment
- Disenrollment
- Cancel enrollment
- Cancel disenrollment
- Address update
- Contractors can request PNT resend
- Modify begin date
- Modify end date

12.2.5. Service-specific WII entities will provide contractors/TAOs a list by name and SSN of those ADSMs currently participating in their WII program at the time the program is implemented by DMDC. The contractors/TAOs shall enter these ADSMs into DOES as enrolled to WII 416 with a start date as the date of implementation, unless another date up to 289 days in the past is provided by the Service-specific WII program entities.

information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.”

7.5. The acknowledgment must be completed by the physician *either before or* at the time that the physician is granted admitting privileges at the hospital, or at the time the physician admits his or her first patient. Existing acknowledgments signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital.

7.6. Outlier Review

Claims that qualify for additional payment as a cost-outlier shall be subject to review to ensure that the costs were medically necessary and appropriate and met all other requirements for payment. In addition, claims that qualify as short-stay outliers shall be reviewed to ensure that the admission was medically necessary and appropriate and that the discharge was not premature.

7.7. Procedures Regarding Certain Services Not Covered By The DRG-Based Payment System

In implementing the quality and utilization review for services not covered by the DRG-based payment system, the requirements of this section shall pertain except that ICD-9 and CPT-4 codes will provide the basis for determining whether diagnostic and procedural information is correct and matches information contained in the medical records.

8.0. RETROSPECTIVE REVIEW REQUIREMENTS FOR OTHER THAN DRG VALIDATION

The contractor shall conduct quarterly focused reviews of a one percent sample of medical records to determine the medical necessity and quality of care provided, validate the review determinations made by review staff, and determine if the diagnostic and procedural information and/or discharge status of the patient as reported on the hospital and/or professional provider’s claim matches the attending physician’s description of care and services documented in the medical record. The specific types of records to be sampled shall be determined separately by each Regional Director who will provide the contractor with the sampling criteria (DRG, diagnosis, procedure, length of stay, provider, incident or occurrence as reported on claim forms) 60 calendar days prior to the quarter from which the review sample is drawn. Within the parameters provided by each Regional Director, the contractor shall ensure that each sample is statistically valid. For all cases selected for retrospective review, the following review activities shall occur:

8.1. Admission Review

The medical record must indicate that inpatient hospital care was medically necessary and provided at the appropriate level of care.

8.2. Invasive Procedure Review

The performance of unnecessary procedures may represent a quality and/or utilization problem. In addition, the presence of codes of procedures often affects DRG

classification. Therefore, for every case under review, the medical record must support the medical necessity of the procedure performed. For this purpose, invasive procedures are defined as all surgical and any other procedures which affect DRG assignment.

8.3. Discharge Review

Records shall be reviewed using appropriate criteria for questionable discharges or other potential quality problems.

8.4. Mental Health Review

The contractor shall review all mental health claims in accordance with the provisions in [32 CFR 199.4\(a\)\(11\)](#) and [\(a\)\(12\)](#).

9.0. REVIEW RESULTS

9.1. Actions As A Result Of Retrospective Review Related To Individual Claims

If it is determined, based upon information obtained during reviews, that a hospital has misrepresented admission, discharge, or billing information, or is found to have quality of care defects, or has taken an action that results in the unnecessary admission of an individual entitled to benefits, unnecessary multiple admission of an individual, or other inappropriate medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries, the contractor shall, as appropriate:

- Deny payment for or recoup (in whole or in part) any amount claimed or paid for the inpatient hospital and professional services related to such determination;
- Require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice;
- Advise the provider and beneficiary of appeal rights, as required by [Chapter 13, Section 4, paragraph 2.0](#).

9.2. Findings Related To A Pattern Of Inappropriate Practices

The contractor shall notify TMA of the hospital and practice involved in all cases where a pattern of inappropriate admissions and billing practices that have the effect of circumventing the TRICARE DRG-based payment system is identified.

9.3. Revision Of Coding Relating To DRG Validation

The contractor shall ensure the application of the following provisions in connection with the DRG validation process.

- If the diagnostic and procedural information attested to by the attending physician is found to be inconsistent with the hospital's coding or DRG assignment, the hospital's coding on the TRICARE claim shall be appropriately

changed and payments recalculated on the basis of the appropriate DRG assignment.

- If the information attested to by the physician as stipulated in [paragraph 7.3](#) is found not to be correct, the contractor shall change the coding and assign the appropriate DRG on the basis of the changed coding in accordance with the paragraph above.

9.4. Notice Of Changes As A Result Of A DRG Validation

The contractor shall notify the provider and practitioner of changes to procedural and diagnostic information that result in a change of DRG assignment within 30 calendar days of the contractor's decision. The notice must be understandable and written in English and shall contain:

- The corrected DRG assignment;
- The reason for the change resulting from the DRG validation;
- A statement addressing who is liable for payment of denied services (e.g., a beneficiary will be liable if the change in DRG assignment results in noncoverage of a furnished service);
- A statement informing each party (or his or her representative) of the right to request a review of a change resulting from DRG validation in accordance with the provisions in [paragraph 9.5](#);
- The locations for filing a request for review and the time period within which a request must be filed; and
- A statement concerning the duties and functions of the multi-function PRO.

9.5. Review Of DRG Coding Change

9.5.1. A provider or practitioner dissatisfied with a change to the diagnostic or procedural coding information made by the contractor as a result of DRG validation is entitled to a review of that change if the change caused an assignment of a different DRG and resulted in a lower payment. A beneficiary may obtain a review of the contractor's DRG coding change only if that change results in noncoverage of a furnished service (see 42 CFR 478.15(a)(2)).

9.5.2. The individual who reviews changes in DRG procedural or diagnostic information shall be a physician, and the individual who reviews changes in DRG coding must be qualified through training and experience with ICD-9-CM coding.

9.5.3. The contractor shall issue written notification of the results of the DRG validation review within 60 days of receipt of the request for review. In the notification, the contractor shall summarize the issue under review and discuss the additional information relevant to such issue. The notification shall state the contractor's decision and fully state the reasons

that were the basis for the decision with clear and complete rationale. The notification shall include a statement that the decision is final and no further reviews are available.

10.0. PREPAYMENT REVIEW

10.1. The contractor shall establish procedures and conduct prepayment utilization review to address those cases involving diagnoses requiring prospective review, where such review was not obtained, to focus on program exclusions and limitations and to assist in the detection of and/or control of fraud and abuse. The contractor shall not be excused from claims processing cycle time standards because of this requirement.

10.2. The contractor shall perform prepayment review of all cases involving diagnoses requiring preauthorization where review was not obtained. No otherwise covered care shall be denied solely on the basis that authorization was not requested in advance, except for care provided by a network provider.

10.3. The contractor shall perform prepayment review of all DRG claim adjustments submitted by a provider which result in higher weighted DRGs.

10.4. Payment reduction for noncompliance with required utilization review procedures shall apply to any case in which a provider was required to obtain preauthorization or continued stay (in connection with required concurrent review procedures) approval; the provider failed to obtain the necessary approval, and the health care services were not disallowed on the basis of necessity or appropriateness. In a case described in this section, reimbursement will be reduced unless such reduction is waived by the contractor based on special circumstances. The amount of the reduction for TRICARE Standard providers will be ten percent of the amount otherwise allowable for services for which preauthorization (including preauthorization for continued stays in connection with concurrent review requirements) approval should have been obtained but was not obtained. The amount of this reduction for network providers shall be in accordance with the provider's contract with the contractor but not less than ten percent.

10.5. The amount of this reduction for a non-network attending physician shall be ten percent of the amount otherwise allowable for services for which preauthorization (including preauthorization for continued stays in connection with concurrent review requirements) approval should have been obtained but was not obtained. Payment reduction for network providers will be subject to the provisions of their respective contracts.

10.6. In the case of hospital admissions reimbursed under the DRG-based payment system, the reduction shall be taken against the percentage (between zero and 100 percent) of the total reimbursement equal to the number of days of care provided without preauthorization approval divided by the total length of stay for the admission.

10.7. In the case of institutional payments based on per diem payments, the reduction shall be taken only against the days of care provided without preauthorization approval.

10.8. For care for which payment is on a per service basis, the reduction shall be taken only against the amount that relates to the services provided without preauthorization approval.

10.9. Unless otherwise specifically provided under procedures issued by the Director, TMA, the effective date of any preauthorization approval shall be the date on which a properly submitted request was received by the review organization designated for that purpose.

10.10. The payment reduction set forth in this section may be waived by the contractor when the provider could not reasonably have been expected to know of the preauthorization requirement or some other special circumstances where the provider may not have known the requirements and that the contractor believes justifies the waiver.

10.11. Services for which payment is disallowed may not be billed to the patient or the patient's family.

11.0. CASE MANAGEMENT

Case management shall not be accomplished for beneficiaries eligible for Medicare Part A and Enrolled in Medicare Part B unless it is specifically contracted for inside an individual MTF or if the individual is part of the Individual Case Management Program for Persons with Extraordinary Conditions (ICMP-PEC).

12.0. CONFIDENTIALITY APPLICABLE TO ALL UTILIZATION MANAGEMENT ACTIVITIES, INCLUDING RECOMMENDATIONS AND FINDINGS

12.1. The contractor shall develop and implement procedures, processes, and policies that meet the confidentiality and disclosure requirements set forth in Title 10, U.S.C., Chapter 55, Section 1102; the Social Security Act, Section 1160, and implementing regulations at 42 CFR 476, the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) Reorganization Act (42 U.S.C. 290dd-2), the Privacy Act (5 U.S.C.552a), [32 CFR 199.15\(j\)](#) and [\(l\)](#). Additionally, the contractor shall display the following message on all quality assurance documents:

"Quality Assurance document under 10 U.S.C. 1102. Copies of this document, enclosures thereto, and information therefrom will not be further released under penalties of law. Unauthorized disclosure carries a possible \$3,000 fine."

12.1.1. Release of Information - If an inquiry is made by the beneficiary, including an eligible family member (child) regardless of age, the reply should be addressed to the beneficiary, not the beneficiary's parent or guardian. The only exceptions are when a parent writes on behalf of a minor child or a guardian writes on behalf of a physically or mentally incompetent beneficiary. The contractor must not provide information to parents/guardians of minors or incompetents when the services are related to the following diagnoses:

- Abortion
- Alcoholism
- Substance Abuse
- Venereal Disease
- AIDS

12.2. The term “minor” means any person who has not attained the age of 18 years. Generally, the parent of a minor beneficiary and the legally appointed guardian of an incompetent beneficiary shall be presumed to have been appointed the representative without specific designation by the beneficiary. Therefore, for beneficiaries who are under the age of 18 years or who are incompetent, a notice issued to the parent or guardian, under established TRICARE procedures, constitutes notice to the beneficiary.

12.3. If a beneficiary has been legally declared an emancipated minor, they are to be considered as an adult. If the beneficiary is under 18 years of age and is (or was) a spouse of an active duty service member or retiree, they are considered to be an emancipated minor.

13.0. DOCUMENTATION

The contractor shall develop and implement a program for providing beneficiaries and providers with the written results of all review activities affecting benefit determinations. All notifications to beneficiaries and providers shall be completed and mailed within the time limits established for the completion of reviews in this section. Notifications of denials shall include: patient’s name, sponsor’s name and last four digits of their social security number, the clinical rationale for denial of payment for specific services (form letters are unacceptable as the clinical rationale shall provide a complete explanation, referencing any and all appropriate documentation, for the cause of the denial), all applicable appeal and grievance procedures, and the name and telephone number of an individual from whom additional information may be obtained.

EXPLANATION OF BENEFITS (EOBs)

1.0. BENEFICIARY, PARENT/GUARDIAN

The contractor shall issue and mail an appropriate and easily understood EOB to the beneficiary (parent/guardian for minors or incompetents) for each claim processed to a final determination. In those circumstances where the beneficiary has no “out of pocket” expenses, including deductibles or cost-shares, and there are no denied charges included on the claim for which he/she is, or may be, responsible, issuance of an EOB may be waived. (For the purpose of issuing EOBs, Prime beneficiary copayments are not considered out-of-pocket expenses.) When an EOB is required, it must be issued to the beneficiary regardless of whether or not the provider is a participating provider and whether or not an actual payment is involved; e.g., allowed amount is applied to the deductible or payment is \$.99 or less and no check is mailed.

2.0. NON-PARTICIPATING PROVIDER

The EOB shall be provided to the non-participating provider with the amount allowed so that he/she can determine what amount may be billed to the beneficiary under the balance billing provision (115% of the TRICARE allowable charge). When a claim for service from a non-participating provider is allowed at the billed charge, the EOB, at the contractor’s discretion, need not be sent to the non-participating provider since the balance billing provision does not apply. Only the charges of the non-participating provider would normally appear on the EOB; however, the non-participating provider should only be provided with information where there is a “need to know.” This means that if other information appears on the EOB that does not pertain to the non-participating provider, the TRICARE contractor is to suppress printing or remove it before sending the EOB to the non-participating provider. The non-participating provider will receive only the EOB and the beneficiary will receive the TRICARE payment.

3.0. PARTICIPATING PROVIDERS

The contractor shall also issue EOBs to participating providers or issue summary vouchers covering multiple claims and beneficiaries in lieu of issuing multiple EOBs. Sufficient information must be included on the vouchers to identify each beneficiary and explain the payment for each line item on each claim. Use of a summary voucher does not change the requirement for a separate EOB to be sent to each beneficiary for each claim. Each contractor shall include adequate identification of the fiscal year involved applicable to the various charges listed on the EOB to help keep the deductible information clear to the beneficiary.

4.0. STATE MEDICAID AGENCY

If the claim is from a state Medicaid agency, the EOB copy usually sent to a participating provider shall be sent to the state agency. The contractor shall include the same information on the copy sent to the state as it normally sends to participating providers. If the state has a need which cannot be accommodated except at extra expense, the contractor may negotiate with the state, if it chooses, and if the state is willing to pay for the accommodation.

5.0. EOB ISSUANCE EXCEPTIONS

5.1. Contractors shall not issue EOBs to beneficiaries (parents/guardians of minors or incompetents) when claims involve services related to any of the following diagnoses:

- Abortion
- AIDS/*HIV*
- Alcoholism
- *Pregnancy*
- Substance Abuse
- *Sexually Transmitted Diseases*

5.2. EOBs must be issued to participating providers, except as noted above. The contractor shall provide an EOB to a beneficiary upon request. When a request is made for a normally suppressed EOB, the copy provided may be a facsimile or a hand-produced copy. It must, however, include the required data and be certified by the contractor.

5.3. When a service(s) is denied due to an abortion, a letter of explanation shall be sent, but only when the denial is questioned by the beneficiary. [Chapter 8, Addendum A, Figure 8-A-4](#) provides suggested wording for abortion claims that are denied. **The explanation shall be provided only to the beneficiary and participating provider.** The special denial letter shall be sent in an envelope marked "personal". **It is EMPHASIZED that using an Explanation of Benefits is NOT acceptable for denial of abortion services.** Only an approved letter may be used.

6.0. PROCEDURES FOR INFORMING THE BENEFICIARY OF CLAIM ACTION

The processing of claims for the diagnoses listed above, requires sensitivity to the beneficiary's right to privacy. Because of the need for contractors to apply reasonable judgment on a case-by-case basis, *TRICARE Management Activity (TMA)* has not prescribed specific procedures except in the case of abortion claims. For claims involving services and supplies for the other diagnoses, a phone call to the beneficiary may serve to obtain information on how the beneficiary wishes to have the EOB handled in some instances. In other cases, a request that the provider serve as an intermediary, or a personal letter to the beneficiary, using a plain envelope, may be appropriate. Whatever approach is chosen, contractors must observe the intent, as well as the letter, of the Privacy Act.

7.0. PAYMENT TO THE PROVIDER OR BENEFICIARY IS 99 CENTS OR LESS

Summary voucher payments or individual claims payment checks for \$.99 or less, shall be written by the contractor, but NOT mailed to the beneficiary or provider, using an

appropriate EOB message. The checks shall be voided and processed as outlined in [Chapter 3, Section 8](#). At the end of the year when the contractor issues the provider's Form 1099, the withheld amounts shall NOT be shown on the Form 1099.

8.0. EOB FORMAT

The form design of the EOB is not specifically prescribed. Contractors shall design the form to fit their individual equipment and system needs. The contractor shall provide their toll-free inquiry number on the EOB. Only the last four digits of the Social Security Number shall appear on the EOB.

9.0. REVERSE OF THE EOB FORM

The following information shall be on the reverse of the EOB:

Right To Appeal

If you disagree with the determination on your claim, you have the right to request a reconsideration. Your signed written request must state the specific matter with which you disagree and **MUST** be sent to the following address no later than 90 days from the date of this notice. If the postmark on the envelope is not legible, then the date of receipt is deemed the date of filing. Include a copy of this notice. On receiving your request, all TRICARE claims for the entire course of treatment will be reviewed.

(Contractor's Address)

FIGURES

FIGURE 8-A-1 DD FORM 2642

TRICARE DoD/CHAMPUS MEDICAL CLAIM PATIENT'S REQUEST FOR MEDICAL PAYMENT		OMB No. 0720-0006 OMB approval expires Aug 31, 2009
<p><small>The public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services Directorate (0720-0005). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.</small></p> <p>PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM TO THE APPROPRIATE CLAIMS PROCESSOR. IF YOU DO NOT KNOW WHO YOUR CLAIMS PROCESSOR IS, CONTACT A BENEFICIARY COUNSELING AND ASSISTANCE COORDINATOR (BCAC) OR TRICARE MANAGEMENT ACTIVITY (303) 676-3400.</p>		
PRIVACY ACT STATEMENT		
<p>AUTHORITY: 44 U.S.C. 3101, 10 U.S.C. 1079 and 1086; 38 U.S.C. 1781; E.O. 9397.</p> <p>PRINCIPAL PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.</p> <p>ROUTINE USE(S): Information from claims and related documents may be given to the Department of Health and Human Services and/or the Department of Homeland Security consistent with their statutory administrative responsibilities under CHAMPUS; to the Department of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service and private collection agencies in connection with recoupment claims; and to Congressional offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.</p> <p>DISCLOSURE: Voluntary, however, failure to provide information will result in delay in payment or may result in denial of claim.</p>		
IMPORTANT - READ CAREFULLY		
<p>Federal Laws (18 U.S.C. 287 and 1001) provide for criminal penalties for knowingly submitting or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States. Examples of fraud include situations in which ineligible persons knowingly use an unauthorized Identification Card in filing of a CHAMPUS claim; or where providers submit claims for treatment, supplies or equipment not rendered to, or used for TRICARE DoD/CHAMPUS beneficiaries; or where a participating provider bills the beneficiary/patient (or sponsor) for amounts over the CHAMPUS-determined allowable charge; or where a beneficiary/patient (or sponsor) fails to disclose other medical benefits or health insurance coverage.</p>		
INCOMPLETE CLAIM FORMS WILL DELAY PAYMENT		
<p>NONAVAILABILITY STATEMENT REQUIREMENTS: If the patient resides within the catchment area of a Military Treatment Facility (MTF) (generally within a 40-mile radius of the MTF), you will need to obtain a Nonavailability Statement (NAS) from the MTF for a hospital admission for mental health that is not a <u>bona fide emergency</u>. Without a necessary NAS your claim will be denied.</p> <p style="text-align: center;">*****</p> <p>ITEMIZED BILL: Ask your provider to complete the HCFA Form 1500 for you. If the provider refuses, complete this form and attach an itemized bill which must be on the provider's billing letterhead. The bill must contain the following information:</p> <ol style="list-style-type: none"> 1. Doctor's or provider's name/address (the one that actually provided your care). If there is more than one provider on the bill, circle his/her name; 2. Date of each service; 3. Place of each service; 4. Description of each surgical or medical service or supply furnished; 5. Charge for each service; 6. The diagnosis should be included on the bill. If not, make sure that you've completed block 8a on the form. <p>DRUGS: Prescription claims require the name of the patient; the name, strength, date filled, days supply, quantity dispensed, and price of each drug; NDC for each drug if available, the prescription number of each drug; the name and address of the pharmacy; and the name and address of the prescribing physician. Billing statements showing only total charges, or canceled checks, or cash register and similar type receipts are not acceptable as itemized statements, unless the receipt provides detailed information required above.</p> <p style="text-align: center;">*****</p> <p>TIMELY FILING REQUIREMENTS: All claims must be filed no later than one year after the services are provided; or for inpatient care, one year from the date of discharge. If a claim is returned for additional information, it must be resubmitted by the filing deadline, or within 90 days of the notice -- whichever date is later.</p> <p style="text-align: center;">*****</p> <p>WHERE TO OBTAIN ADDITIONAL FORMS: You may obtain additional claim forms from your claims processor, the TRICARE Service Center at the nearest military treatment facility or TRICARE Management Activity, 16401 E. Centretch Pkwy., Aurora, CO 80011-9066.</p> <p style="text-align: center;">*** REMINDER ***</p> <p>Before submitting your claim to the claims processor be sure that you have:</p> <ol style="list-style-type: none"> 1. Completed all 12 blocks on the form. <i>If not signed, the claim will be returned.</i> 2. Verified that the sponsor's SSN is correct. 3. Attached your provider's or supplier's bill which specifically identifies the doctor/supplier that provided your care. 4. Attached an Explanation of Benefits if there is other health insurance, Medicare, or Medicare supplemental insurance. 5. Obtained a Nonavailability Statement if required (see information above). 6. Attached DD Form 2527, "Statement of Personal Injury - Possible Third Party Liability TRICARE Management Activity" if accident or work related. See instruction number 7 on reverse side. 7. Ensured that patient's name, sponsor's name and sponsor's SSN are on all attachments. 8. Made a copy of this claim and attachments for your records. 		

TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002

CHAPTER 8, ADDENDUM A

FIGURES

FIGURE 8-A-1 DD FORM 2642 (CONTINUED)

1. PATIENT'S NAME (Last, First, Middle Initial)		2. PATIENT'S TELEPHONE NUMBER (Include Area Code) DAYTIME () EVENING ()	
3. PATIENT'S ADDRESS (Street, Apt. No., City, State, and ZIP Code)		4. PATIENT'S RELATIONSHIP TO SPONSOR (X one) <input type="checkbox"/> SELF <input type="checkbox"/> STEPCCHILD <input type="checkbox"/> SPOUSE <input type="checkbox"/> FORMER SPOUSE <input type="checkbox"/> NATURAL OR ADOPTED CHILD <input type="checkbox"/> OTHER (Specify)	
5. PATIENT'S DATE OF BIRTH (YYYYMMDD)	6. PATIENT'S SEX (X one) <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	7. IS PATIENT'S CONDITION (X both if applicable) ACCIDENT RELATED? <input type="checkbox"/> YES <input type="checkbox"/> NO WORK RELATED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
8a. DESCRIBE CONDITION FOR WHICH THE PATIENT RECEIVED TREATMENT, SUPPLIES OR MEDICATION. IF AN INJURY, NOTE HOW IT HAPPENED. REFER TO INSTRUCTIONS BELOW.		8b. WAS PATIENT'S CARE (X one) <input type="checkbox"/> INPATIENT? <input type="checkbox"/> PHARMACY? <input type="checkbox"/> OUTPATIENT? <input type="checkbox"/> DAY SURGERY?	
9. SPONSOR'S OR FORMER SPOUSE'S NAME (Last, First, Middle Initial)		10. SPONSOR'S OR FORMER SPOUSE'S SOCIAL SECURITY NUMBER	
11. OTHER HEALTH INSURANCE COVERAGE			
a. Is patient covered by any other health insurance plan or program to include health coverage available through other family members? <input type="checkbox"/> YES If yes, check the "Yes" block and complete blocks 11 and 12 (see instructions below). If no, you must check the "No" block and complete block 12. Do not report TRICARE/CHAMPUS supplemental insurance information, but do report Medicare supplements. <input type="checkbox"/> NO			
b. TYPE OF COVERAGE (Check all that apply)			
<input type="checkbox"/> (1) EMPLOYMENT (Group) <input type="checkbox"/> (3) MEDICARE <input type="checkbox"/> (5) MEDICARE SUPPLEMENTAL INSURANCE <input type="checkbox"/> (7) OTHER (Specify)			
<input type="checkbox"/> (2) PRIVATE (Non-Group) <input type="checkbox"/> (4) STUDENT PLAN <input type="checkbox"/> (6) PRESCRIPTION DISCOUNT PLAN			
	c. NAME AND ADDRESS OF OTHER HEALTH INSURANCE (Street, City, State, and ZIP Code)	d. INSURANCE IDENTIFICATION NUMBER	e. INSURANCE EFFECTIVE DATE (YYYYMMDD) f. DRUG COVERAGE?
INSURANCE 1			<input type="checkbox"/> YES <input type="checkbox"/> NO
INSURANCE 2			<input type="checkbox"/> YES <input type="checkbox"/> NO
REMINDER: Attach your other health insurances's Explanation of Benefits or pharmacy receipt that indicates the actual drug cost, amount the OHI paid, and the amount that you paid.			
12. SIGNATURE OF PATIENT OR AUTHORIZED PERSON CERTIFIES CORRECTNESS OF CLAIM AND AUTHORIZES RELEASE OF MEDICAL OR OTHER INSURANCE INFORMATION.			13. OVERSEAS CLAIMS ONLY: PAYMENT IN LOCAL CURRENCY?
a. SIGNATURE	b. DATE SIGNED (YYYYMMDD)	c. RELATIONSHIP TO PATIENT	<input type="checkbox"/> YES <input type="checkbox"/> NO
HOW TO FILL OUT THE TRICARE/CHAMPUS FORM			
<i>You must attach an itemized bill (see front of form) from your doctor/supplier for CHAMPUS to process this claim.</i>			
<p>1. Enter patient's last name, first name and middle initial as it appears on the military ID Card. Do not use nicknames.</p> <p>2. Enter the patient's daytime telephone number and evening telephone number to include the area code.</p> <p>3. Enter the complete address of the patient's place of residence at the time of service (street number, street name, apartment number, city, state, ZIP Code). Do not use a Post Office Box Number except for Rural Routes and numbers. Do not use an APO/FPO address unless the patient was actually residing overseas when care was provided.</p> <p>4. Check the box to indicate patient's relationship to sponsor. If "Other" is checked, indicate how related to the sponsor; e.g., parent.</p> <p>5. Enter patient's date of birth (YYYYMMDD).</p> <p>6. Check the box for either male or female (patient).</p> <p>7. Check box to indicate if patient's condition is accident related, work related or both. If accident or work related, the patient is required to complete DD Form 2527, "Statement of Personal Injury - Possible Third Party Liability TRICARE Management Activity." The form may be obtained from the claims processor, BCAC, or TRICARE Management Activity.</p> <p>8a. Describe patient's condition for which treatment was provided, e.g., broken arm, appendicitis, eye infection. If patient's condition is the result of an injury, report how it happened, e.g., fell on stairs at work, car accident.</p> <p>8b. Check the box to indicate where the care was given.</p> <p>9. Enter the Sponsor's or Former Spouse's last name, first name and middle initial as it appears on the military ID Card. If the sponsor and patient are the same, enter "same."</p> <p>10. Enter the Sponsor's or Former Spouse's Social Security Number (SSN).</p> <p>11. By law, you must report if the patient is covered by any other health insurance to include health coverage available through other family members. If the patient has supplemental TRICARE/CHAMPUS insurance, do not report. You must, however, report Medicare supplemental coverage. Block 11 allows space to report two insurance coverages. If there are additional insurances, report the information as required by Block 11 on a separate sheet of paper and attach to the claim. NOTE: All other health insurances except Medicaid and TRICARE/CHAMPUS supplemental plans must pay before TRICARE/CHAMPUS will pay. With the exception of Medicaid and CHAMPUS supplemental plans, you must first submit the claim to the other health insurer and after that insurance has determined their payment, attach the other insurance Explanation of Benefits (EOB) or work sheet to this claim. <i>The claims processor cannot process claims until you provide the other health insurance information.</i></p> <p>12. The patient or other authorized person must sign the claim. If the patient is under 18 years old, either parent may sign unless the services are confidential and then the patient should sign the claim. If the patient is 18 years or older, but cannot sign the claim, the person who signs must be either the legal guardian, or in the absence of a legal guardian, a spouse or parent of the patient. If other than the patient, the signer should print or type his/her name in Block 12a, and sign the claim. Attach a statement to the claim giving the signer's full name and address, relationship to the patient and the reason the patient is unable to sign. Include documentation of the signer's appointment as legal guardian, or provide your statement that no legal guardian has been appointed. If a power of attorney has been issued, provide a copy.</p> <p>13. If this is a claim for care received overseas, indicate if you want payment in the local currency. NOTE: Payment available only in some local currencies.</p>			

DD FORM 2642 (BACK), APR 2007

COPY 2 - PROCESSOR'S COPY

31.0. REPORTING REQUIREMENTS

Reporting requirements on receivables are contained in [Chapter 3, Sections 7 and 10](#).

NOTE: *Chapter 3, Addendum A, Figure 3-A-4 requires that cases 300 days delinquent with balances less than \$600 be written off and reported on line A.5.*

32.0. CONTRACTOR TRANSITIONS

32.1. In the event of a contractor transition, only offset accounts which have been on offset for less than 12 months shall be transferred to the incoming contractor who shall assume management of the cases in accordance with TOM instructions. Accounts which have been on offset for 12 months or longer, and all installment accounts, shall be transferred to the Recoupment Division, TMA. A list of all installment cases to be transferred and a list of offset accounts to be transferred shall be provided to the Recoupment Branch, TMA before the cases are transferred. Prior to such transfer, the outgoing contractor shall contact the Recoupment Division, TMA, to determine whether additional criteria should be applied to identify those accounts which may be written off, i.e., transferred neither to the incoming contractor nor to TMA. Any offset account received by the incoming contractor as a result of a transition shall be kept in effect for the life of the contract or until the debt is collected in full, transferred to TMA or written off by the contractor. The outgoing contractor shall submit a credit adjustment to include all amounts recouped up to the point of transition. The final Accounts Receivable Report for the outgoing contractor shall reflect the number of cases and the amount of the outstanding debt transferred to the incoming contractor. The incoming contractor shall reflect the number of cases and the amount of the outstanding debt received from the outgoing contractor on the next monthly Accounts Receivable Report following the date of transition.

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

33.0. INTEREST, PENALTIES AND ADMINISTRATIVE COSTS

33.1. The debtor shall be notified in the initial demand letter that interest will accrue from the date of that letter. The rate of interest to be assessed is the United States Treasury Current Value of Funds Rate. The Department of the Treasury publishes a new rate pursuant to Section 11 of the Debt Collection Act of 1982, as Amended (31 USC 3717). The contractor shall obtain the current rate as published in the Federal Register. The Treasury's rate may change on a quarterly basis if the rolling 12 month average used for calculating the rate changes by two percentage points. However, the collection of interest shall be automatically waived on the debt or any portion thereof which is paid within 30 days after the date of the initial demand letter. The contractor is not authorized, under any other circumstances, to waive a debt or any portion of a debt owed the United States Government.

33.2. Debtors shall also be notified in the initial demand letter that a penalty charge, not to exceed six percent per year, will be assessed upon any portion of the debt that is delinquent for more than 90 days, and that administrative costs, (based upon those costs incurred in

processing and handling the debt because it became delinquent) will also be added to their indebtedness. However, the contractor shall not assess administrative costs and penalties (TMA will assess administrative costs and penalties).

33.3. The contractor shall be responsible for the assessment and collection of interest only when the debtor enters into an installment repayment agreement as described in [paragraph 25.0.](#), above. The rate of interest assessed shall be the rate properly reflected in the initial demand letter mailed to the debtor. The rate of interest assessed shall be the rate of the current value of funds to the United States Treasury; i.e., the Treasury Tax and loan account rate. Each installment payment shall be applied first to the accrued interest and then to the outstanding principal balance.

33.4. Interest will not be assessed upon previously accrued interest charges. When the debtor and the contractor enter into an installment repayment agreement, interest will be assessed for the period beginning on the date of the initial demand letter and ending on the due date of the first installment payment. The interest shall be assessed at the rate properly reflected in the initial demand letter on that portion of the debt which remained outstanding 30 days after the date of the initial demand letter. The interest so assessed will be collected and applied to the debtor's account before the due date of the first installment payment. Subsequently, interest shall be computed daily on the outstanding principal balance at the rate properly reflected in the initial demand letter, which shall also be reflected in any promissory note sent to the debtor as required by [paragraph 16.2.3.](#)

33.5. Interest collected under installment agreements shall be reported to TMA monthly with unidentified refunds and refunds \$10.00 or less. The rate of interest, as initially assessed, shall remain fixed for the duration of the indebtedness, except that where a debtor has defaulted on a repayment agreement and seeks to enter into a new agreement, a new interest rate may be set which reflects the current value of funds to the Treasury at the time the new agreement is executed.

33.6. Delinquent installment accounts shall be handled in accordance with the procedures outlined in [paragraph 25.0.](#)

8.0. REPORTING REQUIREMENTS

8.1. General

The contractor shall send a report to TMA reporting the information required in [paragraph 8.2.](#), below, regarding claims investigated and claims referred under the Federal Medical Care Recovery Act (FMCRA). Claims under this act shall be considered to be those which are presented with diagnoses codes which fall within the range from 800 through 999, and under which there is or could be tort liability of a third party for the patient's injury or disease. The report shall be mailed in time to be received at the Office of General Counsel, TMA-Aurora, by *November 1* of each year. The contractor shall use a guaranteed mail service which will ensure delivery to TMA not later than the close of business (4:30 p.m., Mountain Time) on *November 1*, or the next following business day if *November 1* is a Saturday or Sunday.

8.2. Report Content

The annual report shall include the following elements:

8.2.1. Report Heading

- Reporting Period (covering the 12 months of the previous fiscal year)
- The Contractor's Name and Region Name (if applicable)
- The Uniformed Service that the report figures are associated with (i.e., Army, Air Force, Navy & Marine Corps, Coast Guard, USPHS and NOAA).

8.2.2. Report Summary

Create a breakdown for each of the six Uniformed Services listed in [paragraph 8.2.1.](#) above which includes the following categories:

- Number of cases investigated for potential third party liability.
- Total dollar amount actually paid on all claims investigated.
- Number of cases referred to the Uniformed Services for further investigation and collection.
- Actual dollar amount paid on all claims referred to the Uniformed Services for further investigation and collection.

8.2.3. Report Details

For potential third party liability claims that were investigated and/or referred, the contractor shall list the Uniformed Services Claim Office (USCO) where the potential third party liability case was referred. The contractor shall then report the appropriate figures for the categories listed under [paragraph 8.2.2.](#) by the appropriate state(s) and/or countries listed. Please see [Figure 11-5-1](#) for an example.

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CHAPTER 11, SECTION 5

THIRD PARTY RECOVERY CLAIMS

FIGURE 11-5-1 THIRD PARTY RECOVERIES FOR REGION FISCAL YEAR

(CONTRACTOR NAME) THIRD PARTY RECOVERIES FOR (REGION NAME) REGION FISCAL YEAR (YEAR)					
ARMY					
<i>USCO Claims Office Name</i>	<i>TRICARE Region</i>	<i>Number of cases involving TRICARE payments investigated for potential third party liability</i>	<i>Dollar amount of cases involving TRICARE payments investigated for potential third party liability</i>	<i>Number of cases involving TRICARE payments referred to Uniformed Services</i>	<i>Dollar amount of cases involving TRICARE payments referred to Uniformed Services</i>
<i>Ft. Rucker, AL</i>	<i>South</i>	<i>0</i>	<i>0</i>	<i>0</i>	<i>0</i>
<i>Red Stone Arsenal, AL</i>	<i>South</i>	<i>10</i>	<i>\$27,500.25</i>	<i>2</i>	<i>\$14,250.00</i>
<i>Ft. Wainwright, AK</i>	<i>West</i>	<i>20</i>	<i>\$31,827.50</i>	<i>5</i>	<i>\$5,367.20</i>
TOTAL		30	\$59,327.75	7	\$19,617.20

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CHAPTER 11, ADDENDUM B

LISTING OF GOVERNMENT CLAIMS OFFICES

NEW YORK	
ARMY:	NAVY AND MARINE CORPS:
Office of the Staff Judge Advocate US Military Academy ATTN: MAJA CL Thayer Road, Building 606 West Point, NY 10996-1781	Office of the Judge Advocate General Medical Care Recovery Unit, Norfolk 9053 First Street, Suite 100 Norfolk, VA 23511-3605
AIR FORCE:	COAST GUARD:
AFRL/IFOJ 26 Electronic Parkway Rome, NY 13441-4514	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	NOAA:
Jacob Javits Federal Building Suite 3908 26 Federal Plaza New York, NY 10278	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230
NORTH CAROLINA	
ARMY:	NAVY AND MARINE CORPS:
Office of the Staff Judge Advocate Womack Army Medical Center ATTN: MCXC JA Claims Reilly Street, Building 4-2817 Fort Bragg, NC 28307-5000	Office of the Judge Advocate General Medical Care Recovery Unit, Norfolk 9053 First Street, Suite 100 Norfolk, VA 23511-3605
AIR FORCE:	COAST GUARD:
43 WG/JA 374 Maynard Street, Suite A Pope AFB, NC 28308-2381	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	NOAA:
Sam Nunn Atlanta Federal Center 61 Forsyth Street SW, Suite 5M60 Atlanta, GA 30303-8909	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

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NORTH DAKOTA	
ARMY:	NAVY AND MARINE CORPS:
Office of the Staff Judge Advocate Headquarters, 24th Infantry Division (Mechanized) and Fort Riley ATTN: AFZN-JA-CL Building 200, Patton Hall Fort Riley, KS 66442-5017	Office of the Judge Advocate General Medical Care Recovery Unit Pensacola 161 Turner Street, Suite B Pensacola, FL 32508-5526
AIR FORCE:	COAST GUARD:
5 BW/JA 300 Summit Drive, Suite 211 Minot AFB, ND 58705-5038	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	NOAA:
Federal Building 1961 Stout Street, Room 327 Denver, CO 80294-3538	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230
OHIO	
ARMY:	NAVY AND MARINE CORPS:
Office of the Staff Judge Advocate Headquarters, US Army Armor Center and Fort Knox ATTN: ATZK JA Claims Third Avenue, Building 1310 Fort Knox, KY 40121-5000	Office of the Judge Advocate General Medical Care Recovery Unit Pensacola 161 Turner Street, Suite B Pensacola, FL 32508-5526
AIR FORCE:	COAST GUARD:
88 ABW/JAD ATTN: Medical Claims Examiner 5135 Pearson Road, Room 122 Wright-Patterson AFB, OH 45433-5321	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	NOAA:
Office of the General Counsel 233 North Michigan Avenue, Suite 700 Chicago, IL 60601-5519	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

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LISTING OF GOVERNMENT CLAIMS OFFICES

OKLAHOMA	
ARMY:	NAVY AND MARINE CORPS:
Office of the Staff Judge Advocate Headquarters, US Army Field Artillery Center and Fort Sill ATTN: ATZR-J Post Claims Currie Road, Building 2595 Fort Sill, OK 73503-5100	Office Of The Judge Advocate General Medical Care Recovery Unit San Diego 3395 Sturtevant Street, Suite 2 San Diego, CA 92136-5138
AIR FORCE:	COAST GUARD:
OC-ALC/JA 7460 Arnold Street, SE WG Tinker AFB, OK 73145-9002	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	NOAA:
1301 Young Street, Room 1138 Dallas, TX 75202	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230
OREGON	
ARMY:	NAVY AND MARINE CORPS:
Office of the Center Judge Advocate Western Regional Medical Command and Madigan Army Medical Center ATTN: MCHJ-JA Medical Care Recovery Claims 9040 A Fitzsimmons Avenue Tacoma, WA 98431-5000	Office Of The Judge Advocate General Medical Care Recovery Unit San Diego 3395 Sturtevant Street, Suite 2 San Diego, CA 92136-5138
AIR FORCE:	COAST GUARD:
92 ARW/JA 1 East Bong Street, Suite 103 Fairchild AFB, WA 99011-9464	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	NOAA:
Blanchard Plaza Building, Suite 902 2201 Sixth Avenue Seattle, WA 98121-1833	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

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LISTING OF GOVERNMENT CLAIMS OFFICES

PENNSYLVANIA	
ARMY:	NAVY AND MARINE CORPS:
Office of the Staff Judge Advocate Headquarters, US Army Garrison, Fort George G Meade ATTN: ANME JA Claims 2257 Huber Road, Stop 5030 Fort George G Meade, MD 20755-5030	Office of the Judge Advocate General Medical Care Recovery Unit, Norfolk 9053 First Street, Suite 100 Norfolk, VA 23511-3605
AIR FORCE:	COAST GUARD:
436 AW/JA 200 Eagle Way, Room 100 Dover AFB, DE 19902-7216	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	NOAA:
Public Ledger Building, Suite 418 150 South Independence Mall West Philadelphia, PA 19106-3499	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230
PUERTO RICO	
ARMY:	NAVY AND MARINE CORPS:
Office of the Staff Judge Advocate Headquarters, US Army Garrison - Fort Buchanan USARSO ATTN: SOJA Affirmative Claims 218 Brooke Street Fort Buchanan, PR 00934-3400	Office of the Judge Advocate General Medical Care Recovery Unit, Norfolk 9053 First Street, Suite 100 Norfolk, VA 23511-3605
AIR FORCE:	COAST GUARD:
45 SW/JADH HR Claims 642 Omalley Road Patrick AFB, FL 32925	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	NOAA:
Jacob Javits Federal Building Suite 3908 26 Federal Plaza New York, NY 10278	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

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LISTING OF GOVERNMENT CLAIMS OFFICES

RHODE ISLAND	
ARMY:	NAVY AND MARINE CORPS:
Office of the Staff Judge Advocate Headquarters, US Army Garrison Fort Dix ATTN: AFRC FA JAC 5418 S Scott Plaza Fort Dix, NJ 08640-5089	Office of the Judge Advocate General Medical Care Recovery Unit, Norfolk 9053 First Street, Suite 100 Norfolk, VA 23511-3605
AIR FORCE:	COAST GUARD:
66 ABW/JA Hospital Recovery 20 Schilling Circle Hanscom AFB, MA 01731	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	NOAA:
John F Kennedy Federal Building Room 2250 Boston, MA 02203	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230
SOUTH CAROLINA	
ARMY:	NAVY AND MARINE CORPS:
Office of the Staff Judge Advocate Headquarters, US Army Training Center and Fort Jackson ATTN: ATZJ SJA 9475 Kershaw Road, Room 141 Fort Jackson, SC 29207-5000	Office of the Judge Advocate General Medical Care Recovery Unit, Norfolk 9053 First Street, Suite 100 Norfolk, VA 23511-3605
AIR FORCE:	COAST GUARD:
20 FW/JA 504 Shaw Drive, Suite 2025 Shaw AFB, SC 29152-5028	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	NOAA:
Sam Nunn Atlanta Federal Center 61 Forsyth Street SW, Suite 5M60 Atlanta, GA 30303-8909	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

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SOUTH DAKOTA	
ARMY: Office of the Staff Judge Advocate Headquarters, 24th Inf Division (Mechanized) and Fort Riley ATTN: AFZN-JA-CL Building 200, Patton Hall Fort Riley, KS 66442-5017	NAVY AND MARINE CORPS: Office of the Judge Advocate General Medical Care Recovery Unit Pensacola 161 Turner Street, Suite B Pensacola, FL 32508-5526
AIR FORCE: 28 BW/JA 1000 Ellsworth Street, Suite 2700 Ellsworth AFB, SD 57706-4700	COAST GUARD: Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS: Federal Building 1961 Stout Street, Room 327 Denver, CO 80294-3538	NOAA: Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230
TENNESSEE	
ARMY: Office of the Staff Judge Advocate Headquarters, 101st Airborne Division (Air Assault) and Fort Campbell ATTN: AFZB JA 127 Forrest Road Fort Campbell, KY 42223-5208	NAVY AND MARINE CORPS: Office of the Judge Advocate General Medical Care Recovery Unit Pensacola 161 Turner Street, Suite B Pensacola, FL 32508-5526
AIR FORCE: AEDC/JA 100 Kindel Drive, Suite B327 Arnold AFB, TN 37389-2327	COAST GUARD: Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS: Sam Nunn Atlanta Federal Center 61 Forsyth Street SW, Suite 5M60 Atlanta, GA 30303-8909	NOAA: Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

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LISTING OF GOVERNMENT CLAIMS OFFICES

TEXAS	
ARMY:	NAVY AND MARINE CORPS:
Office of the Staff Judge Advocate Headquarters, III Corps and Fort Hood ATTN: AFZF JA Claims Building 1001, Room 226, 2nd Floor East Wing 1001 761st Tank Battalion Avenue Fort Hood, TX 76544-5008	Office of the Judge Advocate General Medical Care Recovery Unit Pensacola 161 Turner Street, Suite B Pensacola, FL 32508-5526
AIR FORCE:	COAST GUARD:
37 TRW/JAT 1701 Kenly Avenue, Suite 117 Lackland AFB, TX 78236-5158 Zip Codes 76500 - 76599 78100 - 78199 76900 - 76999 78200 - 78299 77000 - 77099 78300 - 78399 77100 - 77199 78400 - 78499 77200 - 77299 78500 - 78599 77300 - 77399 78600 - 78699 77400 - 77499 78700 - 78799 77500 - 77599 78800 - 78899 77600 - 77699 78900 - 78999 77700 - 77799 79700 - 79799 77800 - 77899 79800 - 79899 77900 - 77999 79900 - 79999 78000 - 78099	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
7 BW/JA 466 5th Street, Suite 220 Dyess AFB, TX 79607-1240 Zip Codes 75000 - 75099 76600 - 76899 75100 - 75999 79100 - 79699 76000 - 76499	
DHHS:	NOAA:
1301 Young Street, Room 1138 Dallas, TX 75202	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002

CHAPTER 11, ADDENDUM B
LISTING OF GOVERNMENT CLAIMS OFFICES

UTAH	
ARMY:	NAVY AND MARINE CORPS:
Office of the Staff Judge Advocate Headquarters, 7th Infantry Division and Fort Carson ATTN: AFZC JA C 7086 Albanese Loop Fort Carson, CO 80913-4309	Office Of The Judge Advocate General Medical Care Recovery Unit San Diego 3395 Sturtevant Street, Suite 2 San Diego, CA 92136-5138
AIR FORCE:	COAST GUARD:
00-ALC/JAD 6026 Cedar Lane Hill AFB, UT 84056-5812	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	NOAA:
Federal Building 1961 Stout Street, Room 327 Denver, CO 80294-3538	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230
VERMONT	
ARMY:	NAVY AND MARINE CORPS:
Office of the Staff Judge Advocate Headquarters, US Army Garrison Fort Dix ATTN: AFRC FA JAC 5418 S Scott Plaza Fort Dix, NJ 08640-5089	Office of the Judge Advocate General Medical Care Recovery Unit, Norfolk 9053 First Street, Suite 100 Norfolk, VA 23511-3605
AIR FORCE:	COAST GUARD:
AFRL/IFOJ 26 Electronic Parkway Rome, NY 13441-4514	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	NOAA:
John F Kennedy Federal Building Room 2250 Boston, MA 02203	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002

CHAPTER 11, ADDENDUM B

LISTING OF GOVERNMENT CLAIMS OFFICES

VIRGINIA	
ARMY: Office of the Staff Judge Advocate US Army Combined Arms Support Command and Fort Lee ATTN: ATCL JA (Affirmative & Personal Injury Claims) 441 First Street Fort Lee, VA 23801-1507	NAVY AND MARINE CORPS: Office of the Judge Advocate General Medical Care Recovery Unit, Norfolk 9053 First Street, Suite 100 Norfolk, VA 23511-3605
AIR FORCE: 1 FW/JAD ATTN: Medical Claims Examiner 33 Sweeney Blvd Langley AFB, VA 23665-2198	COAST GUARD: Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS: Public Ledger Building, Suite 418 150 South Independence Mall West Philadelphia, PA 19106-3499	NOAA: Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230
WASHINGTON	
ARMY: Office of the Center Judge Advocate Western Regional Medical Command and Madigan Army Medical Center ATTN: MCHJ-JA Medical Care Recovery Claims 9040 A Fitzsimmons Avenue Tacoma, WA 98431-5000	NAVY AND MARINE CORPS: Office Of The Judge Advocate General Medical Care Recovery Unit San Diego 3395 Sturtevant Street, Suite 2 San Diego, CA 92136-5138
AIR FORCE: 92 ARW/JA 1 East Bong Street, Suite 103 Fairchild AFB, WA 99011-9464	COAST GUARD: Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS: Blanchard Plaza Building, Suite 902 2201 Sixth Avenue Seattle, WA 98121-1833	NOAA: Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002

CHAPTER 11, ADDENDUM B
LISTING OF GOVERNMENT CLAIMS OFFICES

WEST VIRGINIA	
ARMY: Office of the Staff Judge Advocate US Army Combined Arms Support Command and Fort Lee ATTN: ATCL JA (Affirmative & Personal Injury Claims) 441 First Street Fort Lee, VA 23801-1507	NAVY AND MARINE CORPS: Office of the Judge Advocate General Medical Care Recovery Unit, Norfolk 9053 First Street, Suite 100 Norfolk, VA 23511-3605
AIR FORCE: 89 AW/JAD ATTN: Claims Department 1535 Command Drive, Suite AA-203 Andrews AFB, MD 20762-7002	COAST GUARD: Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS: Public Ledger Building, Suite 418 150 South Independence Mall West Philadelphia, PA 19106-3499	NOAA: Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230
WISCONSIN	
ARMY: Office of the Command Judge Advocate Headquarters, US Army Garrison, Fort McCoy ATTN: AFRC FM JA 100 East Headquarters Road Fort McCoy, WI 54656-5253	NAVY AND MARINE CORPS: Office of the Judge Advocate General Medical Care Recovery Unit Pensacola 161 Turner Street, Suite B Pensacola, FL 32508-5526
AIR FORCE: 375 AW/JA 101 Heritage Drive, Suite 210 Scott AFB, IL 62225-5001	COAST GUARD: Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS: 233 North Michigan Avenue, Suite 700 Chicago, IL 60601-5519	NOAA: Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002

CHAPTER 11, ADDENDUM B

LISTING OF GOVERNMENT CLAIMS OFFICES

WYOMING	
ARMY: Office of the Staff Judge Advocate Headquarters, 7th Infantry Division and Fort Carson ATTN: AFZC JA C 7086 Albanese Loop Fort Carson, CO 80913-4309	NAVY AND MARINE CORPS: Office Of The Judge Advocate General Medical Care Recovery Unit San Diego 3395 Sturtevant Street, Suite 2 San Diego, CA 92136-5138
AIR FORCE: 90 SW/JA 6307 Randall Avenue, Suite 209 FE Warren AFB, WY 82005-3207	COAST GUARD: Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS: Federal Building 1961 Stout Street, Room 327 Denver, CO 80294-3538	NOAA: Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

2.0. TRICARE OVERSEAS CLAIMS

Under authority of Department of Defense Directive 5515.8, responsibility for claims against the United States and claims for the United States in overseas areas is assigned to a single Military Department for each country. DD Forms 2527 and claims identified as appropriate for investigation of possible recovery under the Medical Care Recovery Act should be sent to the following claims offices including TRICARE EUROPE active duty member overseas claims:

DEPARTMENT OF THE ARMY:

- Services in Austria, Belgium, El Salvador, France, Federal Republic of Germany, Grenada, Honduras, Korea, Marshall Islands, Switzerland, and countries not assigned to another Service for responsibility (Army claims only):

Department of the Army
Commander
US Army Claims Service
ATTN: JACS-TC
4411 Llewellyn Avenue
Fort George G Meade, MD 20755-5360

DEPARTMENT OF THE NAVY:

- Services in Bahrain, Greece, Iceland, Israel, Portugal, and United Arab Emirates:

Office of the Judge Advocate General
Code 353
200 Stovell Street
Alexandria, VA 22332

- Services in Italy:

Naval Legal Service Office, EURSWA
ATTN: Claims
PSC 817 Box 8
FPO AE 09622-0008

- Services in countries not assigned to another Service for responsibility (Navy claims only):

Office of the Judge Advocate General
Medical Care Recovery Unit, Norfolk
9053 First Street, Suite 100
Norfolk, VA 23511-3605

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LISTING OF GOVERNMENT CLAIMS OFFICES

DEPARTMENT OF THE AIR FORCE:

- Services in Australia, Azores, Canada, Cyprus, Denmark, Egypt, India, Japan, Luxembourg, Morocco, Nepal, the Netherlands, Norway, Oman, Pakistan, Saudi Arabia, Spain, Turkey, the United Kingdom, and claims involving, or generated by, the United States Central Command (CENTCOM) and the United States Special Operations Command (USSOC), and countries not assigned to another service for responsibility (Air Force claims only):

AFLOA/JACC
112 Luke Avenue, Suite 343
Bolling AFB, DC 20032-8000

MARKETING AND EDUCATION REQUIREMENTS

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

1.0. MARKETING AND EDUCATION PLAN

1.1. The MCSC shall prepare and submit to TMA C&CS an annual marketing and education plan to inform and educate TRICARE beneficiaries, TRICARE and MHS staff and providers on all aspects of TRICARE programs. The plan shall identify any desired marketing and education materials required from the Government to support the accomplishment of plan goals for marketing and education.

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

2.0. INTERFACE REQUIREMENTS

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

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

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

3.0. REQUIRED EDUCATIONAL MATERIALS

The MCSC shall distribute TRICARE educational materials provided by the Government to all MHS beneficiaries. The government will provide all enrollment materials for distribution by the MCSC.

4.0. DISSEMINATION OF INFORMATION

4.1. No later than 30 days prior to the start of health care delivery, the MCSC shall mail one TRICARE Handbook to all MHS beneficiary households in the region based off DEERS data. The MCSC shall furnish all beneficiaries, sponsors, providers, and Congressional Offices with enrollment information and forms, network provider information, Health Care Finder information, claim forms, claim completion instructions, the TRICARE Handbook, the Provider Handbook, DEERS information and other informational materials upon request. The MCSC shall establish and maintain effective communications with all beneficiaries. (See [Chapter 12, Section 4.](#)) The MCSC shall forward informational bulletins or stuffers that are enclosed with EOBs to TMA and the Regional Director upon mailing to beneficiaries.

4.2. Annually, the MCSC shall effectively distribute quarterly provider newsletters and eight bulletins to all providers, Congressional offices, Beneficiary Counseling and Assistance Coordinators (BCAC), Debt Collection Assistance Officers (DCAO), and Health Benefits Advisors in the region. Newsletters will be no more than six double sided pages in length (8 1/2" x 11"). Bulletins will be no more than two double-sided pages in length (8 1/2" x 11") and shall be distributed in only those months that a newsletter is not distributed. Potential avenues include U.S. Mail, e-mail, and other approaches proposed by the contractor and accepted by the Government.

4.3. The MCSC shall effectively provide all TRICARE Prime enrollees, including active duty personnel; dual-eligible beneficiaries; congressional offices; and Health Benefits Advisors with newsletters three times annually and four bulletins annually. The MCSC shall also provide all non-enrolled TRICARE beneficiaries with an annual newsletter. Newsletters will be no more than six double sided pages in length (8 1/2" x 11"). Bulletins will be no more than two double-sided pages in length (8 1/2" x 11"). Potential avenues include U.S. Mail, e-mail, and other approaches proposed by the contractor and accepted by the Government.

4.4. The TDEFIC shall maintain a supply of beneficiary newsletters and bulletins. The TDEFIC shall provide a copy of the most recent information to any interested party, upon request.

5.0. ORDERING MARKETING AND EDUCATION MATERIALS

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

6.0. MEDICAL MANAGEMENT TRAINING

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

explanation of the action taken within 21 calendar days of the stamped date of receipt of the appeal in the mailroom.

3.0. APPEAL REQUIREMENTS

For all appeals at all levels:

3.1. Must Be Filed In A Timely Manner

The appealing party must comply with the “allowed time to file” requirements established by 32 CFR 199.10 and 199.15 (see Chapter 13, Section 3, paragraph 1.4.).

3.2. Must Be An Appealable Issue

Services or supplies must have been rendered by a TRICARE authorized provider, the denial of which raises a disputed question of fact which, if resolved in favor of the appealing party, would result in an extension of TRICARE benefits or approval as a TRICARE-authorized provider. *Examples of nonappealable issues may be found at* Chapter 13, Section 3, paragraph 1.3.2.

3.3. Must Be An Amount In Dispute

There must be an amount in dispute before an appeal can be accepted (see paragraph 4.0.). This involves the following requirements:

- In a case involving an appeal of denial of authorization in advance of the actual services, the amount in dispute will be the estimated allowable charge for the services requested.
- There must be a legal obligation on the part of the beneficiary, parent, guardian, or sponsor to pay for the service or supply.
- Payment or authorization of TRICARE benefits for the service or supply must have been denied in whole or in part.
- When the episode of care involves the services of both network and non-network providers, only the claims submitted by the non-network providers will be considered in determining the amount in dispute.

NOTE: A non-network provider appealing a denial of its authorized TRICARE provider status will be deemed to have met any required amount in dispute. Also, the amount in dispute will be considered to have been met in an appeal of a request for authorization of benefits for obtaining services or supplies unless the estimated allowable charge involved in such a request would be less than the required amount in dispute.

EXAMPLE: A TRICARE beneficiary who had been hospitalized for ten days was notified by the contractor that benefits would terminate on the 15th day. The beneficiary left the hospital on the 15th day and filed an appeal on the basis that continued hospitalization was medically necessary. In this case, there would be no basis for

the appeal. The beneficiary left the hospital on the day TRICARE benefits terminated and expenses were no longer incurred; therefore, there was no amount in dispute. The beneficiary would be advised that there could be no appeal since there was no amount in dispute.

3.4. Must Be A Proper Appealing Party

See [paragraph 1.0](#).

3.5. Must Be In Writing

All appeal requests must be in writing and submitted by a proper appealing party. A signature is not required if a determination can be made that the request was submitted by a proper appealing party. If it cannot be determined that the appeal request was submitted by a proper appealing party, the proper appealing party shall be instructed by the contractor that a proper appeal, must be filed within 20 calendar days of the contractor's letter or by the appeal filing deadline, whichever is later. A verbal request for a reconsideration cannot be accepted. When telephone calls are received or personal visits occur which relate to an adverse initial determination, the contractor shall make every effort to satisfy the inquirer's complaint, inquiry, or question, including advising the inquirer of his or her right to appeal, if applicable. If an appropriate appealing party or representative submits a letter which includes both an appealable issue and a grievance, the appeal and grievance shall be processed separately under the appropriate appeal and grievance provisions of the Operations Manual.

4.0. AMOUNT IN DISPUTE

An amount in dispute is required for an adverse determination to be appealable. Although some amount must be in dispute for a reconsideration, unless specifically waived (e.g., the appeal involves denial of certification as a TRICARE authorized provider), there is no established minimum dollar amount. *If the contractor's reconsideration determination is less than fully favorable to the appealing party and the remaining amount in dispute is less than 50 dollars, no further appeal rights are available (i.e., 50 dollars or more must be in dispute for a reconsideration to be accepted at the NQMC or a formal review to be accepted at TMA).* Three hundred dollars or more, shall be in dispute for the case to be accepted as a hearing. The determination of "amount in dispute" affects the appealing party's rights and must be carefully evaluated, including, when appropriate, multiple claims for the same service and related claims. Under TRICARE Prime, if the beneficiary has no liability, other than a nominal per visit copayment, there is no amount in dispute (this does not preclude a Prime enrollee from appealing a preadmission/preprocedure denial determination). If the services at issue are not a benefit under TRICARE, and the provider is a network provider, the Prime or Extra beneficiary shall be held harmless by the network provider, unless the beneficiary is properly informed that the care is not covered (or probably is not covered) and agrees in advance to pay for the care. An agreement to pay can be evidenced by, e.g., a progress note in the beneficiary's medical record, entered contemporaneously with the occurrence of the event. (Refer to [Chapter 5, Section 1, paragraph 2.5](#) for additional information regarding "hold harmless".)

4.1. Calculating The Amount In Dispute

The “amount in dispute” is calculated as the actual amount the contractor would pay if the services and/or supplies involved in the dispute were determined to be payable.

4.1.1. Examples Of Excluded Amounts

EXAMPLE 1: Amounts in excess of the TRICARE-determined allowable charge or cost are excluded.

EXAMPLE 2: The beneficiary’s TRICARE deductible and cost-share amounts are excluded.

EXAMPLE 3: Amounts which the TRICARE beneficiary, parent, guardian, or other responsible person has no legal obligation to pay are excluded.

EXAMPLE 4: Amounts under the double coverage provisions of the TRICARE Reimbursement Manual, [Chapter 4](#) are excluded.

4.1.2. Amounts For Preadmission/Preprocedure Appeals

When the dispute involves denial of a request for authorization in advance of actual care or service, the amount in dispute shall be the estimated allowable charge or cost for the service requested.

4.1.3. Amounts For Provider Status Appeals

If the dispute involves the denial of a provider’s request for approval as an authorized TRICARE provider or the determination to terminate a provider as an authorized TRICARE provider, there is no requirement for an amount in dispute. Initial determinations in provider status appeals are considered factual initial determinations (Refer to [Chapter 13, Section 5](#)).

4.2. Combining Claims

Individual claims may be combined to meet the required amount in dispute for referral of the appeal to TMA if all of the following exist:

- Claims involve the same beneficiary (When the episode of care involves the services of both network and non-network providers, only the claims submitted by the non-network providers will be considered in determining the amount in dispute),
- Claims involve the same issue, and
- At least one of the claims, so combined, has had a reconsideration determination issued by a contractor.

4.3. Related Claims

When the contractor receives an appeal on a claim which has been denied, the contractor shall retrieve and examine all claims related to the specific service or supply or episode of care received by the beneficiary to determine if the claim in dispute was properly denied and if related claims were properly processed. All claims which relate to the same incident of care or the same type of service to the beneficiary shall be processed in the same manner and shall be readjudicated and resolved along with the denied claim in the same reconsideration determination. If one claim which relates to an excluded procedure is denied, all claims which relate to the same procedure shall also be denied. If a procedure is covered and one claim involving that procedure and episode of care is paid, other claims relating to the same procedure and/or period of care which have been denied should be examined in conjunction with the paid claim to see if the other claims may be paid or whether all the claims should be uniformly denied. The contractor shall take action in accordance with [paragraph 4.4.2.](#) to determine if any claim for the services or supplies was improperly paid or denied. All related claims shall be made part of the appeal file. The file shall contain full documentation pertaining to the issue and the care in dispute, to include a record of actions taken by the contractor on all claims involving the same issue.

EXAMPLE 1: The contractor receives claims for hospitalization, testing, physician services, and the purchase of a cerebellar stimulator implant device for a TRICARE beneficiary. These claims involve the surgical implant of the cerebellar stimulator in the patient's skull. The claims for the hospital care, physician's services, and the stimulator device are denied by the contractor on the basis that the procedure is unproven. The claims for testing are paid. Upon appeal, the contractor shall retrieve all the claims for the episode of care. The contractor shall find that the charges for the testing were erroneously paid because they relate to the denied unproven procedure. The contractor shall take action in accordance with [paragraph 4.4.2.](#)

EXAMPLE 2: A beneficiary with out-of-control diabetes is hospitalized, during which she receives nutrition counseling, an eye examination and insulin therapy. On the last day of the hospitalization, an M.D. performs an abortion. The initial determination denies cost-sharing for all services and the hospital requests a reconsideration. All services must be reviewed to determine which are related to the covered hospitalization for diabetes and which are related to the noncovered abortion.

EXAMPLE 3: Outpatient psychotherapy sessions are provided to a beneficiary and cost-shared by the contractor for a period of twelve months. All claims for the thirteenth month are denied due to lack of an adequate treatment plan. Upon appeal of the denial of the claim, all previously paid claims shall be retrieved and examined to determine whether all the claims should be paid, all denied, or whether denial is proper for some of the claims.

EXAMPLE 4: The contractor denies a claim for physical therapy on the basis that the services were not medically necessary. At reconsideration, the contractor discovers that previous claims for the same services and condition were paid in error. Because the erroneously paid claims involve the same issue - medical necessity of the

physical therapy - the contractor shall add the erroneously paid claims to the reconsideration and review all claims together.

4.4. Erroneous Payments

In considering an issue under appeal, questions may arise concerning previous payment of services or claims not under appeal. Possible erroneous payments will be reviewed in depth, including medical review if necessary, to determine if, at the time the initial determination was made, there existed any basis for the payment. If the reviewer concludes there was a basis for payment at the time the claim was processed, the payment may stand. When the evidence indicates a payment was erroneous and not supported by law or regulation, the following action will be taken.

4.4.1. Recoupment Involving Separate Issues

The contractor may request a refund and treat the recoupment action as an initial determination. Appeal rights shall be offered to the next level of appeal. Any new appeal must address itself to the benefit issue in dispute and not the fact that a refund has been requested.

4.4.2. Recoupment Involving Issues Under Appeal

When the contractor examines claims which are related to the claim in dispute and determines that one or more of the related claims were improperly paid, the contractor shall explain the erroneous payment in detail and advise the appealing party of any recoupment. If the contractor determines recoupment is appropriate, the amount of the erroneously paid claim(s) will be added to the amount in dispute, and the reconsideration review will consider both the claim(s) in dispute and the erroneously paid related claim(s) which involve the same issue. If the total amount in dispute permits a higher level appeal, the appealing party will be so advised.

FIGURE 13-A-5 TRICARE APPEALS PROCESS - MEDICAL NECESSITY DENIALS

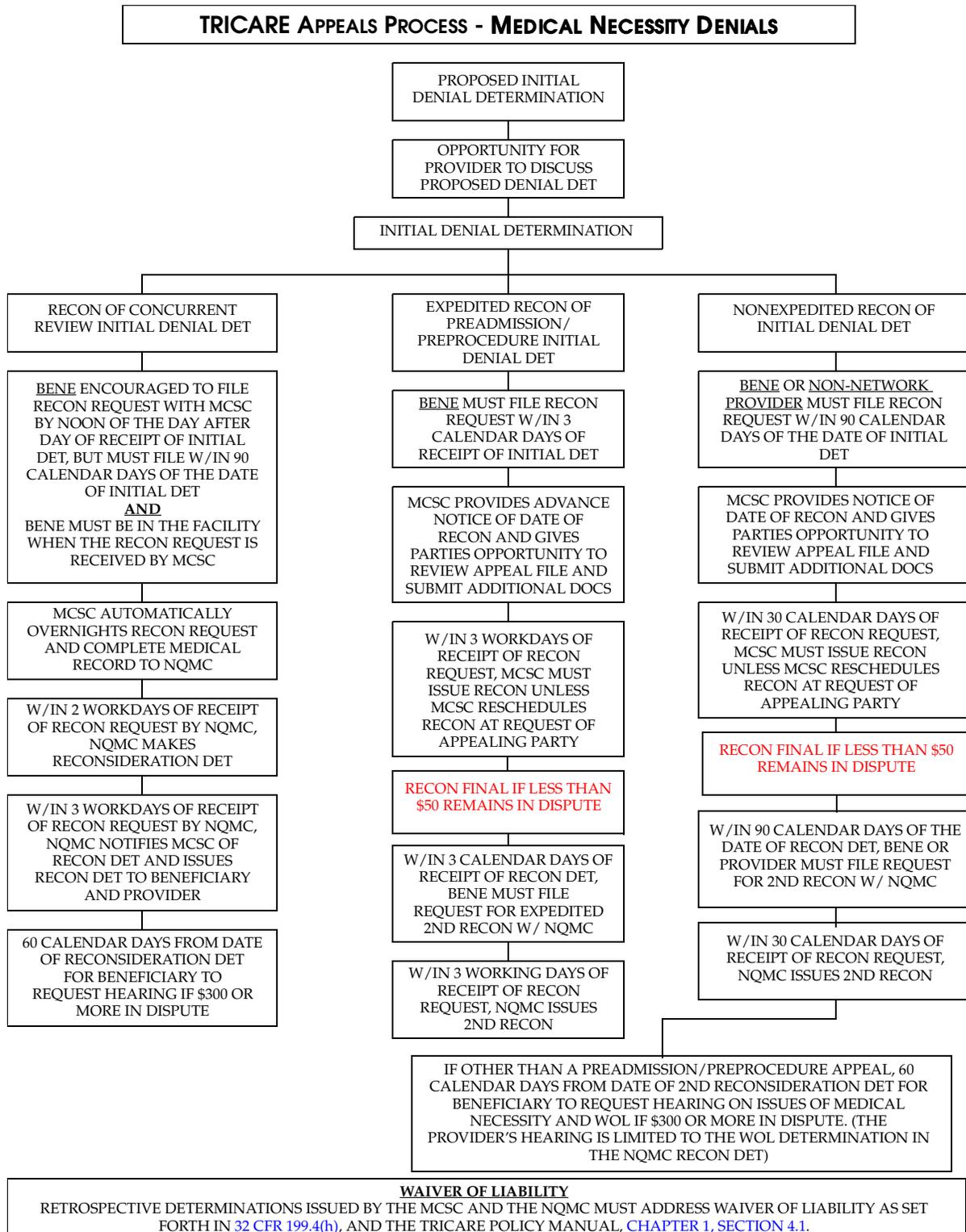
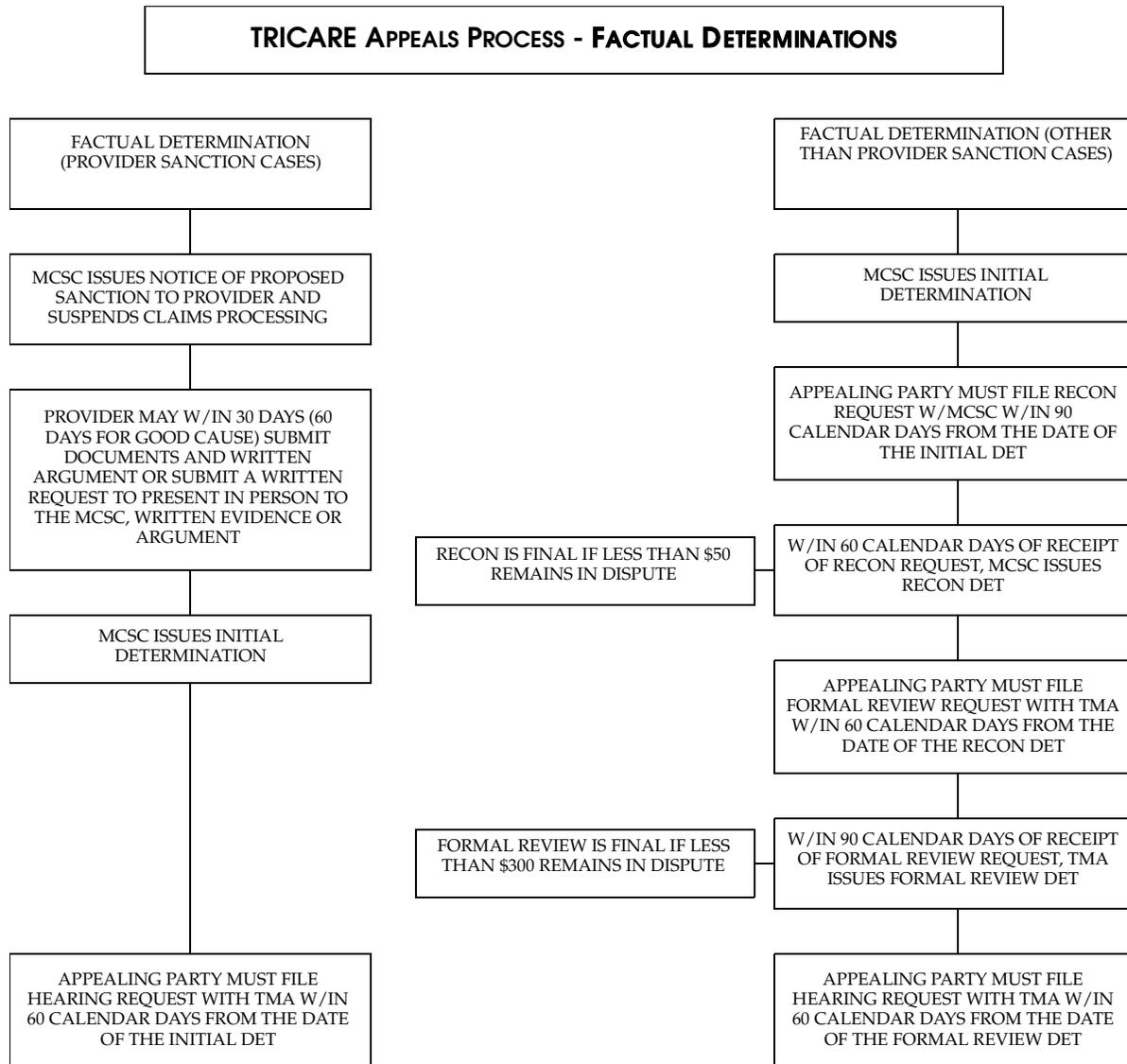


FIGURE 13-A-6 TRICARE APPEALS PROCESS - FACTUAL DETERMINATIONS



See [Chapter 14, Section 7](#), Provider Reinstatements, for additional guidance. The same agencies originally advised of sanction shall also be notified of the reinstatement.

5.2. Contractor Actions Under TRICARE Exclusion Authority - [32 CFR 199.9](#)

5.2.1. The contractor is required to provide written notice to TMA Program Integrity Office of any TRICARE provider who meets the criteria under the exclusion authority granted TRICARE. The notice must include appropriate documentation relevant to the situation (e.g., provider poses unreasonable potential for fraud).

5.2.2. The contractor will be notified immediately of an exclusion action taken by the TMA Program Integrity Office and is responsible for:

5.2.2.1. Ensuring that no payment is made to a sanctioned provider or entity for care provided on or after the date of the TMA action. Neither the provider, entity, nor the patient will be entitled to TRICARE cost-sharing once the exclusion is effective. The contractor must notify TMA Program Integrity Office should a provider or entity attempt to bill the program after the effective date of exclusion. It will not be necessary for the contractor to issue a separate letter notifying the provider of the sanction action. However, notice of sanction action taken by TMA shall be given to all Health Benefit Advisors located within the provider's service area (approximately 100 miles) of the practice address of the excluded provider. Regional Directors in the geographical area(s) of the provider's practice shall also be given notice of sanction action taken.

5.2.2.2. Ensuring that a sanctioned provider or entity is not included in the network. If cancellation of a network provider agreement is required, the contractor shall ensure that the network provider whose contract has been cancelled clearly understands his/her status. This shall be accomplished by providing notice, by certified mail, return receipt requested, that the network provider's agreement has been cancelled.

5.2.2.3. Issuing a special notice to any beneficiary who submits a claim or for whom a claim is submitted, which includes services involving a sanctioned provider. The notice may be enclosed with the EOB, whether the claim is payable or not, or a separate letter may be sent. The substance of the message should be similar to the example shown under [Figure 14-A-9](#).

5.2.2.4. Initiating appropriate action, as instructed, following reversed or vacated decisions issued by the TMA Program Integrity Office or termination of sanction action by TMA. The same agencies originally advised of sanction shall also be notified of the reinstatement.

5.3. Contractor Actions Under TRICARE Exclusion Authority - [32 CFR 199.15](#)

5.3.1. Under the TRICARE regulation, the provisions of 42 CFR 1004.1-1004.90 (Imposition of Sanctions by a PRO) shall apply to the TRICARE program as they do the Medicare program, except that the functions specified in those sections for the DHHS Office of Inspector General shall be the responsibility of TRICARE. As such, contractors shall adopt the DHHS PRO procedures and rules set forth under 42 CFR 1004.

5.3.2. *Contractors who are functioning as PROs have PRO sanction authority under 32 CFR 199.15. The 32 CFR 199.15 establishes the process for imposition of sanctions on health care practitioners and providers of health care services by a PRO. The process includes:*

- *Setting forth certain obligations imposed on practitioners and providers of service under TRICARE;*
- *Establishing criteria and procedures for the reports required from PROs when there is failure to meet those obligations;*
- *Specifying the policies and procedures for making determinations on violations and imposing sanctions; and*
- *Defining the procedures for appeals by the affected party and the procedures for reinstatements.*

5.3.3. *After meeting the objectives and requirements of the review system under 32 CFR 199.15 and taking appropriate action(s) as a result of the review, to include initiating PRO recommended sanctions, the contractor is required to notify TRICARE of all such actions.*

5.3.4. *Following notification to TRICARE Program Integrity Office of the proposed action to sanction under the provisions of 32 CFR 199.15, and following receipt of their decision to either uphold or reverse the recommended sanction action, the contractor shall notify the health care practitioner or provider of care of the final decision. If the sanction action is upheld, the contractor shall advise the provider of the length of exclusion and the right to request a hearing to the extent allowed under the provisions of 32 CFR 199.10. The contractor is also responsible for providing notice to other appropriate agencies or offices in accordance with this chapter.*

5.4. Contractor Requirements For Terminating a Provider

When a provider's status as an authorized TRICARE provider is ended, the contractor will initiate termination action based on a finding that the provider or entity does not meet the qualifications to be an authorized provider.

NOTE: Separate termination action by the contractor will not be required for a provider or entity sanctioned under the exclusion authority granted DHHS/OIG.

5.4.1. Period Of Termination

The period of termination will be indefinite and will end only after the provider or entity has successfully met the established qualifications for authorized provider status under TRICARE and has been reinstated under TRICARE.

5.4.2. Notice Of Proposed Action To Terminate

The contractor shall notify the provider in writing of the proposed action to terminate the provider's status as an authorized TRICARE provider when the provider falls within the contractor's certifying responsibility and the provider fails to meet the requirements of 32 CFR 199.6 (Figure 14-A-10). The provider is not to be terminated when

RESOURCE SHARING

1.0. RESOURCE SHARING PROGRAM AGREEMENTS

Resource sharing consists of internal resource sharing (where the purpose of the resource sharing agreement is to supplement the services provided at MTFs) and external resource sharing (where the purpose of the external resource sharing agreement enables military health care personnel, active duty and civilian, to provide covered medical services to active duty and TRICARE beneficiaries in a network facility.) The following procedures apply to both internal and external resource sharing:

- The contractor shall develop and implement a resource sharing program for seeking agreements with individual MTF Commanders for the provision of medical personnel (who must comply with DoD directives for licensure, clinical appointment with the MTF, and participation in quality assurance reviews), support personnel, equipment and equipment maintenance, and/or supplies, by the contractor from the contractor's provider network and from private sources outside of the network for the purpose of enhancing the capabilities of MTFs to provide needed inpatient and outpatient care to beneficiaries. This program shall also address opportunities for military health care personnel and support personnel to provide covered medical services to MHS beneficiaries in a network facility.

2.0. RESOURCE SHARING PROGRAM REQUIREMENTS

The contractor shall meet the following resource sharing program requirements:

- 2.1. Develop a draft plan for identifying advantageous Resource Sharing opportunities in conjunction with the Regional Director and the MTF Commanders.
- 2.2. Finalize the draft plan for submission through the Regional Director to the Contracting Officer for approval. The contractor shall submit the finalized plan to the Regional Director no later than 60 calendar days prior to the start of each new health care delivery option period. Annually thereafter, a revised plan shall be submitted to the Regional Director 60 days prior to the start of each new health care option period. The plan shall discuss the contractor's general approach and methods for facilitating the identification of resource sharing opportunities throughout the Region, an evaluation of the overall costs and savings potential agreements should generate for the MHS and the contractor, and the contractor's approach to the development of agreements which adhere to resource sharing guidelines in [paragraph 2.0.](#) of this section.
 - 2.2.1. For internal resource sharing agreements, the plan shall include a description of the contractor's proposed methodology for developing a detailed cost analysis for each

resource sharing proposal. The cost analysis shall include the contractor's actual cost of providing the personnel, equipment, equipment maintenance, and/or supplies, the anticipated increase in services provided within the MTFs, the anticipated support required from the MTFs (labor, supplies, etc.) and the net savings to the government and the contractor.

2.2.2. For external resource sharing agreements, the plan shall include a description of the contractor's proposed methodology for developing a detailed cost analysis for each resource sharing proposal. The cost analysis shall include the MTF's actual cost of providing the services, the monetary benefits received by the contractor, projected workload, administrative costs, and the contractor's actual cost of providing services in support of external resource sharing providers.

2.3. The contractor shall comply with the DoD Health Insurance Portability and Accountability Privacy Regulation. The contractor shall develop, document and incorporate into its resource sharing program functions policies and procedures ensuring compliance with HHS Privacy Regulations. The contractor shall require resource sharing providers to use the DoD HIPAA Notice of Privacy Practices and HHS Privacy Regulation compliant authorization forms, when applicable. The contractor shall coordinate with the appropriate Regional Director to determine how they may assist the Military Health System with dissemination of the Notice of Privacy Practices to applicable TRICARE beneficiaries whenever there is a material revision to the DoD Notice of Privacy Practices.

2.4. After contract award, the contractor shall provide the MTF Commanders with a complete cost analysis within 30 calendar days of a written request for consideration of a potential resource sharing opportunity by the MTF Commanders, provided that the MTF is able to provide the MTF-specific cost and workload information necessary to perform the analysis within 15 calendar days of making the written request. The 30 calendar days will be extended on a day-to-day basis if all of the necessary data is not provided by the 15th calendar day after the written request.

2.5. Develop and implement procedures for monitoring resource sharing agreement performances.

3.0. RESOURCE SHARING AGREEMENT GUIDELINES

3.1. Internal Resource Sharing

Internal resource sharing shall be based upon written agreements between the contractor and the MTF Commanders, with Regional Director concurrence, and between the contractor and the resource sharing provider(s), support personnel, and/or equipment and equipment maintenance vendors, and supply vendors. Before a provider is permitted to practice in the MTF, he or she must be granted privileges by the MTF Commander to do so, based upon his or her credentials, in accordance with applicable regulations. Internal resource sharing agreements shall fully set forth the terms, conditions, and limitations of the resource sharing arrangements. Internal resource sharing agreements may include professional and support personnel, equipment and equipment maintenance, and supplies. The contractor shall forward copies of all proposed internal resource sharing agreements to the Regional Director for approval. The Regional Director will provide the contractor written

approval/disapproval within 30 calendar days of receipt. The contractor shall forward copies of all proposed approved resource sharing agreements and all supporting pricing information for the agreement to the Contracting Officer no later than ten calendar days following written notification by the Regional Director of the approval of the agreement. Upon receipt of an approved resource sharing agreement the Contracting Officer will evaluate the agreement and supporting documentation and request from the contractor any necessary information to make a determination that the agreed to amount for the agreement is fair and reasonable. Once the Contracting Officer has determined the amount fair and reasonable, the Contracting Officer will issue a task order obligating funds for the agreement and authorizing the contractor to proceed with performance of the agreement. The contractor shall provide resource sharing clinical personnel for the MTF's credential review within 90 calendar days of the issuance of a task order. The contractor shall provide administrative support personnel *completed credentialing packet* fulfilling the requirements of the resource sharing agreement within 60 calendar days of the issuance of a task order. No services shall be provided until a task order is issued by the contracting officer.

3.2. External Resource Sharing

External resource sharing shall be based upon written agreements between the contractor, the MTF Commander, and the network facility, with the Regional Director's concurrence. Before a military provider is permitted to practice in the network facility, the MTF Commander will ensure that the military provider has active clinical privileges with the network facility. The MTF Commander will also ensure that external resource sharing providers are licensed to practice medicine in a United States jurisdiction during the term of the resource sharing agreement. The resource sharing agreement shall set forth all the terms, conditions and limitations of the resource sharing arrangements. The MTF Commander shall forward copies of all completed external resource sharing agreements to the Regional Director for approval prior to the implementation of any resource sharing agreement. The Regional Director will provide the contractor written approval/disapproval within 30 calendar days of receipt. The MTF Commander shall forward copies of all approved resource sharing agreements to the Contracting Officer no later than ten calendar days following written notification by the Regional Director of the approval of the agreement.

4.0. SELECTION OF PROVIDERS

The contractor shall obtain input from the MTF Commanders regarding the requirements or needs of the Commanders for internal resource sharing providers. Based upon this input, the contractor shall select the resource sharing providers without any further involvement of the Government in the selection process, except for the privileging of the providers by the MTF Commander after the selection has been made.

5.0. COSTS

5.1. Costs borne by the contractor in providing services to TRICARE beneficiaries in MTFs shall be the responsibility of the contractor, subject to the compensation arrangements specified in this contract.

5.2. Under the authority of 10 U.S.C. 1095 and 32 CFR 220.8(k).(2), internal resource sharing providers shall not bill for any form of third party payment. The MTF with which the

resource sharing agreement was entered into will bill for and retain all funds available from a third party. The resource sharing provider's compensation from the contractor, whether by way of salary, fee-for-service, or other means, is entirely independent of any claim to, or payment from, any third party payer.

6.0. PROFESSIONAL LIABILITY

6.1. Internal Resource Sharing

The contractor shall be solely liable for negligent acts or omissions of the contractor's agents and shall ensure that providers maintain full professional liability insurance.

6.2. External Resource Sharing

While performing health care functions authorized by the MTF, designated health care personnel will be acting within the scope of their duties as determined by the Department of Justice. The United States Government will be responsible for their actions within the scope of their duties. As such, any remedy for damages for personal injury, including death, caused by their negligence or wrongful acts or omissions shall be exclusively against the United States under provisions of the Federal Torts Claims Act (title 28 U.S.C., sections 1346(b), 2671-2680) and not against the individual military health care provider. In the event any DoD health care provider is asked to respond to an emergency involving a non-DoD beneficiary, the state's borrowed servant defense and any other applicable defenses and immunities available to the United States will apply to allegations of negligence or wrongful acts or omissions arising from care rendered by the provider.

7.0. CREDENTIALS, PRIVILEGING, AND OTHER PROVIDER REQUIREMENTS

All categories of staff provided by the contractor to the MTF shall meet the licensing and privileging requirements of [32 CFR 199.6](#). In addition, the staff members must agree to comply with the licensing and privileging directives of the MTF and to fully participate in MTF quality assessment and improvement activities required by the MTF. The contractor shall provide the MTF Commander with the original and one copy of all information on credentials for civilian providers working in the MTF. (The original document will be returned upon the completion of the MTF credentialing process.) The contractor is responsible for querying the National Practitioner Data Bank about each provider upon initial appointment and every two years thereafter and for providing the MTF Commanders with copies of the National Practitioner Data Bank report each time one is received on a resource sharing provider. DoD requirements for the basic credentials and privileging of health care providers are set forth in [32 CFR 199.6](#), and DoD Directives 6025.6, 6025.11, and 6025.14. The contractor shall provide the MTF Commanders with all documentation required by these and all applicable Army, Navy or Air Force directives at least 30 calendar days prior to the provider's first day of work in an MTF. For external resource sharing military health care personnel, the MTF Commanders will ensure that the military health care personnel are appropriately licensed and have active clinical privileges with the network facility.

8.0. SUPERVISION OF RESOURCE SHARING PERSONNEL

When contractor personnel are placed in MTF facilities, these personnel are supervised or controlled by the contractor for the purposes of directing the terms and conditions of employment. However, this does not preclude resource sharing personnel from complying with directions received from MTF professional personnel in the course of patient care activities. Additionally, these contractor furnished personnel shall comply with privileging requirements, utilization review / management criteria and procedures, quality assessment procedures and criteria, and peer review and quality of care reviews in accordance with the policy, procedures, and regulatory provisions established for government practitioners (32 CFR 199.6; 32 CFR 199.15; and TRICARE Policy Manual, Chapter 11). With respect to external resource sharing agreements, the external resource sharing health care personnel's military command is responsible for the supervision of the external resource sharing health care personnel.

9.0. RECORD KEEPING

The contractor shall maintain accurate records to document activities related to resource sharing agreements. These records shall include accurate recording of the personnel performing services in network facilities or MTFs, identifying for each individual the name, social security number, type of provider or staff, the hours worked in the facility and/or MTF, and for internal resource sharing agreements, the associated workload, salaries, compensation and expenses for the individual. For equipment, records shall include identifying information, date placed in service, and maintenance information. For supplies, records of types and quantities supplied shall be recorded. For cash payments, records of expenditures shall be kept along with supporting receipts from the MTF. All costs borne by the contractor shall be identified. These records of resources shared shall be provided to the MTF Commanders (or their designees) and the Regional Directors no later than the last working day of the month following the month in which the reported workload was performed.

10.0. AUDITS

Contractor resource sharing expenditures are subject to audit by the government.

GENERAL

1.0. INTRODUCTION

The TRICARE Prime Remote (TPR) program provides health care to active duty service members (ADSMs) in the United States and the District of Columbia who meet the eligibility criteria listed in below.

2.0. ELIGIBILITY

2.1. Eligibility criteria are included for information purposes only. Contractors have no responsibility for determining eligibility or for deciding in which region an active duty service member shall enroll. These responsibilities lie with the Military Services. Regional Directors will furnish contractors with enrollment information (refer to [paragraph 3.0](#) below). If a contractor receives a claim for care provided to an active duty service member who is not enrolled in TPR or who is not enrolled in TRICARE Prime at an MTF, the contractor shall process the claim according to the applicable guidelines of the Supplemental Health Care Program ([Chapters 18](#) or [19](#)).

2.2. To receive health care services under the TRICARE Prime Remote program, an individual must be an active duty member of the Uniformed Services (Army, Air Force, Navy, Marine Corps, Coast Guard, United States Public Health Service [USPHS] and the National Oceanic and Atmospheric Administration [NOAA] including eligible members of the National Guard/Reserves on orders for more than 30 consecutive days) who meets the following eligibility requirements:

2.2.1. Has a permanent duty assignment that is greater than 50 miles (based on ZIP codes) or approximately one hour drive from a military medical treatment facility (MTF) or military clinic designated as adequate to provide the needed primary care services to the active duty service member; and

2.2.2. Pursuant to the assignment of such duty, resides at a location that is greater than 50 miles (based on ZIP codes) or approximately one hour drive from an MTF or military clinic designated as adequate to provide the needed primary care services to the active duty service member.

2.3. The Uniformed Service determines eligibility for the TRICARE Prime Remote (TPR) program; the contractor enrolls designated ADSMs in TPR. At the discretion of the Chief Operating Officer, TRICARE Management Activity (or designee to include the appropriate Regional Director), exceptions to the eligibility criteria may be made as follows:

- 2.3.1.** Where the unit is located in one region (or contract area) and the ADSM lives in an area served by a different contractor, the ADSM may be enrolled with the contractor for the region serving the unit's location rather than the ADSM's residence;
- 2.3.2.** Where the unit is located and the ADSM lives in one region, but the closest PCM is located across the border in another region, the ADSM may be enrolled in the region where the PCM is located rather than the ADSM's residence;
- 2.3.3.** Where geographical barriers or other unique situations are determined to exist (e.g., the drive time to the closest MTF exceeds one hour), the unit commander may submit a request for a waiver of the eligibility criteria to the regional Regional Director. The Regional Director will review the request and forward a recommendation along with the unit commander's request to the Chief Operating Officer, TRICARE Management Activity (TMA), Skyline Five, Suite 810, 5111 Leesburg Pike, Falls Church, VA 22041-3206, for a determination.
- 2.4.** The Military Services may require individual active duty members to enroll to a military Primary Care Manager if there are fitness for duty related concerns, such as for those members in active special duty positions. Each Military Service is responsible for educating and monitoring subordinate commands regarding any special policies.

2.5. *ADSM Astronauts assigned to the Johnson Space Center in Houston, Texas must and shall be enrolled in TPR.*

3.0. TRICARE PRIME REMOTE PROGRAM UNITS

The Military Services will identify the military work units known as TRICARE Prime Remote (TPR) program units to which ADSMs eligible for TPR are assigned and forward the identifying data to the Regional Directors. The Regional Director will supply the contractor with an electronic directory, updated as needed, that lists, by region, the designated TPR ZIP codes for the contractor's region(s). The Regional Director will also provide unit listings to the contractor so that the contractor can mail educational materials to the units. In some instances, individual member listings (as opposed to units) may be provided.

4.0. BENEFITS

4.1. ADSMs enrolled in the TRICARE Prime Remote program are eligible for the Uniform HMO Benefit, even in areas without contractor networks. Some benefits (see [Chapter 17, Section 2](#) and [Chapter 17, Addendum B](#)) require review by the member's SPOC so that the Services are aware of fitness-for-duty issues. In addition, if the contractor determines that services on a TPR enrollee's claim are not covered under the Uniform Benefit, or that the provider of services is not a TRICARE-authorized provider, or that the provider has not been certified as a TRICARE-authorized provider, the contractor shall supply the claim information ([Chapter 17, Addendum D](#)) to the SPOC for a coverage determination. The contractor shall continue with provider certification procedures but shall follow SPOC direction for claim payment with no delay even if the provider certification process is not completed. Upon direction from the member's parent service, the SPOC may authorize health care services not included in the Uniform Benefit and services furnished by providers who are not TRICARE-authorized/certified providers if the health care is

specifically required to maintain fitness-for-duty or retention on active duty. 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. SPOCs do not have the authority to overturn TMA or Department of Health & Human Services provider exclusions. See [Chapter 17, Section 2](#) for referral and authorization requirements.

4.2. SPOC-authorized services (those determined by the member's Service to be necessary to maintain fitness-for-duty and/or retention on active duty) will be covered even if they are not ordinarily covered under the TRICARE Prime program and/or if they are supplied by a provider who is not TRICARE-authorized or certified. A SPOC authorization shall be deemed to constitute referral, authorization, and direction to bypass edits as appropriate to ensure payment of SPOC-approved claims. Contractors shall implement appropriate measures to recognize SPOC authorization in order to expedite claims processing.

5.0. SERVICE POINTS OF CONTACT (SPOC)

Special Military Service controls and rules apply to ADSMs due to unique military requirements to maintain readiness. The Services will always retain health care oversight of their personnel through their Service Points of Contact (SPOCs). The SPOC serves as liaison among the ADSM, the ADSM's Military Service, and the contractor for managing the ADSM's health care services. The SPOC reviews referrals for proposed care as well as information about care already received in order to determine impact on an individual's fitness for duty (see [Chapter 17, Section 2](#) and [Chapter 17, Addendum D](#) for referral and review/authorization procedures). The SPOC, the primary care manager (PCM) (if assigned) and the contractor shall work together in making arrangements for the ADSM's required military examinations. The SPOC will provide the protocol, procedures, and required documentation through the contractor to the provider for these examinations. For required military care that may not be obtainable in the civilian community, the SPOC will refer the ADSM to a military medical treatment facility (MTF) or other military source of care. See [Appendix A](#), for definitions of "Service Point of Contact (SPOC)." Refer to [Chapter 17, Addendum A](#) for the addresses and telephone numbers of the SPOCs.

6.0. APPEAL PROCESS

6.1. If the contractor, at the direction of the Service Point of Contact (SPOC), denies authorization of, or authorization for reimbursement, for a TPR enrollee's health care services, the contractor shall, on the Explanation of Benefits or other appropriate document, furnish the enrollee with clear guidance for requesting a reconsideration from or filing an appeal with the SPOC (see [paragraph 6.2.](#) below). The SPOC will handle only those issues that involve SPOC denials of authorization or authorization for reimbursement. The contractor will handle allowable charge issues, grievances, etc.

6.2. A TPR enrollee may appeal SPOC denials of authorization or authorization for reimbursement through the SPOC--not through the contractor. If the enrollee disagrees with a denial, the first level of appeal will be through the Service Point of Contact. The enrollee may initiate the appeal by contacting his/her Service Point of Contact 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 enrollee of further appeal rights with the appropriate Surgeon General's office.

6.3. If the denial is overturned at any level, the SPOC will notify the contractor and the ADSM.

6.4. 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.

7.0. ACTIVE DUTY FAMILY MEMBERS (ADFMS) AND OTHERS

TRICARE-eligible active duty family members (ADFMs) accompanying ADSMs who are either eligible for or enrolled in the TRICARE Prime Remote program may enroll in TRICARE Prime Remote for Active Duty Family Members Program in accordance with [Chapter 17, Section 6](#).

8.0. TRICARE PRIME REMOTE PROGRAM DIFFERENCES

8.1. ADSMs have no cost-shares, copayments or deductibles.

8.2. If the contractor has not established a network of PCMs in a remote area, a TRICARE Prime Remote designated ADSM will still be enrolled without a PCM assigned. The ADSM without an assigned PCM will be able to use a local TRICARE-authorized provider for primary health care services without SPOC review.

8.3. Point of Service cost-sharing and deductible amounts do not apply to ADSMs enrolled in the TRICARE Prime Remote program. If an ADSM receives primary care without a referral or authorization, the enrolling contractor shall process the claim and make payment if the care meets all other TRICARE requirements (i.e., the care is medically necessary, a benefit of TRICARE Prime, furnished by an authorized/certified provider, etc.). If services do not meet the requirements of TRICARE Prime, the contractor shall supply the claim information to the SPOC for coverage determination. See [Chapter 17, Section 2, paragraph 5.3.2](#) for information on self-referred care.

8.4. Annual ADSM re-enrollment is not required.

8.5. If the armed forces determine that an active duty member is eligible for the TRICARE Prime Remote program, enrollment of the member is mandatory, unless there are service-specific issues that merit assignment to a military PCM (see [paragraph 2.4](#)), or if the ADSM elects to waive access standards and enrolls to an MTF (subject to unit commander/supervisor approval).

8.6. There will be no application by the contractor of OHI processing procedures for ADSM TPR claims.

8.7. If third party liability (TPL) is involved in a claim, ADSM claim payment will not be delayed during the development of TPL information from the ADSM.

MARKETING, ENROLLMENT, AND SUPPORT SERVICES

1.0. MARKETING

Enrollment in the TRICARE Prime Remote Program (TPR) is mandatory for ADSMs who qualify for the program (see [Section 1, paragraph 2.0.](#)); therefore, the MCS contractor shall limit marketing activities for TPR-enrollees to distributing the marketing materials provided by the Government. The Regional Director will determine the initial supply of materials required and the MCS contractor shall forward materials to the TPR Program Units. The contractor shall include enrollment forms for the TRICARE Prime Remote Program in the ADSM marketing materials.

2.0. ENROLLMENT

2.1. The Regional Director will, on an as needed basis, but at least semi-annually, provide the contractor with an update to the TRICARE Prime Remote directory of units whose members are eligible for enrollment in the program according to [Chapter 17, Section 1, paragraph 3.0.](#)

2.2. An enrollment application (supplied by the contractor) must be completed and signed by either the ADSM or the ADSM's unit commander for each ADSM enrolling in the TRICARE Prime Remote Program. The completed and signed application will be submitted to the contractor. The effective date for TRICARE Prime Remote Program enrollment is the date the contractor receives the signed enrollment application.

2.3. ADSM enrollment in the TRICARE Prime Remote Program will be for the tour of duty. Enrollment transfers or disenrollments will occur upon change of duty location out of the region, transfer into an MTF/clinic Prime service area, retirement, or separation from the service. The ADSM will be responsible for notifying the contractor when an enrollment transfer is needed. The contractor shall follow enrollment portability and transfer procedures in [Chapter 6, Section 2.](#)

2.4. The contractor shall enroll the ADSM into the Defense Enrollment Eligibility Reporting System (DEERS) via DEERS Online Enrollment System (DOES). The TPR enrollment card is provided by DMDC. *When processing TPR enrollment applications from ADSM Astronauts, the contractor shall not assign the astronauts to a network or other TRICARE authorized Primary Care Manager (PCM). The NASA providers shall provide primary care for the ADSM Astronauts and the contractor shall use the PCM (unassigned) procedure when enrolling ADSM Astronauts into the TPR program. The contractor shall coordinate referrals and authorizations from the NASA providers for TPR enrolled ADSM Astronauts in accordance with Chapter 17, Section 2, paragraph 5.3. and its subordinate paragraphs.*

3.0. PCM ASSIGNMENT

At the time of enrollment, an ADSM will select (or will be assigned) a PCM in the local community, if available. An ADSM without an assigned PCM may use a local TRICARE-authorized provider for primary care.

4.0. EDUCATION

4.1. The Government will provide all education materials unique to the TRICARE Prime Remote program. Educational issues include the Primary Care Manager concept (and what procedures to follow when a network PCM is not assigned), how to access care in and out of the area using the contractor, how to access specialty care through the contractor and SPOC, and information on filing medical claims.

4.2. The Government will provide all TPR enrollees with information about how to obtain self-care manuals. The contractor shall give ADSMs and their family members the option of participating in health promotion and wellness programs offered in MTF Prime service areas and Prime program locations established by the contractor.

4.3. Educational activities in the TRICARE Prime Remote Program areas shall involve the joint efforts of the service unit of the ADSM, the SPOCs, the Service Medical Departments, the Regional Director, and the contractor. The contractor shall distribute TMA-supplied educational materials unique to the TRICARE Prime Remote Program. The contractor is responsible for postage, envelopes, and mailing costs for distributing educational material.

5.0. The contractor shall include TRICARE Prime Remote Program information and updates as part of all TRICARE briefings. Ongoing briefings will be on an “as needed” basis and will be coordinated with the Regional Director. The contractor shall maintain records of the briefings to include a summary of the briefings with the dates, times, locations, and lists of attendees. The contractor may propose alternative methods for supplying educational information to ADSMs eligible to enroll in the TRICARE Prime Remote Program. The Regional Director and the Military Services will provide TPR briefings on an “as needed” basis.

6.0. SUPPORT SERVICES

6.1. General

The requirements and standards in [Chapters 1](#) and [12](#), apply to the TRICARE Prime Remote Program unless otherwise stated in this chapter.

6.2. Inquiries

6.2.1. The contractor shall designate a point of contact for Government (Regional Director, TMA, and Military Service) inquiries related to the TRICARE Prime Remote Program. The contractor may establish a dedicated unit for responding to inquiries about the TRICARE Prime Remote Program and the Supplemental Health Care Program (see [Chapter 18](#), Civilian Care Referred by MHS Facilities, and [Chapter 19](#), Civilian Health Care of Uniformed Service Members). The contractor shall respond to all inquiries--written,

telephone, walk-in, etc.-- that are not related to dental care or to SPOC reviews of medical care. The contractor shall forward all inquiries that specifically address dental care or SPOC review of medical care to the TPR enrollee's SPOC for response. The requirements and standards in [Chapter 1, Section 3](#), apply to TPR inquiries.

6.3. Toll-Free Telephone Service

The contractor shall provide a dedicated toll-free telephone line or extension for TRICARE Prime Remote (TPR) program beneficiary inquiries. This line may also serve the Supplemental Health Care Program beneficiaries (see [Chapters 18 and 19](#)). See [Chapter 1, Section 3](#) for telephone standards. The contractor shall handle provider inquiries through the contractor's provider inquiry system.

GENERAL

1.0. INTRODUCTION

1.1. The Supplemental Health Care Program (SHCP) replaces the Active Duty Claims Program (ADCP). This chapter provides instructions to contractors regarding their responsibilities under the SHCP as well as providing general information to the contractor regarding the roles and responsibilities of the Uniformed Services.

1.2. The Department of Defense and the Armed Forces have agreed to a mechanism that enables processing and reimbursement of SHCP claims by Managed Care Support (MCS) contractors and payment to the contractors through the TRICARE Management Activity (TMA), Office of Contract Resource Management.

1.3. This chapter addresses payment of claims for civilian services (including internal resource sharing services) rendered pursuant to a referral by a provider in a Military Treatment Facility, with the exception of services rendered to enrollees in the TRICARE Prime Remote program (see [Chapter 17](#)) or as otherwise excepted in [Chapter 18, Section 3, 3.0](#). The fact that civilian services have been rendered to an individual who is enrolled to an MTF PCM does not mean that those services were MTF referred care. If a claim is received for an ADSM MTF enrollee and no authorization is on file, the MTF must be contacted to determine if the care was MTF referred.

1.4. This chapter is not applicable to active duty service members enrolled overseas. Claims authorization and payment procedures for active duty service members enrolled overseas are outlined in the TRICARE Policy Manual, [Chapter 12](#), TRICARE Overseas Program.

2.0. MILITARY SERVICE PARTICIPATION IN THE SHCP

Medical Treatment Facility (MTF) patients may require medical care that is not available at the MTF (e.g., MRI). The provisions of this chapter apply when the MTF refers a patient for civilian medical care (usually a specific test, procedure or consultation), including services rendered by an internal resource sharing provider. Claims for this type of care will usually be submitted by the provider; however, the patient or the Services (e.g., the MTF) may submit the claim depending on the particular situation. The contractor shall ensure cost shares, copayments or deductibles are applied only when appropriate.

3.0. CONTRACTOR RESPONSIBILITIES

As part of the Department of Defense's ongoing efforts to improve coordination between military treatment facilities and civilian treatment sources, the current practice of using TRICARE payment rules for care provided under the SHCP has been expanded. The

contractor shall provide payment for inpatient and outpatient services, for MTF-referred civilian care within the 50 United States and the District of Columbia ordered by an MTF provider for an MTF patient for whom the MTF provider maintains responsibility. After payment of the claim, the contractor shall furnish the Services with information regarding payment of the claim. (See [Chapter 18, Section 3, paragraph 9.0.](#))

4.0. SUPPLEMENTAL HEALTH CARE PROGRAM DIFFERENCES

4.1. Active Duty Service Members (ADSMs) have no cost-shares, copayments or deductibles. If they have been required by the provider to make “up front” payment they may upon approval be reimbursed in full for amounts in excess of what would ordinarily be reimbursable under TRICARE.

4.2. Nonavailability Statement requirements do not apply.

4.3. *SHCP* claims are included in the measurement of the claims processing standards in [Chapter 1, Section 3, paragraph 1.0.](#) and [3.0.](#)

4.4. If *Third Party Liability* (TPL) is involved in a claim, claim payment will not be delayed; the development of TPL information is not required.

4.5. The contractor shall provide MTF-referred patients the full range of services offered to TRICARE Prime enrollees.

PAYMENT FOR CONTRACTOR SERVICES RENDERED

1.0. TED VOUCHER SUBMISSIONS

The contractor shall report the *Supplemental Health Care Program (SHCP)* claims on *TRICARE Encounter Data (TED)* vouchers.

2.0. PAYMENT TO THE CONTRACTOR

The contractor shall be reimbursed on a non-financially underwritten basis for the health care costs incurred for each SHCP claim processed to completion, according to the provisions in [Chapter 3, Section 3](#).

3.0. AUDITS AND INSPECTION OF THE CONTRACTOR'S RECORDS

3.1. The contractor's records and performance shall be subject to periodic inspection at the discretion of the *TRICARE Management Activity (TMA)* and/or any of the Service Project Officers. Such inspections shall be conducted either at TMA or at the contractor's facility in accordance with the provisions described in [Chapter 15, Section 1](#). The Service Project Officers will coordinate with TMA any audit or inspection of the contractor's records.

TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002

CHAPTER 20, SECTION 4

OPERATION NOBLE EAGLE/OPERATION ENDURING FREEDOM RESERVIST AND NATIONAL GUARD
BENEFITS DEMONSTRATION

5.0. EFFECTIVE DATES

This demonstration is effective for claims for services provided on or after September 14, 2001, and before November 1, *2009*.

more than an additional 30 days provided that they notify the individual in writing of the delay and the expected date of completion. Only one 30 calendar day extension may be allowed under the HHS Privacy *Rule*. The contractor shall document receipt of all access requests using a date stamp and maintain an index to record pertinent information and actions. If the contractor denies access to the protected health information or the record, they shall forward the request within seven working days from receipt to the Regional Director. The contractors shall notify the beneficiary within three working days that their request was forwarded to the Regional Director. The Regional Director shall review the request and make a determination within 20 calendar days (50 calendar days for justified delays) of the request. The Regional Director will notify the individual, with a copy to the contractor, of any approved or denied access determinations and the reason for any denial. The individual may appeal the denial determination to the TMA Privacy Officer. In the event of an appeal, the TMA Privacy Officer will notify the individual of the determination, with copies sent to the Regional Director and the contractor.

2.3.6. The contractor shall charge only reproduction costs and fees will be waived when those costs are under \$30. There will be no charge when the copying is for the contractor's or the TRICARE health plan's convenience.

2.3.7. The contractor shall provide a written accounting of disclosures as allowed under the HHS Privacy *Rule* and the DoD Health Information Privacy Regulation upon written request from the individual. The contractor shall use existing disclosure accounting processes in place for the Privacy Act of 1974 as identified in [Chapter 1, Section 5](#). The HHS Privacy *Rule* requires an accounting of disclosures for the previous 6 years from the date of the request.

2.3.8. Requesting An Amendment

The contractor shall document the title(s) of the person(s) or office(s) responsible for receiving and processing requests for amendments by individuals.

2.3.8.1. If an individual requests amendment to their protected health information (PHI) under the Privacy Act of 1974, the contractor shall follow the requirements in [Chapter 1, Section 5](#), to ensure compliance with the Privacy Act of 1974.

2.3.8.2. If an individual requests amendment to their PHI under the HHS Privacy *Rule*, the request shall be processed in accordance with that *rule*.

2.3.8.3. All amendment requests are submitted in writing. The contractor shall amend the PHI or record, within 60 calendar days of receipt of the request. The contractor shall provide a written reason for any extension beyond 60 calendar days from the date of the request and the date of completion to the individual who made the request with a courtesy copy to the Regional Director. Only one 30-calendar day extension may be allowed under the HHS Privacy *Rule*. The contractor shall document receipt of all amendment requests using a date stamp and maintain an index to record pertinent information and actions. If the contractor decides they will not amend the PHI or the record, they shall forward the request to the Regional Director within 20 calendar days from receipt of the request. The Regional Director shall review the request and make a determination within 45 calendar days (80 days for justified delays) from the receipt of the request. The Regional Director will notify the

individual, with a copy to the contractor, of any approved or denied amendment determinations and the reason for any denial. The individual may appeal the denial determination to the TMA Privacy Officer. Whoever makes the decision on whether to amend or not shall be the responsible agent for communicating with the beneficiary regarding their amendment request and will furnish copies of the determination to the appropriate parties.

2.3.9. The contractor shall permit individuals to request and must accommodate reasonable requests by individuals to receive communications of protected health information from the contractor by alternative means or at alternative locations. Requests for confidential communications shall be addressed to the contractor. The contractor shall maintain a log of all requests for alternative communications to include a control number, name and address of individual, date request received, date request was completed, and the requested action.

2.4. Reports To TRICARE Management Activity

2.4.1. The contractor shall forward a monthly report to the Regional Director with copies to the TMA Privacy Officer and the COs, which identifies the beneficiary's name, nature of the complaint, the steps taken to resolve the complaint, the date of the initial complaint, and the expected date of resolution or the date resolved. This report shall be sent no later than the 10th calendar day of the month following the month being reported. The contractor shall use the sample report at [Chapter 21, Addendum C, Figure 21-C-1](#).

2.4.2. The contractor shall approve or disapprove the restriction requests on protected health information within seven working days of receiving the request. If the request is approved the contractor shall notify the requestor and the Regional Director and shall implement the provision of the restriction within seven working days of the decision. If the request is denied the contractor shall notify the requestor of the reason for denial within seven working days of the decision. Termination of restriction requests by individuals must be in writing.

2.4.3. Requests received by the contractor for a restriction placed on communications by individuals must be in writing. The contractor shall accommodate reasonable requests by individuals to receive communications of protected health information to alternative locations or means if the individual clearly states the disclosure of all or part of their protected health information could endanger them. For example, an individual requests that the explanation of benefits about particular services be sent to their work place rather than a home address because the individual is concerned that a member of their household might read the explanation of benefits and become abusive towards them.

2.5. Authorizations

2.5.1. The contractor shall use authorizations conforming to the core elements identified in the HHS Privacy Rule at §164.508(c), as necessary. The contractor shall obtain a signed authorization for any use and disclosure consistent with the DoD Health Information Privacy Regulation Chapter 5 and the HHS Privacy Rule §164.508(a). When an authorization is obtained from an individual, a copy shall be furnished to them. The contractor shall allow individuals to revoke their authorization.

2.5.2. If the contractor requires the psychotherapy notes of an individual, the contractor shall obtain a signed authorization from that individual. Under the HHS Privacy Rule, the MCSC shall not release the psychotherapy notes to the individual who is the subject of the notes. However, under the Privacy Act of 1974 case law, the individual may have access to all of their health information, including their psychotherapy notes. Due to such complexities, the MCSC shall refer all determinations for release of psychotherapy notes to the TMA Office of General Counsel.

2.5.3. The contractor shall ensure special report requests using or disclosing individuals' protected health information comply with the HHS Privacy Rule definitions of treatment, payment or health care operations. If not, an authorization from the beneficiary is required.

2.5.4. HIPAA authorizations acquired or used by the contractor in the development and processing of claims or required for other contractor functions, such as fraud and abuse, shall be stored and maintained with the appropriate record categories described in [Chapter 2](#).

2.5.5. When the beneficiary requests the contractor to release PHI to other individuals, except for purpose of treatment, payment, and healthcare operations, the beneficiary must have executed a HIPAA compliant authorization in accordance with [paragraph 2.5.1](#). Without an authorization neither TMA nor its contractors may release the PHI to other individuals. However, TMA and its contractors may release PHI when an authorization form is signed by an individual who is the attorney-in-fact (grantee) for a beneficiary (grantor) provided the beneficiary has executed a proper power of attorney. A proper power of attorney will authorize the attorney-in-fact to perform acts on behalf of the beneficiary and has similar language to the following examples of acceptable language: "Handle the grantor's medical affairs"; or "Prepare and file government applications and requests"; or Power and authority to do and perform each and every act and matter concerning the grantor's affairs as fully and effectually to all intents and purposes as the grantor could do legally if the grantor were present."

2.5.5.1. The contractor shall ensure that when a beneficiary cannot execute an authorization, that they and/or their attorney-in-fact is informed, that the attorney-in-fact can execute a HIPAA compliant authorization provided the beneficiary has executed a proper power of attorney as described above.

2.6. Notice Of Privacy Practices

2.6.1. The contractor shall annually notify individuals, who are normally mailed educational literature on TRICARE, of the availability of the Notice of Privacy Practices and how to obtain it. This notification shall occur only through beneficiary education as permitted within existing contract limitations and requirements. No additional or special marketing or beneficiary education campaigns are required.

2.6.2. The contractor shall provide a copy of the notice to TRICARE beneficiaries upon request. TMA will maintain a current notice on the TRICARE web site at <http://www.tricare.osd.mil>. The contractor shall maintain a link to the TMA Notice of Privacy Practices on their web site. The TMA Privacy Officer is responsible for maintenance of the notice.

2.7. Business Associate Contracts

TMA considers the contract between TMA and the contractor as a business associate. Specifically, [Chapter 21, Section 2](#), which is incorporated into the contract by reference, satisfies the requirements of §164.504(e).

2.7.1. The contractors shall ensure that any subcontractors or agents to whom it provides protected health information received from, or created or received by the contractor on behalf of the TRICARE health plan, agrees to the same restrictions and conditions that apply to the contractor with respect to such information.

2.7.2. The contractor shall use and disclose protected health information for the proper management and administration and to carry out the legal responsibilities of the contractor. The contractor may disclose the information received by them in this capacity if:

- The disclosure is required by law; or
- The contractor obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person; and
- The person notifies the contractor of any instances of which it is aware when the confidentiality of the information has been breached.

2.7.3. The contractor shall not use or further disclose the protected health information other than as permitted or required by this section, or as required by the HHS Privacy Rule, DoD Health Information Privacy Regulation, or law.

2.7.4. The contractor shall report to TMA through the Regional Director any use or disclosure of the information not provided for by its contract of which it becomes aware.

2.7.5. The contractor shall make available protected health information in accordance with the HHS Privacy Rule, §164.524, DoD Health Information Privacy Regulation, Chapter 11 and TMA Privacy requirements.

2.7.6. The contractor shall make available information required to provide an accounting of disclosures in accordance with the HHS Privacy Rule, §164.528, DoD Health Information Privacy Regulation, Chapter 13 and TMA Privacy requirements.

2.7.7. The contractor shall make its internal practices, books, and records relating to the use and disclosure of protected health information received from, created, or received by the contractor on behalf of the TRICARE health plan, available to TMA, or at the request of TMA to the Secretary, for purpose of the Secretary determining the TRICARE health plan's compliance with the HHS HIPAA Privacy Rule.

2.7.8. The contractor agrees to mitigate, to the extent practicable, any harmful effect that is known to the contractor of a use or disclosure of protected health information by the contractor in violation of the requirements of this agreement.

2.7.9. The contractor agrees to provide access, at the request of TMA, and in the time and manner designated by TMA, to protected health information in a designated record set, to TMA or as directed by TMA, to an individual in order to meet the requirements under the HHS Privacy Rule §164.524 and the DoD Health Information Privacy Regulation, Chapter 11.

2.7.10. The contractor agrees to make any amendment(s) to protected health information in a designated record set that TMA directs or agrees to pursuant to the HHS Privacy Rule, §164.526 or the DoD Health Information Privacy Regulation, Chapter 12, at the request of TMA or an individual, and in the time and manner designated by TMA.

2.8. Documentation

2.8.1. The contractor shall document, implement and maintain policies and procedures required to comply with HHS Privacy Rule and the DoD Health Information Privacy Regulation. These policies and procedures shall be made available upon government request. The contractor shall develop or update their policies and procedures to include, for example, the following:

- Minimum Necessary Rule.
- Verifying identity of persons seeking disclosure.
- Identify circumstances when the entire medical record is needed.
- Disclosure accounting documentation.
- All privacy complaints received and their disposition.
- To cooperate and coordinate with HHS Secretary and Office of Civil Rights (OCR) when investigating privacy violations.
- The name and title of the privacy official and contact person or office who is responsible for receiving complaints and requests for access and amendments by individuals.
- Training requirements.
- Sanctions imposed against non-complying workforce members.
- Whistleblower provisions.
- Release of PHI to personal representatives, release of PHI related to deceased individuals, and release in abuse, neglect and endangerment situations.
- Providing an individual access to their protected health information, except for those instances identified in the HHS Privacy Rule, §164.524.
- Providing an individual the right to request restrictions of uses and disclosures of their protected health information to carry out treatment, payment, and

health care operations; and disclosures to family and friends involved in the patient's care. All restriction requests must be submitted in writing.

- Restriction terminations.
- Providing individuals the right to receive confidential communications.
- Providing individuals the right to request amendment of protected health information.
- Performing initial and periodic information privacy risk assessments and conducting related ongoing compliance monitoring activities, as applicable.
- Safeguarding protected health information from intentional or unintentional misuse.
- Authorizations, including revocation procedures.

2.8.2. The contractor shall retain all documentation, files, and records related to protected health information in accordance with [Chapter 2, Section 2](#).

2.9. Safeguards

The contractor shall have in place administrative, technical, and physical safeguards to protect the privacy of protected health information in all forms, including electronic communications, oral communications and paper formats. The safeguards shall be in accordance with [Chapter 1, Section 5, paragraph 4.3](#). and the DoD Privacy Program, DoD 5400.11-R, Chapter 1, paragraph D, regarding safeguarding and individual's protected health information applicable for compliance with the Privacy Act of 1974.

2.10. Regional Director/MTF And Contractor Interfaces

2.10.1. Resource sharing is considered a covered function of treatment, payment and health care operations by the HHS Privacy Rule and the DoD Health Information Privacy Regulation. Contractors as business associates are subject to the HHS Privacy Rule when conducting resource sharing functions as outlined in [Chapter 16, Section 2](#).

2.10.2. The contractor shall develop, document and incorporate into its resource sharing program functions policies and procedures ensuring compliance with the HHS Privacy Rule and the DoD Health Information Privacy Regulation.

2.10.3. The contractor shall require resource sharing providers to use the MHS Notice of Privacy Practices and HHS Privacy Rule compliant authorization forms, when applicable.

2.10.4. The contractor shall coordinate with the appropriate Regional Director to determine how they may assist the Military Health System with dissemination of the Notice of Privacy Practices to applicable TRICARE beneficiaries whenever there is a material revision to the MHS Notice of Privacy Practices.

2.10.5. The contractor shall forward initial privacy risk assessments and the accompanying action plan to the Contracting Officer with copies to the Regional Director, the Administrative Contracting Officer and the TMA Privacy Officer, for review and monitoring of compliance (see [paragraph 2.2.1.](#)).

2.10.6. The contractor shall forward an annual letter of assurance ([Chapter 21, Addendum C, Figure 21-C-2](#)) to the Regional Director, with copies to the CO, ACOs, CORs and the TMA Privacy Officer.

2.10.7. The contractor shall forward all requests for non-routine disclosures through the Regional Director to the TMA Privacy Officer (see [paragraph 2.3.3.](#)).

2.10.8. The contractor shall provide a copy of all amendment response extensions to the Regional Director (see [paragraph 2.3.8.3.](#)).

2.10.9. The contractor shall document receipt of all access requests using a date stamp and maintain an index to record pertinent information and actions. If the contractor decides they will not grant access to the protected health information or the record, they shall forward the request within seven working days from receipt of the request to the Regional Director (see [paragraph 2.3.4.](#)).

2.10.10. The contractor shall forward a monthly report to the Regional Director, which identifies the beneficiary's name, nature of the complaint, the steps taken to resolve the complaint, the date of the initial complaint, and the expected date of resolution or the date the complaint was resolved (see [paragraph 2.4.1.](#)).

REPORTS

FIGURE 21-C-1 COMPLAINT REPORT (SAMPLE)

CONTRACTOR MONTHLY COMPLAINT REPORT TO THE REGIONAL DIRECTOR					
BENEFICIARY'S NAME	NATURE OF COMPLAINT	CONTRACTOR'S STEPS TO RESOLVE COMPLAINT	DATE OF INITIAL COMPLAINT	DATE OF EXPECTED RESOLUTION	DATE COMPLAINT RESOLVED

FIGURE 21-C-2 ANNUAL RISK ASSESSMENT LETTER OF ASSURANCE (SAMPLE)

TRICARE Management Activity (TMA)/Contract Management
16401 E. Centretch Parkway
Aurora, Colorado 80011
ATTN: Administrative Contracting Officer

Dear _____:

An annual risk analysis of all systems, policies, procedures and practices of (name of contractor) in effect during the year ended (date) was performed in accordance with requirements outlines in the TRICARE Operations Manual, [Chapter 21, Section 3](#), and the HHS HIPAA Privacy *Rule*.

The objectives of the risk analysis were to provide reasonable assurance that:

1. Review policies, procedures, processes and practices relating to privacy, and the uses and disclosures of PHI to ensure compliance with the requirements set forth in the TRICARE Operations Manual, [Chapter 21, Section 3](#).
2. Identify gaps between current policies and procedure relative to HIPAA Privacy requirements.
3. Determine areas of non-compliance and risk.
4. identify and document an action plan to correct deficiencies.

The results of the risk assessment, assurances given by appropriate (name of contractor) officials, and other information provided, indicate that the procedures and policies of (name of contractor) in effect during the year ended (date), comply with the requirements in the TRICARE Operations Manual, [Chapter 21, Section 3](#). The following action plans describe the risk identified during the annual assessment and the plan to correct deficiencies and achieve compliance. Please indicate "NONE" if the annual risk analysis did not identify weaknesses.

Attachment A to this statement contains (1) the (name of contractor) plans and schedules for correcting such weaknesses, and (2) the status of actions taken to correct weaknesses identified in prior years' reports.

Sincerely,
Name, Title and Office

cc: Regional Director
TMA Contracting Officer (CO)
TMA Privacy Officer
TMA Contracting Officers Representative (COR)

Enclosure(s) (if any)

Note to Contractor

- (1) If there are no material weaknesses, this sentence should be deleted, and there would be no list or Attachment A containing plans and schedules for correcting such weaknesses.
- (2) If there were no actions taken during the past year to correct weaknesses, or no identified weaknesses for which corrective actions remain to be taken, this phrase would be deleted.

CLAIMS PROCESSING FOR DUAL ELIGIBLES

1.0. GENERAL

Claims under the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFFIC) will be adjudicated under the rules set forth below. In general, TRICARE is last payer after Medicare and any other coverage.

2.0. DETERMINING PAYMENTS DUE AFTER COORDINATION WITH MEDICARE

Special double coverage procedures are to be used for all claims for beneficiaries who are eligible for Medicare, including active duty dependents who are age 65 and over as well as those beneficiaries under age 65 who are eligible for Medicare for any reason. For specific instructions, refer to the TRICARE Reimbursement Manual, [Chapter 4, Section 4](#).

3.0. OTHER HEALTH INSURANCE (OHI) AND TIMELY CLAIMS FILING

3.0.1. The contractor may grant exceptions to the claims filing deadline requirements, if the beneficiary submitted a claim to a primary health insurance, i.e., double coverage, and the OHI delayed adjudication past the TRICARE deadline.

3.0.2. These claims must have been originally sent to the OHI prior to the TRICARE filing deadline or must have been filed with a TRICARE contractor prior to the deadline but returned or denied pending processing by the OHI.

3.0.3. The beneficiary must submit with the claim a statement indicating the original date of submission to the OHI, and date of adjudication, together with any relevant correspondence and an Explanation of Benefits or similar statement.

3.0.4. The claim form must be submitted to the contractor within 90 days from the date of the OHI adjudication.

4.0. CLAIMS DEVELOPMENT REQUIREMENTS

4.1. Medicare Providers

4.1.1. The contractor shall accept the Medicare certification of *individual professional* providers who have a like class of *individual professional* providers under TRICARE without further authorization *unless there is information indicating Medicare, TRICARE or other federal health care program integrity violations by the physician or other health care practitioner. Individual professions* providers without a like class (*e.g.*, chiropractors) under TRICARE shall be denied.

4.1.2. TRICARE claims which TRICARE processes after Medicare, do not need to be developed to the individual provider level for home health or group practice claims.

4.2. Civilian Services Rendered To MTF Inpatients

Civilian claims for TRICARE dual eligible beneficiaries shall be processed by Medicare first without consideration of the Supplemental Health Care Program (*SHCP*).

4.3. *Preauthorization Requirements*

Services outlined in the TRICARE Policy Manual (TPM), Chapter 1, Section 7.1 require preauthorization, and if necessary, review of waivers of the day limits for dual eligible beneficiaries when TRICARE is the primary payer. As secondary payer, TRICARE will rely on and not replicate Medicare's determination of medical necessity and appropriateness in all circumstances where Medicare is primary payer (see the TRICARE Reimbursement Manual (TRM), Chapter 4, Section 4). In the event that TRICARE is primary payer for these services and preauthorization was not obtained, the contractor shall obtain the necessary information and perform a retrospective review.

5.0. UTILIZATION MANAGEMENT

Any utilization management provisions applied under the TRICARE Managed Care Support Services contracts, except for those specifically required by the Policy Manual, Reimbursement Manual or Operations Manual, shall not apply under the TDEFIC contract. Region-specific requirements shall not apply.

6.0. END OF PROCESSING

6.1. Beneficiary Cost Shares

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

6.2. Application Of Catastrophic Cap

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

6.3. Appeals And Grievances

6.3.1. TRICARE For Life Initial Determinations

Services and supplies denied payment by Medicare will not be considered for coverage by TRICARE if the Medicare denial of payment is appealable under the Medicare appeal process. If, however, a Medicare appeal results in some payment by Medicare, the services and supplies covered by Medicare will be considered for coverage by TRICARE. Services and supplies denied payment by Medicare will be considered for coverage by TRICARE, if the Medicare denial of payment is not appealable under the Medicare appeal

OTHER CONTRACT REQUIREMENTS

1.0. CUSTOMER SERVICE

1.1. Telephone Inquiries

The contractor must provide nationwide around-the-clock toll-free telephone access to a customer service staff in order to enable providers and *TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC)* beneficiaries to determine claims status as well as general TDEFIC information. Access outside of normal business hours for a *Continental United States (CONUS)* caller's time zone may be by automated means, such as provision for leaving messages and/or for obtaining information via an automated response mechanism. During normal CONUS business hours, callers must be offered the option of speaking live with a customer service representative. Responses must be furnished within the time frames mandated under the TDEFIC contract.

1.2. Written Inquiries

The contractor must respond promptly and meaningfully to all written inquiries, including inquiries received via E-mail. Responses must be furnished within the time frames mandated under the TDEFIC contract.

2.0. REFERRALS

All MHS beneficiaries are allowed under the Managed Care Support (MCS) contract requirements to contact the TRICARE Service Center for referrals to network providers. This shall continue with TRICARE/Medicare dual eligible individuals under the TDEFIC. The MCS contractor is not required to make appointments with network providers. The MCS contractor shall provide the TDEFIC beneficiary with the name, telephone number, and address of network providers of the appropriate clinical speciality located within the beneficiary's geographic area.

3.0. CONTRACTOR'S RESPONSIBILITY IN PROGRAM INTEGRITY

In relation to TDEFIC, at any time the contractor receives an allegation of fraudulent behavior, or any type of improper activity relating to either a beneficiary or provider submitted claim, the contractor shall review the claim to ensure it was processed properly *by the TDEFIC contractor. Following completion of the review, if an error in payment is not detected the contractor shall follow the requirements in Chapter 14.*

4.0. AUDITS OF TDEFIC CLAIMS

Claim audits shall be performed for claims processed under the TDEFIC contract. Sample means will be used as point estimates of payment and occurrence errors. There will be two kinds of payment samples, one for non-denied claims and one for denied claims. The design of non-denied payment and the occurrence samples utilizes a 90% confidence level, while the denied payment sample design uses an 80% confidence level. Precision estimates are 1% for the non-denied payment sample, 2% for the denied payment sample, and 1.5% for the occurrence sample. The non-denied payment sample will be drawn from all records with government payments of \$1.00 to \$25,000. In addition, all records with a government payment of \$25,000 and over will be audited. The denied payment sample will be drawn from all records with billed amounts of \$1.00 to \$500,000. In addition, all records with billed amounts of \$500,000 and over will be audited. The non-denied payment sample will be stratified at multiple levels within the \$1.00 to \$25,000 range and the denied payment sample will be stratified at multiple levels within the \$1.00 to \$500,000 range. Samples will be drawn on a quarterly basis from TEDs which pass TMA validity edits. Records to be sampled will be "net" records (i.e., the sum of transaction records available at the time the sample was drawn related to the initial transaction record). TEDs in vouchers which fail TRICARE validity edits or which are otherwise unprocessable as submitted by the contractor will be excluded from the sampling frame.

5.0. CLAIMS AGING REPORT BY STATUS/LOCATION

The contractor shall produce and furnish to the Contracting Officer's Representative Claims aging reports by Status Location on the first workday following the reporting week. These reports shall be sorted to enable a count of the total number of claims pending for a specified length of time; e.g., over 30 days, over 60 days and over 120 days. The contractor shall include excluded and retained claims on each report. Unless specifically requested by TMA or unless the contractor customarily makes a run of these reports concurrent with preparation of the month-end reports to TMA, they need not balance with the end-of-month reports. *The TDEFIC* contractor shall prepare an explanation of the individual reports and interpretation of the locations specific to each report to enable TMA staff to effectively review the data.

6.0. CUSTOMER SATISFACTION REPORT

Monthly, by the tenth calendar day following the end of the reported month, the contractor shall report to the Government the state of TDEFIC customer satisfaction during the previous reporting period. The report shall be provided to the Contracting Officer.

7.0. MEDICARE CROSSOVER FEES

Medicare crossover fees are paid to Medicare contractors by TMA contractors. These fees cover the transmission of data on paid claims from the Medicare contractor to TMA contractors in order to facilitate TMA processing as second payer on the TFL claims. The contractor shall submit non-TED vouchers (see [Chapter 3, Section 4](#)) covering these expenses to TMA on an as needed basis, generally once or twice a month.

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

7.0. COMMUNICATIONS AND CUSTOMER SERVICE

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

7.1. Customer Education

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

7.1.2. Upon start of coverage under TRS each contractor shall mail one copy of the TRS Handbook to each first-time TRS member with TRS member-only coverage and one copy to the household of each TRS member with TRS member and family coverage. Each contractor shall send additional handbooks upon request, such as when TRS members and covered family members live in different locations (split coverage).

7.2. Customer Service

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

8.0. ANALYSIS AND REPORTING

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

9.0. PAYMENTS FOR CONTRACTOR SERVICES RENDERED

9.1. Claims Reporting

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

9.2. Fiduciary Responsibilities

9.2.1. The contractor shall act as a fiduciary for all funds acquired from TRS premium collections, which are government property. The contractor shall develop strict funds control processes for its collection, retention and transfer of premium funds to the government. All

premium collections received by the contractor shall be maintained in accordance with these procedures.

9.2.2. The contractor shall select a commercial bank that is a member of the Federal Reserve Bank. A separate non-interest bearing account shall be established for the collection and disbursement of TRS premiums. The bank name, address, and account number shall be provided to the COR and to the TMA Contract Resource Management (CRM). The contractor shall make daily deposits of premium collections to the established account.

9.2.3. The contractor shall wire-transfer the premium collections and net of refund payments, monthly to a specified government account as directed by TMA-CRM Finance and Accounting Office. The government will provide the contractor with information for this government account. The contractor shall notify the TMA-CRM Finance and Accounting Office by e-mail within one business day of the deposit specifying the date and amount of the deposit. *Collections for delinquency cases that have been transferred to TMA OGC-AC, shall be wire-transferred separately. The contractor shall notify TMA-CRM Finance and Accounting and TMA OGC-AC by email within one business day of the day of deposit, specifying the sponsor name, sponsor SSN (last four digits), payment amount, payment date, date case was transferred to TMA OGC-AC and the date and amount of the deposit.*

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

9.2.5. The contractor shall electronically submit monthly reports of premium activity supporting the wire transfer of dollars to the Contracting Officer.

10.0. DELINQUENT PREMIUMS

10.1. The contractor shall no longer collect delinquent premiums with two exceptions:

- Contractors shall continue to collect delinquent premiums in cases in which TRS members and/or family members have entered into installment payment agreements.
- Contractors shall continue to collect delinquent premiums in cases in which TRS members and/or family members received health care services during the grace period.

10.2. The contractor shall terminate collection of delinquent premiums for all other cases within 60 days through an adjustment to the account and issue written notification to the debtor that collection has been terminated. Language for a sample letter is included at [Addendum A, Figure 24-A-1](#). A summary report of all cases terminated shall be provided to the Office of General Counsel (OGC) within 30 days following termination of all cases. Such report shall include the sponsor's name, SSN, debt amount and date closed.

10.3. The contractor shall be responsible for coordinating with DEERS to ensure coverage dates for all TRS members and/or family members are correct. The coverage dates in DEERS will not be changed for those members and/or family members who have entered into

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installment payment agreements or for cases in which TRS members and/or family members obtained medical services during the grace period. OGC will provide the premium paid through dates to the contractor for cases for which the premiums were not collected by OGC so that DEERS can be updated accordingly.

