CONTRACTOR RESPONSIBILITIES

1.0. CONTRACTOR RECEIPT AND CONTROL OF SHCP CLAIMS

1.1. Post Office Box

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

1.2. Claims Processing

1.2.1. Claims Processing And Reporting

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

1.2.2. Civilian Services Rendered To MTF Inpatients

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

1.2.3. Outpatient Care

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

other than active duty, (e.g., ROTC, former members on the Temporary Disability Retirement List (TDRL), Reserve Component (RC), National Guard, *eligible members enrolled in the Federal Recovery Coordination Program (FRCP),* foreign military, etc.) claims will be paid based on an MTF authorization despite the lack of any DEERS indication of eligibility.

1.2.4. Emergency Civilian Hospitalization

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

1.2.5. Temporary Disability Retirement List (TDRL)

Effective March 30, 2009, claims for periodic physical exams for participants on the TDRL will be processed based on the MTF authorization. These claims are SHCP claims, but will be maintained and tracked separately from other SHCP claims. It is the responsibility of the MTF to identify such referrals as TDRL referrals to the contractor at the time of authorization. SHCP funds shall not be used to treat the conditions which caused the member to be placed on the TDRL or for conditions discovered during the physical examination. The TRICARE Encounter Data (TED) record for each TDRL physical exam claim must reflect the Enrollment/Health Plan Code "SR' and the Special Processing Code "DE".

1.2.6. Comprehensive Clinical Evaluation Program (CCEP)

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

1.2.7. Foreign Claims Processing

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

1.2.7.2. Forward claims received for personnel permanently assigned to an overseas location to the appropriate overseas claims processor for processing in accordance with the TPM, Chapter 12, TRICARE Overseas Program (TOP).

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

The contractor shall use the same best business practices as used for other Prime enrollees in determining Episode Of Care (EOC) when the claims are received with lines of care that contain both MTF-Referred and non-referred lines. Claims received which contain services outside the originally referred EOC on an Active Duty Service Member (ADSM)

must come back to the Primary Care Manager (PCM) for approval. Laboratory tests, radiology tests, echocardiogram, holter monitors, pulmonary function tests, and routine treadmills associated with that EOC may be considered part of the originally requested services and do not need to come back to the PCM for approval.

1.2.9. Medical and Dental Care for Former Members with Serious Injuries or Illnesses

Medically retired former members of the Armed Services enrolled in the FRCP shall receive the same medical and dental care for that severe or serious illness or injury that would be available to an ADSM when the care is not reasonably available through the Department of Veterans Affairs (DVA).

1.2.9.1. *Under the Department of Defense (DoD)/VA FRCP, injured or ill service members are categorized based on the severity of their illness or injury. The severely injured or ill (category 3) are identified and assigned Federal Recovery Coordinators (FRCs). The seriously injured or ill (category 2) are identified and assigned a Recovery Care Coordinator (RCC). The role of these coordinators is to facilitate and track enrolled members' recovery.*

1.2.9.2. *In cases where care cannot be reasonably provided in a timely manner through the VA, the FRC or RCC, working through the FRCP, will facilitate care through MTFs or TRICARE providers. The FRCP will notify the Military Medical Support Office (MMSO) when the VA cannot reasonably provide an EOC in a timely manner. MMSO, in turn, will send to the contractor authorization to pay for the EOC under the SHCP. This authorization will supersede any DEERS eligibility response.*

1.2.9.3. *Qualification for this program will terminate for those members who are initially authorized while included on the TDRL when/if it is determined they achieve a "fit for duty" status.*

1.2.9.4. *Care authorized by Section 1631 will expire December 31, 2012.*

1.2.9.5. *TRICARE Encounter Data (TED) records must reflect Enrollment/Health Plan Code "SR - SHCP Referred Care."*

1.3. Authorization Verification

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

1.3.1.1. When a MTF referral directs evaluation or treatment of a condition, as opposed to directing a specific service(s), the Managed Care Support Contractor (MCSC) shall use its best business practices in determining the services encompassed within the EOC, indicated by the referral. The services may include laboratory tests, radiology tests, echocardiogram, holter monitors, pulmonary function tests, and routine treadmills associated with that EOC. A separate MTF authorization for these services is not required. If a civilian provider requests additional treatment outside of the original EOC, the MCSC shall contact the referring or enrolling MTF for approval.

1.3.1.2. If an authorization is not on file, then the contractor shall place the claim in a pending file and verify authorization with the MTF to which the ADSM is enrolled. The contractor shall contact the MTF within one working day. If the MTF retroactively authorizes the care, then the contractor shall enter the authorization and notify the claims processor to

process the claim for payment. If the MTF determines that the care was not authorized, the contractor shall notify the claims processor and an Explanation of Benefits (EOB) denying the claim shall be initiated. If the contractor does not receive the MTF's response within four working days, the contractor shall, within one working day, enter the contractor's authorization code into the contractor's claims processing system. Claims authorized due to a lack of response from the MTF shall be considered as "Referred Care."

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

2.0. COVERAGE

2.1. Normal TRICARE coverage limitations will not apply to services rendered to supplemental health care patients. Services that have been authorized will be covered regardless of whether they would have ordinarily been covered under TRICARE policy. In no case shall a payment be made for outpatient institutional services listed on the inpatient only procedure list except for inpatient procedures performed in an emergency room on a beneficiary who dies prior to admission. Reference the TRICARE Reimbursement Manual (TRM), Chapter 13, Section 2, paragraph III.D. On occasion a referral may be made for services from a provider of a type which is not TRICARE authorized. The contractor shall not make claims payments to sanctioned or suspended providers. (See Chapter 14, Section 6.) The claim shall be denied if a sanctioned or suspended provider bills for services. MTFs do not have the authority to overturn the TRICARE Management Activity (TMA) or Department of Health and Human Services (DHHS) provider exclusions. TRICARE utilization review and utilization management requirements will not apply.

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

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

2.4. Ancillary Services

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

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

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

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

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

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

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

2.5.5. Contractors shall follow the provisions of the TRICARE Systems Manual (TSM), Chapter 2, Sections 2.8 and 6.4 regarding the TED special processing code for the ADSM respite benefit. Claims should indicate an appropriate procedure code for respite care (CPT[1] 99600 or HCPCS S9122-S9124) and shall be reimbursed based upon the allowable charge or the negotiated rate.

2.5.6. Respite care services and requirements are as follows:

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

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

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

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

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

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

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

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

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

2.6. Transitional Care For Service-Related Conditions (TCSRC)

2.6.1. Introduction

The NDAA for FY 2008, Section 1637 provides extended TCSRC for former ADSMs during the Transitional Assistance Management Program (TAMP) coverage period. This change does not create a new class of beneficiaries, but expands/extends the period of TRICARE eligibility for certain former ADSMs, with certain service-related conditions, beyond the TAMP coverage period.

2.6.2. Prerequisites For TCSRC

In accordance with NDAA 2008, a member, who is eligible for care under the TAMP, and who has a medical (as defined in 32 CFR 199.2) or adjunctive dental condition believed to be related to their service on active duty may receive extended transitional care for that condition. The diagnosis determination must include the following criteria:

2.6.2.1. *To be service-related; and*

2.6.2.2. *To have been first discovered/diagnosed by the member's civilian or TRICARE health care practitioner during the TAMP period and validated by a DoD physician; and*

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

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

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

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

2.6.3. Eligibility

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

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

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

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

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

2.6.4.1. *TMA Communications and Customer Service (C&CS) will educate beneficiaries on the Section 1637 benefit. Contractors will collaborate with C&CS in the development of materials that support both beneficiary and provider education.*

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

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

2.6.4.4. *If the DoD physician determines the individual is eligible for the Section 1637 program, MMSO will provide the enrollment information (Enrollment Start date and condition authorized for treatment) to the member and the contractor responsible for enrollments in the region where the former service member resides. This notice will clearly identify it is for the Section 1637 program. The contractor shall enroll the former service member into the Section 1637 program on DEERS using DEERS Online Enrollment System (DOES) within four business days of receiving the notification from MMSO. This entry will include the Start Date (date condition validated by the DoD physician), an EOC Code, and an EOC Description. The contractor will enter the validated condition covered by the Section 1637 program (received from MMSO) into the contractor's referral and authorization system within eight business days of receipt of the notification from MMSO. The MCSC shall actively assist the member using the HCF program in determining the location of final restorative healthcare*

for the identified Section 1637 condition. The location of service shall be determined as defined in paragraph 2.6.4.3. The MCSC shall instruct the accepting provider on the terms of this final "eval and treat" referral from MMSO and when and where to send clinical results/findings to close out MMSO's files on the Section 1637 eligible member. DEERS shall store the secondary Health Care Delivery Plan (HCDP) code, the date the condition was validated by the DoD physician, the EOC Code, and the EOC Description. DEERS shall return the HCDP code, the start and end dates for the coverage plan, the EOC Code, and the EOC Description with every eligibility query. This program is portable across all contractors.

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

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

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

2.6.5. Claims Processing And Payment

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

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

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

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

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

2.6.5.4. *Jurisdiction rules for Section 1637 coverage shall be in accordance with Chapter 8, Section 2.*

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

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

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

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

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

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

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

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

2.6.6. Definitions

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

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

3.0. ENROLLMENT STATUS EFFECT ON CLAIMS PROCESSING

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

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

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

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

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

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

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

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

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

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

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

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

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

4.0. MEDICAL RECORDS

The current contract requirements for medical records shall also apply to ADSMs in this program. Narrative summaries and other documentation of care rendered (including laboratory reports and X-rays) shall be given to the ADSM for delivery to his/her PCM and inclusion in his/her military health record. The contractor shall be responsible for all administrative/copying costs. Under no circumstances will the ADSM be charged for this documentation. Network providers shall be reimbursed for medical records photocopying and postage costs incurred at the rates established in their network provider participation agreements. Participating and non-participating providers shall be reimbursed for medical records photocopying and postage costs on the basis of billed charges. ADSMs who have paid for copied records and applicable postage costs shall be reimbursed for the full amount paid to ensure they have no out of pocket expenses. All providers and/or patients must submit a claim form, with the charges clearly identified, to the contractor for reimbursement. ADSM's claim forms should be accompanied by a receipt showing the amount paid.

5.0. REIMBURSEMENT

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

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

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

5.4. Pending development and implementation of recently enacted legislative authority to waive CMACs under TRICARE, the following interim procedures shall be followed when necessary to assure adequate availability of health care to ADSMs under SHCP. If required services are not available from a network or participating provider within the medically appropriate time frame, the contractor shall arrange for care with a non-participating provider subject to the normal reimbursement rules. The contractor initially shall make every effort to obtain the provider's agreement to accept, as payment in full, a rate within the 100% of CMAC limitation. If this is not feasible, the contractor shall make every effort to obtain the provider's agreement to accept, as payment in full, a rate between 100% and 115% of CMAC. If the latter is not feasible, the contractor shall determine the lowest acceptable rate that the provider will accept and communicate the same to the referring MTF. A waiver of CMAC limitation must be obtained by the MTF from the Regional Director (RD), as the designee of the Chief Operating Officer (COO), TMA, before patient referral is made to ensure that the patient does not bear any out-of-pocket expense. Upon approval of a CMAC waiver by the RD, the MTF will notify the contractor who shall then conclude rate negotiations, and notify the MTF when an agreement with the provider has been reached. The contractor shall ensure that the approved payment is annotated in the authorization/claims processing system, and that payment is issued directly to the provider, unless there is information presented that the ADSM has personally paid the provider.

5.5. Referred patients who have been required by the provider to make "up front" payment at the time services are rendered will be required to submit a claim to the contractor with an explanation and proof of such payment.

5.5.1. Supplemental health care claims for uniformed service members, members enrolled in the FRCP, and all MTF inpatients receiving referred civilian care while remaining in an MTF inpatient status shall be promptly reimbursed and the patient shall not be required

to bear any out of pocket expense. If such payment exceeds normally allowable amounts, the contractor shall allow the billed amount and reimburse the patient for charges on the claim. As a goal, no such claim should remain unpaid after 30 calendar days.

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

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

6.0. END OF PROCESSING

6.1. Explanation Of Benefits

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

6.2. Appeal Rights

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

7.0. CLAIMS PAYMENTS AND CONTRACTOR REIMBURSEMENT

7.1. Referred Care For MTF Inpatients

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

7.2. MTF Referred Outpatient Care

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

8.0. TED SUBMITTAL

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

9.0. REQUIRED REPORTS

Summary reports reflecting government dollars paid for supplemental health care claims shall be prepared and submitted to each Service Headquarters every month. Separate reports shall be produced for services rendered to Army National Guard members. All reports described below shall be submitted in electronic media in an Excel format. Payments for CCEP claims, TDRL claims, and for members enrolled in the FRCP shall each be reported separately. A separate report of payments on behalf of non-DoD patients shall also be prepared and forwarded to TMA, Managed Care Support Operations Branch. Summary and detailed reports (also reflecting government dollars paid) for each month will be prepared and submitted to each referring MTF. These reports will be submitted no later than the 15th calendar day of the month following the reporting period. SHCP and CCEP reports will reflect total care paid, and the total dollar amount contained in data elements (paragraphs 9.1.1. through 9.1.3.), will equal the total amount requested for reimbursement from TMA, Office of Contract Resource Management for each report. For those data elements in items (paragraphs 9.1.1. through 9.1.3.), which require a count, the contractor must ensure that no workload is double counted. Data elements to include in the reports are:

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

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

9.1.2. Total Number and Dollar Amount of Claims Paid

9.1.3. Inpatient Dollars Paid - Institutional

9.1.4. Inpatient Dollars Paid - Professional Services

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

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

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

9.1.8. Total Admissions/Dispositions

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

9.1.10. Total Ambulatory Surgeries/Procedures, including all Ancillary

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

9.1.12. CPT Codes/DRG/ICD-9 Codes

9.1.13. Other items paid

9.2. Detailed Reports For Each MTF

9.2.1. Patient DMIS-ID Code (enrollment DMIS)

9.2.2. Referring MTF's DMIS-ID code

9.2.3. Patient Name/Social Security Number (SSN)

9.2.4. Sponsor SSN

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

9.2.6. MTF PCM (if available)

9.2.7. Referring provider (if available)

9.2.8. Civilian Provider's Name/Provider ID#

9.2.9. Dates of Care (Outpatient or Inpatient Admission)

9.2.10. Care End Date (FY - Month)

9.2.11. Admitting Diagnoses (Primary/Secondary)

9.2.12. Dispositioning Diagnoses (Primary/Secondary)

9.2.13. CPT Codes/DRG/ICD-9 Codes Related to Inpatient Claim

9.2.14. Total Bed Days/LOS (Inpatient)

9.2.15. Inpatient Institutional $ Paid

9.2.16. Inpatient Professional $ Paid

9.2.17. CPT Codes/ICD-9 Codes Related to Outpatient Claim (including Professional and Ancillary Services)

9.2.18. Outpatient Clinic $ Paid (Including Professional and Ancillary Services)

9.2.19. CPT Codes/ICD-9 Codes Related to Ambulatory Surgery/Procedure Claim (including Professional and Ancillary Services)

9.2.20. Ambulatory Surgery/Procedure $ Paid (Professional)

9.2.21. Ambulatory Surgery/Procedure $ Paid (Institutional)

9.3. Additional Reports

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

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

9.3.3. Workload Reports

9.3.3.1. The contractor shall prepare and submit a monthly SHCP claims workload report for each branch of service (to include Army National Guard separately), as well as one workload report which shows the cumulative totals for all services. The branch of service shall be determined by the service affiliation of the referring MTF and not by the branch of service of the active duty member. The following data shall be included in the workload reports:

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

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

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

9.3.4. Timeliness Reports

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

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

9.4. SHCP Claims Listing

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

10.0. CONTRACTOR'S RESPONSIBILITY TO RESPOND TO INQUIRIES

10.1. Telephonic Inquiries

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

10.1.1. Congressional Telephonic Inquiries

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

10.1.2. Provider And Other Telephonic Inquiries

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

10.2. Written Inquiries

10.2.1. Congressional Written Inquiries

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

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

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

10.2.3. MTF Written Inquiries

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

11.0. DEDICATED SHCP UNIT

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