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TRICARE  
MANAGEMENT ACTIVITY

OD

CHANGE 94  
6010.51-M  
MARCH 11, 2010

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL  
FOR  
TRICARE OPERATIONS MANUAL (TOM), AUGUST 2002**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

**CHANGE TITLE:** OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) TECHNICAL  
CHANGES, FEBRUARY 2010

**CONREQ:** 14925

**PAGE CHANGE(S):** See page 2.

**SUMMARY OF CHANGE(S):** This changes contains OPPS changes to include Active Duty Service Member (ADSM) inpatient procedures performed on an outpatient basis, changes to the observation stay policy, and the addition of new modifiers.

**EFFECTIVE DATE:** May 1, 2009, unless otherwise indicated.

**IMPLEMENTATION DATE:** Upon direction of the Contracting Officer.

This change is made in conjunction with Aug 2002 TPM, Change No. 119, Aug 2002 TRM, Change No. 110, and Aug 2002 TSM, Change No. 79.

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Director, Operations Division

**ATTACHMENT(S):** 13 PAGES  
**DISTRIBUTION:** 6010.51-M

**CHANGE 94**  
**6010.51-M**  
**MARCH 11, 2010**

**REMOVE PAGE(S)**

**CHAPTER 18**

Section 3, pages 3 through 8

**CHAPTER 19**

Section 3, pages 3 through 9

**INSERT PAGE(S)**

Section 3, pages 3 through 8

Section 3, pages 3 through 9

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. 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<sup>1</sup> 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](#).

**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.

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**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*

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

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

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

### **5.2. Non-Emergent Care**

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

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

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

### **5.3. Ancillary Services**

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

## **6.0. COVERAGE**

**6.1.** Normal TRICARE coverage limitations will not apply to services rendered to SHCP eligible uniformed service members covered by this chapter. Services that have been authorized by the SPOC will be covered regardless of whether they would have ordinarily been covered under TRICARE policy. Occasionally, care may be authorized which was not rendered by a TRICARE authorized provider. Contractors shall not make claims payments to sanctioned or suspended providers. (See [Chapter 14, Section 6](#).) The claim shall be denied if a sanctioned or suspended provider bills for services. SPOCs do not have the authority to overturn the TRICARE Management Activity (TMA) or Department of Health and Human Services (DHHS) provider exclusions. Customary TRICARE utilization review and utilization management requirements will not apply.

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

## **7.0. MEDICAL RECORDS**

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

## **8.0. REIMBURSEMENT**

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

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

**8.3.** Pending development and implementation of recently enacted legislative authority to waive CMACs under TRICARE, the following interim procedures shall be followed when necessary to assure adequate availability of health care to ADSMs under SHCP. If required services are not available from a network or participating provider within the medically appropriate time frame, the contractor shall arrange for care with a non-participating provider subject to the normal reimbursement rules. The contractor initially shall make every effort to obtain the provider's agreement to accept, as payment in full, a rate within the one 100% of CMAC limitation. If this is not feasible, the contractor shall make every effort to obtain the provider's agreement to accept, as payment in full, a rate between 100 and 115% of CMAC. If the latter is not feasible, the contractor shall determine the lowest acceptable rate that the provider will accept. The contractor shall then request a waiver of CMAC limitation

from the Regional Director, as the designee of the Chief Operating Officer (COO), TMA, before patient referral is made to ensure that the patient does not bear any out-of-pocket expense. The waiver request shall include the patient name, ADSM's location, services requested (CPT-4) codes, CMAC rate, billed charge, and anticipated negotiated rate. The contractor must obtain approval from the Regional Director before the negotiation can be concluded. The contractors shall ensure that the approved payment is annotated in the authorization/claims processing system, and that payment is issued directly to the provider, unless there is information presented that the ADSM has personally paid the provider.

**8.4.** Eligible uniformed service members who have been required by the provider to make "up front" payment at the time services are rendered will be required to submit a claim to the contractor with an explanation and proof of such payment. If the claim is payable without SPOC review the contractor shall allow the billed amount and reimburse the ADSM for charges on the claim. If the claim requires SPOC review the contractor shall pend the claim to the SPOC for determination. If the SPOC authorizes the care the contractor shall allow the billed amount and reimburse the ADSM for charges on the claim.

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

## **9.0. END OF PROCESSING**

### **9.1. EOB**

An appropriate EOB shall be prepared for each supplemental health care claim processed, and copies sent to the provider and the patient (uniformed service member) in accordance with normal claims processing procedures. The EOB will also include the following statement, "This is a supplemental health care claim, not a TRICARE claim. Questions concerning the processing of this claim must be addressed to the SPOC." Any standard TRICARE EOB messages which are applicable to the claim are also to be utilized, e.g., "No authorization on file."

### **9.2. Appeal Process**

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

**9.2.2.** An ADSM will appeal SPOC denials of authorization or authorization for reimbursement through the SPOC--not through the contractor. If the ADSM disagrees with a denial, the first level of appeal will be through the SPOC who will coordinate the appeal with

the appropriate Regional Director. The ADSM may initiate the appeal by contacting his/her SPOC or by calling the Military Medical Support Office (MMSO) at 1-888-647-6676. If the SPOC upholds the denial, the SPOC will notify the ADSM of further appeal rights with the appropriate Surgeon General's office. If the denial is overturned at any level, the SPOC will notify the contractor and the ADSM.

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

## **10.0. TED VOUCHER SUBMITTAL**

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

## **11.0. REPORTS FOR SHCP**

### **11.1. Required Reports**

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

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

**11.1.3.** Data elements to include in the reports are:

**11.1.3.1.** DMIS ID Code - enrollment MTF

**11.1.3.2.** Total Number and Dollar Amount of Claims Paid

**11.1.3.3.** Inpatient Dollars Paid - Institutional

**11.1.3.4.** Inpatient Dollars Paid - Professional Services

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

**11.1.3.6.** Outpatient Dollars Paid - Ambulatory Surgeries/ Procedures - Professional Services

**11.1.3.7.** Outpatient Dollars Paid - Ambulatory Surgeries/ Procedures - Institutional

**11.1.3.8.** Total Admissions/Dispositions

**11.1.3.9.** Total Bed Days/LOS

**11.1.3.10.** Total Ambulatory Surgeries/Procedures, including all Ancillary

**11.1.3.11.** Total Outpatient Visits, Excluding Ambulatory Surgeries but including all Ancillary related to the outpatient visits

**11.1.3.12.** CPT Codes/DRG/ICD-9 Codes

**11.1.3.13.** Other Items Paid

## **11.2. Additional Reports**

The contractor shall produce monthly workload and timeliness reports for the SHCP. The reports cover the period beginning on the first day of the month and closing on the last day of the month. The reports are due on the 15th calendar day of the month following the month being reported. The contractor shall prepare a cover letter when forwarding reports, which shall identify the reports being forwarded, the period being reported, the date the cover letter is prepared by the contractor, and a contractor point of contact should there be any questions regarding the reports.

### **11.2.1. Workload Reports**

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

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

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

### **11.2.2. Timeliness Reports**

The contractor shall prepare and submit a separate monthly cycle time and aging report for SHCP claims, containing the same elements and timeliness breakouts as submitted for other TRICARE claims. The contractor shall send a copy of the SHCP Timeliness Reports to the Regional Directors; Chief Financial Officer, TMA; and to the Chief, Special Contracts and Operations Office, TMA.

### **11.2.3. Aging Claims Report**

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

### **11.2.4. SHCP Claims Listing**

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

## **12.0. CONTRACTOR'S RESPONSIBILITY TO RESPOND TO INQUIRIES**

### **12.1. Telephonic Inquiries**

Inquiries relating to the SHCP need not be tracked nor reported separately from other inquiries received by the MCS contractor. All inquiries to the contractor should come from the MTFs/claims offices, the Service Project Officers, the TMA, or SPOC. However, inquiries may be received from congressional representatives, providers and/or patients. To facilitate this process, the contractor shall provide a specific telephone number, different from the public toll-free number, for inquiries related to the SHCP Claims Program. The line shall be operational and continuously staffed according to the hours and schedule specified in the contractor's TRICARE contract for toll-free and other service phone lines. It may be the same line as required in support of TRICARE Prime Remote under [Chapter 17](#) and may be the same line required under [Chapter 18](#). The telephone response standards of [Chapter 1, Section 3, paragraph 3.4](#) shall apply to SHCP telephonic inquiries.

**12.1.1. Congressional Telephonic Inquiries**

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

**12.1.2. Provider And Other Telephonic Inquiries**

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

**12.2. Written Inquiries**

**12.2.1. Congressional Written Inquiries**

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

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

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

**12.2.3. MTF Written Inquiries**

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

**13.0. DEDICATED SHCP UNIT**

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

