Chapter 17 Section 3

Contractor Responsibilities

1.0 CONTRACTOR RECEIPT AND CONTROL OF SUPPLEMENTAL HEALTH CARE PROGRAM (SHCP) CLAIMS

1.1 Claims Processing

1.1.1 Claims Processing And Reporting

Regardless of who submits the claim, SHCP claims shall be processed using the same standards and requirements 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. If the member is not enrolled, the contractor for the region in which the member resides shall process the claim. Claims for inpatient and outpatient medical services shall be processed to completion without application of a cost-share, copayment, or deductible.

1.1.2 Civilian Services Rendered To Military Treatment Facility (MTF) Inpatients

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

1.1.3 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., Reserved Officer Training Corps (ROTC), Reserve Component (RC), National Guard, Foreign military, etc.) claims will be paid based on an MTF authorization despite the lack of any DEERS indication of eligibility.

1.1.4 Department of Defense (DoD)/Department of Veterans Affairs (DVA) Memorandum of Agreement (MOA)

Claims for care provided under the national DoD/DVA MOA for Spinal Cord Injury (SCI), Traumatic Brain Injury (TBI), and Blind Rehabilitation shall be processed in accordance with Section

2, paragraph 3.1.

1.1.5 Emergency Civilian Hospitalization

If an emergency civilian hospitalization becomes necessary during the test or procedure referred by the MTF, or a hospitalization of an Active Duty Service Member (ADSM) comes to the attention of the contractor, it will be reported to the referring MTF or the enrolled MTF if not referred. The MTF will have primary case management responsibility, including authorization of care and patient movement for all civilian hospitalizations.

1.1.6 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.

1.1.7 Foreign Claims Processing

The contractor shall process claims 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). Forward claims received for personnel permanently assigned to an overseas location to the appropriate overseas claims processor in accordance with Chapter 24, TRICARE Overseas Program (TOP).

1.1.8 Claims Received With Both MTF-Referred And Non-Referred Lines

1.1.8.1 The contractor shall use the same best business practices as used for other Prime enrollees for ADSMs in determining Episode of Care (EOC) when claims are received with lines of care that contain both MTF-referred and non-referred lines. Laboratory tests, radiology tests, echocardiogram, holter monitors, pulmonary function tests, and routine treadmills logically associated with the referred EOC may be considered part of the originally requested services and do not need to come back to the Primary Care Manager (PCM) for approval. Claims received which contain services outside the originally referred EOC on an ADSM must come back to the PCM for approval.

1.1.8.2 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.

1.2 Eligibility Verification

1.2.1 MTF Referred Care

If an MTF referral is on file, process the claim in accordance with the provisions in paragraph 1.2.2.2. The contractor shall verify that care provided was authorized by the MTF. 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 (except for care provided by the DVA under the current national MOA for SCI, TBI, and Blind Rehabilitation, see Section 2, paragraph 3.1). 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".

1.2.2 Non-MTF Referred Care

1.2.2.1 Check DEERS Status

If the patient is listed in the DEERS as Direct Care (DC) eligible, process the claim in accordance with paragraph 1.4, Types of Care. If, in the process of the DEERS check, the contractor determines the ADSM is enrolled in TRICARE Prime Remote (TPR), then the claim shall be processed as a TPR claim in accordance with Chapter 16. The contractor for the region in which the member is enrolled shall process the claim to completion. If the ADSM is enrolled to an MTF, the claim shall be processed in accordance with paragraph 1.2.2. If the ADSM is not enrolled (or is a member of the RC), the claim shall be processed in accordance with paragraph 1.2.3.

1.2.2.2 Check for Service Point of Contact (SPOC) Preauthorization

If a SPOC preauthorization exists, process the claim to completion in accordance with this chapter whether or not the patient is listed in DEERS.

1.2.2.3 Check Claim For Attached Documentation

If the patient is listed in DEERS as not direct care eligible, but the claim or its attached documentation indicates potential eligibility (e.g., military orders, commander's letter), pend the case and forward a copy of the claim and attached documentation to the SPOC for an eligibility determination.

1.2.2.4 National Guard and Reserve

Claims for National Guard or Reserve sponsors with treatment dates outside their eligibility dates cannot be automatically adjudicated. Claims for ineligible sponsors are to be suspended and routed to MMSO for payment approval or denial. If a payment determination is not received within the 115th day of receipt, the claim is to be denied.

1.2.2.5 Criteria Not Met

If none of the conditions stated above are met, the claim may be returned uncontrolled to the submitting party in accordance with established procedures.

1.2.3 For outpatient active duty and non-TRICARE eligible patients, and for all SHCP inpatients, there will be no application by the contractor of the DEERS Catastrophic Cap and Deductible Data (CCDD) file, 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.

1.3 TPL

TPL processing requirements (Chapter 10) shall be applied to all claims covered by this chapter. However, adjudication action on claims will not be delayed awaiting completion of the requisite questionnaire and compilation of documentation. Instead, the claim will be processed to completion and the TPL documentation will be forwarded to the appropriate uniformed service claims office when complete.

1.4 Types Of Care

Contractor staff shall receive and accept calls directly from Active Duty Service Members (ADSMs) requesting authorization for care which has not been MTF referred. If the caller is requesting after hours authorization for care while physically present in the Prime service area of the MTF to which he/she is enrolled, the care shall be authorized in accordance with the MCSC-MTF Memoranda of Understanding (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.

1.4.1 Emergency Care (As Defined In The TPM)

Subsequent to the eligibility verification process described in paragraph 1.2, 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 or the MTF to which the active duty member is enrolled. The SPOC or the MTF to which the active duty member is enrolled will have primary case management responsibility, including authorization of care and patient movement for all civilian hospitalizations.

1.4.2 Non-Emergent Care

Subsequent to eligibility verification as described in paragraph 1.2, 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 Addendum C for SPOC referral and review procedures.

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

1.4.2.2 If the SPOC determines that the civilian health care was not authorized, the contractor shall follow normal TRICARE requirements for issuing EOB and summary vouchers.

2.0 COVERAGE

2.1 Normal TRICARE coverage limitations will not apply to services rendered for supplemental health care for ADSMs. For ADSMs, the Director, TRICARE Management Activity (TMA), at the request of an authorized official of the uniformed service concerned, may authorize coverage for services that would not have ordinarily been covered under TRICARE policy based on that such waiver is necessary to assure adequate availability of health care services to active duty members. TRICARE coverage limits apply to services to TRICARE-eligible covered beneficiaries provided under the SHCP. 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 3.4. On occasion care may be referred or authorized 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 13, Section 6.) The claim shall be denied if a sanctioned or suspended provider bills for services. MTFs do not have the authority to overturn 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 or SPOC 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 Ancillary Services

The Regulation governing the SHCP requires that each service under the SHCP be authorized, with very limited exceptions. For purposes of SHCP claims processing, an MTF authorization for care will be deemed to include authorization of any ancillary services directly and clearly related to the specific episode of health care authorized (e.g., evaluation or treatment of a specific medical condition). Any questions of whether a particular service is related to the care already authorized should be resolved by means of seeking MTF authorization for the service in question.

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 services provided under the current MOU between the DoD (including Army, Air Force, and Navy/Marine Corps facilities) and the DHHS (including the Indian Health Service, Public

Health Service, etc.) are not SHCP claims. They should be adjudicated under the claims processing provisions applicable to those specific agreements.

3.4 Claims for services provided under any local MOU between the DoD (including the Army, Air Force and Navy/Marine Corps facilities) and the Department of Veterans' Affairs (DVA) are not SHCP claims. They should be adjudicated under the claims processing provisions applicable to those specific agreements. (Claims for services provided under the current national MOA for Spinal Cord Injury (SCI), Traumatic Brain Injury (TBI), and Blind Rehabilitation are covered, see Section 2, paragraph 3.1.)

3.5 Claims for participants in the Comprehensive Clinical Evaluation Program (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.

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

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

4.0 MEDICAL RECORDS

The current contract requirements for medical records shall also apply to ADSMs in this program, with the additional requirement that ADSMs must also be given copies directly. 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 Primary Care Manager (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., Diagnostic Related Groups (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 supplemental health care claims.

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 3.4. 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 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. In the case of non-MTF referred care, the contractor shall submit the waiver request to the RD.

5.4 Eligible uniformed service members and/or 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. For eligible uniformed service members, 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.

- Supplemental health care claims for uniformed service members and all MTF inpatients receiving referred civilian care while remaining in an MTF inpatient status shall be promptly reimbursed and the patient shall not be required to bear any out of pocket expense. If such payment exceeds normally allowable amounts, the contractor shall allow the billed amount and reimburse the patient for charges on the claim. As a goal, no such claim should remain unpaid after 30 calendar days.

5.5 In no case shall a uniformed service member be subjected to "balance billing" or ongoing collection action by a civilian provider for referred, 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 referring MTF or SPOC, as appropriate, for determination. The referring MTF or SPOC will issue an authorization to the contractor for payments in excess of CMAC or other applicable TRICARE payment ceilings, provided the referring MTF or SPOC has requested and has been granted a waiver from the COO, TMA, or designee.

6.0 END OF PROCESSING

6.1 EOB

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 SHCP claims, the EOB will include the statement that this is a supplemental health care claim, not a TRICARE claim. The EOB will also indicate that questions concerning the processing of the claim must be addressed to the TRICARE Service Center (TSC) or SPOC, as appropriate. 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

6.2.1 For supplemental health care claims, the appeals process in Chapter 12, 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/SPOC 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/SPOC here**)." TRICARE appeal rights shall pertain to outpatient claims for treatment of TRICARE eligible patients. 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.

6.2.2 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 RD. The ADSM may initiate the appeal by contacting his/her SPOC or by calling the 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.

6.2.3 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.

7.0 TRICARE ENCOUNTER DATA (TED) SUBMITTAL

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

8.0 CONTRACTOR'S RESPONSIBILITY TO RESPOND TO INQUIRIES

8.1 Telephonic Inquiries

Inquiries relating to the SHCP need not be tracked nor reported separately from other inquiries received by the contractor. Most SHCP inquiries to the contractor should come from MTFs/ claims offices, the Service Project Officers, TMA, or the SPOC. In some instances, inquiries may also come from Congressional offices, patients, or providers. To facilitate responsiveness to SHCP

inquiries, the contractor shall provide MTFs/claims offices, the Service Project Officers, TMA, and the SPOC 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 16. The telephone response standards of Chapter 1, Section 3, shall apply to SHCP telephonic inquiries.

8.1.1 Congressional Telephonic Inquiries

The contractor shall refer any congressional telephonic inquiries to the referring MTF or the SPOC, as appropriate, 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.

8.1.2 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 or the SPOC, as appropriate, 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.

8.2 Written Inquiries

8.2.1 Congressional Written Inquiries

For MTF-referred care, 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. For non-MTF referred care, the inquiry shall be referred to the SPOC. 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.

8.2.2 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 or the SPOC, as appropriate, if the inquiry pertains to the authorization or non-authorization of a specific claim; or to the appropriate Service Project Officer if it is a general inquiry regarding the SHCP.

8.2.3 MTF Written Inquiries

The contractor shall provide a final written response to all written inquiries from the MTF within 10 work days of the receipt of the inquiry, or if appropriate, refer the inquiry to the SPOC upon receipt of the inquiry.

9.0 SHCP 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.

- END -