



DEFENSE  
HEALTH AGENCY

**HPOS**

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**CHANGE 110  
6010.56-M  
NOVEMBER 20, 2013**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL  
FOR  
TRICARE OPERATIONS MANUAL (TOM), FEBRUARY 2008**

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

**CHANGE TITLE: ELIMINATION OF WALK-IN CUSTOMER SERVICE AT TRICARE SERVICE CENTERS**

**CONREQ: 16705**

**PAGE CHANGE(S): See pages 2 through 4.**

**SUMMARY OF CHANGE(S): This change eliminates the walk-in customer service provided at the TRICARE Service Centers (TSCs) located within the 50 United States. Due to the unique needs at our overseas installations, walk-in customer service will continue to be offered at the TSCs located overseas. No other customer service functions are affected, i.e., education, briefings, and Military Treatment Facility (MTF) Commander hours.**

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

**IMPLEMENTATION DATE: April 1, 2014.**

**This change is made in conjunction with Feb 2008 TPM, Change No. 100.**

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**ATTACHMENT(S): 143 PAGES  
DISTRIBUTION: 6010.56-M**

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

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## **2.0 MANAGEMENT**

### **2.1 Filing**

The contractor shall file all hard copy, microform copies and digital/optical disk imaging of claims/adjustment claims, with attached documentation by Internal Control Number (ICN) by state or contract number within five calendar days after they are processed to completion. The claim and all supporting documents shall be maintained in hard copy, microcopy, or digital image or optical disk. Provisions shall be made for appropriate retention and disposition of files in accordance with the Federal Records Act and TMA instructions (see [Chapter 2](#)).

### **2.2 Availability Of Information**

Information required for appropriate responses to inquiries, including but not limited to claim files, appeals files, previous correspondence, and check files shall be retrievable and forwarded within five workdays following a request for the information.

## **3.0 BENEFICIARY AND PROVIDER SERVICES (BPS)**

For all processing standards, the actual date of receipt shall be counted as the first day. The date the reply is mailed shall be counted as the processed to completion date. The standards with which the contractor shall comply include:

### **3.1 Routine Written Inquiries**

All routine written inquiries shall be stamped with the actual date of receipt within three workdays of receipt in the contractor's custody. The contractor shall provide final responses to routine written inquiries as follows:

- Eighty-five percent (85%) within 15 calendar days of receipt;
- Ninety-seven percent (97%) within 30 calendar days of receipt; and
- One hundred percent (100%) within 45 calendar days of receipt.

### **3.2 Priority Written Inquiries (Congressional, ASD(HA), And TMA)**

All priority written inquiries shall be stamped with the actual date of receipt within three workdays of receipt in the contractor's custody. The contractor shall provide final responses to priority written inquiries as follows:

- Eighty-five percent (85%) within 10 calendar days of receipt;
- One hundred percent (100%) within 30 calendar days of receipt.

### **3.3 Walk-In Inquiries (TRICARE Overseas Contract Only)**

- Ninety-five percent (95%) of walk-in inquiries shall be acknowledged and be assisted by a service representative within 15 minutes of entering the reception area.
- Ninety-nine percent (99%) of walk-in inquiries shall be acknowledged and assisted by a service representative within 20 minutes of entering the reception area.

### **3.4 Telephone Inquiries**

**3.4.1** The following required levels of service shall be available at all times - daily, weekly, monthly, etc. Averages are not acceptable.

- Blockage rates shall never exceed 5%. Never is defined as at any time during any day.
- Ninety-five percent (95%) of all telephones shall be answered within two rings by a Automated Response Unit (ARU). The caller shall have only two choices: transfer to an ARU (e.g., automated claims inquiry, recorded messages where to submit claims or correspondence, etc.) or to an individual.
- If transferred to an ARU, 100% of all telephone calls shall be acknowledged within 20 seconds.
- If transferred to an individual, 90% of all calls shall be answered by an individual (not an answering machine) within 30 seconds.
- Total "on hold" time for 95% of all calls shall not exceed 30 seconds during the entire telephone call.
- Eighty-five percent (85%) of all inquiries shall be fully and completely answered during the initial telephone call. (Applies to all calls transferred to an individual.)
- Ninety-nine and one-half percent (99.5%) of all inquiries not fully and completely answered initially shall be fully and completely answered within 10 business days.

#### **3.4.2 Telephone Inquiries to Behavioral health Provider Locator and Assistance Service**

For all telephone calls made to the contractor's dedicated behavioral health provider locator and assistance service during normal business hours for all time zones within the region, ninety-five percent (95%) shall be answered by a contractor staff member within 30 seconds.

### **4.0 APPEALS**

#### **4.1 Expedited Preadmission/Preprocedure Reconsiderations**

One hundred percent (100%) of requests for expedited preadmission/preprocedure reconsiderations processed to completion within three working days of the date of receipt by the contractor of the reconsideration request (unless the reconsideration is rescheduled at the written request of the appealing party). Expedited preadmission/preprocedure requests are those requests filed by the beneficiary within three calendar days after the beneficiary receipt of the initial denial determination.

## Management

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### 1.0 GENERAL

The contractor shall establish and maintain sufficient staffing and management support services and commit all other resources and facilities necessary to achieve and maintain compliance with all quantitative and qualitative standards for claims processing timeliness, claims inventory levels, claims control, and claims accuracy. The requirements below outline minimum requirements of TRICARE Management Activity (TMA). Contractors are encouraged to develop and employ the most effective management techniques available to ensure economical and effective operation.

### 2.0 SYSTEM ADDITIONS OR ENHANCEMENTS

#### 2.1 Implementation of Changes in Program Requirements

The contractor shall have the capacity, using either directly employed personnel or contracted personnel, to maintain and operate all required systems and to achieve timely implementation of changing program requirements.

#### 2.2 Maintaining Current Status of Diagnostic and Procedural Coding Systems

Contractors are required to use the current versions of the updated American Medical Association Physicians Current Procedural Terminology, 4th Edition (CPT-4), and the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnostic coding system; and any special codes that may be directed by TMA. Beginning with dates of **service** on or **after October 1, 2014**, for outpatient facility and all non-facility services, and for inpatient facility charges with discharge dates on or after **October 1, 2014**, contractors will be required to replace the use of ICD-9-CM diagnosis codes with the current version of the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) and the International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) for inpatient hospital procedures. The contractor is responsible for using the most current codes correctly. That responsibility includes making any needed revisions required by periodic CPT-4 and ICD-9-CM or ICD-10-CM and ICD-10-PCS updates issued by the publishers. When updates occur, contractors will be notified of the date the TRICARE Encounter Data (TED) editing system will be accepting changes in the codes.

#### 2.3 Zip Code File

The contractor shall update and maintain an electronic file of inpatient catchment area zip codes using the electronic zip code directory furnished by the Government. This electronic zip code directory defines Inpatient Catchment Areas that shall be used for verifying geographic Non-Availability Statement (NAS) requirements in accordance with the TRICARE Policy Manual (TPM), [Chapter 1, Section 6.1](#). The contractor shall update and maintain a second electronic file of all zip

codes using a separate Government-furnished electronic zip code directory. The contractor shall incorporate this second electronic file in its claims processing system to determine the validity of a beneficiary or provider zip code. These directories will be provided by the Government no less than four and no more than 12 times per calendar year. Updates to these electronic zip code directories for the purposes of contract modifications, directed policy actions, changes to catchment area definitions, and expansion or termination of zip codes by the U.S. Postal Service (USPS), shall be accomplished at no additional cost to the Government.

## **2.4 Updating And Maintaining TRICARE Reimbursement Systems**

The contractor, at no additional cost to the Government and as directed by TMA shall implement all policy changes and clarifications to existing TRICARE reimbursement systems affecting both the level of payment and the basic method of reimbursement as they apply to current provider categories implemented at the time of contract award. The TRICARE Reimbursement Manual (TRM) is the source for instructions and guidance on all existing reimbursement systems for current provider categories.

## **3.0 MANAGEMENT CONTROLS**

The contractor shall develop and employ management procedures necessary to ensure control, accuracy, and timeliness of transactions associated with operation of **their call center**, TRICARE Service Center (TSC) functions (**TRICARE overseas contract only**), authorizations, provider referrals, claims processing, beneficiary services, provider services, reconsiderations, grievances, Automatic Data Processing (ADP), and financial functions. These procedures include such elements as:

**3.1** An automated claims aging report, by status and location, for the purpose of identifying backlogs or other problem areas delaying claims processing. At a minimum, this report must be sorted to enable a count of the total number of claims pending for a specified length of time, e.g., the time periods specified in the Monthly Cycle Time/Aging Report.

**3.2** An automated returned claims report counting the number of claims returned by the time periods specified in the Monthly Cycle Time/Aging Report.

**3.3** Procedures to assure confidentiality of all beneficiary and provider information, to assure that the rights of the individual are protected in accordance with the provisions of the Privacy Act and the HIPAA and Health and Human Services (HHS) Privacy Regulation and prevent unauthorized use of TMA files.

**3.4** A system to control adjustments to processed claims which will document the actual date the need for adjustment is identified, the reason for the adjustment and the names of both the requesting and authorizing persons. The controls shall also ensure the accurate and timely update of the beneficiary history files, the timely and accurate submission of the TED data and issuance of the proper notice to the beneficiaries and providers affected by the adjustments.

**3.5** A set of processing guidelines, desk instructions/user's manuals and reference materials for internal use, at least 10 calendar days prior to the first day of delivery of health care services. These materials shall be maintained, on a current basis, for the life of the contract. Desk instructions shall be available to each employee in the immediate work area. Reference material such as procedure

codes, diagnostic codes, and special processing guidelines, shall be available to each work station with a need for frequent referral. Other reference materials shall be provided in each unit with a reasonable need and in such quantity as to ensure the ease of availability needed to facilitate work flow. Electronic versions may be used.

#### **4.0 QUALITY CONTROL**

**4.1** The contractor shall develop and implement an end-of-processing quality control program which assures accurate input and correct payments for authorized services received from certified providers by eligible beneficiaries.

**4.2** The contractor shall have a quality control program consisting of supervisory review on all appeals, grievances, correspondence, and telephone responses. This must begin by the end of the third month of operation and be carried out monthly thereafter. The review shall include a statistically valid sample or 30 records which ever is greater of all appeals, grievances and correspondence processed and telephonic responses completed. The criteria for review shall be accuracy and completeness of the written or telephonic response, clarity of the response, and timeliness with reference to the quantitative standards for the processing of appeals, grievances, and correspondence. Any lack of courtesy or respect in the response shall also be noted. All findings shall be documented, provided to TMA Contracting Officer's Representative (COR) staff, or authorized auditors, and used in a documented training program.

**4.3** The quality review program will sample each quarter, a sufficient number of all processed claims and adjustments to ensure maintenance of quality of adjudication and processing and provide adequate management control. Claims in the sample shall include all claim types and be selected randomly, or by other acceptable statistical methods, in sufficient number to yield at least a 90% confidence level with a precision of 2%. The sample will be drawn at or near the end of each quarter from claims completed during the review period. The contractor may draw the sample up to 15 calendar days prior to the close of the quarter, but must include claims completed in the period between the date the sample is drawn and the close of the quarter in the next quarterly sample. The contractor shall reflect the inclusive processing dates of the claims in the sample in the report submitted to TMA. The sampling will begin by the end of the first quarter of processing. Documentation of the results shall be completed within 45 calendar days of the close of each contract quarter.

**4.4** The contractor shall retain copies of the reviewed claims, appeals, grievances, correspondence, and related working documents, in separate files, for a period of no less than four months following submission of audit results to the Procuring Contracting Officer (PCO). TMA staff will review the results and will on a regular basis audit a selected sampling of the audited/quality review documents, either at the contractor's site or via forwarding of selected work for review at TMA.

#### **5.0 STAFF TRAINING PROGRAM**

The contractor shall develop and implement a formal initial and ongoing staff training program including training on program updates as they occur, to ensure a high quality of service to beneficiaries and providers. Such training shall include mandatory, documented training in Confidentiality of Patient Records (42 United States Code (USC) [290dd-3]) requirements (see [Section 5](#)). The contractor shall not only provide education in these requirements but must

document the personnel files of the staff members who receive the training. Centralized documentation shall also be maintained of the training session agendas, identity of attendees, actual dates and duration of training sessions, etc. The contractor is also responsible for ensuring that subcontractor staff is also trained.

## **6.0 INTERNAL AUDITS AND MANAGEMENT CONTROL PROGRAMS**

**6.1** Using its corporate internal review capability, the contractor is responsible for verifying that accounting data are correct, reliable and comply with all Government accounting standards and requirements. The contractor's corporate internal review staff must conduct regular, routine reviews to ensure proper monitoring in areas of finance, financial accounting, internal controls, special checks issued and returned, and selected history maintenance transactions for possible fraud or abuse.

**6.2** Within one year of the start of health care delivery, and any time a new function is added to requirements, contractor management shall perform vulnerability assessments in accordance with the Office of Management and Budget's (OMB's) Circular A-123.

**6.3** An internal control review of all functions which are rated as highly vulnerable shall be performed by the corporate audit staff within one year of the date of the vulnerability assessment. Within three years of the date of the vulnerability assessment, the internal audit staff shall make an internal control review of all functions rated as having a medium vulnerability. Internal control reviews shall be performed in accordance with the OMB's Circular A-123.

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## Transitions

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### 1.0 CONTRACT PHASE-IN

#### 1.1 Start-Up Plan

This comprehensive plan shall be submitted electronically, in Microsoft® Project files, as described in Exhibit B, Contract Data Requirements Lists (CDRL), of the contract.

#### 1.2 Transition Specifications Meeting

The incoming contractor shall attend a two to four day meeting with the outgoing contractor and TRICARE Management Activity (TMA) within 15 calendar days following contract award. This meeting is for the purpose of developing a schedule for phase-in and phase-out activities. TMA will notify the contractor as to the exact date of the meeting. Contractor representatives attending this meeting shall have the experience, expertise, and authority to provide approvals and establish project commitments on behalf of their organization.

#### 1.3 Interface Meetings

Within 30 calendar days from contract award, the incoming contractor shall arrange meetings with Government and external agencies to establish all systems interfaces necessary to meet the requirements of this contract. TMA representatives shall be included in these meetings and all plans developed shall be submitted to the TMA Procuring Contracting Officer (PCO) and the Contracting Officer's Representative (COR) within 10 calendar days after the meeting.

### 2.0 START-UP REQUIREMENTS

#### 2.1 Systems Development

Approximately 60 calendar days prior to the initiation of health care delivery, the non-claims processing systems and the telecommunications interconnections between these systems shall be reviewed by the TMA or its designees, to include a demonstration by the contractor of the system(s) capabilities, to determine whether the systems satisfy the requirements of TRICARE as otherwise provided in the contract. This includes the telecommunications links with TMA and Defense Enrollment Eligibility Reporting System (DEERS). The review will also confirm that the hardware, software, and communications links required for operating the automated TRICARE Duplicate Claims System (DCS) have been installed and are ready for TMA installation of the DCS application software (see Chapter 9). This review is in addition to Benchmark testing. The contractor shall effect any modifications required by TMA prior to the initiation of services.

## **2.2 Execution Of Agreements With Contract Providers**

**2.2.1** All contract provider agreements shall be executed, and loaded to the contractor's system, 60 calendar days prior to the start date of TRICARE Prime in the Prime Service Area (PSA) or at such other time as is mutually agreed between the contractor and TMA.

**2.2.2** The contractor shall begin reporting on network adequacy on a monthly basis during the transition.

## **2.3 Provider Certification**

The outgoing contractor shall transfer the provider certification documentation to the incoming contractor. The incoming contractor shall limit certification actions to new providers and shall verify a provider's credentials once, upon application to become a certified provider.

## **2.4 Execution Of Memoranda Of Understanding (MOU)**

### **2.4.1 MOU With Military Treatment Facility (MTF) Commanders**

No Later Than (NLT) 30 days following contract award, the outgoing contractor shall provide the incoming contractor the most recent version of all MTF MOUs in place at that time for the purpose of ensuring continuity of services to the MTFs and continuity of care for TRICARE beneficiaries. Sixty calendar days prior to the start of health care delivery, the contractor shall have executed an MOU with all MTF Commanders in the region. The MOU shall include, but not be limited to, MTF Optimization, **Customer Service, Education and Health Care Finder (HCF) functions, Government-furnished services, surveillance and reporting, use of facilities, Medical Management, and TRICARE Service Center (TSC) locations (TRICARE Overseas Program (TOP) MOUs only)**. The contractor shall provide two copies of each executed MOU to the PCO and the COR within 10 calendar days following the execution of the MOU.

### **2.4.2 MOU with TMA Beneficiary Education and Support Division (BE&SD)**

The contractor shall meet with the TMA BE&SD within 60 calendar days after health care contract award to develop a MOU, including deliverables and schedules. The MOU shall be executed within 30 days of the MOU meeting with the BE&SD. The contractor shall provide copies of the executed MOU to the PCO and the COR within 10 calendar days following the execution of the MOU.

## **2.5 Phase-In of TRICARE Prime Enrollment**

The contractor shall begin the enrollment process for the TRICARE Prime Program NLT 60 calendar days prior to the scheduled start of health care delivery, with actual enrollment processing to begin 40 days prior to the start of health care delivery, subject to TMA approval of systems under the contract.

### **2.5.1 Enrollment Actions During 45 Day Transition Period**

**2.5.1.1** For enrollments in the region with an effective date prior to the start of health care delivery (e.g., active duty (AD) enrollment, mid-month enrollment; transfer-in), the incoming

contractor must effect an enrollment to begin on the start of health care delivery once notified by the outgoing contractor of the new enrollment. (Defense Manpower Data Center (DMDC) may run a report at the end of the transition period that reflects new additions.)

**2.5.1.2** When a current enrollment in the region requires deletion with an effective date prior to the start of health care delivery (e.g., transfers out; disenrollments for failure to pay fees; cancellations, etc.), when requested by the outgoing contractor, the incoming contractor must cancel the future enrollment segment and notify the outgoing contractor when this action has been completed.

**2.5.1.3** For all other enrollment actions with an effective date prior to start of health care delivery (e.g., PCM changes; Defense Medical Information System Identification Code (DMIS-ID) changes; enrollment begin date changes; etc.), when requested by the outgoing contractor, the incoming contractor must cancel the future enrollment segment and notify the outgoing contractor when this action has been completed. When notified by the outgoing contractor that their change has been effected, the incoming contractor must reinstate the future enrollment segment.

**2.5.1.4** Once health care delivery begins, all enrollment actions will be accomplished by the incoming contractor. If the outgoing contractor requires a retroactive change, they must submit their request to the incoming contractor who will perform the change and notify the outgoing contractor when it is complete.

**2.5.2** In addition to other contractually required enrollment reports, the contractor, shall submit the Enrollment Plan Implementation Report on progress made in implementing TMA approved enrollment plan.

## **2.6 Transfer Of Enrollment Files**

**2.6.1** The incoming contractor shall obtain enrollment policy information from DEERS through an initial enrollment load file. DMDC will provide the incoming contractor with an incremental enrollment load file for each contract transition. The incoming contractor shall process each enrollment load file within 24 hours or less from receipt of the file.

**Note:** Each contract transition shall require a three-day freeze of enrollment and claim processing. This freeze will occur beginning the first weekend that precedes the 60 day window prior to the start of health care delivery. The actual calendar dates will be determined during the transition meeting.

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

**2.6.3** Outstanding enrollment record discrepancies and issues reported to the DEERS Support Office (DSO) by the outgoing contractor will be transferred to the incoming contractor for reconciliation. Records will be reconciled in accordance with TRICARE Systems Manual (TSM), [Chapter 3, Section 1.5](#).

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## 2.7 Enrollment Fees

**2.7.1** The incoming contractor shall obtain the cumulative total of enrollment fees and paid-through dates for the policies from the outgoing contractors with the enrollment transition information. The contractor who collects the enrollment fee will retain the enrollment fee based on the start date of the enrollment. The incoming contractor shall resolve any discrepancies of cumulative enrollment fees and paid-through dates with the outgoing contractor within 90 days of start of health care on policies inherited during the transition. The incoming contractor shall send the corrected fee information to DEERS using the Fee/Catastrophic Cap and Deductible (CCD) Web Research application or the batch fee interface outlined in the TSM, [Chapter 3](#).

**2.7.2** The incoming contractor will obtain information from the outgoing contractor on fees that are being paid monthly (i.e., by allotment or Electronic Funds Transfer (EFT) and transition these monthly payment types in the least disruptive manner for the beneficiary.

**2.7.3** The incoming contractor shall coordinate the transition of allotment data, through TMA Purchased Care Systems Integration Branch (PCSIB) and/or the applicable TMA Program Office, with the Defense Finance and Accounting Service (DFAS), the Public Health System (PHS) and the U.S. Coast Guard (USCG) during the transition-in period of the contract (see the TSM, [Chapter 1, Section 1.1](#)).

## 2.8 Phase-In Requirements Related to the HCF Function

The hiring and training of **call** center HCF function staff shall be completed prior to the start of health care delivery for TRICARE Prime in each PSA. The provider/beneficiary community shall be advised of the procedures for **obtaining** HCF **assistance** prior to the start of health care delivery.

## 2.9 Phase-In Requirements of the TSCs (**TRICARE Overseas Contract Only**)

**2.9.1** The incoming contractor will utilize the existing TSCs. The outgoing contractor shall allow reasonable access to the incoming contractor throughout the transition period to **become familiar with the** communication lines, equipment and **office layout**.

**2.9.2** The final schedule for access to and occupancy of the TSCs will be determined at the Transition Specifications Meeting. The approved schedule must allow the outgoing contractor to fulfill all contract requirements through the last day of health care delivery, and must provide the incoming contractor sufficient access to **the TSC to prepare for delivery of** all required functions on the first day of **their contract**.

## 2.9.3 Acquisition of Resources

All **Managed Care Support Contractor (MCSC) Customer Service, Education and HCF Field Representatives and overseas TSC representatives** shall be fully trained and available for all duties no less than 40 calendar days prior to initiation of health care services.

#### **2.10.4 Prior Authorizations and Referrals**

The incoming contractor shall honor outstanding prior authorizations and referrals issued by the outgoing contractor, covering care through 60 days after the start of health care delivery under the incoming contract, in accordance with the outgoing contractors existing practices and protocols, within the scope of the TRICARE program and applicable regulations or statutes. In the case of Residential Treatment Care (RTC) care, both the incoming and outgoing contractors are responsible for authorizing that part of the stay falling within their areas of responsibility; however, the incoming contractor may utilize the authorization issued by the outgoing contractor as the basis for continued stay.

#### **2.10.5 Case Management and Disease Management**

The incoming contractor shall receive case files and documentation regarding all beneficiaries under case management or disease management programs. The incoming contractor shall ensure seamless continuity of services to those beneficiaries.

#### **2.10.6 Program Integrity**

The incoming contractor shall receive case files and documentation regarding all open program integrity cases from the outgoing contractor NLT 30 days from the start of health care delivery. The incoming contractor shall work with the TMA Program Integrity Office (PI) to ensure seamless continuity of oversight of these cases.

#### **2.10.7 Health Insurance Portability And Accountability Act of 1996 (HIPAA)**

The incoming contractor, as a covered entity under HIPAA, may honor an authorization or other express legal document obtained from an individual permitting the use and disclosure of protected health information prior to the compliance date (HHS Privacy Regulation, §164.532).

#### **2.10.8 Installation And Operation Of The Duplicate Claims System (DCS)**

The incoming contractor shall have purchased, installed, configured, and connected the personal computers and printers required to operate the DCS NLT 60 days prior to the start of the health care delivery. See [Chapter 9](#), for hardware, software, printer, configuration and communications requirements and contractor installation responsibilities. Approximately 30-45 days prior to health care delivery, TMA will provide and install the DCS application software on the incoming contractor designated personal computers and provide on-site training for users of the DCS in accordance with [Chapter 9](#). Following the start of health care delivery, the DCS will begin displaying identified potential duplicate claim sets for which the incoming contractor has responsibility for resolving. The incoming contractor shall begin using the DCS to resolve potential duplicate claim sets in accordance with [Chapter 9](#) and the transition plan requirements.

#### **2.10.9 Processing of Residual Claims**

**2.10.9.1** After 120 days following the start of health care delivery for all claims, the incoming contractor shall process claims received for care that occurred during the outgoing contractor's health care delivery period. (Prior to these dates, any claims received for care that occurred during the outgoing contractor's period, shall be transferred to the outgoing contractor for processing.) In

the case of network claims, the incoming contractor shall attempt to obtain any negotiated rate or discount information for reimbursement purposes. If the incoming contractor is unable to obtain this information, the claim shall be reimbursed using standard TRICARE reimbursement methodologies as if no negotiated or discount rates were in effect.

#### **2.10.9.2 Processing of Overseas Residual Claims**

Residual claims for overseas care shall be processed by the TOP contractor. One hundred twenty days following the end of any MCSC's health care delivery period, the TOP contractor shall process all claims, including adjustments, received for care in a foreign country that occurred during the outgoing MCSC's health care delivery period.

#### **2.11 Contractor Weekly Status Reporting**

The incoming contractor shall submit a weekly status report of phase-in and operational activities and inventories.

#### **2.12 Public Notification Program-Provider And Congressional Mailing**

The contractor shall prepare a mailing to all non-network TRICARE providers and Congressional offices within the region by the 45th calendar day prior to the start of health care delivery according to the specifications of the official transition schedule. The proposed mailing shall be submitted to the PCO and the COR, and the TMA Marketing and Education Committee (MEC) for approval NLT 90 calendar days prior to the start of each health care delivery period. The mailing shall discuss any unique processing requirements of the contractor and any other needed information dictated by the official transition schedule.

#### **2.13 Web-Based Services And Applications**

NLT 15 days prior to the start of health care delivery, the incoming contractor shall demonstrate to TMA successful implementation of all web-based capabilities as described in the contract.

#### **2.14 TRICARE Handbook Mailing**

NLT 30 days prior to the start of health care delivery, the MCSC shall mail one TRICARE Handbook to every residence in the region based on DEERS data.

### **3.0 INSTRUCTIONS FOR BENCHMARK TESTING**

#### **3.1 General**

**3.1.1** Prior to the start of health care delivery, the incoming contractor shall demonstrate the ability of its staff and its automated enrollment, authorization and referral, and claims processing systems to accurately process TRICARE claims in accordance with current requirements. This will be accomplished through a comprehensive Benchmark Test. The Benchmark Test is administered by the contractor under the oversight of TMA and must be completed NLT 60 days prior to the start of services delivery. In the event that an incumbent contractor succeeds itself, the extent of Benchmark testing may be reduced at the discretion of the TMA PCO.

**3.1.2** A Benchmark Test shall consist of at least 300 but not more than 1,000 network and non-network claims, testing a multitude of claim conditions including, but not limited to, TRICARE covered/non-covered services, participating/non-participating providers, certified/non-certified providers and eligible/non-eligible beneficiaries. This Benchmark Test will require a TMA presence at the contractor's site.

**3.1.3** A Benchmark Test is comprised of one or more cycles or batches of claims. When more than one cycle is used, each cycle may be submitted on consecutive days. Each cycle after the initial one will include new test claims, as well as claims not completed during preceding cycles. At the government's discretion, any or all aspects of claims processing may be tested, e.g., receiving and sending electronic transactions, provider file development and maintenance including interface with the National Provider System when implemented, screening, coding, data entry, editing, pricing, data management, data linking, record building, and access control.

**3.1.4** The contractor shall demonstrate its ability to conduct enrollment, authorization and referral, and claims processing functions to include: claims control and development, accessing and updating internal and external enrollment data, accessing and updating DEERS for eligibility status, calculating cost-shares and deductibles, querying and updating internal and external family and patient deductible and cost-share files on the Catastrophic Cap and Deductible Database (CCDD), submitting and modifying provider and pricing records, issuing referrals and authorizations, applying allowable charge parameters, performing duplicate checking, applying prepayment utilization review criteria, adjusting previously processed claims, demonstrating recoupment and offset procedures and producing the required output for paper and electronic transactions (Explanation of Benefits (EOB), summary vouchers, payment records, checks, and management reports). Clerical functions will be evaluated including correctly coding diagnoses, medical and surgical procedures and accurately resolving edit exceptions. Enrollment and case management functions may also be included in the benchmark. At the government's discretion, the Benchmark Test may include testing of any or all systems (internal and external) used by the contractor to process claims. In addition to testing claims processing records, the Benchmark will test generation and acceptance of TRICARE Encounter Data (TED) records for every test claim. Contractor compliance with applicable HIPAA requirements and security requirements will be included in Benchmark tests as appropriate.

**3.1.5** The Benchmark Test will be comprised of both paper and electronic claims. The contractor shall be required to create test claims, including referrals and authorizations from test scenarios provided to the incoming contractor by TMA. The contractor shall supplement these test scenarios with any internal conditions they feel appropriate for testing to ensure a minimum of 1,000 claims are tested. Under certain circumstances, however, this number may be reduced at the discretion of the PCO.

**3.1.6** A Benchmark Test of a current contractor's system may be administered at any time by TMA upon instructions by the PCO. All contractor costs incurred to comply with the performance of the Benchmark Test are the responsibility of the contractor.

## **3.2 Conducting The Benchmark**

**3.2.1** At the time of the scheduled Benchmark Test a TMA Benchmark Team comprised of up to 12 people will arrive at the contractor's work site to conduct the testing and evaluate the Benchmark Test results.

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#### Transitions

**3.2.2** The amount of time a contractor shall have to process the Benchmark Test claims and provide all of the output (excluding TEDs) to the Benchmark Team for evaluation will vary depending on the scope of the Benchmark and volume of claims being tested. As a guide, the following table is provided for contractor planning purposes:

NUMBER OF BENCHMARK CLAIMS/SCENARIOS	NUMBER OF DAYS TO COMPLETE PROCESSING
UP TO 100	1-2
UP TO 500	2-4
UP TO 1000	4-7

**3.2.3** The contractor will be informed at the pre-benchmark meeting (see [paragraph 3.3.1](#)) of the exact number of days to be allotted for processing the benchmark claims and test scenarios and providing all of the output (excluding TEDs) to the Benchmark Team for evaluation.

**3.2.4** The Benchmark Team will provide answers to all contractors written and telephonic development questions related to the test scenarios provided by TMA and will evaluate the contractor's output against the Benchmark Test conditions.

**3.2.5** The Benchmark Team will require a conference room that can be locked with table(s) large enough to accommodate up to 12 people. The conference room must also be equipped with two telephones with access to internal and outside telephone lines.

**3.2.6** The incoming contractor shall provide up-to-date copies of the TRICARE Operations Manual (TOM), TRICARE Policy Manual (TPM), TRICARE Reimbursement Manual (TRM), and TRICARE Systems Manual (TSM), a complete set of the current International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnostic coding manuals for dates of service on or before September 30, 2014, or a complete set of the current International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) diagnostic coding manual and International Classification of Diseases, 10th Revision, Procedure Classification System (ICD-10-PCS) procedure coding manual for dates of service on and after October 1, 2014, the currently approved HCPCS and CPT-4 procedural coding manual, in either hard copy or electronic versions. The contractor shall also provide Transaction Guides for all HIPAA transactions used by the contractor for claims adjudication, as well as any applicable supporting references to the Transaction Guides (e.g., HIPAA Health Care Provider Taxonomy, Claim Adjustment Reason Codes, etc.) explanations of the contractor's EOB message codes, edits, and denial reason codes, and any overlays required to evaluate EOB, checks, or summary vouchers.

**3.2.7** The incoming contractor shall provide an appropriate printer and a minimum of three computer terminals in the conference room with on-line access to all internal and external systems used to process the Benchmark Test claims to include, but not limited to: provider files (TEPRVs), including the contracted rate files for each provider; pricing files (TEPRCs) (area prevailing and CHAMPUS Maximum Allowable Charge (CMAC) pricing) DEERS; catastrophic cap and deductible files; and any other files used in processing claims, authorizations, referrals, and enrollments. The contractor's requirements for issuing system passwords for members of the Benchmark Team will be discussed at the pre-benchmark meeting.

**3.2.8** The contractor shall provide an organizational chart and personnel directory including telephone numbers. A listing of the contractor's staff involved in performing the Benchmark Test by

function (e.g., data entry, development, medical review, etc.) is also required. Claims flow/decision diagrams including authorization and referral requirements will be provided prior to the Benchmark Test.

### 3.3 Procedures

**3.3.1** Approximately 60 calendar days following award to the contractor, representatives from TMA will meet with the incoming contractor's staff to provide an overview of the Benchmark Test process, receive an overview of the claims processing system, collect data for use in the Benchmark, and discuss the dates of the test and information regarding the administration of the Benchmark Test. At this time, TMA will provide the test scenarios to the contractor that are to be used in the development of their test claims.

**Note:** At TMA's discretion, the test must be completed NLT 60 days prior to the start of health care delivery to allow time to make any needed corrections. The pre-benchmark meeting will be conducted at the incoming contractor's claims processing site. Provider and beneficiary data, to include enrollment forms, physician referrals, and authorizations, will be coordinated at the pre-benchmark meeting to ensure that the contractor adequately prepares all files prior to the Benchmark. Electronic transaction requirements shall be discussed to include timing and logistics.

**3.3.2** On the first day of the Benchmark Test, a brief entrance conference will be held with contractor personnel to discuss the schedule of events, expectations and administrative instructions.

**3.3.3** During the Benchmark Test the contractor shall process the claims and provide TMA with all output, including EOBs, summary vouchers, suspense reports, checks, and claims histories. Paper checks and EOBs may be printed on plain paper, with EOB and check overlays. Electronic output is required for electronic transactions.

**3.3.4** The contractor shall provide output for evaluation by the TMA Benchmark Team as the claims are processed to completion. The specific schedule for claims processing and the procedures for providing the output to the Benchmark Team will be discussed with the contractor at the pre-benchmark meeting.

**3.3.5** TMA personnel will compare the Benchmark Test claim output against the benchmark test conditions for each claim processed during the test and provide the findings to the contractor. All appropriate contractor and Benchmark Team personnel shall be present to answer any questions raised during the Benchmark Test claims review.

**3.3.6** At the conclusion of the on-site portion of the Benchmark Test, an exit conference may be held with the contractor staff to brief the contractor on all findings identified during the Benchmark. The initial test results will be provided to the contractor. The initial Benchmark Test Report will be forwarded to the contractor by TMA within 20 calendar days of the last day of the on-site test. For any claims processing errors assessed with which the contractor disagrees, a written description of the disagreement along with any specific references must be included with the claims. The contractor's response to the Initial Benchmark Test Report shall be submitted to the TMA Contracting Officer (CO) within 20 days. Following the contractor's response, TMA shall provide the Final Benchmark Test Report to the contractor within 20 calendar days.

**3.3.7** The contractor shall prepare and submit the initial TED submission to TMA for evaluation during the Benchmark Test. A TED record shall be prepared for each Benchmark claim processed to completion, whether allowed or denied, within two calendar days from the processed date. TED records will not be created for claims removed from the contractor's processing system, i.e., out of jurisdiction transfers. The contractor shall be notified of any TEDs failing the TMA edits. The contractor shall make the necessary corrections and resubmit the TEDs until 100% of the original Benchmark Test TEDs have passed the edits and are accepted by TMA. TEDs submission files related to the Benchmark Tests must be identified by transmission file and batch/voucher numbers prior to submission to TMA.

**3.3.8** The contractor has 45 calendar days from the date of the initial Benchmark Test report to submit the final corrected TEDs to TMA. New TEDs need not be generated to reflect changes created from claims processing corrections, however, all TEDs originally submitted for the Benchmark Test claims which did not pass the TMA edits must continue to be corrected and resubmitted until all edit errors have been resolved and 100% of the TEDs have been accepted by TMA. TEDs submission files related to the Benchmark Tests must be identified by transmission file and batch/voucher numbers prior to submission to TMA.

### **3.4 Operational Aspects**

**3.4.1** The Benchmark Test may be conducted on the contractor's production system or an identical copy of the production system (test system). Whichever system is used for the Benchmark, it must meet all TRICARE requirements and contain all the system interconnections and features of the production system in the contractor's proposal. When the Benchmark Test is conducted on the contractor's production system, the contractor shall prevent checks and EOBs from being mailed to the beneficiaries and providers, and prevent production TEDs from being generated and sent to TMA.

**3.4.2** Certain external test systems and files (e.g., DEERS) are an integral component of the Benchmark Test and the contractor is expected to perform all necessary verifications, and queries, according to TRICARE procedures and policy. The contractor shall coordinate through the TMA, Contract Operations Branch, to ensure that direct interface with any required external test systems (i.e., DEERS) is established and operational prior to the Benchmark Test.

**3.4.3** TEDs shall be generated from the Benchmark Test claims and provided to TMA for processing as scheduled at the pre-benchmark meeting. The contractor shall coordinate with the TMA, O/ATIC, for TED submission procedures.

## **4.0 CONTRACT PHASE-OUT**

### **4.1 Transition Specifications Meeting**

The outgoing contractor shall attend a meeting with representatives of the incoming contractor and TMA at the TMA office in Aurora, Colorado, within 15 calendar days following contract award. This meeting is for the purpose of developing a schedule of phase-out/phase-in activities. TMA will notify the contractor as to the exact date of the meeting. The outgoing contractor shall provide a proposed phase-out plan at the Transition Specifications Meeting.

## **4.2 Data**

The outgoing contractor shall provide to TMA (or, at the option of TMA, to a successor contractor) such information as TMA shall require to facilitate transitions from the contractor's operations to operations under any successor contract. All files shall be provided in a non-proprietary format and the contractor shall include such file specifications and documentation as may be necessary for interpretation of these files. Such information may include, but is not limited to, the following:

- The data contained in the contractor's enrollment information system.
- The data contained in the contractor's claims processing systems.
- Information about the management of the contract that is not considered, under applicable Federal law, to be proprietary to the contractor.

## **4.3 Phase-Out of the Contractor's Claims Processing Operations**

Upon notice of award to another contractor, and during the procurement process leading to a contract award, the contractor shall undertake the following phase-out activities regarding services as an outgoing contractor.

### **4.3.1 Transfer of Electronic File Specifications**

The outgoing contractor shall transfer to the incoming contractor by express mail or similar overnight delivery service, NLT three calendar days following award announcement, electronic copies of the record layouts with specifications, formats, and definitions of fields, and data elements, access keys and sort orders, for the following:

- The TRICARE Encounter Provider Files (TEPRVs).
- The TRICARE Encounter Pricing Files (TEPRCs).
- The Enrolled Beneficiary and PCM Assignment Files.
- Mental Health Provider Files - The outgoing contractor must assure that the incoming contractor has been given accurate provider payment information on all mental health providers paid under the TRICARE inpatient mental health per diem payment system. This should include provider name; tax identification number; address including zip code; high or low volume status; if high volume, provide the date the provider became high volume; and the current per diem rate along with the two prior year's per diem amounts. The providers under the per diem payment system must be designated by Medicare, or meets exemption criteria, as exempt from the inpatient mental health unit, the unit would be identified as the provider under the TRICARE inpatient mental health per diem payment system.

### **4.3.2 Transfer Of ADP Files (Electronic)**

The outgoing contractor shall prepare in non-proprietary electronic format and transfer

to the incoming contractor or TMA, by the 15th calendar day following the Transition Specifications Meeting unless, otherwise negotiated by the incoming and outgoing contractors, all specified ADP files, such as the Provider and Pricing files, in accordance with specifications in the official transition schedule and will continue to participate in preparation and testing of these files until they are fully readable by the incoming contractor or TMA.

#### **4.3.3 Outgoing Contractor Weekly Shipment Of History Updates**

The outgoing contractor shall transfer to the incoming contractor, in electronic format, all beneficiary history and deductible transactions (occurring from the date of preparation for shipment of the initial transfer of such history files and every week thereafter) beginning the 120th calendar day prior to the start of health care delivery (until such a time that all processing is completed by the outgoing contractor) in accordance with the specifications in the official transition schedule.

#### **4.3.4 Transfer Of Non-ADP Files**

The outgoing contractor shall transfer to the incoming contractor all non-ADP files (e.g., authorization files, clinic billing authorizations, and tapes/CDs, which identify PSAs, Congressional and TMA completed correspondence files, appeals files, TRICARE medical utilization, and administration files) in accordance with the specifications in the official transition schedule and [Chapter 2](#). The hard copies of the Beneficiary History Files are to be transferred to the incoming contractor or Federal Records Center (FRC) as required by [Chapter 2](#). The contractor shall provide samples and descriptions of these files to the incoming contractor at the Transition Specification Meeting.

#### **4.3.5 EOB Record Data Retention And Transmittal**

If the contractor elects to retain the EOB data on a computer record, it must, in the event of a transition to another contractor, provide either a full set of electronic records covering the current and two prior years, or, at the PCO's discretion, provide the data and necessary programs to reproduce the EOB in acceptable form and transfer such data and programs to the successor contractor or to TMA. TMA shall be the final authority in determining the form and/or acceptability of the data.

#### **4.3.6 Outgoing Contractor Weekly Status Reporting**

Until all inventories have been processed, the outgoing contractor shall submit a weekly status report of inventories and phase-out activities to TMA beginning the 20th calendar day following the Specifications Meeting until otherwise notified by the PCO to discontinue. This shall be done in accordance with specifications of the official transition schedule.

#### **4.3.7 Prior Authorizations and Referrals**

The outgoing contractor shall provide all prior authorizations and referrals that cover care spanning the start of health care delivery under the new contract or care that could potentially begin in the incoming contractor's health care delivery period. The outgoing and incoming contractor shall mutually agree to the date and schedule for transfer of this information.

#### **4.3.8 Case Management and Disease Management Files**

NLT 60 days prior to the start of health care delivery under the new contract, the outgoing contractor shall provide the incoming contractor with all files pertaining to beneficiaries covered under a Case Management or Disease Management program. Electronic files shall be provided under a non-proprietary format. The outgoing contractor shall cooperate with the incoming contractor to ensure seamless continuity of care and services for all such beneficiaries.

#### **4.3.9 MTF MOUs**

NLT 30 days following contract award, the outgoing contractor shall provide the incoming contractor the most recent version of all MTF MOUs in place at that time for the purpose of ensuring continuity of services to MTFs and continuity of care for TRICARE beneficiaries.

#### **4.3.10 Program Integrity Files**

NLT 30 days prior to the start of health care delivery under the new contract, the outgoing contractor shall provide the incoming contractor with all active Program Integrity case files that have been forwarded to TMA Program Integrity Office (PI). The outgoing contractor shall also provide weekly updates of Program Integrity case file, including new cases initiated through the end of the contract delivery period.

#### **4.3.11 Provider Certification File**

NLT 30 days after contract award and on a monthly basis until the start of health care delivery, the outgoing contractor shall provide the incoming contractor with copies of all provider certification files.

### **4.4 Final Processing Of Outgoing Contractor**

The outgoing contractor shall:

- Process all claims and adjustments for care rendered prior to the start of health care delivery of the new contract that are received through the 120th day following cessation of the outgoing contractor's health care delivery. Processing of these claims shall be completed within 180 calendar days following the start of the incoming contractor's health care delivery. All claims shall meet the same standards as outlined in the current outgoing contract. Any residual claim received after 120 days shall be forwarded to the incoming contractor within 24 hours of receipt.
- Be liable, after the termination of services under this contract, for any payments to subcontractors of the contractor arising from events that took place during the period of this contract.
- Refer to [paragraph 2.10.3](#), for transitional case requirements.
- Process all correspondence, allowable charge complaints, and incoming telephonic inquiries which pertain to claims or services processed or delivered under this contract within the time frames established for response by the standards of the contract.

- Complete all appeal and grievance cases that pertain to claims or services processed or delivered under this contract within the time frames established for response by the standards of the contract.

#### 4.4.1 Correction of Edit Rejects

The outgoing contractor shall retain sufficient resources to ensure correction (and reprocessing through TMA) of all TED record edit errors NLT 210 calendar days following the start of the incoming contractor's health care delivery.

#### 4.4.2 Phase-Out of the Automated TRICARE DCS

The outgoing contractor shall phase-out the use of the automated TRICARE DCS in accordance with [Chapter 9](#) and transition plan requirements.

#### 4.4.3 Phase-Out Of The Contractor's Provider Network, TSCs (TRICARE Overseas Contract Only), And MTF Agreements

**4.4.3.1** Upon notice of award to another contractor, the outgoing contractor shall provide full cooperation and support to the incoming contractor, to allow an orderly transition, without interruption, of all functions relating to the MTF interface and the establishment of a provider network by the incoming contractor. This shall include, but is not limited to, data relating to on-site service centers, resource sharing agreements, equipment, telephones and all other functions having an impact on the MTFs.

**4.4.3.2** Within 15 calendar days of the Transitions Specifications Meeting the outgoing contractor shall draft and submit a revised plan for transition of the MTF interfaces. Resolution of differences identified through the coordination process must be accomplished in collaboration with the Transition Monitor appointed by TMA and according to the guidelines in the transition schedule.

**4.4.3.3** The outgoing contractor shall ensure a HCF function continues through the last date of health care delivery under the current contract, unless otherwise negotiated with the incoming contractor during the Transition Specifications Meeting. The outgoing contractor shall also vacate the TSCs (TRICARE overseas contract only) on the 40th calendar day prior to the start of the health care delivery and establish a centralized HCF function.

**4.4.3.4** The outgoing contractor shall continue to issue prior authorizations for care for which it is financially responsible. However, authorization-related information shall be shared between the incoming and the outgoing contractors to preclude requiring a provider or beneficiary to duplicate the paperwork and other effort related to establishing prior authorizations. The outgoing contractor may issue prior authorizations as late as midnight on the day prior to the end of its health care delivery for inpatient stays that will continue as transitional cases. The two contractors shall interface on the clinical issues of a case where both contractors will, or can reasonably expect to have periods of liability for the same EOC.

**4.4.3.5** The outgoing contractor shall maintain toll-free lines and web-based customer service capabilities, accessible to the public during the first 90 calendar days of dual operations in order to properly respond to inquiries related to claims processed for services incurred during the period of

their respective liability. Beneficiary inquiry lines will continue to be staffed as defined in the contract. In general, the outgoing contractor shall maintain adequate toll-free line coverage to ensure that the blockage rate does not exceed the blockage rate on the contractor's most critical private or other government business access line.

#### **4.5 Phase-Out of Enrollment Activities**

**4.5.1** Prior to the start of health care delivery under the successor contract, for all enrollment renewals or payments in which the new enrollment period or period covered by the premium payment will begin under the new contract, the outgoing contractor shall amend renewal notices and billing statements (or include a stuffer/insert) to advise the enrollee to direct any enrollment-related correspondence and enrollment fee payments to the successor contractor.

**4.5.2** Prior to the start of health care delivery under the successor contract, the Government will provide the outgoing contractor with the software for the DOES version to be used during transition. The software version should be loaded and used for the phase-out of enrollment activities.

#### **4.5.3 Enrollment Actions During 45 Day Transition Period**

**4.5.3.1** For new enrollments in the region with an effective date prior to the start of health care delivery (e.g., AD enrollment, mid-month enrollment; and transfer-in), the outgoing contractor must effect an enrollment action with an end date of the current contract period (i.e., one day prior to the start of health care delivery under the incoming contract). Any enrollment fees due for an effective date that is prior to the start of health care delivery will be retained by the outgoing contractor. Once the enrollment is effected, the outgoing contractor will notify the incoming contractor of the new enrollment.

**4.5.3.2** When a current enrollment in the region requires deletion with an effective date prior to the start of health care delivery (e.g., transfers out; disenrollments for failure to pay fees; cancellations, etc.), the outgoing contractor must request the incoming contractor to cancel the future enrollment segment that was included on the Gold File. Once notified by the incoming contractor that the segment has been cancelled, the outgoing contractor completes the appropriate disenrollment action.

**4.5.3.3** For all other enrollment actions with an effective date prior to start of health care delivery (e.g., PCM changes; DMIS-ID changes; and enrollment begin date changes), the outgoing contractor must request the incoming contractor cancel the future enrollment segment. Once notified that the cancellation has been completed, the outgoing contractor will make the necessary change. Upon completion of the change, the outgoing contractor must notify the incoming contractor so that the future enrollment segment can be restored.

**4.5.3.4** The outgoing contractor should complete all pending enrollment actions prior to the DEERS freeze to transition enrollment. Any enrollment action not completed by the outgoing contractor prior to the freeze (and after the Gold File is created) will have to be accomplished following the above procedures.

**4.5.3.5** Once health care delivery begins, all enrollment actions will be accomplished by the incoming contractor. If the outgoing contractor requires a retroactive change, they must submit

their request to the incoming contractor who will perform the change and notify the outgoing contractor when it is complete.

**4.5.4** Any enrollment-related correspondence and/or enrollment fee payments subsequently received by the outgoing contractor shall be forwarded to the incoming contractor within three working days of receipt.

**4.5.5** The outgoing contractor shall terminate marketing and enrollment activity 40 calendar days prior to the start of the incoming contractor's health care delivery. Any enrollment requests or applications received after the 40th calendar day shall be transferred to the incoming contractor by overnight delivery at the outgoing contractor's expense.

**4.5.6** Throughout the transition period, the outgoing and incoming contractors shall coordinate enrollment files no less than weekly to ensure that new enrollments and enrollment renewals are accurately and timely reflected in the incoming contractor's enrollment files and in DEERS.

#### **4.6 Cost Accounting**

If the outgoing contractor succeeds itself, costs related to each contract shall be kept separate for purposes of contract accountability, according to the above guidelines.

#### **4.7 Records Disposition**

The outgoing contractor shall comply with the provisions of [Chapter 2](#), in final disposition of all files and documentation. The contractor shall include a records disposition plan as part of the phase-out plan submitted to TMA at the Transition Specifications Meeting.

#### **4.8 Provide Information**

The contractor shall, upon receipt of a written request from TMA, provide to potential offerors such items and data as required by TMA. This shall include non-proprietary information, such as record formats and specifications, field descriptions and data elements, claims and correspondence volumes, etc.

- END -

## Enrollment Processing

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The contractor shall record all enrollments on Defense Enrollment Eligibility Reporting System (DEERS), as specified in the TRICARE Systems Manual (TSM), [Chapter 3](#).

The contractor shall develop and implement an enrollment plan to support contractor enrollment of beneficiaries. The contractor shall consult with the Regional Director (RD) and all Military Treatment Facility (MTF) Commanders where Prime is offered in developing the enrollment plan.

### 1.0 ENROLLMENT PROCESSING

**1.1** The contractor shall use the TRICARE Prime Enrollment Application and Primary Care Manager (PCM) Change Form (one combined form) Department of Defense (DD) Form 2876, and the TRICARE Prime Disenrollment Form DD Form 2877. The contractor shall ensure aforementioned forms are readily available to potential enrollees. The contractor shall implement enrollment processes (which do not duplicate Government systems) that ensure success and assistance to all beneficiaries.

**1.1.1** The contractor shall collect TRICARE Prime enrollment applications at a site(s) mutually agreed to by the contractor, RD, and the MTF Commander, by mail, or by other methods proposed by the contractor and accepted by the Government. **The contractors shall encourage the beneficiaries to use the Beneficiary Web Enrollment (BWE) system to enroll. The overseas contractor shall also collect applications at their TRICARE Service Centers (TSCs).**

**1.1.2** Enrollment applications must be signed by the sponsor, spouse or other legal guardian of the beneficiary. A signed enrollment application includes those with (1) an original signature, (2) an electronic signature offered by and collected by the contractor, or (3) the self attestation by the beneficiary when using the BWE system. An Active Duty Service Member (ADSM) or Active Duty Family Member (ADFM) signature is not required to make enrollment changes using the Enrollment Portability process outlined in [Chapter 6, Section 2, paragraph 1.4](#). A signature from an ADSM, although desired, is not required to complete Prime enrollment as enrollment in Prime is mandatory per the TRICARE Policy Manual (TPM), [Chapter 10, Section 2.1, paragraph 1.1](#).

**1.1.3** The contractor shall also accept and process TRICARE Prime enrollment applications via the BWE process.

**1.2** The contractor shall provide beneficiaries who enroll full and fair disclosure of any restrictions on freedom of choice that apply to enrollees, including the Point of Service (POS) option and the consequences of failing to make enrollment fee payments on time.

**1.3** Enrollment shall be on an individual or family basis. For newborns and adoptees, see the TPM, [Chapter 10, Section 3.1](#).

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#### Enrollment Processing

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**1.4** The contractor shall follow the specifications of the Memorandum of Understanding (MOU) with the appropriate MTF Commander and RD and any other instructions from the RD in performing and coordinating enrollment processing with the MTF, the appropriate RD, and DEERS.

**1.5** The contractor shall record all Prime enrollments from a centralized contractor data entry point on the DEERS using a Government-furnished systems application, the DEERS Online Enrollment System (DOES). The equipment needed to run the DEERS desktop enrollment application shall be furnished by the Managed Care Support Contractor (MCSC) and shall meet technical specifications in the TSM, [Chapter 3](#).

**1.5.1** MCSCs shall resend PCM Information Transfers (PITs) to MTFs when requested.

**1.5.2** The MCSC shall submit required changes to the DEERS Support Office (DSO) as required.

**1.6** At the time of enrollment processing, the contractor shall access DEERS to verify beneficiary eligibility and shall update the residential and mailing addresses and any other fields that they can update on DEERS.

**1.6.1** If the enrollment form contains neither a residence address nor a mailing address, the contractor shall attempt to develop the enrollment form for a residence address. If it is determined the beneficiary does not have an established residence address or that the beneficiary's mailing address differs from the residence address, the contractor shall also develop the enrollment form for a mailing address.

**1.6.2** Enrollees may submit a temporary address (i.e., Post Office Box, Unit address, etc.), until a permanent address is established. Temporary addresses must be updated with the permanent address when provided to the contractor by the enrollee in accordance with the TSM, [Chapter 3, Section 1.4](#). Contractors shall not input temporary addresses not provided by the enrollee.

**1.6.3** If the DEERS record does not contain an address, or if the application contains information different from that contained on DEERS in fields for which the contractor does not have update capability, the contractor shall contact the beneficiary by telephone within five calendar days, outlining the discrepant information and requesting that the beneficiary contact the military personnel information office.

**1.7** Defense Manpower Data Center (DMDC)/DEERS shall print and mail the Universal TRICARE Beneficiary Cards directly to the enrollee at the residential mailing address specified on the enrollment application after receipt of the enrollment record. DMDC will also provide notification of PCM assignments for new enrollments, enrollment transfers, PCM changes, and the replacement of TRICARE Universal Beneficiary Cards. (See TSM, [Chapter 3, Section 1.4](#).) The return address on the envelope mailed by DMDC will be that of the appropriate MCSC. In the case of receiving returned mail, the MCSC shall develop a process to fulfill the delivery to the enrollee.

**1.8** An enrollee must present both a TRICARE Prime identification card and a military identification card to a provider to demonstrate eligibility for TRICARE Prime program benefits.

**5.8.1 Monthly Under Report (Prior To October 1, 2012)**

Enrollment fees are considered delinquent and will show up on the Monthly Under Report when the paid-through date associated with a policy is greater than 60 days in the past. The Under Report will be provided on the first of each month. The contractor is required to analyze and correct all reported delinquencies within 30 days of the report's availability. The corrections may include synchronizing the fee data between the contractor's system and DEERS, correcting data discrepancies, and potentially terminating enrollments for failure to pay fees.

**5.8.2 Monthly Over Report (Prior To October 1, 2012)**

The Monthly Over Report will identify those policies where the paid amount is over the amount owed. Amount owed is based on the enrollment begin date, the paid-through date, any existing fee waivers, and DEERS data used to determine payment tiers (if applicable) and/or freezes of enrollment fees (premium override periods). The Over Report will be provided before the 10th business day of each month. The contractor is required to analyze and correct all reported accounts within 30 days of the report's availability. The contractor is responsible for correcting any data inaccuracies within the enrollment fee reporting system to include the refunding of any enrollment fees in excess of what is due if necessary.

**5.8.3 Quarterly Under Report (Prior To October 1, 2012)**

The Quarterly Under Report will identify all terminated policies since the inception of the contract that have an associated paid-through date prior to the termination date. The Quarterly Report will be provided on the first day of the first month of the fiscal quarter (i.e., October 1, January 1, April 1, and July 1). The contractor shall correct all data discrepancies within 60 days of the report's availability.

**5.8.4 Monthly Reports (On or After October 1, 2012)**

**5.8.4.1** DEERS will provide the following reports on a monthly basis:

- Current policies that are two months past due (paid period end date more than two months in the past)
- Any policies where the paid period end date exceeds the policy end date
- Policies where the paid period end date meets the policy end date but a credit exists
- Terminated policies where the paid period end date does not meet the policy end date

**5.8.4.2** These reports will be provided before the 10th business day of each month. The contractor is required to analyze and correct all report accounts within 30 days of the report's availability. The contractor is responsible for correcting any data inaccuracies within the enrollment fee reporting system to include the refunding of any enrollment fees in excess of what is due if necessary. For enrollment fee payments effective on or after October 1, 2012, the contractor shall update DEERS with any fee amount refunded within 30 calendar days.

## 6.0 ENROLLMENT OF FAMILY MEMBERS OF E-1 THROUGH E-4

**6.1** When family members of E-1 through E-4 reside in a Prime Service Area (PSA) of an MTF offering TRICARE Prime, the family members will be encouraged to enroll in TRICARE Prime. Upon enrollment, they will choose or be assigned a PCM located in the MTF. Such family members may, however, specifically decline such enrollment without adverse consequences. The choice of whether to enroll in TRICARE Prime, or to decline enrollment is completely voluntary. Family members of E-1 through E-4 who decline enrollment or who enroll in Prime and subsequently disenroll may re-enroll at any time. The completion of an enrollment application is a prerequisite for enrollment of such family members.

**6.2** Enrollment processing and allowance of civilian PCM assignments will be in accordance with the Memorandum of Understanding between the contractor and the MTF.

**6.3** The primary means of identification and subsequent referral for enrollment will occur during in-processing. Non-enrolled E-4 and below families may also be referred to the MCSC's call center, Commanders, First Sergeants/Sergeants Major, supervisors, Family Support Centers, and others. Beneficiaries at overseas locations may also be referred to their local TSC.

**6.4** MCSC representatives at their call center and those giving beneficiary education briefings will provide enrollment information and support the family member in making an enrollment decision (i.e., to enroll in TRICARE Prime or to decline enrollment). The education of such potential enrollees shall specifically address the advantages of TRICARE Prime enrollment, including guaranteed access, the support of a PCM, etc. The contractor shall reinforce that enrollment is at no cost for family members of E-1 through E-4 and will give them the opportunity to select or be assigned an MTF PCM, to select a civilian PCM if permitted by applicable MOU, or to decline enrollment in TRICARE Prime.

**6.5** The contractor shall also discuss the potential effective date of the enrollment, explaining that the actual effective date will depend upon the date the enrollment application is received, consistent with current TRICARE rules (i.e., the "20th of the month" rule). The effective date of enrollment shall be determined by the date the enrollment application is received by the MCSC. These enrollments and enrollment refusals should not be tracked, nor the enrollees identified differently than enrollments initiated through any other process, such as the MCSC's own marketing efforts.

**6.6** Enrollment may be terminated at any time upon request of the enrollee, sponsor or other party as appropriate under existing enrollment/disenrollment procedures. Beneficiaries in this group may re-enroll at any time without restriction or penalty. However, such re-enrollments are subject to the 20th of the month rule.

**6.7** Contractors are not required to screen TRICARE claims to determine whether it may be for treatment of a non-enrolled ADFM of E-1 through E-4 living in a PSA. Rather, they are to support the prompt and informed enrollment of such individuals when they have been identified by DoD in the course of such a person's interaction with the military health care system or personnel community and have been referred to the contractor for enrollment.

## **7.0 TRICARE ELIGIBILITY CHANGES/REFUNDS OF FEES**

**7.1** Refer to the TPM, [Chapter 10, Section 3.1](#), for information on changes in eligibility.

**7.2** The contractor shall allow a TRICARE-eligible beneficiary who has less than 12 months of eligibility remaining to enroll in TRICARE Prime until such time as the enrollee loses his/her TRICARE eligibility. The beneficiary shall have the choice of paying the entire enrollment fee or paying the fees on a more frequent basis (e.g., monthly or quarterly). If the enrollee chooses to pay by installments, the contractor shall collect only those installments required to cover the period of eligibility. For enrollment fee payments effective on or after October 1, 2012, DEERS will calculate the paid-through date based on the enrollment fee amount collected and entered into DEERS by the contractor, which in this circumstance, should cover the period of the beneficiary's eligibility. The contractor shall refund any overpayment of \$1 or more that DEERS does not use to extend the paid-through date to the policy end date (or the last day of the month in which a Prime policy ends). The contractor shall include an explanation to the beneficiary for the fee refund. The contractor shall update DEERS with any fee amount refunded within 30 calendar days.

**7.3** Contractors shall refund the unused portion of the TRICARE Prime enrollment fee to retired TRICARE Prime enrollees and their families who have been recalled to active duty. The contractor shall include an explanation to the beneficiary for the fee refund. Contractors shall calculate the refund using monthly prorating, and shall report such refunds to DEERS within 30 calendar days. If the reactivated member's family chooses continued enrollment in TRICARE Prime, the family shall begin a new enrollment period and shall be offered the opportunity to keep its PCM, if possible. Any enrollment/fiscal year catastrophic cap accumulations shall be applied to the new enrollment period.

**7.4** The contractor shall refund enrollment fees for deceased enrollees upon receiving a written request from the remaining enrollee or the executor of the decedent's estate. The contractor shall include an explanation to the beneficiary for the fee refund. The enrollee's request must include a copy of the death certificate. Refunds shall be prorated on a monthly basis and apply both to individual plans where the sole enrollee is deceased and to the conversion of a family enrollment to an individual plan upon the death of one or more family members. For individual enrollments, the contractor shall refund remaining enrollment fees to the executor of the estate. For family enrollments that convert to individual plans, the contractor shall either credit the excess fees to the individual plan or refund them either to the remaining enrollee or to the executor of the decedent's estate, as appropriate. Enrollment fees for family enrollments of three or more members are not affected by the death of only one enrollee and no refunds shall be issued. The contractor shall update DEERS with any amount refunded within 30 calendar days.

**7.5** The contractors shall refund the unused portion of the TRICARE Prime enrollment fee to TRICARE Prime enrollees who become eligible for Medicare Part A based upon disability, End Stage Renal Disease (ESRD) or upon attaining age 65, provided the beneficiary has Medicare Part B coverage.

**7.5.1** The contractor shall issue refunds to these beneficiaries upon receiving (1) a written request from the beneficiary (that includes a copy of their Medicare card) and either confirming their Part B enrollment in DEERS or in a previous Policy Notification Transaction (PNT), or (2) upon receipt of an unsolicited PNT noting a beneficiary's fee waiver update based on the Part B enrollment. DEERS generates a PNT when the Centers for Medicare and Medicaid Services (CMS)

sends DEERS data indicating a Part B enrollment or disenrollment. Refunds are required for all payments that extend beyond the date the enrollee has Medicare Part B coverage, as calculated by DEERS. The contractor shall update DEERS with any amount refunded within 30 calendar days. The contractor shall include an explanation to the beneficiary for the fee refund. Effective October 1, 2012, if the fee waiver is a 100% waiver of the Prime enrollment fee, the contractor shall send a refund to the beneficiary. If the fee waiver is a 50% waiver of the Prime enrollment fee, DEERS will automatically calculate the overpayment and extend the paid through date for the policy, as appropriate; therefore, a refund may not be required unless a credit remains when the policy is paid in full.

**7.5.2** For Prime enrollees who become Medicare eligible and who maintain Medicare Part B coverage, refunds are required for overpayments occurring on and after the start of health care delivery of all MCS contracts. The contractor shall utilize the PNTs received indicating a fee waiver based on Medicare to substantiate any claim of overpayment.

**7.5.3** Medicare eligible ADFMs age 65 and over are not required to have Medicare Part B to remain enrolled in TRICARE Prime. To maintain TRICARE coverage upon the sponsor's retirement, they must enroll in Medicare Part B during Medicare's Special Enrollment Period prior to their sponsor's retirement date. (The Special Enrollment Period is available anytime the sponsor is on active duty or within the first eight months of the sponsor's retirement. If they enroll in Part B after their sponsor's retirement date, they will have a break in TRICARE coverage.)

**7.5.4** Medicare eligibles age 65 and over who are not entitled to premium-free Medicare Part A are not required to have Medicare Part B to remain enrolled in TRICARE Prime. Because they may become eligible for premium-free Medicare Part A at a later date, under their or their spouse's SSN, they should enroll in Medicare Part B when first eligible at age 65 to avoid the Medicare surcharge for late enrollment.

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

## **8.0 WOUNDED, ILL, AND INJURED (WII) ENROLLMENT CLASSIFICATION**

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

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

- ADSMs must be enrolled to a TRICARE Prime program prior to, or at the same time, as being enrolled into a WII 415 or WII 416 program.
- A member cannot be enrolled in WII 415 and WII 416 programs at the same time.

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

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

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

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

**8.1.2** The Service-specific WII entity will stamp the front page of the DD Form 2876, enrollment application form, with WII 415 for new enrollments that begin after the DEERS implementation date. The enrollment form will then be sent to the appropriate contractor who shall perform the enrollment in the DOES and include the following information:

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

**8.1.3** WII 415 enrollments will be in conjunction with an MTF enrollment only, not to civilian network PCMs under TPR enrollment rules. DEERS will end WII 415 enrollments upon loss of member's active duty eligibility. WII 415 program enrollments will not be portable across programs or regions. The TOP contractor will enter WII 415 enrollments through DOES for outside the 50 United States and the District of Columbia.

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

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

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

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

**8.2.1** Service defined eligible ADSMs may be assigned to a WII 416 Program such as the Army's CBHCO and receive required medical care near the member's home. The service member shall be enrolled to TRICARE Prime, TPR, TOP Prime, or TOP Prime Remote prior to or at the same time as being enrolled into WII 416. Members cannot be enrolled to the WII 416 program without a concurrent Prime, TPR, TOP Prime, or TOP Prime Remote enrollment. Service appointed case managers will coordinate with the contractor or MTF to facilitate TRICARE Prime or TPR PCM assignments for eligible beneficiaries. The contractor shall then assign a PCM based on the MTF MOU and in coordination with the WII entity (e.g., CBHCO). WII 416 enrollments will not run in conjunction with TAMP.

**8.2.2** The Service-specific WII Program will stamp the front page of the DD Form 2876, enrollment application form, with WII 416 for all new enrollments. The begin date will be the date the contractors receive the signed enrollment form. A signed enrollment application includes those with (1) an original signature, (2) an electronic signature offered by and collected by the contractor, or (3) the self attestation by the beneficiary when using the BWE system. The enrollment form will then be sent to the appropriate contractor who shall perform the enrollment in the DOES and include the following information:

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

An ADSM or ADFM signature is not required to make enrollment changes when using the Enrollment Portability process outlined in [Chapter 6, Section 2, paragraph 1.4](#).

**8.2.3** WII 416 enrollments can be in conjunction with an MTF, TPR, TOP Prime, or TOP Prime Remote enrollment. DEERS will end WII 416 enrollments upon loss of member's active duty eligibility. WII 416 program enrollments will not be portable across programs or regions.

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

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

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

## **9.0 TRICARE POLICY FOR ACCESS TO CARE (ATC) AND PRIME SERVICE AREA (PSA) STANDARDS**

**9.1** Non-active duty beneficiaries in the Continental United States (CONUS) and Hawaii who reside more than 30 minutes travel time from their desired PCM must waive primary and specialty drive-time ATC standards. (Due to the unique health care delivery challenges in Alaska, the requirement to request a waiver for the drive-time access standard does not apply to beneficiaries in Alaska.) Before effecting an enrollment or portability transfer request, contractors shall ensure that the applicant has waived travel time ATC standards either by signing Sections V and VI of the DD Form 2876 enrollment application (this includes an electronic signature offered by and collected by the contractor) or by requesting enrollment through the BWE service (for both civilian and MTF PCMs). An approved waiver for a beneficiary residing less than 100 miles from their PCM will remain in effect until the beneficiary changes residence.

**9.2** Contractors must estimate the travel time or distance between a beneficiary's residence to a PCM (either a civilian PCM or an MTF) using at least one web-based mapping program. The choice of the mapping program(s) is at the discretion of the contractor, but the contractor must use a consistent process to determine the driving distance for each enrollee applicant who may reside more than 30 minutes travel time from their PCM. The time or distance shall be computed between the enrollee's residence and the physical location of the PCM (including MTFs). It is not acceptable to use a geographic substitute, such as a geographic centroid.

**9.3** Contractors (in conjunction with MTFs for MTF enrollees) are responsible for beneficiary drive-time waiver education and must ensure that beneficiaries who choose to waive these standards have a complete understanding of the rules associated with their enrollment and the

travel time standards they are forfeiting. This includes educating beneficiaries who waive their ATC travel standards of the following:

- They should expect to travel more than 30 minutes for access to primary care (including urgent care) and possibly more than one hour for access to specialty care services.
- They will be held responsible for POS charges for care they seek that has not been referred by their PCM (or for MTF enrollees, by another MTF provider).
- They should consider whether any delay in accessing their enrollment site might aggravate their health status or delay receiving timely medical treatment.

**9.4** Enrollment shall only be effected for beneficiaries who reside in the Region. If at any point during the enrollment period the contractor determines or is advised that a beneficiary's residential address is outside the Region, the contractor shall inform the beneficiary of the discrepant address situation. This notification shall occur when the discrepant information is known to the contractor (i.e., not wait until the end of the enrollment period). When there is a discrepant address situation, the contractor shall confirm with the beneficiary the correct address. If the beneficiary confirms that a DEERS-recorded address is incorrect, the contractor shall request the beneficiary update DEERS with correct information (and assist as appropriate). If the contractor determines that the beneficiary resides outside the Region in which they are enrolled, the contractor shall inform the beneficiary no later than two months prior to expiration of the current enrollment period that enrollment will not be renewed to a Region in which they do not reside. The contractor shall provide information necessary for the beneficiary to contact the contractor for the region in which they do reside to request enrollment in that region.

## **9.5 MTF Enrollees**

**9.5.1** Non-active duty beneficiaries must reside within 30 minutes travel time from an MTF to which they desire to enroll. If a beneficiary desiring enrollment resides more than 30 minutes (but less than 100 miles) from the MTF, they may be enrolled so long as they waive primary and specialty ATC standards and the MTF Commander (or designee) approves the enrollment. (If the MOU includes zip codes or drive-time distances for which the MTF is willing to accept enrollments that are beyond a 30 minute drive, this constitutes approval. If not addressed in the MOU, the contractor shall submit each request to the MTF Commander (or designee) in a method that is outlined in the MOU.) The TRICARE Regional Office (TRO) Director may approve waiver requests from beneficiaries who desire to enroll to an MTF and who reside 100 miles or more from the MTF. In these cases, the MTF Commander must also be agreeable to the enrollment and have sufficient capacity and capability.

**9.5.2** The contractor shall process all requests for enrollment to an MTF in accordance with the MOU between the MTF and the contractor. Enrollment guidelines in MOUs may include:

**9.5.2.1** Zip codes and/or distances for which the MTF Commander is mandating enrollment to the MTF. These mandatory MTF enrollment areas must be within access standards (i.e., a 30 minute drive-time of the MTF) and can apply to all eligible beneficiaries or can be based on beneficiary category priorities for MTF access.

**Note:** Non-active duty TRICARE Prime applicants who reside more than 30 minutes travel time from an MTF must be afforded the opportunity to enroll with a civilian PCM if they live in a PSA.

**9.5.2.2** Zip codes and/or distances for which the MTF Commander is willing to accept enrollment. This can include both areas within a 30 minute or less drive-time and over a 30 minute drive but within 100 miles. Any enrollment for a beneficiary with a drive of more than 30 minutes requires a signed waiver of access standards. If an enrollee applicant resides within a zip code previously determined to lie entirely within 30 minutes travel time from the MTF, the contractor need not compute the travel time for that applicant.

**9.5.2.3** Whether or not the MTF Commander will consider a request for enrollment for 100 miles or greater. In determining whether or not the MTF Commander will consider a request for enrollment beyond 100 miles, the MTF Commander may use zip codes to designate those areas the MTF Commander will consider requests or will not consider requests.

**9.5.3** The contractor shall notify the MTF Commander (or designee) when a beneficiary residing 100 miles or more from the MTF, but in the same Region, requests a new enrollment or portability transfer to the MTF. Such notification is not necessary if the MOU has already established that the MTF Commander will not accept enrollment of beneficiaries who reside 100 miles or more from the MTF. The contractor shall make this notification by any mutually agreeable method specified in the MOU. The contractor shall not make the MTF enrollment effective unless notified by the MTF to do so.

**9.5.3.1** The MTF Commander will notify the TRO Director of their desire to enroll a beneficiary who resides 100 miles or greater from the MTF and request approval for the enrollment. The TRO Director will make a determination on whether or not to approve or deny the request and notify the MTF Commander of their decision by a mutually agreeable method. The MTF Commander is responsible for notifying the contractor of all approved enrollment requests for beneficiaries who reside 100 miles or greater from the MTF. The contractor shall notify the beneficiary of the final decision.

**9.5.3.2** Approved waivers for beneficiaries residing 100 miles or more from the MTF shall remain in effect until the beneficiary changes residence or unless the MTF Commander determines that they will no longer allow these enrollments. Even if a beneficiary has previously waived travel time standards, any MTF Commander may revise the MOU (following the MOU revision process) to state that enrollment of some or all current enrollees who reside 100 or more miles from the MTF are not to be renewed at the end of the enrollment period. The contractor shall inform such beneficiaries no later than two months prior to expiration of the current enrollment period that they are no longer qualified for renewal of enrollment to the MTF. Prior to notification, the contractor shall obtain the rationale for the change from the MTF to include in the notice to the beneficiary. The proposed notice shall be reviewed and concurred on by the TRO prior to being sent to the impacted beneficiaries. (The TRO will coordinate notices with the TRICARE Management Activity (TMA) Beneficiary Education and Support Division (BE&SD) prior to approval.)

**9.5.4** At any time during the enrollment period, if the contractor determines there is no signed travel time waiver on file for a current MTF enrollee who resides more than 30 minutes from the MTF, the contractor shall, at the next annual TRICARE Prime renewal point, require the beneficiary to waive the primary and specialty care ATC standards before the enrollment will be renewed. (This includes monitoring address changes received by the contractor from all sources.) The contractor

shall notify the beneficiary of this waiver requirement no later than two months before expiration of the annual enrollment period. The language for all beneficiary notices shall be reviewed and concurred on by the TRO prior to being sent to beneficiaries. (The TRO will coordinate notices with TMA BE&SD prior to approval.)

- Any notice to a beneficiary that is requesting they sign a waiver of access standards, denying their enrollment, or advising them they are not eligible for re-enrollment to an MTF, shall include information on any alternative options for enrollment. The notice must also advise the beneficiary of the option to participate in TRICARE Standard, Extra, or the USFHP where available.

**9.5.5** For each approved enrollment to an MTF where the beneficiary has waived access standards (whether by DD Form 2876 or BWE), the contractor shall retain the enrollment request in a searchable electronic file until 24 months after the beneficiary is no longer enrolled to the MTF. The contractor shall provide the retained file to a successor contractor at the end of the final option period.

**9.5.6** When an enrollment request requires MTF Commander or TRO Director approval, any contractual requirements relating to processing timeliness for enrollment requests will begin when the contractor has obtained direction from the MTF Commander or TRO Director regarding waiver approval or disapproval.

**9.5.7** The contractor shall apprise the MTF Commander (or designee) of all enrollees to the MTF who have waived their ATC travel standards. The contractor shall separate the information into two categories, those who reside within 100 miles of the MTF and those who reside 100 miles or more from the MTF. This notification shall be by any mutually agreement means specified in the MOU between the contractor and the MTF Commander.

## **9.6 Civilian Enrollees**

**9.6.1** Within a PSA, the civilian network must have the capability and capacity to allow beneficiaries who reside in the PSA to enroll to a PCM within access standards. If a beneficiary who resides in the PSA requests enrollment to a specific PCM who is located more than a 30 minute drive from the beneficiary's residence, the contractor may allow the enrollment so long as the beneficiary waives travel time access standards. (Also, see [Chapter 5, Section 1](#).)

**9.6.2** For new enrollments (including portability transfers), the contractor is not required to establish a network with the capability and capacity to grant enrollment to beneficiaries who reside outside a PSA. Requests for new enrollments to the civilian network from beneficiaries residing outside a PSA will be granted provided there is sufficient unused network capacity and capability to accommodate the enrollment and that the PSA civilian network PCM to be assigned is located less than 100 miles from the beneficiary's residence. Beneficiaries who reside outside the PSA and enroll in TRICARE Prime must waive their primary and specialty care travel time access standards. (The network shall have the capability and capacity to allow beneficiaries enrolled in TRICARE Prime, residing outside of PSAs, with a civilian network PCM prior to the beginning of Option Period One of the applicable regional Managed Care Support (MCS) contract to enroll to a PSA PCM provided the beneficiary resides less than 100 miles from an available network PCM in the PSA and waives both primary and specialty care travel time standards.)

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**9.6.3** Beneficiaries who reside outside the PSA and are 100 miles or greater from an available civilian network PCM in the PSA shall not be allowed to enroll in TRICARE Prime.

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## Enrollment Portability

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**1.0** The term “contractor” applies to Uniformed Services Family Health Plan (USFHP) Designated Providers (DPs) as well as to Managed Care Support Contractors (MCSCs) for purposes of enrollment portability.

**1.1** TRICARE Prime enrollees retain Prime coverage whenever they move or travel. Enrollment portability provisions apply to TRICARE Prime enrollees’ travel or relocation to or from all areas, including the Continental United States (CONUS), Europe, Latin and South America, the Pacific, Alaska, and any others. The contractor for the region in which the beneficiary is enrolled on Defense Enrollment Eligibility Reporting System (DEERS) is responsible for providing continuing coverage and updating catastrophic cap accumulations for the enrollee while the enrollee is traveling or relocating, except in the case of care provided overseas (i.e., care outside of the 50 United States and the District of Columbia). Civilian health care while traveling or visiting overseas shall be processed by the TOP contractor, regardless of where the beneficiary resides or is enrolled.

**1.2** A Prime enrollee may transfer enrollment after moving either temporarily or permanently to a new location. The enrolling contractor shall continue to provide health care coverage until the enrollment is transferred to the gaining contractor, the beneficiary is no longer eligible for enrollment in Prime, the beneficiary disenrolls, or the beneficiary is disenrolled due to failure to pay required enrollment fees, whichever occurs first. Referral and authorization rules continue to apply. Primary Care Manager (PCM) referrals are required for non-emergency, specialty, or inpatient care (see 32 CFR 199.17(n)(2)). Claims for non-emergency care without a referral shall be processed under the Point Of Service (POS) option. Under no circumstances will retroactive disenrollment be allowed in order to avoid POS cost-sharing provisions. Even though a Prime enrollee who is relocating must request a referral for non-emergency care from the losing contractor, the enrollee shall not be required to use a network provider, and the contractor shall ensure that the relocating TRICARE Prime enrollee’s copayment is applied correctly to claims for authorized care.

**1.3** Retirees and their family members who are TRICARE Prime enrollees and who are relocating to another contractor’s region or service area, where Prime is available, can transfer enrollment from the losing contractor to the gaining contractor by contacting the gaining contractor via the contractor’s toll-free, **call center** number. During the initial contact, the gaining contractor shall provide region/site specific educational materials, key telephone numbers, the opportunity to select a new PCM, and the opportunity to disenroll completely from TRICARE Prime. If the enrollee chooses disenrollment, the gaining contractor shall send a disenrollment transaction to DEERS using the Government-furnished systems application and DEERS shall notify the losing contractor of the disenrollment.

**1.3.1** For retirees and their family members, on the day the gaining contractor receives either a TRICARE Prime beneficiary’s signed enrollment application or a request via the Beneficiary Web Enrollment (BWE) service agreeing to a transfer of enrollment to the new region, the beneficiary

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shall be considered enrolled at the new location and should contact the new PCM, the new region's Health Care Finder (HCF), or the DP for health care and health related assistance.

**Note:** The effective date for transfer of enrollment differs from the effective date for initial enrollment. See [Section 1, paragraph 4.1](#) for information on initial enrollment in TRICARE Prime. For transfers, the original enrollment period on DEERS will remain in effect.

**1.3.2** Within four calendar days of receipt of a beneficiary's signed enrollment application agreeing to a transfer of enrollment, the gaining contractor shall submit the transfer of enrollment to DEERS using the Government-furnished systems application DEERS Online Enrollment System (DOES). The effective date of the transfer shall be the day the gaining contractor received the signed enrollment application. Upon acceptance of the transfer of enrollment, DEERS will automatically notify the losing contractor of the change. **A signed enrollment application includes those with (1) an original signature, (2) an electronic signature offered by and collected by the contractor, or (3) the self attestation by the beneficiary when using the BWE system.**

**1.4** Active Duty Service Members (ADSMs) and Active Duty Family Members (ADFM) who are relocating to another contractor's region or service area may transfer enrollment by contacting their current (losing) regional contractor to notify them of an upcoming move. The current regional contractor shall offer to obtain the sponsor's name, all family members transferring, the sponsor's Social Security Number (SSN), the ADSM or spouse's cellular telephone number and/or e-mail address, an estimated date of the relocation, and information on the location the ADSM/ADFM enrollee is moving to. If the enrollee(s) are moving out of the current contractor's area of responsibility, then the current contractor shall notify the gaining contractor of the upcoming move and provide the gaining contractor the aforementioned information obtained from the ADSM/ADFM enrollee. **An ADSM or ADFM signature is not required to make enrollment changes when using the Enrollment Portability process outlined in this paragraph. ADSM or ADFM enrollment transfers may be completed by phone as long as the verbal request is documented.**

**1.4.1** The current regional contractor shall notify the gaining contractor of the upcoming transfers by sending the required data elements via an encrypted and/or password protected Microsoft® Excel spreadsheet. The current contractor shall send this data transfer once each work day.

**1.4.2** When a gaining contractor is notified by a losing contractor of an upcoming ADSM/ADFM move, the contractor shall contact the enrollee no later than five business days after the estimated relocation date to begin the enrollment transfer. The purpose of this contact is for the gaining contractor to obtain information necessary to effect an enrollment transfer (i.e., verify date of arrival in the new region/service area) and provide the ADSM enrollee/family member with specific information about their enrollment options to include enrolling with a DP. The gaining contractor is authorized to request any information needed to enroll, including information necessary to assign an MTF PCM, in accordance with the applicable MTF Memorandum of Understanding (MOU) guidance or other local procedures agreed upon between the MTF and the contractor. If all information needed to effect an enrollment transfer is not available during this initial contact, the gaining contractor shall continue to follow-up with the ADSM/ADFM making at least three attempts on different days to collect the needed information.

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**1.4.3** The enrollment effective date is the day the gaining contractor makes contact with the beneficiary and the beneficiary agrees to the transfer of enrollment (even if all information needed to process enrollment is not yet available).

**1.4.4** Within four calendar days of when the gaining contractor has received all of the information necessary to effect an enrollment transfer, the contractor shall submit the transfer of enrollment to DEERS (using DOES). Upon acceptance of the transfer of enrollment, DEERS will automatically notify the losing contractor of the change. This enrollment transfer will take place without the beneficiary having to complete a new enrollment form. The gaining contractor shall also update the DEERS beneficiary address based on the information received from the ADSM/ADFM.

**1.4.5** If an ADSM does not notify the losing contractor of an upcoming move, but rather contacts the gaining contractor upon their arrival in the new region/service area, then the gaining contractor will offer to transfer the enrollment via telephone or will provide the beneficiary education on how to **request the transfer of enrollment** using one of the other enrollment transfer options. Specifically, they can enroll online via the BWE web site **or** submit a TRICARE Prime Enrollment and PCM Change Form to the regional contractor through the mail, **fax, e-mail (if provided by the contractor), or at the MTF form drop-off site**. They may also follow local inprocessing procedures at their new location.

**1.5** When TRICARE Prime enrollment changes from one contractor to another prior to the annual renewal for enrollees in beneficiary categories required to pay enrollment fees, future unpaid enrollment fees, such as those paid on an installment basis, will be due the gaining contractor. There will be no transfers of funds between contractors, and, if the enrollee relocates to an area where TRICARE Prime is not offered, there shall be no refund of the unused portion of the enrollment fee.

**1.5.1** Enrollees in the following categories who are relocating to an area served by a different contractor shall be allowed two "out-of-contract" enrollment transfers (refer to [Appendix B, Definitions](#)) per enrollment year:

- TRICARE Prime enrollees in beneficiary categories required to pay enrollment fees (e.g., retirees, retiree family members), and
- TRICARE/Medicare eligible enrollees who are not ADFMs. (Note: The enrollment fee is waived for those beneficiaries who are eligible for Medicare on the basis of disability or End Stage Renal Disease (ESRD) and who maintain enrollment in Part B of Medicare.)

**1.5.2** "Within-contract" enrollment transfers are not limited.

**1.6** TRICARE Prime USFHP enrollees who are not TRICARE-eligible may only transfer enrollment from one USFHP DP to another USFHP DP; they may not transfer to a MCSC.

**1.7** A TRICARE-eligible Prime enrollee who is not relocating may either transfer enrollment from a MCSC to a USFHP DP or from a USFHP DP to an MCSC under the rules of this section. However, such

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transfers are allowed only once during an enrollment period and no transfer back to the other plan during that enrollment period is permitted.

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## TRICARE Plus

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### 1.0 BACKGROUND

TRICARE Plus is a Military Treatment Facility (MTF) based program designed to allow Military Health System (MHS) beneficiaries an opportunity to obtain a primary care coordinator within the MTF and to be assured access to MTF primary care appointments meeting TRICARE Prime primary care access standards. MTF Commanders will determine the number of TRICARE Plus enrollees at their MTF. A TRICARE Plus enrollment indicator will appear on Composite Health Care System (CHCS) for appointment clerks to appropriately book MTF appointments for TRICARE Plus enrollees in accordance with the criteria established by MTF commanders. (See [Appendix B](#) for the TRICARE Plus definition.)

### 2.0 ENROLLMENT

**2.1** Completed and approved enrollment/disenrollment forms for TRICARE Plus will be sent to the **Managed Care Support Contractor (MCSC)** by the MTFs no less frequently than weekly. The MTF is responsible for ensuring that the enrollment form is complete with validated eligibility through Defense Enrollment Eligibility Reporting System (DEERS) before submitting the forms to the MCSC. The MCSC shall return incomplete forms or any application for which enrollment/disenrollment cannot be effected, for any reason other than internal MCSC contractor systems or process problems. The MCSC shall make no effort to correct or complete any TRICARE Plus enrollment/disenrollment application.

**2.2** It is the MTF's responsibility to manage Primary Care Clinic capacity for TRICARE Plus enrollment and ensure that the capacity is reflected on the DEERS PCM Repository.

**2.3** The MCSC is responsible for ensuring that all TRICARE Plus enrollments received are entered in the DEERS Online Enrollment System (DOES).

**2.4** All initial enrollments for beneficiaries over the age of 64 shall begin on the date the contractor enters the TRICARE Plus application or the first day the beneficiary loses eligibility for TRICARE Prime, whichever is later. All initial enrollment periods for beneficiaries under age 65 shall begin on the date after disenrollment from TRICARE Prime or the date the contractor enters the TRICARE Plus application, whichever is later. Enrollment in TRICARE Plus requires disenrollment from TRICARE Prime.

### 3.0 DISENROLLMENT

Beneficiaries may disenroll from TRICARE Plus at any time. Disenrollment forms will be sent to the MCSCs by the MTFs no less frequently than weekly. MCSCs shall process disenrollments in accordance with [paragraph 2.1](#).

#### 4.0 PORTABILITY

TRICARE Plus enrollment is not portable between MTFs. Beneficiaries who wish to change their TRICARE Plus enrollment to a different MTF will have the same opportunity to enroll at the new MTF as any other beneficiary without an established relationship with a primary care coordinator. There is no priority stemming from previous enrollment in TRICARE Plus.

#### 5.0 REFERRALS

MHS beneficiaries may contact the MCSCs' Health Care Finder (HCF) representatives for assistance with locating network providers. The contractor is not required to make appointments with network providers. The contractor shall provide the beneficiary with the name, telephone number, and address of network providers of an appropriate specialist within the beneficiary's geographic area.

- END -

**5.3** In the event that there is no spouse, parent or guardian to sign the claim form for a deceased beneficiary, the claim must be signed by the surviving next of kin or a legally appointed representative (indicate relationship to beneficiary).

**5.4** When there is no spouse, parent or guardian to sign the claim form for a deceased beneficiary, no next of kin, and no legal representative, the contractor shall arrange to pay the provider whether network or non-network for services rendered in accord with state law and corporate policy.

## **6.0 BENEFICIARY SIGNATURE ON FILE**

Use of the signature on file procedure is the provider's indication that he or she agrees to the following requirements: Verification of the beneficiary's TRICARE eligibility at the time of admission or at the time care or services are provided. Incorporation of the language below, or comparable language acceptable to the TRICARE contracts, into the provider's permanent records.

### **6.1 Institutional Providers**

"I request payment of authorized benefits to me or on my behalf for any services furnished me by **(Name of Provider)**, including physician services. I authorize any holder of medical or other information about me to release to **(Contractor's Name)** any information needed to determine these benefits or benefits for related services." Professional providers who submit claims on the basis of an institution's signature on file should include the name of the institutional provider that maintains the signature on file. The Centers for Medicaid and Medicare Services (CMS) 1450 UB-04 instructions shall be followed for certifying signature on file except that the permanent hospital record containing a release statement will be recognized. Institutional includes all claims related to an institution."

### **6.2 Professional Providers**

"I request that payment of authorized benefits be made either to me or on my behalf to Dr. \_\_\_\_\_, for any services furnished me by that physician. I authorize any holder of medical information about me to release to **(Contractor's Name)** any information needed to determine these benefits or the benefits payable for related services."

**6.2.1** If a claim is submitted by a nonparticipating provider and payment will not be made to the patient, the provider must indicate the name, address, and relationship of the person to whom payment will be made. This will be the sponsor, other parent or a legal guardian for minor children or incompetent beneficiaries, except for claims involving abortion, venereal disease or substance/ alcohol abuse.

**6.2.2** Cooperate with the contractor postpayment audits by supplying copies of the requested signature(s) on file within 21 days of the date of the request and/or allow the contractor access to the signature files for purposes of verification. See [Chapter 1, Section 4, paragraph 4.1](#) and [Chapter 11, Section 5, paragraph 6.3](#) for audit requirements.

**6.2.3** Correct any deficiencies found by the contractor audit within 60 days of notification of the deficiency of participation in the signature relaxation program will be terminated.

### **6.3 Institutional Claims**

Outpatient hospital, professional inpatient and outpatient hospital services for release of information purposes, the provider must obtain the beneficiary or other authorized signature on a permanent hospital admission record for each separate inpatient admission. A professional provider submitting a claim related to an inpatient admission must indicate the name of the facility maintaining the signature on file. Claim forms must indicate that the signature is on file.

### **6.4 Professional Provider Claims**

Outpatient professional such as physician's office and suppliers such as Durable Medical Equipment (DME). Authorized individual providers have the option to retain on their own forms appropriate beneficiary release of information statements for each visit or obtain and retain in his or her files a one-time payment authorization applicable to any current and future treatment that the physician may furnish him or her. Claim forms must indicate that the signature is on file.

### **6.5 Outpatient Ancillary Claims**

Such as claims that are submitted from an independent laboratory where, ordinarily, no patient contact occurs. A provider submitting a claim for diagnostic tests or test interpretations, or other similar services, is not required to obtain the patient's signature. These providers must indicate on the claim form: "patient not present." For services when there is patient contact, such as services furnished in a medical facility which is visited by the beneficiary, the same procedure used for professional claims for outpatient services is required, except that the provider will indicate along with "signature on file" information, the name of the supplier or other entity rather than a physician maintaining the signature on file.

### **6.6 Verification Of Provider's Compliance With The Beneficiary Signature On File Requirement**

The contractor shall verify beneficiary signature on file compliance using the postpayment audit requirement in [paragraph 6.2.2](#), and [Chapter 1, Section 4, paragraph 4.1](#), and the audit procedures in [Chapter 11, Section 5, paragraph 6.3](#).

### **7.0 UNACCEPTABLE SIGNATURES**

A provider or an employee of an institution providing care to the patient may not sign the claim form on behalf of the beneficiary under any circumstances. Nor can an employee of a contractor execute a claim on behalf of a beneficiary (unless such employee is the beneficiary's parent, legal guardian, or spouse). Beneficiaries who have no legal guardian or family member available to sign claims, can provide documentation (i.e., a report from a physician describing the physical and/or mental incapacitating illness). For those conditions/illnesses which are temporary, the signature waiver needs to specify the inclusive dates of the condition/illness. If the beneficiary is unable to sign due to an incapacitating condition/illness, the provider can annotate in the Signature Box on the TRICARE claim form "Unable to sign." A letter from the provider shall be attached to the claim form describing the physical and or mental incapacitating illness. For those illnesses which are temporary, the letter needs to specify the inclusive dates of the illness.

## Chapter 11

### Beneficiary Education And Support Division (BE&SD)

Section/Addendum	Subject/Addendum Title
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1	Education Requirements
2	Government Staff And Beneficiary Education
3	Beneficiary, Congressional, Media, Beneficiary Counselling and Assistance Coordinator (BCAC), Debt Collection Assistance Officer (DCAO), And Health Benefit Advisor (HBA) Relations
4	Inquiry Services Department - General
5	Correspondence Control, Processing, And Appraisal
6	Telephone Inquiries
7	Allowable Charge Reviews
8	Grievances And Grievance Processing
9	Collection Actions Against Beneficiaries
A	TRICARE Logo Figure 11.A-1 Requirements And Guidelines For The Use Of The TRICARE Logo



## Education Requirements

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The education of TRICARE beneficiaries, TRICARE providers, and Military Health System (MHS) staff and providers will be accomplished through a collaborative effort between the TRICARE Management Activity (TMA) Beneficiary Education and Support Division (BE&SD), the Managed Care Support Contractors (MCSCs), and other TRICARE contractors. This collaboration will ensure information and education about the TRICARE Program, policies, health care delivery requirements, and changes and/or addition to benefits are effectively provided. Educational activities include research and analysis to determine targeted audience and the provision of educational materials, and training programs and briefings in accordance with the Section 2. The Government will furnish all printed educational materials, except for regional providers. The MCSC and/or other TRICARE contractors will be responsible for the individual distribution of Government-furnished materials.

### 1.0 EDUCATION PLAN

The MCSC shall submit an annual education plan to inform and educate TRICARE beneficiaries, TRICARE and MHS staff, and providers on all aspects of TRICARE programs. BE&SD and the TRICARE Regional Office (TRO) will review the plan, and provide concurrence or appropriate feedback for recommended changes.

### 2.0 INTERFACE REQUIREMENTS

**2.1** TMA BE&SD will meet with each MCSC and TRICARE contractor within 60 calendar days after contract award to develop and establish a Memorandum of Understanding (MOU). The MOU will establish the review and approval process for annual education plans, and identify the TMA process for obtaining education materials. The MOU shall also address the ordering and bulk shipment of materials. The MOU shall be effective No Later Than (NLT) 30 days following the meeting between TMA BE&SD and the contractor.

**2.2** The MCSC shall participate in monthly TRICARE beneficiary and provider workgroup meetings, comprised of the TROs marketing representatives, OCONUS marketing representative and the TRICARE Beneficiary Publications Office/BE&SD. As advisors, the contractors shall provide unique perspectives, ideas, and recommendations regarding the development and maintenance of TRICARE educational materials to the group. The goal of the monthly meetings is to present status updates on production, address issues, and provide new information and propose new ideas for products and/or initiatives. All requests for marketing and educational materials shall be submitted by the contractor via the appropriate TRO for review and consideration. Approval shall be based on justification that supports a uniform image and consistency in the provision of TRICARE Program information, and available funding. The contractor shall provide a primary and alternate representative for attendance and participation in the monthly meetings, to be held approximately 12 times per contract year in the Washington, DC area. Meetings may be attended via teleconference, video telecommunications, or in person, as directed by the Government.

### **3.0 REQUIRED EDUCATIONAL MATERIALS**

The Government will furnish all beneficiary educational materials which may include printed and electronic media. Materials developed by the Government and distributed in support of the TRICARE program will be selected on the basis of recommendations by contractors, program managers, the Services, TMA leadership and others with interests and concerns about the information being provided to TRICARE beneficiaries and other stakeholders. BE&SD and the TROs will review all recommendations and will prioritize products in accordance with funding availability. TMA/BE&SD will have final approval authority. The MCS and/or other TRICARE contractors will be responsible for the distribution of Government-furnished materials to MHS beneficiaries. The Government will provide all enrollment materials for distribution by the MCSC to MHS beneficiaries. The enrollment form will be provided electronically.

### **4.0 DISSEMINATION OF INFORMATION**

**4.1** The MCSC shall distribute TRICARE information using effective methods that ensure timely delivery and receipt to all MHS beneficiary households in the region based on Defense Enrollment Eligibility Reporting System (DEERS) data. See Exhibit B, Contract Data Requirements List (CDRL), DD Form 1423, P050 for the Marketing and Education Plan. In addition, the MCSC shall be required to do a mailing pertaining to a benefit update, within the contract period, to all eligible beneficiary households. The MCSC shall furnish enrollment information and forms, network provider information, Health Care Finder (HCF) information, claims forms, claim completion instructions, the TRICARE Handbook, DEERS information and other informational materials upon request to beneficiaries, providers, and congressional offices. The MCSC shall establish and maintain effective communications with all beneficiaries (see [Section 3](#)).

**4.2** Annually, the MCSC shall be responsible for all provider education, which may include producing and distributing an annual Provider Handbook, newsletters, and/or bulletins. The MCSC may use any method of distribution that ensures timely receipt by all providers. Copies of TRICARE educational materials distributed to providers will be provided to the TMA Regional Director (RD), TMA BE&SD, and congressional offices. The Government reserves the right to evaluate the success of the MCSC provider relations effort via scientific surveys and other data collection efforts with the network providers.

**4.3** The MCSC shall distribute a quarterly newsletter to all TRICARE Prime enrollees, including active duty personnel, dual-eligible beneficiaries, congressional offices, and Health Benefits Advisors (HBAs). The MCSC shall also distribute an annual TRICARE Standard newsletter to beneficiaries not enrolled in Prime using information contained in DEERS or provided by beneficiaries. Newsletters will generally be no more than six double-sided pages in length (8½" x 11"). The MCSC shall not modify the content or length of the beneficiary newsletter prior to distribution. The MCSC may use any method of distribution that ensures timely delivery and receipt to all recipients.

**4.4** The TDEFIC contractor shall maintain a supply of TRICARE For Life (TFL) beneficiary educational materials. The TDEFIC contractor shall provide a copy of the most recent information upon request.

## Government Staff And Beneficiary Education

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The Managed Care Support Contractor (MCSC) will conduct training for Military Health System (MHS) providers and staff regarding the TRICARE benefit. MCSCs will also develop a beneficiary education program to educate beneficiaries concerning all components of the TRICARE benefit to include the TRICARE Standard Program, TRICARE Prime, and Extra programs, and the TRICARE For Life (TFL) Program. Training materials may include a broad range of materials (slides, CDs DVDs). The Government is responsible for material development. Contractor suggestions for additional materials shall be reviewed and approved by the Government on a case-by-case basis.

### 1.0 EDUCATION REQUIREMENTS FOR GOVERNMENT PERSONNEL

**1.1** The MCSC shall conduct one three-day TRICARE training course each quarter covering all aspects of the program including, but not limited to, TRICARE, overseas, and dual-eligibles. The location of the course shall be within the region; however, the exact location will change each quarter to allow maximum participation by Government personnel who require an in-depth understanding of TRICARE to successfully accomplish their assigned duties. The contractor shall follow the Government-provided training material in delivering the course. The Government will provide all handouts for the course. Government furnished facilities may be provided if determined by the Government to be in the best interest of the Government. The Government will be responsible for registration of attendees and collection of attendee evaluations. The MCSC will provide written feedback to the Government following each course to assist the Government in providing appropriate training materials. The TRICARE Regional Office (TRO) will provide oversight of the training.

**1.2** The MCSC shall conduct three one-hour training sessions, followed by a question and answer session, for clinical and administrative personnel at each Military Treatment Facility (MTF) monthly. Training sessions will be at the date and time specified by the MTF Commander and shall correspond with the hours personnel work at the facility. The contractor shall follow the Government-provided training material in delivering the course which will cover all aspects of TRICARE including, but not limited to, TRICARE Prime, Extra, and Standard, the financial impact of MTF decisions on both the beneficiary and the MHS. The Government will provide all training materials and handouts for the course. Government-furnished facilities will be provided for the course location.

**1.3** The MCSC shall provide one one-hour briefing, followed by a question and answer session, weekly to an audience specified by the MTF Commander. Such audiences might be Ombudsmen, support groups, obstetrical patients, retiree groups, parent groups, or dual-eligibles. The contractor shall follow the Government provided training material in delivering the course. Government-furnished facilities will be provided for the course location. The MCSC shall actively announce each briefing time, location, and audience through base publications, local fraternal organizations, and flyers posted throughout the installation.

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### Government Staff And Beneficiary Education

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**1.4** The MCSC shall conduct three one-hour briefings, followed by a question and answer session, for military recruiters in the region, annually. Whenever possible, the briefings shall occur during the recruiters' annual regional/district conference, and cover all aspects of TRICARE. The contractor shall use the Government provided training materials (slides, notes, etc.) in delivering the course. The Government will provide all handouts for the course. Government-furnished facilities will be provided for the course location.

**1.5** The MCSC shall provide one one-hour briefing covering all aspects of TRICARE, followed by a question and answer session, annually, at each Reserve/National Guard unit listed in the web sites below. The Regional Director (RD) will provide the date and time of each briefing. The MCSC shall use the Government-provided training materials (slides, notes, etc.). Government-furnished facilities will be provided at the course location. The Government will provide all handouts for the course.

- Air National Guard: [http://www.goang.com/about/aboutang\\_locations.aspx](http://www.goang.com/about/aboutang_locations.aspx)
- Army National Guard: <http://www.arng.army.mil/tools/unit.asp>
- Navy Reserve: <http://www.navalreserve.com>
- Marine Reserves: <http://www.marforres.usmc.mil/Units>
- Air Force Reserves: <http://www.afrc.af.mil/units.htm>
- Army Reserves: <http://www.army.mil/organization/reserveunits.html>
- Coast Guard Reserves: <http://www.uscg.mil/hq/reserve/reshmpg.html>

## **2.0 BENEFICIARY SURVEYS**

In accordance with Department of Defense Instruction (DoDI) 1100.13, and Health Affairs Policy Memorandum 97-012, surveys of military members, retirees and their families must be approved and licensed through issuance of a Report Control Symbol (RCS). Contractors shall not conduct written or telephonic beneficiary surveys without the approval of the TRICARE Management Activity (TMA) Health Program Analysis and Evaluation Directorate (HPA&E). TMA has an ongoing survey research and analysis program which includes periodic population-based and encounter-based surveys of DoD beneficiaries. The surveys address beneficiary information seeking strategies and preferences, health status, use of care, satisfaction with military and civilian care, and attitudes toward TRICARE. The data are collected at the Prime Service Area (PSA) level and can be aggregated to the regional level. Regional reports containing PSA data are available through the RD. Contractors shall work with the RDs to define both their ongoing and special purpose requirements for survey data. Contractors with special needs not met by an existing instrument may submit surveys, sampling plans, and cost estimates through the RD to the TMA, HPA&E, for approval and licensing.

## **3.0 BENEFICIARY CONTACT DATA**

MCSCs shall collect and report customer service and beneficiary support workload to include categorization of the reason and volume of beneficiary inquiries received by **their** call center activities in accordance with government-directed data collection requirements contained in the contract and as directed in [Chapter 14](#).

#### **4.0 BENEFICIARY EDUCATION**

The beneficiary educational program shall include the distribution of education materials to all eligible households in accordance with [Section 1](#). Educational efforts include supplying educational materials and brochures to the MTFs, participating in “newcomer orientations” at military bases, outreach to National Guard and Reserve units, briefing at mobilization and demobilization sites and conducting general information sessions for all demographic categories (for example, active duty personnel, Active Duty Family Members (ADFM), new retirees and their dependents, dual-eligible beneficiaries). The MCSC may use other communication tools to educate the beneficiaries including the news media ([Section 3](#)), via the World Wide Web (WWW), correspondence ([Section 3](#)), telephone ([Section 3](#)), and via e-mail, videos, CDs and DVDs.

#### **5.0 WWW**

MCSCs may elect to provide a web site for beneficiaries to access information specific to the MCSC’s management of the TRICARE benefit. This web site shall not merely duplicate beneficiary information contained on the TRICARE web site (<http://www.tricare.mil>). Information posted on the MCSC web site will reflect the “look and feel” of the TRICARE web site (<http://www.tricare.mil>), and will be appropriately linked to information on that site. Information contained on the MCSC web site will not substitute for written or telephonic communication with the beneficiary if those communication tools are in the best interest of the beneficiary.

#### **6.0 BENEFICIARY E-MAIL**

MCSCs may elect to communicate with beneficiaries via e-mail. All beneficiary communications must be in accordance with Health Insurance Portability and Accountability Act (HIPAA) and the Privacy Act, and may not substitute for telephone or written communications if those are in the best interest of the beneficiary.

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## Beneficiary, Congressional, Media, Beneficiary Counselling and Assistance Coordinator (BCAC), Debt Collection Assistance Officer (DCAO), And Health Benefit Advisor (HBA) Relations

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### 1.0 GENERAL

In a service relations program, the contractor's primary responsibilities are to the beneficiaries and the providers. However, in meeting these responsibilities, it is frequently necessary to respond to Congressional Offices or to Beneficiary Counselling and Assistance Coordinators (BCACs), Debt Collection and Assistance Officer (DCAO), and Health Benefit Advisors (HBAs) who are intervening on behalf of a beneficiary or provider. To facilitate handling of these contacts, the contractor should establish a working relationship with the Congressional delegations in each state and with the BCACs, DCAOs, and HBAs in the Region. These individuals can often assist in resolving questions/problems of the beneficiary and provider population.

### 2.0 BENEFICIARY RELATIONS

The contractor will be invited to attend and participate in beneficiary meetings, such as the retired military associations. These meetings provide opportunity for the contractor to make presentations and distribute educational materials to the beneficiaries.

### 3.0 CONGRESSIONAL AND HBA RELATIONS

The contractor is responsible for performance of the following minimum functions in carrying out a Congressional and HBA relations programs within the region.

#### 3.1 Establish Communications

**3.1.1** The contractor shall establish and maintain effective communication with the Congressional office staffs, BCACs, DCAOs, and HBAs in the Region. To do this, the contractor shall establish procedures and provide staffing to perform all necessary functions.

**3.1.2** The contractor shall provide written notification of the contractor's point(s) of contact [name(s), address(es), e-mail addresses and phone number(s)] to all congressional offices and BCACs, DCAOs, and HBAs serving the region. The contractor shall provide separate telephone numbers (lines) reserved exclusively for congressional offices and BCACs, DCAOs, and HBAs. This service is not required to be toll-free; however, the contractor shall provide sufficient telephone lines and TRICARE-dedicated staff to meet the requirements in [Chapter 1, Section 3](#). In addition, when it is appropriate because of the volume or character of Congressional office inquiries received, a contractor representative may visit a Congressional office to resolve problems and/or

educate the staff about TRICARE operations and requirements. In most MTF Prime Service Areas (PSAs), it is expected that a contractor's **representative** will have regular, if not daily, interface with the BCACs, DCAOs, and HBAs. In other areas, the contractor shall develop a program of regular BCAC, DCAO, and HBA contact which includes a contractor representative meeting with the BCACs, DCAOs, and/or HBAs at least semi-annually. When serious problems or other needs arise, more frequent contact will be required.

#### **4.0 SPECIAL BCAC, DCAO, HBA MEETINGS**

TMA conducts workshops with HBAs in various locations throughout the year. The contractor shall provide representation to participate in the workshops where BCACs, DCAOs, and HBAs from the contractor's region will be present in significant numbers. TMA will provide at least 30 calendar days notice of such a requirement. TMA will also outline the expected nature of contractor's participation. If a contractor has a specific problem or issue which should be addressed at an BCAC, DCAO, and HBA meeting, TMA should be notified at least 21 days prior to the scheduled meeting.

#### **5.0 MEDIA RELATIONS**

Media relations programs implemented by the Government and the Managed Care Support Contractors (MCSCs) on behalf of the Government will have three objectives: educate beneficiaries about changes to their TRICARE benefit, respond to media queries quickly and accurately; and inform the American public about Government activities related to the TRICARE program. The MCSCs will conduct a media-relations program in accordance with Department of Defense (DoD) guidelines and guidance provided by TMA/Beneficiary Education and Support Division (BE&SD). The MCSC will provide regular feedback to TMA BE&SD regarding their media activities, including coordination of proposed responses to media queries for sensitive and controversial issues. The MCSCs will keep TMA BE&SD and TRICARE Regional Office (TRO) leadership aware of public and beneficiary perceptions regarding TRICARE policies and procedures, and advise TMA on proposed communication strategies for responding to these issues. All published materials will communicate consistent TRICARE program messages with one voice and tone. MCSCs will perform the following in their media relations program:

**5.1** Establish and maintain effective working relationships with members of the regional and local news media.

**5.1.1** Contractors are encouraged to work directly with the news media to provide information on new programs, changes to the benefit, and other "good news" stories.

**5.1.2** Contractors will also be expected to respond to media questions about contractor roles, responsibilities and actions on behalf of the Government in support of the TRICARE program.

**5.1.3** Contractors must work closely with the Government to ensure that information provided to the media is consistent and accurate.

**5.1.3.1** Contractors should coordinate all proposed media activities including new releases, press conferences and other media events with TMA prior to release of the information whenever feasible.

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**5.1.3.2** When immediate action is required, contractors will follow-up all media contacts by sending copies of information provided to the media and a summary of any discussions to BE&SD.

**5.1.4** Contractors shall speak only on issues for which they have direct responsibility and shall not speculate on issues beyond the scope of the support they are providing to the Government.

**5.2** Share information, including news releases, fact sheets, talking points, communications plans, and public affairs guidance with TMA/BE&SD to ensure TMA is aware of pending news stories and the information provided to the media.

**5.3** Assist TMA BE&SD in planning, designing, and implementing a comprehensive communications program that incorporates diverse functions and issues, serves numerous distinct and specialized audiences and responds rapidly, in crisis conditions to changing demands.

**5.4** Work with TMA to ensure beneficiaries receive unified, timely, accurate, consistent, and effective products and tools that improve their access, understanding, and appreciation of TRICARE.

- END -



## Inquiry Services Department - General

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### 1.0 INQUIRY SERVICE DEPARTMENT OBJECTIVES

Contractors shall implement an inquiry processing service which ensures that all inquiries received from TRICARE beneficiaries, providers, and other interested parties are processed in a timely and consistent manner and that information delivered about the TRICARE program is accurate. The services department shall be able to assist in settling TRICARE claims and provide program information whether the inquiry is by telephone, letter, or electronic media. For inquiries regarding active duty claims, contractors shall follow the procedures as outlined in the [Chapter 17](#).

### 2.0 WRITTEN INQUIRIES

The contractor shall process both routine and priority correspondence in accordance with the standards and requirements set forth in [Chapter 1, Section 3](#).

### 3.0 TELEPHONES

The contractor shall provide trained personnel to answer all TRICARE inquiries [beneficiaries, Regional Directors (RDs), providers, Assistant Secretary of Defense (Health Affairs) (ASD(HA)), TRICARE Management Activity (TMA), Beneficiary Counselling and Assistance Coordinators (BCACs), Debt Collection and Assistance Officer (DCAO), Health Benefit Advisors (HBAs), and congressional offices]. TRICARE has established the TRICARE Information Service (TIS), reachable by a series of 1-800-XXXX telephone numbers. The TIS will refer incoming calls to the appropriate contractor for action. The Managed Care Support Contractor (MCSC) and TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) contractor and the TRICARE Pharmacy (TPharm) contractor shall provide the Procuring Contracting Officer (PCO) with the single telephone number to which these calls shall be routed No Later Than (NLT) 150 calendar days prior to the start of services.

### 4.0 TRAINING OF SERVICE REPRESENTATIVES

All representatives must be knowledgeable with a high level of communication skills. Online access to claims history and all other necessary information shall be provided. Service representatives must be thoroughly trained in the areas outlined in [Chapter 1](#). Special emphasis should be placed on medical terminology, program benefit policies (including both TRICARE Standard, TRICARE Extra, and TRICARE Prime) and how the programs are applied in processing, Privacy Act and Freedom of Information Act (FOIA) requirements, contractor claims processing system capabilities, and training in the identification and reporting of potential fraud and abuse situations. All personnel shall receive communications training including how to listen for content, ensure customer courtesy and effectively manage time.

## **5.0 ONLINE TRICARE PROVIDER SEARCH TOOL**

The contractor shall provide a regional online provider search tool on the contractor's public web site for use by beneficiaries to search for and display TRICARE network and TRICARE authorized (non-network) providers (Professional, Ancillary, Facility, Allied Health, and Behavioral Health) information. The tool shall allow the beneficiary, at a minimum, to search by provider name, provider organization (if applicable), provider type, provider specialty, and distance from their residence. The tool shall display, at a minimum, the provider's name, provider organization (if applicable), specialty, office location, office phone number (if available), and distance from the beneficiary's zip code. For network providers, the tool shall indicate whether the provider is accepting new patients. For non-network providers, the listing shall clearly indicate the provider is non-network. Also, for non-network providers, the listing shall be based on claims submissions for a rolling 14 month period not to include the latest two months of claims. Contractors are responsible to immediately remove provider information if a provider has been excluded, suspended, or terminated from TRICARE (see [Chapter 13, Section 6](#)). Upon request of the provider or organization, non-network provider information will be removed within 30 days and no longer further displayed. A standard disclaimer shall be posted on the tool and outputs of the tool that providers have accepted TRICARE patients in the past, but may not accept them routinely and to contact the provider to validate whether TRICARE beneficiaries are currently being accepted; if no telephone number is provided, consult their local telephone directory. The overseas contractor is exempt from providing an online directory of non-network providers.

- END -

## Correspondence Control, Processing, And Appraisal

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### 1.0 GENERAL

The contractor shall provide timely, accurate answers to all TRICARE inquiries. Written inquiries received shall be sorted and categorized as defined in [paragraph 3.0](#). For standards, refer to [Chapter 1, Section 3](#). On all outgoing correspondence from the contractor to the beneficiary, if the SSN is used it shall be limited to the last four digits.

### 1.1 Correspondence Receipt And Control

The contractor shall establish and maintain an automated control system for routine and priority correspondence, appeals, and grievances which meets the requirements of [Chapter 1, Section 3](#); [Chapters 11](#); and [12](#). The contractor shall capture and retain needed data for input to workload and cycle time aging reports.

### 1.2 Availability Of information

Information required for appropriate responses to inquiries, must be retrievable from the contractor's internal records as specified in [Chapter 2, Section 1](#).

### 2.0 CONTROL

Correspondence shall be controlled and stamped with the actual date of receipt in the contractor's custody. The control system shall be automated unless the contractor receives approval for another system which will produce comparable results. When appropriate, contractor must be able to associate incoming correspondence with prior inquiries. All correspondence or other documents received or generated in the services department shall be filed in accordance with [Chapter 2, Section 1](#). If correspondence is answered by telephone, a record of the conversation shall be filed with the inquiry.

### 3.0 CATEGORIES OF CORRESPONDENCE

All incoming correspondence shall be separated into the following categories for reporting purposes:

- Appeals
- Grievances
- Priority correspondence
- Routine inquiries
- Allowable Charge Complaints

#### **4.0 ROUTINE CORRESPONDENCE**

**4.1** Responses may be provided by telephone, form letter, preprinted information, or individual letter as appropriate. A copy of the response shall be filed with the inquiry. The text of written responses shall be typed. On form letters or preprinted information, the address may be neatly handwritten, if the contractor chooses. In situations of potential fraud or abuse, a referral to the contractor's Program Integrity Unit shall be completed and a copy of the referral filed with the correspondence. For beneficiary and provider services standards, see [Chapter 1, Section 3](#).

**4.2** The contractor shall develop inquiries that do not contain enough information to identify the specific concern, using the quickest and most cost effective method for acquiring the information. Telephone contact is recommended. After a reasonable effort has been made to acquire the missing information, the contractor shall notify the correspondent that a response is not possible without the requested information. The contractor may then close the item for reporting purposes.

**4.3** Correspondence status inquiries, such as "tracer" claims from providers or beneficiaries and provider and beneficiary letters inquiring about the status of a claim, may be closed without a written response if the claim was processed within five calendar days prior to receipt of the inquiry. The day that the determination was made that the inquiry may be closed without a written response is the day the inquiry is to be closed for correspondence cycle time purposes. Otherwise, "tracer" claims, usually submitted by providers, are to be researched to determine whether the initial claim was received. If the initial claim was received and processed to completion, the contractor shall advise the provider of the date processed and the amount of payment, if any, or reason for denial. If the initial claim was not received, the contractor shall indicate this on the claim and submit the claim for normal processing, advising the provider of this action.

#### **5.0 PRIORITY CORRESPONDENCE**

**5.1** Priority written correspondence is correspondence received from members of the U.S. Congress, the Office of the Assistant Secretary of Defense (Health Affairs) (OASD(HA)), TRICARE Management Activity (TMA), a Regional Director's (RD's) office and such other classes as may be designated as "priority" by the Contracting Officer (CO). Inquiries from the Surgeons General, Flag Officers, and state officials, such as insurance commissioners, are considered priority correspondence.

**5.2** The contractor shall forward all Congressional inquiries involving Defense Enrollment Eligibility Reporting System (DEERS) to the DEERS Research and Analysis Section, Defense Manpower Data Center (DMDC)/DEERS, 400 Gigling Road, Seaside, California 93955-6771, including any claim information required for that organization to respond to the inquiry. A notification shall be sent to the Congressional office informing it that the letter has been forwarded to the DMDC Support Office (DSO).

**5.3** For priority written inquiry standards, refer to [Chapter 1, Section 3](#). The MCSC will forward all copies of Congressional correspondence to TMA including the correspondence from the Congressional office and the MCSC response.

## **6.0 CORRESPONDENCE COMPLETION AND QUALITY CONTROL**

**6.1** A piece of correspondence shall be considered answered when the contractor's response to the individual or office provides a detailed outline of all actions taken to resolve the problem(s) and includes, as appropriate:

- An explanation of the requirements leading to the benefit determination;
- A clear, complete response to all stated or implied questions;
- When necessary to understanding, copies of Explanation(s) of Benefits (EOB(s)), claim number(s) of the original claim(s), and the claim number(s) of adjustment claim(s) including sufficient details to establish an easily followed audit trail.
- Other documents for full explanation and clarity.
- Clear explanation of any additional actions that require an action or reply by the inquirer before the contractor can take final action on the matter.
- A referral form to the contractor's Program Integrity Unit if potential fraud or abuse is identified. A copy of the referral shall be filed with the correspondence.

**6.2** When TMA staff requests the contractor to provide claims processing information required by TMA to answer inquiry correspondence, the contractor need not provide detailed explanations of TRICARE policy, but shall provide a regulatory citation in support of the benefit determination, the date the claim was first received, the date the EOB was mailed, and a detailed explanation of any delay. When requested, the contractor shall furnish TMA with copies of all claims, supporting documents, previous correspondence relating to the particular case, a recapitulation, and a narrative description of the claims processing history for that claim; e.g., date received, date completed, date paid, etc. In the case of a TRICARE Prime beneficiary, it may be necessary to provide information about special coverage, pamphlets, enrollment information, or copies of all or parts of a health care record.

**6.3** The contractor shall ensure the correspondence it prepares is accurate, responsive, clear, timely, and that its tone conveys concern and a desire to be of service. To monitor correspondence, contractors shall establish a quality control procedure to ensure its correspondence reflects the elements previously listed. The findings of the quality control review shall be incorporated into training programs to upgrade the performance of all persons involved in correspondence preparation. Contractors are free to tailor the program to meet their needs. Service to the beneficiaries and providers, as reflected in the quality and timeliness of correspondence, is a key management responsibility.

## **7.0 REQUIRED REPORTS**

The contractor shall have the capability to provide data for the following management reports:

**7.1** An open correspondence reporting system which identifies priority correspondence over 10 days old and routine inquiries over 15 days old for management follow-up action. This report shall

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include the sponsor's name and SSN, the patient's name, the name of the correspondent, the date of the correspondence, the date the correspondence was received by the contractor, the current status of the correspondence, the date of the latest interim response, and the anticipated or final response statement. This report is for contractor use only and the contractor may use any reporting system it chooses, provided there are adequate controls to meet timeliness standards.

**7.2** Correspondence statistics for prompt and accurate completion of the TRICARE Monthly Workload and Cycle Time/Aging Reports.

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## Telephone Inquiries

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### 1.0 TELEPHONE SYSTEM

**1.1** The contractor shall provide an incoming telephone inquiry system. All telephones must be staffed and able to respond in a manner that meets performance standards throughout the entire period. A recorded message indicating normal business hours shall be used on the telephone lines after hours. Calls will be handled in the order they are received. The phone number(s) shall be published on the Explanation of Benefits (EOB) and otherwise be made known to beneficiaries, providers, Beneficiary Counselling and Assistance Coordinators (BCACs), Debt Collection and Assistance Officer (DCAO), Health Benefit Advisors (HBAs), and Congressional offices.

**1.2** The telephone system must include a 24-hour, seven days a week, nationally accessible service, for all Military Health System (MHS) beneficiaries, including beneficiaries traveling in the contractor's region, seeking information and/or assistance in locating a network provider, to include behavioral health providers willing to accept TRICARE. Callers seeking this information must have the ability to speak with live personnel. These personnel shall be able to enter authorizations for urgent care for beneficiaries traveling outside of their Prime Service Area (PSA).

### 2.0 RESPONSIVENESS

Telephone inquiries shall be answered according to the standards in [Chapter 1, Section 3](#). Contractors may respond to telephone inquiries by letter if they cannot contact the caller by phone or if a complex explanation is required. The contractor staff shall be trained to respond in the most appropriate, accurate manner. Telephone inquiries reporting a potential fraud or abuse situation shall be documented and referred to the contractor's Program Integrity Unit.

### 3.0 REQUIREMENTS

There should be no differentiation in the service provided whether the call originates locally or through the toll-free lines. The contractor shall provide the availability of telephone contact as a service to all TRICARE inquiries (active duty personnel, TRICARE beneficiaries, dual-eligible beneficiaries, Regional Directors (RDs), providers, Assistant Secretary of Defense (Health Affairs) (ASD(HA)), TRICARE Management Activity (TMA), BCACs, DCAOs, HBAs, and Congressional offices). At a minimum, the telephone system shall be fully staffed and service shall be continuous during normal business hours which are defined as 8:00 a.m. through 6:00 p.m. (except weekends and holidays) in all time zones within the region. All customer service provided by telephone shall be without long distance charges to the beneficiary. Telephone service is intended to assist the public in securing answers to various TRICARE questions including, but not limited to:

**3.1** General program information;

**3.2** Specific information regarding claims in process and claims completed, including explanations of the methods and specific facts employed in making reasonable charge and medical necessity determinations, and information regarding types of medical services submitted (The contractor shall transfer out-of-jurisdiction calls requiring the assistance of another contractor. The contractor shall answer program information and network provider availability/assistance calls without regard to jurisdiction.);

**3.3** When the inquiry concerns questions about Defense Enrollment Eligibility Reporting System (DEERS) or DEERS eligibility, the contractor shall refer the caller to the Defense Manpower Data Center (DMDC) Beneficiary Telephone Center, 6:00 a.m. to 3:30 p.m. Pacific Time, toll-free 1-800-538-9552, TTY/TDD 1-866-363-2883. These numbers cannot be used by the **Managed Care Support Contractor (MCSC)** or other service provider; they are only for the beneficiary's use.

**3.4** Additional information needed to have a claim processed;

**3.5** Information about review and appeal rights and the actions required by the beneficiary or provider to use these rights.

**3.6** Information about and procedures for the TRICARE Program, *i.e.*, **enrollment, TRICARE plans available, Point of Service (POS) option, continuity of care, referral management, provider directories.**

**3.7** Information concerning benefit authorization requirements and procedures for obtaining authorizations. Provisions must be included to allow the transfer of calls to the authorizing organization (within the contractor's organization, to include subcontractor) without disconnecting the call. **The contractor shall ensure eligibility for care and enrollment status of beneficiaries before making any arrangements for medical services.**

**3.8** General information on eligibility for the TRICARE Dental Plans (Active Duty Dental Program (ADDP), TRICARE Dental Plan (TDP), and TRICARE Retired Dental Plan (TRDP)) and how to obtain dental plan information from the appropriate dental contractor. The beneficiaries shall be referred to the appropriate dental contractor for additional information.

**3.9** When the inquiry concerns questions about a Department of Defense (DoD) Self-Service Logon (DS Logon), the contractor shall refer the caller to the DoD MyAccessCenter application help section at <https://myaccess.dmdc.osd.mil/>. This web site provides information that will help the beneficiary determine the most efficient means for obtaining a DS Logon based on their affiliation and current status. A DS Logon is a secure, self-service logon that allows DoD and Veterans Affairs (VA) affiliates to access certain web sites using a single username and password.

### **3.10 Telephone Standards**

Refer to [Chapter 1, Section 3, paragraph 3.4.](#)

### **3.11 Toll-Free Telephone Service**

Toll-free service can be provided by a number of means available from local telephone companies. These include, but are not limited to: Wide Area Telephone Service (WATS), and Foreign Exchange (FX) lines. The contractor is not restricted to the use of any long distance carrier and may

change companies at its discretion to improve the efficiency and cost effectiveness of the toll-free service. Should changes in long distance carriers occur, these changes must be transparent to MHS beneficiaries and providers. The Procuring Contracting Officer (PCO) shall be notified of any proposed change in companies at least 30 calendar days prior to the actual change of companies. The contractor shall advertise the toll-free service using all available media including the EOB; newsletters; telephone directories published by the contractor, military organizations, etc. and other appropriate sources.

### **3.12 Telephone Monitoring Equipment**

The MCSC shall utilize telephone equipment that is programmed to measure and record response times of incoming calls and determine whether TMA standards are met. See [Chapter 1, Section 3, paragraph 3.4](#) for standards.

#### **3.12.1 Measure Busy Signal Level**

“Busy signal level” is defined as the percentage of time a caller receives a busy signal. The busy signal rate shall be expressed as a percentage, which is to be determined as follows: divide the number of calls answered by the contractor by the number of calls reaching and attempting to reach the contractor.

#### **3.12.2 Measure Call Volumes And Handling Times**

Contractors shall measure the number of calls received each month and the time elapsing between acknowledgment and handling by a telephone representative or Automated Response Unit (ARU). Measures shall include all calls that are directly answered by an individual or ARU (no waiting time). The on-hold time period begins when the telephone call is acknowledged and does not include the ring time.

### **3.13 Additional Equipment Requirements**

The contractor shall furnish the following:

**3.13.1** Access to a CRT for each telephone representative to retrieve or provide the information required in [paragraphs 3.0 through 3.9](#). The Computer Remote Terminal (CRT) shall be located to allow the telephone representatives to research data without leaving their work stations.

**3.13.2** Outgoing lines sufficient to allow call backs.

**3.13.3** Hard copy management reports regarding All Trunks Busy (ATB) data and the waiting time measurements. The hard copy management reports shall also include the total number of calls received, the number where all questions presented were answered at the time of the call, the number fully answered within 10 calendar days, the number fully answered within 20 calendar days, and the percentage of each.

**3.13.4** A supervisor’s console to monitor telephone representatives’ telephone calls for accuracy, responsiveness, clarity, and tone.

**3.13.5** Automatic call distributors and ARUs with after hours message recorders, an automated, interactive, 24-hour call-handling system designed to ensure maximum access to the toll-free lines. This system shall provide automated responses to requests for general program information and to beneficiary requests for claims status.

#### **4.0 REPORTS**

Telephone activity shall be reported in accordance with contract requirements.

#### **5.0 TELEPHONE APPRAISAL SYSTEM**

The MCSC shall provide real-time remote and on-site call monitoring capabilities to TMA government staff identified by the applicable TMA office (the Regional Director (RD) or other applicable Program Office for which this is a contractual requirement) and designated by the Contracting Officer (CO). This requirement for remote call monitoring access does not apply to the TRICARE Overseas Program (TOP) contractor.

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## Allowable Charge Reviews

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### 1.0 GENERAL

Beneficiaries and providers have the right to question the amount allowed for services received or rendered for non-network care. Network providers should have complaint procedures included in their contracts or the administrative procedures established with the TRICARE contractor. When a complaint is received, the accuracy of the application of the reimbursement methodology, including the procedure code and the profile development must be verified. The amount of the allowance is not an appealable issue under the appeals procedures and the program.

### 2.0 ALLOWABLE CHARGE REVIEW CRITERIA

#### 2.1 Requirements

The allowable charge inquiry must be received or postmarked within 90 days from the date of the Explanation Of Benefits (EOB) or it may be denied for lack of timeliness. If the inquiry is in writing and the issue is not clearly a question of allowable charge, any doubt must be resolved in favor of handling the case as an appeal under [Chapter 12](#). The contractor shall respond only to a person entitled to the information; i.e., beneficiary, parent/guardian, participating provider, other TRICARE contractors, or TRICARE Management Activity (TMA). Allowable charge complaints shall be reported on the workload report as required by the contract.

#### 2.2 Allowable Charge Complaint Procedures

An allowable charge complaint need not be submitted in writing. Oral inquiries or complaints shall be documented on a contact report, by contractor staff. The handling requirements for timeliness of contractor processing are the same as for routine or priority correspondence. Occasionally the allowable charge complaint or inquiry will be sent directly to TMA instead of the contractor. When this occurs, the complaint/inquiry will be forwarded to the contractor for response. Upon receipt of an allowable charge complaint, the contractor shall recover the claim and all related documents necessary to completely review the case and establish accuracy of processing. The following checklist is suggested:

**2.2.1** Was the correct procedure code used?

**2.2.2** Were there any clerical errors, such as wrong type of service code, which may have caused the difference?

**2.2.3** Did the case go to medical review?

**2.2.4** Was all needed medical documentation present to make a completely accurate determination?

**2.2.5** Should the case be further documented and referred to medical review?

**2.2.6** Was the profiled fee calculated correctly?

**Note:** Contractors need not routinely validate the fee calculation; however, if the difference between billed and allowed is 20% or more, the dollar value of the difference is significant and all other factors appear to be correct, there is reason to question the validity of the fee.

### **2.3 Responses To Allowable Charge Complaints**

A written response to allowable charge complaints is preferred, but the inquiry can be handled by documented telephone call, as may other correspondence. If the complaining party indicates dissatisfaction with the contractor's oral explanation of an adverse determination, the contractor will send a detailed letter advising of the results. The beneficiary or provider must be offered a written response in all cases.

#### **2.3.1 Adverse Determination**

If the processing and payment were correct, the inquirer shall be told of the outcome and advised of the methodology for determining allowable charges. The explanation shall clearly indicate that the determination was based on the information presented and, if more complex procedures were involved or if the case was unusually complex, whether additional information could change the determination. If such information is available to the inquirer, it should be submitted to the contractor for further review. If, after the contractor's review, it is determined that the original amount is still correct, the inquirer shall be informed that this is the final determination.

#### **2.3.2 Additional Payment Due**

If it is found that an error has occurred, or if added information is secured which changes the determination, an adjustment shall be made. The notice of the determination shall explain the reason for the adjustment. Adjustments shall be prepared in accordance with instructions in [Chapter 10](#).

### **3.0 EXCESS CHARGES BILLED IN PARTICIPATING PROVIDER CLAIM CASES**

If an allowable charge inquiry/complaint indicates a participating provider is improperly billing for more than the allowable charge, refer to [Chapter 13](#).

### **4.0 CHAMPUS MAXIMUM ALLOWABLE CHARGE SYSTEM**

**4.1** For allowable charge complaints involving reimbursement based on the CHAMPUS Maximum Allowable Charge (CMAC) System, the contractor shall have no responsibility for determining whether or not the profiled fee for any given Medicare locality was calculated correctly. Once the contractor verifies that the correct procedure code was used, no data entry errors were made (including determination of where the service was rendered), and that referral to

second level or medical director review was appropriate, the contractor shall respond to the inquiry stating that the payment calculation was correctly computed.

**4.2** If it is determined that an error was made by the contractor in calculating the correct payment, the contractor shall follow the procedures in this section.

**4.3** In the event TMA determines that an error was made in the basic CMAC calculations, the contractor will receive a letter from TMA with the corrected CMAC. The contractor shall replace the incorrect CMAC with the corrected CMAC as soon as possible, but No Later Than (NLT) 10 working days after receipt of the TMA letter. Contractors are not required to adjust all the claims processed with the incorrect CMACs; however, contractors shall adjust any claims which were processed using the incorrect CMAC when a provider or beneficiary requests that adjustment.

## **5.0 DIAGNOSIS RELATED GROUP (DRG) REVIEWS**

The request from a hospital for reclassification of a claim to a higher DRG must be received or postmarked within 60 days from the date of the EOB; otherwise, the request will be denied for lack of timeliness. The contractor review is the final determination; there is no further review.

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## Grievances And Grievance Processing

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### 1.0 GRIEVANCE PROCESSING JURISDICTION

The regional contractor with claims processing jurisdiction for the beneficiary's claim is responsible for processing grievances filed by or in behalf of the beneficiary. Should a grievance pertain to an issue that is the responsibility of another contractor, the other contractor will assist the contractor with jurisdiction in resolving the issue.

### 2.0 GRIEVANCE SYSTEM

The contractor shall develop and implement a grievance system, separate and apart from the appeal process. The grievance system shall allow full opportunity for aggrieved parties to seek and obtain an explanation for and/or correction of any perceived failure of a network provider, contractor, or subcontractor personnel to furnish the level or quality of care and/or service to which the beneficiary may believe he/she is entitled. Any TRICARE beneficiary, sponsor, parent, guardian, or other representative who is aggrieved by any failure or perceived failure of the contractor, subcontractor or contracted providers of service or care to meet the obligations for timely, quality care and service at appropriate levels may file a grievance. All grievances must be submitted in writing. The subjects of grievances may be, but are not limited to, such issues as the refusal of a Primary Care Manager (PCM) to provide services or to refer a beneficiary to a specialist, the length of the waiting period to obtain an appointment, undue delays at an office when an appointment has been made, poor quality of care, or other factors which reflect upon the quality of the care provided or the quality and/or timeliness of the service. If the written complaint reveals an appealable issue, the correspondence shall be forwarded to the contractor's appeals unit for a reconsideration review.

### 3.0 CONTRACTOR RESPONSIBILITIES

It is the contractor's responsibility to conduct an investigation and, if possible, resolve the aggrieved party's problem or concern. In this responsibility, the contractor shall:

**3.1** Ensure that information for filing of grievances is readily available to all Military Health System (MHS) beneficiaries within the service area.

**3.2** Maintain a system of receipt, identification, and control which will enable accurate and timely handling. All grievances shall be stamped with the actual date of receipt within three workdays of receipt by the contractor. The date of receipt shall be counted as the first day.

**3.3** Investigate the grievance and document the results within 60 calendar days of receipt of the grievance. The contractor shall notify the Procuring Contracting Officer (PCO) of all grievances for which reviews were not completed within 60 days of receipt.

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**3.4** Provide interim written responses by the 30th calendar day after receipt for all grievances not Processed To Completion (PTC) by that date.

**3.5** Take positive steps to resolve any problem identified within 60 days of the problem identification. If the problem cannot be resolved within that period of time, the PCO or Contracting Officer's Representative (COR) shall be informed of the nature of the problem and the expected date of resolution. If there is no resolution to the problem, the contractor shall acknowledge receipt of the grievance and explain to the grievant why the problem cannot be resolved.

**3.6** Written notification of the results of the review shall be submitted to the beneficiary within 60 days of the original receipt of the grievance. The letter will indicate who the grievant may contact to obtain more information and provide an opportunity for the grievant, if not satisfied with the resolution, to request a second review by a different individual.

**3.7** Ensure the involvement in the grievance review process of appropriate medical personnel, including personnel responsible for the contractor's quality assurance program in any case where the grievance is related to the quality of medical care or impacts on utilization review activities.

**3.8** Maintain records for all grievances, including copies of the correspondence, the results of the review/investigation and the action taken to resolve any problems which are identified through the grievance.

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## Collection Actions Against Beneficiaries

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### 1.0 GENERAL

**1.1** No patient, family member or sponsor shall be subjected to ongoing collection action undertaken by or on behalf of a provider of services or supplies, as a result of the inappropriate non-payment of claims for services which should have been covered under TRICARE. When the Government becomes aware that such collection action has been initiated, it will intervene on behalf of the party against whom the collection action has been taken.

**1.2** While the Government will assist in the resolution of collection matters, the ultimate responsibility for resolving collection actions lies with the patient, family member, or sponsor. The Government will not provide legal representation to resolve these issues and will not pay attorneys' fees, court costs, collection agency fees, accrued interest, late charges, etc. TRICARE can only assume responsibility for collection assistance for medically necessary supplies and services as authorized for coverage under the TRICARE regulation.

### 2.0 DEBT COLLECTION ASSISTANCE INTERVENTION

Upon notification of a problem, Department of Defense (DoD) will investigate and, when appropriate, resolve and/or assist in the clarification of collection issues for TRICARE beneficiaries.

### 3.0 CONTRACTOR RESPONSIBILITIES

#### 3.1 Research Assistance

The contractor shall provide immediate assistance to the Government in support of the debt collection assistance function. In addition to identifying specific underpayments, the contractor shall also:

**3.1.1** Designate specific individuals and provide resources to work collection issues with Government representatives during normal weekday business hours.

**3.1.2** Provide Web-site access and/or e-mail addresses, mailing addresses, fax numbers and direct phone number(s) of specialized collections research and support staff to the Government.

**3.1.3** Meet required response time for problem resolution (Standard: 85% within 10 days, 100% within 30 days). Resolution is the completion of research by the Managed Care Support Contractor (MCSC) (and/or their subcontractor(s)) to define the course of actions that have taken place on the claims that have gone to collection, to correct previous erroneous actions, if any, by the MCSC or its subcontractors, and to define clearly the remaining liability, if any, which is the responsibility of the patient. The date of resolution is the date a final, case-specific response is furnished to the Government. The response shall include all the information listed in [paragraph 3.1.6](#). If applicable,

the response to the DCAO should note that a check is being issued to the beneficiary or provider on a priority basis, and the approximate date payment is expected.

**3.1.4** Maintain records and processing statistics on collection activity. The records to be maintained shall include a detailed chronological record of all actions taken, including names and telephone numbers of all parties contacted in the course of the actions taken, as well as copies of all correspondence sent and received.

**3.1.5** When violation of the participation agreement or balance billing is not at issue, issue letters to providers and conduct provider education when the provider was at fault.

**3.1.6** The contractor shall furnish reports of all completed collection cases.

**3.1.7** In newsletters and other materials, publicize and educate beneficiaries and providers on the Debt Collection Assistance Program. This would include informing providers of the availability of the contractor's support services to assist in resolution of claims problems, and encouraging providers to contact the contractor's priority unit for assistance prior to initiating any collection action against beneficiaries. If the contractor participates in beneficiary, sponsor or provider training, workshops or briefings at Military Treatment Facilities (MTFs) or elsewhere in the Region in accordance with specific regional requirements, the Debt Collection Assistance Program should also be covered.

### **3.2 Expedited Payment**

All requests for expedited payment will be coordinated through the TRICARE contractor for the region. When research reveals a processing error by the contractor or subcontractor, any additional payment due shall be processed on an expedited basis, and the MCSC's response to the Government shall reflect an expected date of payment.

### **3.3 Referrals to Program Integrity, TMA**

When it has been determined that balance billing or violation of the participation agreement is at issue, the matter will continue to be handled in accordance with the existing program integrity guidelines contained in [Chapter 13, Section 6](#).

- END -

## **10.0 QUALITY OF CONTRACTOR RECONSIDERATION CASES**

The contractor shall implement a process to ensure that 90% of contractor reconsideration cases demonstrate accurate contractor processing of the appeal, consistent with the TRICARE Operations Manual (TOM) requirements and the documentation in the case file.

## **11.0 SERVICES AND SUPPLIES AUTHORIZED IN ERROR**

If a contractor authorizes services or supplies, and the beneficiary obtains the services or supplies based on the authorization, and the services or supplies are later determined not to be a benefit under TRICARE, Government funds cannot be used to pay for the services or supplies.

## **12.0 DOCUMENTATION**

The contractor shall deliver to TMA, Appeals and Hearings Division, one complete set of its processing guidelines, desk instructions, and reference materials covering all tasks required in [Chapter 12](#) and [Chapter 11, Section 8](#), No Later Than (NLT) 60 calendar days prior to the start of health care delivery.

- END -



## Reconsideration Procedures

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### 1.0 REQUIREMENTS FOR REQUESTING A RECONSIDERATION

#### 1.1 Must Be In Writing

#### 1.2 Must Be Made By A Proper Appealing Party

A network provider is never a proper appealing party. Disputes between a network provider and the contractor concerning authorization of services are not subject to the appeal process. Network provider disputes are addressed under the provider contract provisions, the contractor's administrative procedures, or through the state courts. Because non-network, nonparticipating providers are not proper appealing parties, non-network, nonparticipating provider disputes regarding waiver of liability determinations are addressed as allowable charge reviews rather than reconsideration reviews. If the contractor or the TRICARE Quality Monitoring Contractor (TQMC) receives a timely appeal request for reconsideration from a person who is not authorized to participate in the appeal, before the expiration of the appeal filing deadline, the contractor or the TQMC shall treat the request as routine correspondence, and add the request to the claim file. The contractor or the TQMC shall advise the proper appealing party in writing (see [Addendum A, Figure 12.A-4](#)) with a copy to the improper appealing party. A blank "Appointment of Representative," form shall be enclosed with the letter to the proper appealing party (see [Addendum A, Figure 12.A-1](#)). The proper appealing party shall be told that an appeal must be filed within 20 calendar days of the date of the contractor's or the TQMC's letter or by the expiration of the appeal filing deadline, whichever is the later.

#### 1.3 Must Include An Appealable Issue

##### 1.3.1 Appealable Issues

**1.3.1.1** A TRICARE Prime enrollee, a TRICARE Extra user or a TRICARE Standard beneficiary making use of the authorization process who requests authorization to receive services and such authorization is denied by the contractor, may appeal even though no care has been provided and no claim submitted. (Refer to [paragraph 7.2](#) and [Section 4, paragraph 3.1.2](#), for additional information relating to preadmission/preprocedure denials).

**1.3.1.2** The decision by the contractor to cost-share services under the Point-of-Service (POS) Option is not appealable; with the exception of the issue of whether services were related to an emergency and, therefore, exempt from the requirement for referral and authorization. Whether services were related to an emergency is a factual determination and is appealable. The TRICARE Prime enrollee must demonstrate that the care would qualify as an emergency under the criteria for emergency care set forth in [32 CFR 199.4](#). Should the beneficiary prevail in the appeal, the amount cost-shared would be the difference between the amount cost-shared under the POS option and the amount that would have been cost-shared had the beneficiary received the care

from a network provider. A determination by the contractor that services received under the point-of-service option are not a TRICARE benefit would be appealable as a medical necessity or factual denial determination.

**1.3.1.3** The decision by a contractor to deny a request by the Primary Care Manager (PCM) to refer a beneficiary to a specialist is an appealable issue, if the reason for the denial is a determination by the contractor that a referral is not needed.

**1.3.1.4** Concurrent review authorizations granting 48 hours or less of additional services beyond the previous authorization when the provider has requested more than 48 hours of additional services. If the concurrent review authorization grants more than 48 hours of additional services beyond the previous authorization, but less than the period requested by the provider, an appeal does not exist. In such a case, the letter authorizing the additional period would inform the provider that a subsequent concurrent review will be conducted within 48 hours prior to the expiration of the newly authorized period.

### **1.3.2 Nonappealable Issues**

The following issues are not appealable and shall not be accepted for reconsideration. They should be counted as correspondence for both workload report and processing purposes.

#### **1.3.2.1 Allowable Charge**

The amount of the TRICARE-determined allowable cost or charge for services or supplies is not appealable, since the methodology for determining allowable costs or charges is established by regulation. One example involving an allowable charge issue would be the contractor's decision to pay benefits under the POS option (absent any claim that the care was emergency in nature and was, therefore, exempt from the requirement for referral and authorization). In cases involving contractor cutbacks or downcoding of diagnoses or procedure codes, there is no issue with respect to the medical necessity of the services provided and therefore, no appealable issue (i.e., the contractor does not determine that the services are not a benefit under TRICARE). The sole issue in these cases is the level of payment for the medically necessary services - an allowable charge issue. If, however, the contractor cutback or downcoding results in the noncoverage of a furnished service, then an appealable issue would exist. See [Chapter 11, Section 7](#).

#### **1.3.2.2 Eligibility**

Determination of a person's eligibility as a TRICARE beneficiary is not appealable since this determination is the responsibility of the Uniformed Services. See the TRICARE Policy Manual (TPM), [Chapter 10, Section 1.1](#).

#### **1.3.2.3 Denial of NAS Issuance**

Determinations relating to the issuance of a Non-Availability Statement (NAS) (DoD Document (DD) Form 1251) based on the availability of care at the MTF are not appealable since these determinations are the responsibility of the Uniformed Services. For non-enrolled beneficiaries, when the issuance of an NAS is denied based on a medical necessity or a factual determination (including a determination that the facts of the case do not demonstrate an emergency for which an NAS is not required), the beneficiary and/or civilian participating provider

has the right to reconsideration. Refer to the TPM, [Chapter 1, Section 6.1](#).

#### **1.3.2.4 Provider Or Entity Sanction**

If the decision to disqualify or exclude a provider or entity because of a determination against that provider or entity resulting from abuse or fraudulent practices or procedures under another federal or federally-funded program is not appealable, the provider or entity is limited to exhausting administrative appeal rights offered under the federal or federally-funded program that made the initial determination. A determination to sanction a provider or entity because of abuse or fraudulent practices or procedures under TRICARE is an initial determination which is appealable under 32 CFR 199. See [Chapter 13](#). A sanction imposed pursuant to [32 CFR 199.15\(m\)](#) is appealable as described in [32 CFR 199.15\(m\)\(3\)](#).

#### **1.3.2.5 Network Provider Or Entity/Contractor Disputes**

Disputes between a network provider or entity and the contractor concerning payment for services provided by the network provider are not appealable.

**Note:** Network pharmacies are not subject to hold harmless provisions, and, therefore, beneficiary liability and appeal rights arise from a denial issued at a network pharmacy. The beneficiary may appeal such a denial.

#### **1.3.2.6 Provider Not Authorized**

The denial of services or supplies received from a provider not authorized to provide care under TRICARE is not appealable.

#### **1.3.2.7 Denial Of A Treatment Plan**

The denial of a treatment plan when an alternative treatment plan is selected is not appealable. Peer to peer dialogue resulting in selection and approval of another treatment option is not a denial of care.

#### **1.3.2.8 Denial Of Services By A PCM**

The refusal of a PCM to provide services or to refer a beneficiary to a specialist is not an appealable issue. A beneficiary who has been refused services or a referral by a PCM may file a grievance under [Chapter 11, Section 8, paragraph 1.0](#). The decision by the contractor to deny a PCM's request to refer a beneficiary to a specialist is an appealable issue and is addressed in [paragraph 1.3.1.3](#).

#### **1.3.2.9 Designation Of Providers**

The contractor's designation of a particular network or non-network provider to perform requested services is not appealable.

#### **1.3.2.10 Point Of Service (POS)**

The decision by the contractor to cost-share services under the POS option is not

appealable, with the exception of the issue of whether the services were related to an emergency and are therefore exempt from the requirement for referral and authorization.

#### **1.4 Must Be Filed Timely**

An appeal must be filed before the expiration of the appeal filing deadline or within 20 calendar days of the date of the contractor's letter, referenced in [paragraph 1.2](#). In calculating the number of days elapsed, the day following the date of the previous determination is counted as day "one" with the count progressing through actual calendar days including the date the request is filed. The contractor or TQMC shall treat an untimely request for reconsideration as routine correspondence, and add the request to the claim file.

##### **1.4.1 By Mail**

If the appeal is not filed timely, the contractor shall advise the appealing party that the appeal cannot be accepted since the time limit for filing was exceeded, based on the receipt date of the appeal request or the postmark date on the envelope. For the purposes of TRICARE, a postmark is a cancellation mark issued by the United States Postal Service (USPS) (i.e., private mail carriers do not issue postmarks). If there is no postmark or the date of the postmark is illegible, the date of receipt by the contractor shall be used to determine timeliness of filing.

##### **1.4.2 By Facsimile**

A request for reconsideration submitted by facsimile transmission (fax) is considered filed on the date the fax is received by the contractor.

##### **1.4.3 By Electronic Mail**

A request for reconsideration submitted by electronic mail (e-mail) is considered filed on the date the e-mail is received by the contractor.

#### **1.5 Must State The Issue In Dispute And Include Previous Determination**

The request should state the specific issue in dispute and be accompanied by a copy of the previous denial determination notice. If a contractor or the TQMC receives a request for reconsideration which otherwise satisfies the requirements as stated above, the request shall be accepted notwithstanding the failure of the appealing party to provide a copy of the previous denial determination notice or to state the specific issue in dispute. In such cases, the contractor or the TQMC shall accept the request for reconsideration and shall supply a copy of the previous denial determination notice from its files or shall initiate communication with the appealing party to clarify the specific issue in dispute, as appropriate.

#### **2.0 EXTENSION OF APPEAL FILING DEADLINE**

If the appeal is untimely the appealing party shall be told that if it can be shown to the satisfaction of the contractor or the TQMC, that timely filing of the request was not possible due to extraordinary circumstances over which the appealing party had no practical control, an extension of the appeal filing deadline may be granted. A determination by the contractor or the TQMC that extraordinary circumstances do not exist is not appealable.

## Regional Directors (RDs)/Military Treatment Facility (MTF) Commanders Interface

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The contractor shall assist the Regional Directors (RDs) and Military Treatment Facility (MTF) Commanders in coordinating health care delivery in their Prime Service Areas (PSAs) and in ensuring the optimal use of MTF capacities. No later than 60 calendar days following contract award, the contractor shall meet with each MTF Commander, Clinic Commander, and the RD to develop a Memorandum of Understanding (MOU) with each facility. The contractor shall prepare and present to each facility a draft MOU No Later Than (NLT) the 75th calendar day prior to the first option period. By the 60th calendar day prior to the start of the first option period, a MOU shall be executed between the contractor, each individual MTF Commander and the RD on these responsibilities. All MOUs shall be approved by the Procuring Contracting Officer (PCO) and the RD. Annually, the MOUs shall be re-executed and approved by the RD and the PCO. A sample MOU is shown in [Addendum A](#). Each MOU shall contain the following provision: "Contract personnel working in the Department of Defense (DoD) MTFs shall comply with all local Employee Health Program (EHP) and Federal Occupational Safety and Health Act (OSHA) Bloodborne Pathogens (BBP) Program requirements." Copies of local program documentation may be obtained through the RD. The contractor shall also execute MOUs with the RD which incorporate the contractor's MOUs with each MTF as attachments. The contractor shall provide copies of each MOU executed to the PCO, TMA, through the RD, within 10 calendar days following the execution of the MOU.

### 1.0 COORDINATION PROCEDURES TO ENSURE BALANCED WORKLOADS

The contractor shall meet with the RD and each MTF Commander to discuss referral patterns and to enter into written agreements to ensure balanced workloads between the military and civilian components of the Military Health System (MHS). These agreements shall provide mechanisms to reallocate workloads, establish priorities for needed network development, and determine Primary Care Manager (PCM) assignment locations for enrollees. The agreements shall also include methods by which the contractor shall ensure that any MTF underutilization is remedied via changes in contractor referral patterns. The agreements may be modified during the year; however, all agreements/modifications shall be concurred upon by the RD prior to implementation. The contractor shall be kept updated on the current status of MTF capabilities through close liaison. The contractor shall be responsible for initiating meetings and/or other actions with the RD and MTF Commanders to assist in remedying problems which can be resolved within the scope of the contractor's responsibility and authority. The contractor shall follow the direction of the MTF Commanders, in consonance with the RD requirements, regarding the priorities for the assignment of enrollees to PCMs. Additionally, the contractor shall respond to requests for meetings initiated by the RD and MTF Commanders. The contractor shall provide appropriate staff to meet with the RD and/or MTF Commanders within two work days of receiving either a verbal or written request.

## **2.0 RD AND MTF INTERFACE FOR PRIMARY CARE MANAGEMENT**

Both civilian and military individual providers may act as PCMs for TRICARE Prime. During the MOU development process, the contractor shall obtain guidelines from the RD and MTF commanders for PCM assignment (by category of beneficiary) or choice for enrollees who reside in the MTFs' PSAs. MTF Commanders will designate whether these enrollees shall have MTF or network PCMs. The contractor shall assign enrollees to PCMs in accordance with the RD and MTF Commanders' determinations.

## **3.0 RD AND MTF INTERFACE FOR SPECIALTY SERVICES**

The contractor shall obtain direction from the RD and the MTF commanders regarding which specific specialty services shall be referred to the MTF. Nonenrollees shall be encouraged to use available MTF specialty services in lieu of civilian providers.

## **4.0 RD/MTF AND CONTRACTOR INTERFACES FOR THE DOD HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY PRIVACY REGULATION**

**4.1** The contractor shall forward initial and annual privacy risk assessments and action plans to the respective RD through the PCO for review and monitoring of compliance. (See [Chapter 19, Section 3](#).)

**4.2** The contractor shall forward all requests for non-routine disclosures through the RD to the TMA Privacy Officer. (See [Chapter 19, Section 3](#).)

**4.3** The contractor shall provide a courtesy copy of all amendment response extensions to the RD. (See [Chapter 19, Section 3](#).)

## **5.0 ADMINISTRATIVE COORDINATION WITH THE RD AND THE MTF**

The contractor shall meet with each MTF Commander or designee monthly and with the RD or designee at least quarterly to facilitate activity coordination between the MTFs and civilian networks. These meetings shall review current contractor activities in quality management, utilization management, marketing, network development, external resource sharing and other activities such as briefings to provider or beneficiary groups or interface with congressional or other Governmental officials. The MTF Commander and/or RD may specify the target audience for any briefing. The frequency of these meetings may be reduced at the discretion of the RD.

## **6.0 RD AND MTF COMMANDER LIAISON**

**The contractor** shall provide assistance to each RD and MTF Commander and their designees in coordination of TRICARE Prime. The **contractor** shall ensure that the RD and MTF Commanders have access to contractor personnel to facilitate MTF interface activities and shall ensure that MTF Commanders are kept informed of **their** program or policy changes which affect the MTF.

- END -

## Chapter 15

## Addendum A

### Model Memorandum Of Understanding (MOU)

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**Note:** Model provided for example only. This is not intended to be all inclusive.

This Agreement is entered into this \_\_\_\_ day of 200\_\_ by and between \_\_\_\_\_ (“Contractor”) and \_\_\_\_\_ (“MTF” or “Regional Director”).

This Memorandum of Understanding (MOU) describes the respective responsibilities of both parties under the Managed Care Support (MCS) program. This MOU reflects the actions expected to be taken by the Contractor and the Military Treatment Facility (MTF) Commander (or Regional Director) and the degree to which each party will consult with the other before taking certain actions. All actions executed within the scope of this MOU will be reflected as a change to the Regional Health Services Plan and coordinated with the Regional Director prior to implementation.

The MTF Commander (or Regional Director) will take certain actions without a requirement to consult with the Contractor. The Contractor shall be informed as expeditiously as possible of the Commander’s decisions on all these actions. These actions include:

- determining which enrollees will be assigned PCMs at the MTF;
- determining the types of specialty care cases to be referred to the MTF;
- establishing the utilization management and quality assurance procedures employed for case management cases of care delivered in both the direct and civilian care settings;
- changing MTF capabilities/staffing.

The MTF Commander (or Regional Director) will take certain actions only after receiving input from the Contractor. These activities include:

- changing the location of the TRICARE Service Centers (**TRICARE overseas contract only**); and
- acting on early TRICARE PRIME disenrollment requests.

The Contractor will take certain actions only after receiving input from the MTF Commander (or Regional Director). These include:

- developing beneficiary referral and reallocation patterns to the MTF (see Attachment A);
- developing external resource sharing agreements and clinical support agreements;
- developing the enrollment plan and procedures;

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Model Memorandum Of Understanding (MOU)

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- developing TRICARE PRIME disenrollment procedures;
- changing TRICARE Service Center staffing levels (**TRICARE overseas contract only**); and
- conducting provider education programs.

The Contractor will take certain actions without a requirement to consult with MTF Commanders (or Regional Director). These are:

- meeting other contractual obligations specified in the Contractor's contract with the Department of Defense.

In witness whereof, the parties have executed this Memorandum of Understanding.

\_\_\_\_\_  
(Signature) (Date)

\_\_\_\_\_  
(Signature) (Date)

\_\_\_\_\_  
Printed Name and Title of  
Contractor Representative

\_\_\_\_\_  
Printed Name and Title of MTF  
Commander or Representative  
(Not Required if this is a Regional  
Director MOU)

Approved

\_\_\_\_\_  
(Signature) (Date)

\_\_\_\_\_  
(Signature) (Date)

\_\_\_\_\_  
Procuring Contracting Officer (PCO)

\_\_\_\_\_  
Printed Name and Title of Lead  
Agent or Representative

## 2.5.2 Prerequisites For TCSRC

In accordance with the NDAA for FY 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:

**2.5.2.1** To be service-related; and

**2.5.2.2** 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

**2.5.2.3** 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.

- 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.
- 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.
- 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 time lines: 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).

## 2.5.3 Eligibility

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

**2.5.3.2** A DoD physician must determine that the condition meets the criteria in [paragraph 2.5.2](#). 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.

**2.5.3.3** Enrollment in the TCSRC includes limited eligibility for MTF Pharmacy, Retail Pharmacy, and TRICARE Pharmacy (**TPharm**) **contract, TRICARE Pharmacy Home Delivery Program** benefits.

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#### **2.5.4 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 2.5.4.1 through 2.5.4.7. These steps, requirements, and responsibilities are applicable to MMSO, the **Managed Care Support Contractor (MCSC)**, TRICARE civilian providers, and the Armed Forces, and are provided to make each aware of the steps, processes, and responsibilities/requirements of each organization.

**2.5.4.1** TMA Beneficiary Education and Support Division (BE&SD) will educate beneficiaries on the Section 1637 benefit. Contractors will collaborate with BE&SD in the development of materials that support both beneficiary and provider education.

**2.5.4.2** 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.

**2.5.4.3** 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 contractor will execute a referral and authorization to support health care delivery for the area in which the member resides. Based on the member's residential address, the contractor will locate the proper health care 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 contractor should ascertain if a 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 contractor shall locate a civilian provider that has both the capability and capacity to accept this referral request within the prescribed ATC standards. The contractor 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 contractor under the normal "urgent/72 hour" requirement. The contractor 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 contractor 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.

**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 **MCSC** 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. 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 or MTF denials of authorization or authorization for reimbursement to the appropriate SPOC or MTF. The contractor shall refer telephonic inquiries related to SPOC denials to the appropriate SPOC or MTF.

## **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 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. The contractor shall respond as appropriate to general written inquiries 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 -



**6.2.3** Verify the letter from the facility includes the patient's name, sponsor's Social Security Number (SSN), the title and phase of the protocol, and the NCI number of the protocol and/or other appropriate evidence of NCI sponsorship.

**6.2.4** Subscribe to the NCI's Comprehensive Cancer Database known as the PDQ, to assist in determining whether a particular study meets the requirements of the Demonstration and whether the patient is eligible for a particular protocol. For those studies that are not listed on the PDQ, the contractor will work with NCI staff to verify NCI sponsorship.

**6.2.4.1** Unlike the other NCI sponsorship categories listed in [paragraph 3.1](#), protocols for Cancer Center Studies are not individually reviewed by the NCI. Instead, the NCI designates specific institutions as meeting NCI criteria for clinical and comprehensive cancer centers. Cancer center protocols receive approval through an NCI approved institutional peer review and quality control system at the institution. Protocols which have been through this process receive formal notification of approval from The Clinical Protocol Review and Monitoring Committee and, therefore, are considered NCI sponsored, but may not appear in the PDQ. A provider who is seeking to enter a patient into a Cancer Center Study must provide evidence of NCI sponsorship by forwarding the formal notification of approval from this specific committee. Formal notification of approval by the Clinical Protocol Review and Monitoring Committee will be required for approval of treatment in Cancer Center Studies which are not otherwise sponsored through the CTEP program, NCI cooperative groups, or NCI grants.

**6.2.4.2** Certain protocols listed in the PDQ may not be clearly identified in terms of NCI sponsorship. Clinical trials conducted as part of an NCI grant, or those identified with a "V" number, must be verified for NCI sponsorship with the NCI project officer. Physicians who are holders of the grant at the institution must provide written clarification that the proposed treatment is a protocol under their NCI grant. The grant title and number must be specified.

**6.2.4.3** Requests for treatment in clinical trials overseas must be verified as to NCI sponsorship with the NCI project officer.

**6.2.4.4** Protocols that are co-sponsored by the NCI and other Federal Agencies must be verified by the NCI project officer.

**6.2.5** Verify the patient's eligibility on the Defense Enrollment Eligibility Reporting System (DEERS).

**6.2.5.1** If the patient is authorized to receive the care under the Demonstration, but DEERS reflects that the patient is not eligible, a statement shall be added to the authorization letter indicating before benefits can be paid, the patient must be listed as eligible on DEERS.

**6.2.5.2** The patient shall be referred to the pass/ID card section of the military installation nearest their home for an eligibility determination.

**6.2.5.3** If a patient is listed on DEERS as being eligible as of the date the cancer therapy begins, all services provided as a result of participation in an NCI sponsored study shall be covered. This also applies to patients whose treatment is in progress when the Demonstration expires.

**6.2.6** Issue an authorization (Figure 18.2-2) or denial (Figure 18.2-3) letter to the applicant provider and patient once a determination is made regarding a particular protocol.

**6.2.7** Establish and maintain a database of patients participating in the Demonstration. The database shall include the patient's name, sponsor's SSN, name and number of protocol, type of cancer, hospital name, and address and total cost.

**6.2.8** Furnish a list of enrollees in the Demonstration to the contractor's Program Integrity Unit with instructions to run an annual post-payment report to determine if hospitals are receiving additional unlawful payments as a result of also receiving payment under TRICARE. If such payment exists, it shall be the responsibility of the contractor to initiate recoupment action for any Demonstration benefits paid in error. This function will be supervised by the TMA Program Integrity Office (PI).

**6.3** The contractor may at its discretion establish a dedicated toll-free telephone number to receive inquiries from both patients and providers regarding the Demonstration. If a dedicated toll-free telephone number is established for this demonstration, the phone shall be staffed seven hours a day during normal business hours. In the absence of a dedicated toll-free number for Demonstration inquiries, contractors shall use their primary toll-free telephone inquiry system (see Chapter 11, Section 6 and Chapter 20, Section 4).

**6.4** The contractor may at its discretion establish a dedicated mailing address where Demonstration inquiries and claims shall be sent for expedited response and/or claims adjudication. In the absence of a dedicated mailing address for Demonstration inquiries and claims, contractors shall use their primary address(es) for written correspondence and claims (see Chapter 11, Sections 4, 5, and Chapter 20, Section 4).

## **7.0 CLAIMS PROCESSING REQUIREMENTS**

**7.1** Verify TRICARE-eligibility on the DEERS prior to payment.

**7.2** Both institutional and professional charges shall be reimbursed based on billed charges.

**7.2.1** The cancer center shall submit all charges on the basis of fully itemized bills. Each service and supply shall be individually identified and submitted on the appropriate claim forms.

**7.2.2** All claims for medical care required as a result of participation in an NCI sponsored study for cancer prevention or treatment that is not a TRICARE benefit, shall be processed and paid under the demonstration.

**7.3** Cost-shares and deductibles applicable to TRICARE will also apply under the Demonstration. For TRICARE Prime enrollees, including those enrolled in USFHP, applicable copays will apply.

**7.3.1** The contractor shall query the DEERS Catastrophic Cap and Deductible Data (CCDD) to determine the status of deductible and catastrophic cap met amounts for TRICARE-eligible beneficiaries at the time the costs are listed on the voucher for processing and payment.

## **2.3 Tracking And Accounting**

**2.3.1** Under the "Minimum Necessary Rule," the contractor shall identify and document those persons or classes of persons, as appropriate, in their workforces who require access to PHI to carry out their duties. For each person or class of persons identified, the contractor shall document the category or categories of PHI needed and any conditions appropriate to such access.

**2.3.2** The contractor shall identify and document the circumstances when the entire medical record is required. For example, if the entire record is needed to complete a review, claims or appeals/hearings function, the contractor shall document the circumstances and justification.

**2.3.3** The contractor shall forward privacy requests for nonroutine or nonrecurring disclosures to the RDs within three working days of receipt of the request. Nonroutine or nonrecurring disclosures are any disclosures outside the current routine uses published in the **Federal Register** under the Privacy Act of 1974. Privacy requests for PHI must be made in writing. The RDs, in consultation with the contractor, will forward the request and recommendation within 10 working days of receipt of the request to the HA/TMA Privacy Officer. The HA/TMA Privacy Officer will make the final determination as to what information is reasonably necessary to accomplish the purpose for which the disclosure or request is sought. The HA/TMA Privacy Officer will notify the RDs, with a copy to the contractor, as to what information may be released to the requestor.

**2.3.4** If the contractor grants an individual's request for access to their PHI, they shall inform the individual of the acceptance of the request and provide the access requested No Later Than (NLT) 30 calendar days after receipt of the request. If the contractor is unable to take the requested action within 30 calendar days, they may extend the time for no more than an additional 30 days provided that they notify the individual in writing of the delay and the expected date of completion. Only one 30 calendar day extension may be allowed under the HIPAA Privacy Rule. The contractor shall document receipt of all access requests using a date stamp and maintain an index to record pertinent information and actions. If the contractor denies access to the PHI or the record, they shall forward the request within seven working days from receipt to the RD, Privacy Official, or designee. The contractors shall notify the beneficiary within three working days that their request was forwarded to the RD. The RD shall review the request and make a determination within 20 calendar days (50 calendar days for justified delays) of the request. The RD will notify the individual, with a copy to the contractor, of any approved or denied access determinations and the reason for any denial. The individual may appeal the denial determination to the HA/TMA Privacy Officer. In the event of an appeal, the HA/TMA Privacy Officer will notify the individual of the determination, with copies sent to the RD and the contractor.

**2.3.5** The contractor shall charge only reproduction costs for providing copies of an individual's health records/PHI and fees will be waived when those costs are under \$30. There will be no charge when the copying is for the contractor's or the TRICARE health plan's convenience.

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

## **2.4 Requesting An Amendment, Alternate Means of Communication, or Restriction**

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

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

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

**2.4.4** All amendment requests are submitted in writing. The contractor shall document receipt of all amendment requests using a date stamp and maintain an index to record pertinent information and actions. If the contractor agrees to amend the PHI or record, it shall do so within 60 calendar days of receipt of the request. The contractor shall provide a written reason for any extension beyond 60 calendar days from the date of the request and the date of completion to the individual who made the request with a courtesy copy to the RD. Only one 30 calendar day extension may be allowed under the HIPAA Privacy Rule. If the contractor decides they will not amend the PHI or the record, they shall forward the request to the RD within 20 calendar days from receipt of the request. The RD shall review the request and make a determination within 45 calendar days (80 days for justified delays) from the receipt of the request. The RD will notify the individual, with a copy to the contractor, of any approved or denied amendment determinations and the reason for any denial. The individual may appeal the denial determination to the HA/TMA Privacy Officer. Whoever makes the decision on whether to amend or not shall be the responsible agent for communicating with the beneficiary regarding their amendment request and will furnish copies of the determination to the appropriate parties.

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

**2.4.6** The contractor shall approve or disapprove the restriction requests on protected health information within seven working days of receiving the request. If the request is approved the contractor shall notify the requestor and the RD and shall implement the provision of the restriction within seven working days of the decision. If the request is denied the contractor shall notify the requestor of the reason for denial within seven working days of the decision. Requests received by the contractor for a restriction placed on communications by individuals must be in writing. Termination of restriction requests by individuals must be in writing.

## **2.5 Complaints And Security Incident Tracking And Reporting**

**2.5.1** The contractor shall document privacy and security complaints and retain a case file of all documentation associated with a complaint. These files shall be retained in accordance with [Chapter 2](#). The contractor shall use the existing grievance process and timelines as identified in [Chapter 11, Section 8](#), to provide a process for individuals to make complaints concerning either

## Other Contract Requirements

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### 1.0 CUSTOMER SERVICE

#### 1.1 Telephone Inquiries

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

#### 1.2 Written Inquiries

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

### 2.0 REFERRALS

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

### 3.0 CONTRACTOR'S RESPONSIBILITY IN PROGRAM INTEGRITY

In relation to TDEFIC, at any time the contractor receives an allegation of fraudulent behavior, or any type of improper activity relating to either a beneficiary or provider submitted claim, the contractor shall review the claim to ensure it was processed properly by the TDEFIC contractor. Following completion of the review, if an error in payment is not detected, the contractor shall follow the requirements in [Chapter 13](#).

### 4.0 MEDICARE CROSSOVER FEES

Medicare crossover fees are paid to Medicare contractors by the TRICARE Management Activity (TMA) contractors. These fees cover the transmission of data on paid claims from the Medicare contractor to TMA contractors in order to facilitate TMA processing as second payer on

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Other Contract Requirements

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the TRICARE For Life (TFL) claims. The contractor shall submit non-TRICARE Encounter Data (TED) vouchers covering these expenses to TMA on an as needed basis, generally once or twice a month.

**5.0 THIRD PARTY RECOVERY CLAIMS**

Any inpatient or outpatient claim with a diagnosis code of 800-999 which exceeds a TRICARE liability of \$500 shall be considered a potential third party claim and shall be developed with the questionnaire, "Statement of Personal Injury - Possible Third Party Liability DD Form 2527." The remainder of [Chapter 10, Section 5, paragraph 5.1.1](#) continues to apply.

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## TRICARE Alaska

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### 1.0 GENERAL

**1.1** All provisions contained in the TRICARE Managed Care Support (MCS) contract, TRICARE Operations Manual (TOM), TRICARE Policy Manual (TPM), TRICARE Systems Manual (TSM), or TRICARE Reimbursement Manual (TRM) shall apply in the state of Alaska except as specifically modified by this chapter. Chapter references in this section refer to the TOM unless otherwise specified.

**1.2** The TRICARE program is not automatically implemented in all areas where it is potentially applicable. Implementation of the program requires an official action by an authorized individual in accordance with 32 CFR 199.17(a)(5). Network implementation will be published in the **Federal Register**.

### 2.0 OPTIMIZATION

While overall responsibility and accountability remains with the Regional Director (RD), TRICARE Regional Office West (TRO-W), the MCS Contractor (MCSC) is responsible for managing network provider development and operations in the state of Alaska.

**2.1** Consistent with existing Memorandums of Understanding (MOUs), the MCSC shall optimize the Military Treatment Facility (MTF) for all appropriate specialty requests for care received from outside of the MTF within established TRICARE guidelines and access standards. Specialty care that cannot be provided by the MTF or scheduled within TRICARE access standards in the MTF shall be referred to the network as determined by MCSC in coordination with the MTF.

**2.2** The MCSC shall use every appropriate opportunity for beneficiary and provider education to influence beneficiary and provider behavior in a manner that encourages MTF optimization.

### 3.0 BENEFICIARY SATISFACTION

The contractor shall achieve the highest level of beneficiary satisfaction possible in the state of Alaska. The contractor's administrative processes shall be designed and operate to ensure ease in accessing TRICARE information and benefits. These processes shall be designed recognizing the unique nature of health care delivery within the state of Alaska and continuously operated in a manner that achieves the highest level of beneficiary satisfaction. Additionally, beneficiary satisfaction activities shall be coordinated with MTFs and the TRO-W Alaska Branch to achieve a coordinated, uniform approach to Department of Defense (DoD) customer services in Alaska.

#### **4.0 BEST VALUE HEALTH CARE**

The contractor shall support the best value in the delivery of health care services in the state of Alaska through the efficient operation of all administrative processes. This includes supporting MTF right of first refusal, educating beneficiaries and providers on the benefit of using the MTF based on the collaborative agreement with the MTF Commander, and efficiently and effectively operating all administrative processes.

#### **5.0 TRANSITIONS**

The contractor shall be fully responsible for all transition activities in the state of Alaska. The contractor shall ensure all required contractor services are fully operational in accordance with [Chapter 1](#).

#### **6.0 ACCESS TO DATA**

The contractor shall provide ready access to Government personnel for the state of Alaska in the same manner as provided in all other West Region locations.

#### **7.0 ADMINISTRATION**

The contractor shall comply with all provisions of [Chapter 1](#), with the following exceptions:

**7.1** Contractor accomplished preauthorization shall be limited to inpatient mental health care for non-Prime enrollees and those enrolled to civilian Primary Care Managers (PCMs). The MTF will preauthorize/authorize all services for TRICARE Prime enrollees, as required. The MCSC shall comply with the preauthorization requirements specified in [Chapter 7, Section 2](#) for Standard beneficiaries and those enrolled to civilian PCMs.

**7.2** The contractor shall process any grievance related to contractor personnel or contractor actions. Grievances related to MTF providers shall be forwarded to the responsible MTF within five calendar days of receipt (see [paragraph 19.0](#) for appeals) for resolution. The contractor shall process all grievances related to civilian providers consistent with [Chapter 11, Section 8](#).

**7.3** The contractor shall accomplish all Start-up Requirements as specified in the TOM except the provisions of [Chapter 1, Section 7, paragraph 2.2](#), "Execution of Agreements With Contract Providers" shall not apply. However, the MCSC shall load all preferred providers to the MCSC's provider directory within 30 days.

#### **8.0 RECORDS MANAGEMENT**

The contractor shall comply with the provisions of [Chapter 2](#).

#### **9.0 FINANCIAL ADMINISTRATION**

The contractor shall comply with all of the provisions of the TOM. The contractor shall apply the appropriate financial provisions to the claims for TRICARE enrollees in the state of Alaska based on the Government's ultimate decision regarding the underwriting of health care performed in Alaska.

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## 10.0 PROVIDER CERTIFICATION AND CREDENTIALING

The contractor shall comply with the provisions of [Chapter 4](#) for providers rendering care in the state of Alaska.

## 11.0 SUPPORT OF TRICARE PROVIDERS

**11.1** The contractor is required to provide assistance to the Government in servicing participating and non-participating providers. This assistance shall include certifying and credentialing providers according to [paragraph 10.0](#). The contractor shall provide the appropriate level and number of provider representatives to service the participating and non-participating providers throughout the state of Alaska. The provider representative shall be located in contractor furnished facilities in close proximity to the MTF. The provider representative shall assist in establishing provider networks. The contractor's provider representatives shall also assist providers with TRICARE questions/problems as necessary. In this role, the provider representative shall be supported by all appropriate contractor staff and systems. For example, if a provider wishes to determine the status of a claim, he can call the contractor's claims information toll-free telephone number or check the status via an electronic means. However, if a provider requests the assistance of an individual on-site at the provider's office to resolve problems, the provider representative shall provide the assistance.

**11.2** Alaskan providers shall not be required to submit claims electronically. As such, Alaskan claims shall be removed from both the numerator and the denominator when computing the percentage of claims submitted electronically.

## 12.0 ENROLLMENT

**12.1** The contractor is responsible for all enrollment activity in the state of Alaska in accordance with the provisions of [Chapter 6](#). Enrollments within the state of Alaska shall all be to PCMs located within a MTF or in PSAs around a limited number of MTFs, to PCMs in the TRICARE network.

**12.2** Where enrollment to private sector PCMs is permitted, the contractor shall coordinate with the MTF Commander to ensure the combined total of MTF and private sector enrollees does not exceed the number for which compliance with TRICARE Prime access to care standards can be assured, considering MTF and preferred provider network resources together. Enrollment will be to the MTF first and then to the private sector at the discretion of the MTF Commander in coordination with the contractor.

## 13.0 UTILIZATION AND QUALITY MANAGEMENT

The contractor shall comply with the provisions of [Chapter 7](#), regarding utilization and quality management. In doing so, the contractor shall establish a separate utilization management plan for care received in the state of Alaska. This plan shall recognize that the MTF PCM is responsible for services rendered to his/her TRICARE Prime enrollees. As such, the MTF is responsible for issuing all authorizations for its Prime enrollees. The contractor is responsible for ensuring that MTF issued authorizations are entered into all applicable contractor systems to ensure accurate, timely customer service, and claims adjudication.

**13.1** Cases for care rendered in the state of Alaska shall be included in the selection of cases for review by the TRICARE Quality Monitoring Contractor (TQMC) per [Chapter 7, Section 3](#). If the TQMC identifies an aberrant provider from the state of Alaska, and the provider is a network provider, the MCSC shall advise the TRO-W Alaska Branch of the findings.

**13.2** The contractor shall comply with and include care rendered in the state of Alaska in its Clinical Quality Management Program (CQMP) per [Chapter 7, Section 4](#). The Clinical Quality Management Program Annual Report (CQMP AR) shall include a separate section specifically addressing Alaska.

**13.3** All potential quality issues and unusual provider findings by the TQMC during their case reviews shall be processed and investigated by the MCSC per existing Clinical Quality Management (CQM) policies.

#### **14.0 CLAIMS PROCESSING**

The contractor shall process claims in accordance with [Chapter 8](#).

#### **15.0 DUPLICATE CLAIMS**

The contractor shall comply with [Chapter 9](#), as appropriate, for the identification, correction and resolution of duplicate and potentially duplicate claims.

#### **16.0 CLAIMS ADJUSTMENTS AND RECOUPMENTS**

The contractor shall comply with the provisions of [Chapter 10](#), regarding claims adjustments and recoupments.

#### **17.0 BENEFICIARY AND PROVIDER SERVICES**

**17.1** The contractor shall comply with the provisions of [Chapter 11, Section 1](#) relating to the provision of marketing and education materials in the state of Alaska.

**17.2** The contractor shall comply with the provisions of [Chapter 11, Section 2](#) and the TRICARE MCS contract, Section C-7.17 regarding briefings within the state of Alaska.

#### **18.0 CUSTOMER SERVICE OPERATIONS**

The contractor shall **provide customer service support to include benefit and enrollment assistance to all beneficiaries** in the state of Alaska. The functions of the **contractor's call center** shall be as specified in [Chapter 11](#). In providing assistance with referrals, the MCSC shall first direct all beneficiaries to the MTF (beneficiaries referred out of the MTF for specialty services shall not be referred back to the MTF) and then to the network providers. The MCSC shall maintain an up-to-date list of network providers.

**18.1** The contractor shall comply with the provisions of [Chapter 11, Section 3](#) in accomplishing Beneficiary, Congressional, and Health Benefits Advisor (HBA) relations within the state of Alaska.

**18.2** The contractor shall comply with the provisions of [Chapter 11, Section 4](#) in responding to inquiries regarding TRICARE within the state of Alaska.

**18.3** The contractor shall comply with the provisions of [Chapter 11, Section 5](#).

**18.4** The contractor shall provide toll-free telephone service to Alaskan beneficiaries in accordance with the provisions of [Chapter 11, Section 6](#).

**18.5** The contractor shall provide allowable charge reviews in accordance with the provisions of [Chapter 11, Section 7](#).

**18.6** The contractor shall operate a grievance process in accordance with [paragraph 7.2](#) and [Chapter 11, Section 8](#).

**18.7** The contractor shall administer collection actions against beneficiaries in accordance with [Chapter 11, Section 9](#).

## **19.0 APPEALS AND HEARINGS**

The contractor shall implement and operate an appeals system for services requested or rendered in the state of Alaska in accordance with [Chapter 12](#).

## **20.0 PROGRAM INTEGRITY**

The state of Alaska shall be included in the contractor's regional Program Integrity Program per [Chapter 13](#).

## **21.0 AUDITS, INSPECTIONS, AND REPORTS**

**21.1** The contractor shall comply with the provisions of [Chapter 14](#), regarding audits, inspections, and reports. The MCSC shall provide a monthly preferred provider adequacy report as described in the Contract Data Requirements List (CDRL) DD Form 1423, and submit the information to the Contracting Office and the RD, TRO-W.

**21.2** The TRICARE network should be developed so that 75% of enrollee referrals are to an MTF or civilian network provider.

## **22.0 REGIONAL DIRECTOR (RD)/MTF CONTRACTOR INTERFACES**

The contractor shall comply with the requirements of [Chapter 15](#) when developing and operating MTF and RD interfaces. The contractor shall also enter into an agreement with the TRO-W Alaska Branch, as required by the MCSC, regarding contractor activities in the state of Alaska.

## **23.0 TRICARE PRIME REMOTE (TPR) PROGRAM**

The contractor shall operate the TPR program in the state of Alaska in accordance with [Chapter 16](#).

**24.0 CIVILIAN CARE REFERRED BY MHS FACILITIES**

The contractor shall comply with the provisions of Chapter 17 in the state of Alaska.

**25.0 CIVILIAN HEALTH CARE (CHC) OF UNIFORMED SERVICE MEMBERS**

The contractor shall comply with the provisions of Chapter 17 for services in the state of Alaska provided through the Supplemental Health Care Program (SHCP).

**26.0 DEMONSTRATIONS**

The contractor shall comply with the provisions of Chapter 18 for eligible beneficiaries in the state of Alaska.

**27.0 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)**

The contractor shall comply with the provisions to Chapter 19 when administering the TRICARE program in the state of Alaska.

**28.0 TRICARE DUAL ELIGIBLE FISCAL INTERMEDIARY CONTRACT (TDEFIC)**

The contractor shall not be responsible for services that are the responsibility of the TDEFIC contractor in the state of Alaska. This does not relieve the MCSC from their customer service responsibilities to dual eligible beneficiaries.

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The TRICARE Overseas Program (TOP) contractor shall perform these services for TRS members/survivors residing outside of the 50 United States or the District of Columbia. See the TSM, [Chapter 2, Addendum L](#) for a full list of TRS Health Care Delivery Plan (HCDP) Coverage Code Values. The TRICARE South Region contractor shall perform these services for TRS members or survivors residing outside the 50 United States or the District of Columbia until such time specified in the transition schedule to the new overseas contractor.

#### 4.1 Purchasing Coverage

To purchase TRS coverage, qualified RC members and qualified survivors must complete the prescribed form using the appropriate online web application and submit it, along with an initial payment in the amount of the first two months of premium, within deadlines specified in the following paragraphs. The initial payment may be made with a personal check, cashier's check, money order, or credit/debit card (i.e., Visa/MasterCard). No handwritten TRS requests are to be accepted by the contractor. The contractor shall collect completed TRS requests submitted by mail, **at overseas TRICARE Service Centers (TSCs)**, and by other means determined by the contractor. If a lockout is in place, the contractor may accept and process requests up to 45 days before the end of the 12 month lockout period for new coverage to begin after the 12 month lockout period ends. The contractor shall not process new coverage transactions into DOES unless the initial payment received is the correct amount for the type of coverage. The procedures for determining the effective date of coverage are specified in the following paragraphs.

##### 4.1.1 Continuation Coverage

A qualified member or qualified survivor may purchase TRS coverage with an effective date immediately following the termination of coverage under another TRICARE program. The TRS request required by [paragraph 4.1](#) must be either received **by the MCSC/TOP contractor** or postmarked NLT 30 days after the termination of other TRICARE coverage.

##### 4.1.2 Qualifying Life Events

A qualified member may purchase TRS coverage in connection with a Qualifying Life Event (QLE) that results in a change of family composition. First, qualified members are responsible to report all changes in family composition to military personnel officials with Real-Time Automated Personnel Identification System (RAPIDS) access to appropriately update DEERS. Second, the TRS request form identifying the QLE, required by [paragraph 4.1](#) must be either received **by the MCSC/TOP contractor** or postmarked NLT 60 days after the date of the QLE. The following QLEs are processed through DEERS and are recognized by TRS. The effective date of coverage is the date the QLE occurred (i.e., date of marriage, Date of Birth (DOB), etc.).

- Marriage;
- Birth or adoption of child;
- Placement of a child in the legal custody of the member by an order of the court for a period of at least 12 months;
- Divorce or annulment;
- Death of a spouse or family member, survivor; or
- Last family member/survivor becomes ineligible (e.g., child ages out).

### 4.1.3 Open Enrollment

A qualified member or qualified survivor may purchase TRS coverage throughout the year. If the request and premium payment required by [paragraph 4.1](#) are received by the MCSC/TOP contractor or postmarked by the last day of the month, the effective date of TRS coverage shall either be the first day of the next month or the first day of the second following month as indicated on the TRS request. Requests for next month that are postmarked in that month will be processed with an effective date of the first day of the month following the postmark date.

### 4.1.4 Survivor Coverage Under TRS

If a Reserve sponsor dies while in a period of TRS coverage, the surviving eligible family members may purchase (or continue) TRS coverage for up to six months beyond the date of the member's death. Except for automatic transfers specified in [paragraph 4.1.4.1](#), effective dates and deadlines specified in [paragraphs 4.1.1](#), [4.1.2](#), and [4.1.3](#) apply. The effective date of TRS survivor coverage is the day after the date of death. Applicable premium rates are specified in [paragraph 2.0](#).

**4.1.4.1** If TRS member and family coverage was in effect on the date of the member's death, DEERS will automatically transfer covered family members to TRS survivor coverage with an effective date of the day after the date of death and establish an end eligibility date in DEERS six months from the date of the member's death. Defense Manpower Data Center (DMDC) will issue letters to survivors advising them of their continued coverage and their option to suspend coverage, if so desired, by completing a TRS request form via the appropriate online web application or in a written letter to the appropriate Managed Care Support Contractor (MCSC). The DMDC generated survivor letter will include instructions on how to obtain a DoD Self-Service Logon (DS Logon) to access the TRS Web Portal or the option to suspend coverage via a written letter.

**4.1.4.2** If TRS member-only coverage was in effect on the date of the member's death, DEERS will terminate coverage with an effective date coinciding with the date of death. Eligible family members may purchase coverage by completing a TRS request. The TRS request required by [paragraph 4.1](#) must be either received by the MCSC/TOP contractor or postmarked NLT 60 days after the date of death of the Selected Reservist. DMDC will issue letters to survivors advising them of the option to purchase coverage.

## 4.2 Changes in TRS Coverage

Once TRS coverage is in effect, TRS members, which include TRS-covered survivors, may request the following types of changes.

### 4.2.1 Type of Coverage Changes

A TRS member/survivor may change TRS type of coverage following procedure for a QLE specified in [paragraph 4.1.2](#) or procedures for open enrollment specified in [paragraph 4.1.3](#). The contractor shall follow procedures specified in [paragraph 5.4](#) for premium adjustments resulting from changes in coverage.

#### **4.2.2 Addition Of Family Members to TRS Member and Family Coverage**

TRS members/survivors may request to add eligible family members to an existing TRS member and family coverage plan at any time, once eligibility for the family is established. Eligibility is established by going to a military personnel office with RAPIDS capability to appropriately update DEERS. The effective date of coverage for the added family member(s) shall follow procedures specified in [paragraphs 4.1.2 or 4.1.3](#). The TRS request must be either received by **the MCSC/TOP contractor** or postmarked NLT 60 days after that date.

#### **4.2.3 TRS Newborn/New Child Policy**

**4.2.3.1** A newborn/new child will be covered from the date of birth/custody only if, (a) the TRS member registers the newborn/new child in DEERS within 60 days of birth/custody, and (b) the TRS request is either received by **the MCSC/TOP contractor** or postmarked NLT 60 days after the date of birth/custody. The contractor shall handle claims associated with the newborn/new child as specified in [paragraph 6.2](#). The contractor shall make adjustments in premiums as specified in [paragraph 5.4](#).

**4.2.3.2** TRS members who reside overseas may have difficulty in obtaining the documentation required to register a newborn/new child in DEERS. As with all other late submissions of enrollment requests, the member may submit a request for reconsideration to the appropriate TRICARE Regional Director (RD) (or their designee), or the TRICARE Area Office (TAO) Director consistent with [paragraph 4.5.1](#).

#### **4.3 Processing**

**4.3.1** The contractor shall process all TRS transactions through DOES for members or survivors with a DEERS residential address in the contractor's region. The contractor shall process TRS requests received along with the initial premium payment (see [paragraph 4.1](#)) NLT 10 calendar days after receipt.

**4.3.2** If the contractor is unable to enroll the member/survivor in DOES due to (a) a 90-day future enrollment limitation, (b) DEERS not reflecting eligibility, (c) the application being incomplete, (d) a missing initial premium payment, or (e) the initial premium payment not being in the correct amount; the contractor shall return a copy of the original application and any incorrect premium payments to the member, within 10 business days, with an explanation of what is needed for the contractor to accept the application for processing.

#### **4.4 Suspension of TRS Coverage**

The contractor shall initiate return of any excess premium amounts paid prorated to the day as indicated NLT 10 business days after the effective date of the suspension or after receipt of a Policy Notification Transaction (PNT) notifying the contractor of a suspension, whichever is later. The contractor shall also update DEERS with any premium amount refunded within 30 calendar days. The contractor shall include an explanation for the premium refund.

##### **4.4.1 Loss of TRS Eligibility**

The effective date of suspension for a member covered under TRS shall be the effective

date of the loss of their qualification for TRS coverage. The contractor shall place the TRS member, their family members, and/or survivors in a suspended status from the last paid-through date by “applying a lockout” in DOES. While DOES will apply a “lockout” status, the TRS member, family members, and/or survivors are considered to be in a “suspended” status, subject to reinstatement in certain circumstances, for the period of 12 months from the last paid-through date and will not incur a lockout when coverage is terminated due to a loss of TRS eligibility (i.e., member no longer qualifies to purchase TRS due to status change of Active Duty or FEHBP).

#### **4.4.1.1 Sponsor Loss of Eligibility**

When a sponsor’s eligibility is terminated at a date other than the anticipated end date, DEERS will send the contractor an unsolicited PNT advising the contractor of the suspended coverage. When a sponsor’s eligibility is terminated at the anticipated end date, DEERS will not send the contractor an unsolicited PNT advising the contractor of the suspended coverage. The contractor shall suspend coverage for the sponsor as appropriate (see [paragraph 4.4.1](#)).

#### **4.4.1.2 Individual Family Member or Survivor Loss of Eligibility**

In the case of a family member or survivor losing eligibility in DEERS, DEERS will send the contractor an unsolicited PNT advising the contractor to suspend coverage for that individual. When an individual family member’s or survivor’s eligibility is terminated at the anticipated end date, DEERS will not send the contractor an unsolicited PNT advising the contractor of the suspended coverage. The contractor shall suspend coverage for the family member(s) or survivor(s) as appropriate (see [paragraph 4.4.1](#)).

#### **4.4.1.3 Sponsor Involuntarily Removed**

When a Selected Reserve member’s service has recorded in DEERS that the member is being involuntarily removed from the Selected Reserve under other than adverse conditions, and the member was covered by TRS on the last day of his or her Selected Reserve membership, DEERS will terminate TRS coverage 180 days after the date on which the member is removed from the Selected Reserve. DEERS will send the contractor an unsolicited PNT advising the contractor of the adjusted anticipated end date. The contractor shall continue to collect monthly premiums until the adjusted anticipated end date (see [paragraph 5.2](#)) unless the coverage is otherwise suspended/terminated earlier. This extended TRS coverage provision expires December 31, 2018.

#### **4.4.2 Member or Survivor Gains Other TRICARE Coverage**

No lockout shall be applied for suspension due to the gain of other TRICARE coverage.

**4.4.2.1** If a TRS member gains other TRICARE coverage for a period of 30 days or less, TRS coverage will continue unchanged.

**4.4.2.2** If a TRS member or survivor gains other TRICARE coverage for a period of more than 30 days, DEERS will suspend TRS coverage in accordance with [paragraph 4.4.1.1](#). The contractor must be aware of the fact that DEERS may reflect ADSM and ADFM TRICARE coverage before the member actually reports for active duty.

**4.4.2.3** If a TRS member gains other TRICARE coverage via a family member, the member and family members may suspend coverage under TRS without incurring a lockout.

#### **4.4.3 Failure to Make Payment**

**4.4.3.1** Failure to pay monthly premiums in accordance with the procedures in this chapter shall result in suspension of coverage. The effective date of suspension is the first day following the paid-through date. The contractor shall automatically suspend coverage of the TRS member, all covered family members and survivors, if the monthly premium payment is not received by the last day of the month of coverage. After the last day of the month, the contractor shall suspend coverage up to 12 months from the last paid-through date. DMDC will provide written notification to the TRS member or survivor of the suspension along with the reason, noting the suspension may become a retroactive termination and 12 month lockout from the last paid-through date. During a suspension, the contractor may pend any claims received for health care furnished to the TRS member, family members, and/or survivors during the period for which premiums have yet to be paid, to avoid creating recoupment of health care costs for ineligible beneficiaries. The TRS member, family members, and/or survivors will be responsible for the cost of any health care received after the termination date following retroactive termination of coverage. If claims are not pended, the contractor shall initiate recoupment of health care costs following the procedures in [Chapter 11, Section 3](#).

**4.4.3.2** Upon failure of a TRS member or survivor to pay monthly premiums in accordance with [paragraph 4.4.3](#), a contractor shall place the TRS member, family members, and/or survivors in a suspended status for a period of 12 months from the last paid-through date by “applying a lockout” in DOES. The DMDC written notification of suspension (see [paragraph 4.4.3.1](#)) includes notice that the suspended coverage shall be considered to become terminated coverage retroactive to the last paid-through date.

#### **4.4.4 Member/Survivor Request for Voluntary Suspension**

A contractor shall place the TRS member, family members, and/or survivors in a suspended status for a period of 12 months from the last paid-through date by “applying a lockout” in DOES. While DOES will apply a “lockout” status, the TRS member, family members, and/or survivors are considered to be in a “suspended” status, subject to reinstatement in certain circumstances, for the period of 12 months from the last paid-through date. When the 12 month suspension expires, the suspended coverage shall be considered to become terminated coverage retroactive to the last paid-through date.

##### **4.4.4.1 Suspension of Existing Plan(s)**

The contractor shall accept requests for suspension of coverage from TRS members or survivors at any time. The effective date of suspension is either (a) the last day of the month in which the request was postmarked or received **by the MCSC/TOP contractor** or (b) the last day of a future month as specified in the request given that the request was postmarked or received **by the MCSC/TOP contractor** in the month preceding the requested month of suspension. The contractor shall place the TRS member, family members and/or survivors in a suspended status for a period of 12 months from the terminations last paid-through-date by “applying a lockout” in DOES. The DMDC written notification of the suspension (see [paragraph 4.4.3.1](#)) includes notice that the suspended coverage shall be considered to become terminated coverage retroactive to the last

paid-through date.

#### **4.4.4.2 Suspension of an Individual's Coverage**

The contractor shall accept requests for suspension of coverage from individual family members of TRS members or survivors at any time. The effective date of suspension is either (a) the last day of the month in which the request was postmarked or received **by the MCSC/TOP contractor** or (b) the last day of a future month as specified in the request, if the request was postmarked or received **by the MCSC/TOP contractor** in the month preceding the requested month of suspension. The contractor shall apply a suspension to individual family members or survivors whose TRS coverage was suspended upon request for a period of 12 months from the effective date of suspension initiated by the TRS member or survivor. The DMDC written notification of the suspension (see [paragraph 4.4.3.1](#)) includes notice that the suspended coverage shall be considered to become terminated coverage retroactive to the last paid-through date.

#### **4.4.4.3 Cancelled Eligibility and Enrollment**

When the contractor receives a PNT for a cancelled enrollment, the contractor will generate a letter notifying the covered member of the cancellation and refund any unused portion of the premium payment. The contractor shall update DEERS with any premium amount refunded within 30 calendar days. No lockout shall be applied for a cancelled enrollment. The contractor shall include an explanation for the premium refund.

#### **4.4.5 TRS Survivor Coverage Suspension**

If TRS coverage is continued as described in [paragraph 4.1.4.1](#) and the survivors do not wish to keep the coverage, the survivors must submit a request in writing, in accordance with procedures described in [paragraph 4.1.4.1](#), to be received by the contractor NLT 60 days after the date of death in order to suspend coverage retroactive to the day after the member's death. Alternatively, the survivor may request to suspend coverage in accordance with [paragraph 4.4.4](#). Otherwise, DEERS will terminate TRS survivor coverage six months after the date of the member's death. Refunds of premiums will be handled as specified in [paragraph 4.4](#).

### **4.5 Exceptions**

#### **4.5.1 Reconsiderations of Member's and Survivor's Request to Enroll**

The contractor shall advise TRS members/survivors that all reconsideration requests for a refusal of a late submission of a request to enroll shall be submitted to the appropriate TRICARE RD, or their designee, or the TAO Director, or their designee for determination. The TRICARE RD, or their designee, or the TAO Director, or their designee will issue decisions for all reconsideration requests. If changes are to be made to a member's/survivor's coverage as a result of a reconsideration determination, the TRICARE RD, or their designee, or the TAO Director, or their designee will send instructions to the contractor. The contractor shall carry out such instructions NLT 10 calendar days after receipt from the TRICARE RD, or their designee, or the TAO Director, or their designee.

#### **4.5.2 Administrative Issues Regarding Requests to Enroll**

The TRICARE RD, or their designee, or the TAO Director will notify the contractor when the

government determines that an administrative situation occurred that prevented a member's or survivor's request to enroll from being accepted for processing according to submission deadlines specified in this section.

#### 4.5.3 Contractor-Approved Reinstatement of TRS Coverage

A TRS member/survivor may submit a request to the contractor to reinstate suspended TRS coverage NLT three months after the paid-through date with no justification needed. The contractor shall accept the request and reinstate coverage if the request meets all of the following conditions:

- The request is received **by the MCSC/TOP contractor** or postmarked NLT three months after the paid-through date;
- No suspension has been lifted within 12 months preceding the paid-through date;
- Payment of overdue and current premiums in full is included (to include any administrative fees); and
- Information is provided to establish recurring electronic premium payments as specified in [paragraph 5.2.2](#).

The contractor shall reject the request if any of the conditions above are not met. The contractor shall issue a response to the member/survivor within 10 calendar days of receipt for all reinstatement requests. The response is either a rejection of the request with reason specified or notification that the TRS coverage has been reinstated.

#### 4.5.4 TMA Deputy Director-Approved Reinstatement of TRS Coverage

The contractor shall direct a TRS member/survivor who is not able to fulfill the requirements under [paragraph 4.5.3](#) to their respective TRICARE Regional Office (TRO) to submit a request in writing to the TRICARE RD for reconsideration of reinstatement if he/she can justify undue hardship. The TRICARE RD will review each request for completeness. If complete, the RD will forward to the TMA Deputy Director with a recommendation and justification for either approval or disapproval. If incomplete, the TRICARE RD will reject and return the request to the member. The TMA Deputy Director has approval authority. If denied by the TMA Deputy Director, the TRICARE RD will notify the contractor of final determination and the contractor will apply a 12-month lockout from the last paid-through date, the coverage will be considered terminated, and the contractor will notify the member. If approved, the TRICARE RD will provide the contractor with specific instructions about reinstating the TRS coverage. All past and current premiums (to include any administrative fees) must be paid in full first without exception and the member must provide information necessary to establish/validate a recurring electronic method of payment for all future premiums, NLT 30 days after the date of notification of approval. NLT 10 calendar days after all the instructed actions have been completed, the contractor shall lift any suspension and lock-out, then process the reinstatement of coverage through DOES.

## 5.0 PREMIUM COLLECTION

The contractor shall perform all premium collection functions required for TRS. Service members or survivors are responsible for all premium payments for the type of coverage elected (i.e., TRS member-only or TRS member and family). After enrollment, only monthly premium payments are permitted. Premium related transactions shall be reported through the enrollment fee payment interface or Catastrophic Cap and Deductible (CC&D) Fee Web (see the TSM, [Chapter 3, Section 1.4](#)).

### 5.1 Jurisdiction for Premium Collection

**5.1.1** The particular contractor servicing the residential address for the TRS member or survivor shall perform premium collection functions for the TRS member or survivor. The contractor shall identify the financially responsible individual for survivor plans from the survivors actually covered by TRS in descending order of precedence:

- Spouse
- Oldest Enrolled Child (or Legal Guardian as applicable)

**5.1.2** Any time the servicing contractor notices that a new residential address is in the servicing area of another TRICARE contractor, the losing contractor shall notify the TRS member or survivor within 10 calendar days that they need to contact the servicing contractor in their new area to transfer their coverage to the new area. A TRS member or survivor may elect to provide an alternate mailing address, but the servicing contractor shall be based on the TRS member's or financially responsible survivor's residential, not alternate mailing address. Any TRS member/financially responsible survivor may transfer regions at any time. The gaining contractor shall perform the premium collections for future payments.

**5.1.3** All unsolicited PNTs for TRS members or survivors will be evaluated to determine if residential address changes require a notification to the TRS member or survivor (see [paragraph 5.1.2](#)).

### 5.2 Premium Collection Processes

**5.2.1** The contractor shall credit the TRS member or survivor for premium payments received. In the case of a start date of coverage at any time other than the first of a month, the first payment collected by the contractor shall include the prorated amount on a daily basis necessary to synchronize billing to the last day of the month. The daily prorated amount shall be equal to 1/30th of the appropriate premium (rounded to the penny) regardless of how many days are actually in the month. DEERS will automatically prorate the premium due for mid-month enrollments from the effective date of coverage to the end of that first enrollment month, e.g., from the 18th of the month to the 31st.

**5.2.2** The contractor shall collect monthly premium payments from TRS members or survivors as appropriate and shall report the premium amount paid for those payments to DEERS (see the TSM, [Chapter 3](#)), including any overpayments that are not refunded to the TRS member or survivor. In the event that there are insufficient funds to process a premium payment, the contractor may assess the account holder a fee of up to 20 United States (U.S.) dollars (\$20.00). The contractor shall provide commercial payment methods for TRS premiums that best meet the needs of beneficiaries

while conforming to [paragraphs 5.2.3](#) through [5.2.8](#).

**5.2.3** Monthly premiums must be paid through an automated, recurring electronic payment through Electronic Funds Transfer (EFT) or Recurring Credit/Debit Card (RCC) (i.e., Visa/MasterCard) from a designated financial institution. These are the only acceptable payment methods for the recurring monthly premiums. An EFT payment or a RCC payment shall be processed within the first five business days of the month of coverage. The contractor shall advise TRS members or survivors at the time of EFT/RCC election that an insufficient funds fee of up to \$20 U.S. may be assessed, if sufficient funds are not available.

**5.2.4** TRS members or survivors must make the required initial payment (as specified in [paragraph 4.1](#)) at the time the TRS application is submitted to allow time for the EFT/RCC to be established for subsequent monthly premium payments.

**5.2.5** The contractor shall establish recurring monthly EFTs/RCCs and is responsible for obtaining and verifying the information necessary to do so.

**5.2.6** The contractor shall initiate action to modify EFT/RCC payment amounts to support premium changes.

**5.2.7** When an administrative issue arises that stops or prevents an automated monthly payment from being received by the contractor (e.g., incorrect or transposed number provided by the beneficiary, credit card expired, bank account closed, etc.), the contractor shall grant the TRS member or survivor 30 days after the paid-through date to provide information for a new automated monthly payment method. The contractor may accept payment in accordance with [paragraph 4.1](#) during this 30 day period in order to preserve the TRS member's or survivor's enrollment status.

**5.2.8** The contractor shall directly bill the TRS member or survivor only when a problem occurs in setting up or maintaining the EFT or RCC payment; to include a fee of up to \$20 U.S. due to insufficient funds. Bills may be sent to the residential or alternate mailing address designated by the TRS member or survivor. All bills shall specify that the premium payment is due for receipt by the contractor no later than the last business day of the month. Premium payments shall be made payable to the contractor servicing the member's or survivor's coverage as specified in [paragraph 5.1](#). The contractor shall terminate billing once the problem with EFT/RCC payment is resolved.

### **5.3 Annual Premium Adjustment**

**5.3.1** Contractors shall notify current TRS members or survivors in writing of any annual premium adjustments NLT 30 days after the contractors receive notification of the updated premiums.

**5.3.2** For premium adjustments that go into effect at any time other than January the first, the government will provide instructions about notification of TRS members or survivors.

### **5.4 Premium Adjustments from Changes Associated with QLEs**

**5.4.1** When a QLE is processed that changes the premium, the effective date of the premium change shall be the date of the QLE.

**5.4.2** If the change from a QLE results in an increase in the premium, the contractor shall notify the TRS member or survivor of the increase and adjust the next premium amount due, to include any underpaid amount (prorated to the day as specified in [paragraph 5.2](#)), to the effective date of the change.

**5.4.3** If the change from a QLE results in a decrease in the premium, the contractor shall retain any overpaid amount and apply it to subsequent electronic payments until all of the overpayment is exhausted.

## **5.5 Suspensions/Terminations**

The contractor shall initiate the process to refund any premium amounts applied for coverage after the date of suspension/termination as specified in [paragraph 4.4](#).

## **5.6 Online Transactions**

In addition to requirements specified in [paragraph 5.0](#) and its subordinate paragraphs, the contractor may provide online capability for TRS members or survivors to conduct business related to premium collection and other applicable administrative services through secure access to the contractor's web site.

## **6.0 CLAIMS PROCESSING**

**6.1** The contractor shall process TRS claims under established TRICARE Standard and TRICARE Extra ADFM cost-sharing rules and guidance. Normal TRICARE Other Health Insurance (OHI) processing rules apply to TRS.

**6.2** The contractor shall pend all claims for health care provided to a newborn/new child of a TRS member until the member completes the process specified in [paragraph 4.2.3.1](#). If the contractor becomes aware that a TRS member has an unregistered newborn/new child, the contractor shall notify the TRS member of the requirement to register the newborn/new child in DEERS and submit a TRS request form for the newborn/new child NLT 60 days after birth/custody. When the member completes the process specified in [paragraph 4.2.3.1](#), the contractor shall process any claims associated with the newborn/new child's health care. If the member fails to complete the process as specified in [paragraph 4.2.3.1](#), the contractor shall deny any claims associated with the newborn/new child's health care.

**6.3** Premium payments made for TRS coverage shall not be applied to the fiscal year deductible or catastrophic cap limit.

**6.4** Non-Availability Statement (NAS) requirements shall apply to TRS members, family members, and survivors in the same manner as for ADFMs under TRICARE Standard/Extra.

**6.5** Medicare is the primary payer for TRICARE beneficiaries who are eligible for Medicare. Claims under the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) will be adjudicated under the rules set forth in the TRICARE Reimbursement Manual (TRM), [Chapter 4, Section 4](#). The Managed Care Support Contractors (MCSCs) shall follow procedures established in [Chapter 8, Section 2](#), regarding claims jurisdiction for dual eligibles.

**6.6** If the contractor receives a PNT notifying them of a retroactive TRS disenrollment the contractor shall initiate recoupment of claims paid, if appropriate, as specified in [Chapter 10](#).

**6.7** If at any time the contractor discovers that the Selected Reserve member may be eligible for or enrolled in the FEHBP, the contractor shall report the discovery to the appropriate TRICARE RD, or their designee, or TAO Director NLT one business day after discovery. As applicable, the contractor shall follow [paragraph 4.4.1](#) and its subordinate paragraphs for loss of TRS qualification.

## **7.0 BENEFICIARY EDUCATION AND SUPPORT DIVISION (BE&SD)**

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

### **7.1 Customer Education**

**7.1.1** Information materials (i.e., public notices, flyers, informational brochures, etc.) will be developed and printed centrally by Department of Defense (DoD), TRICARE Management Activity (TMA), Office of BE&SD. The contractor shall distribute all documents associated with the TRS Program to the same extent and through the same means as TRICARE Standard materials are distributed. Copies of the TRICARE handbook and other information materials may be ordered through the usual TMA BE&SD ordering process.

**7.1.2** Upon start of coverage under TRS the contractor shall mail one copy of the TRICARE handbook to each first time TRS member's or survivor's household. The TRS member's or survivor's servicing contractor shall send additional handbooks upon request.

### **7.2 Customer Service**

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

## **8.0 ANALYSIS AND REPORTING**

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

**8.2** The contractor shall electronically submit monthly reports of TRS reinstatement activity as described in the Contract Data Requirements List (CDRL) DD Form 1423 NLT the 10th day of the month following the reported month.

## **9.0 PAYMENTS FOR CONTRACTOR SERVICES RENDERED**

### **9.1 Claims Reporting**

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

## 9.2 Fiduciary Responsibilities

**9.2.1** The contractor shall act as a fiduciary for all funds acquired from TRS premium collections, which are government property. The contractor shall develop strict funds control processes for its collection, retention and transfer of premium funds to the government. All premium collections received by the contractor shall be maintained in accordance with these procedures.

**9.2.2** Either a separate non-interest bearing account shall be established for the collection and disbursement of TRS premiums or the account used for TRICARE Retired Reserve (TRR) premium collections, when established, shall be used for TRS premiums as well. The contractor shall deposit premium collections to the established account within one business day of receipt.

**9.2.3** The contractor shall wire-transfer the premium collections and net of refund payments monthly to a specified government account as directed by the TMA Contract Resource Management (CRM) Finance and Accounting Office (F&AO). The government will provide the contractor with information for this government account. The contractor shall notify the TMA CRM F&AO, by e-mail, within one business day of the deposit specifying, the date and amount of the deposit, as well as its purpose (i.e., TRS premiums). Premiums for TRS and TRR, when established, may be sent as a single wire as long as CRM is notified of the amounts of each type of premium. Collections for delinquency cases that have been transferred to TMA Office of General Counsel - Appeals, Hearings & Claims Collection Division (OGC-AC) shall be wire-transferred separately. The contractor shall notify TMA CRM F&AO and TMA OGC-AC by e-mail within one business day of the day of deposit, specifying the sponsor name, sponsor Social Security Number (SSN) (last four digits), payment amount, payment date, date case was transferred to TMA OGC-AC and the date and amount of the deposit.

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

## 10.0 DELINQUENT PREMIUMS

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

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

**10.2** The contractor shall terminate collection of delinquent premiums for all other cases within 60 days through an adjustment to the account and issue written notification to the debtor that collection has been terminated. Language for a sample letter is included at [Addendum A, Figure 22.A-1](#). A summary report of all cases terminated shall be provided to the OGC within 30 days following termination of all cases. Such report shall include the sponsor's name, SSN, debt amount, and date closed.

**10.3** The contractor shall be responsible for coordinating with DEERS to ensure coverage dates for all TRS members and/or family members are correct. The coverage dates in DEERS will not be

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

- END -



## 4.1 Purchasing Coverage

To purchase TRR coverage, Retired Reserve members and qualified survivors must complete the prescribed form using the appropriate online web application and submit it, along with an initial payment in the amount of the first two months of premium, within deadlines specified in the following paragraphs. The initial payment may be made with a personal check, cashier's check, money order, or credit/debit card (i.e., Visa/MasterCard). No handwritten TRR requests are to be accepted by the contractor except in accordance with requirements in [paragraph 4.5](#). The contractor shall collect completed TRR requests submitted by mail, **at overseas TRICARE Service Centers (TSCs)**, and by other means determined by the contractor. If a lockout is in place, the contractor may accept the process requests up to 45 days before the end of the 12 month lockout period for new coverage to begin after the 12 month lockout period ends. The contractor shall not process new coverage transactions into DOES unless the initial payment received for the first two months of coverage is the correct amount for the type of coverage purchased. The procedures for determining the effective date of coverage are specified in the following paragraphs.

### 4.1.1 Continuation Coverage

A qualified Retired Reserve member or qualified survivor may purchase TRR coverage with an effective date immediately following the termination of coverage under another TRICARE program. The TRR request required by [paragraph 4.1](#) must be either received **by the MCSC/TOP contractor** or postmarked NLT 30 days after the termination of other TRICARE coverage.

### 4.1.2 Qualifying Life Events

A qualified Retired Reserve member may purchase TRR coverage in connection with a Qualifying Life Event (QLE) that results in a change of family composition. First, qualified members are responsible to report all changes in family composition to military personnel officials with Real-Time Automated Personnel Identification System (RAPIDS) access to appropriately update DEERS. Second, the request form, identifying the QLE required by [paragraph 4.1](#), must be either received **by the MCSC/TOP contractor** or postmarked NLT 60 days after the date of the QLE. The following QLEs are processed through DEERS and are recognized by TRR. The effective date of coverage is the date the QLE occurred (i.e., date of marriage, date of birth, etc.).

- Marriage;
- Birth or adoption of child;
- Placement of a child in the legal custody of the member by an order of the court for a period of at least 12 months;
- Divorce or annulment;
- Death of a spouse, family member, or survivor; or
- Last family member/survivor becomes ineligible (e.g., child ages out).

### 4.1.3 Open Enrollment

A qualified Retired Reserve member or qualified survivor may purchase TRR coverage throughout the year. If the request and premium payment required by [paragraph 4.1](#) are received **by the MCSC/TOP contractor** or postmarked by the last day of the month, the effective date of TRR coverage shall either be the first day of the next month or the first day of the second following month as indicated on the request form.

#### 4.1.4 Survivor Coverage Under TRR

If a Retired Reserve member dies while in a period of TRR coverage, the surviving family members may purchase (or continue) TRR coverage until the date on which the deceased member of the Retired Reserve would have attained age 60. Except for automatic transfers specified in [paragraph 4.1.4.1](#), effective dates and deadlines specified in [paragraphs 4.1.1](#), [4.1.2](#), and [4.1.3](#) apply. Applicable premium rates are specified in [paragraph 2.0](#).

**4.1.4.1** If TRR member-and-family coverage was in effect on the date of the member's death, DEERS will automatically transfer covered family members to TRR survivor coverage with an effective date of the day after the date of death and establish an end-eligibility date in DEERS that is the date on which the deceased member of the Retired Reserve would have attained age 60. The Defense Manpower Data Center (DMDC) will issue letters to survivors advising them of their continued coverage and their option to terminate coverage, if so desired, by completing a TRR request form via the appropriate online web application or in a written letter to the appropriate Managed Care Support Contractor (MCSC). The DMDC generated survivor letter will include instructions on how to obtain a DoD Self-Service Logon (DS Logon) to access the TRR Web Portal or the option to terminate coverage via a written letter.

**4.1.4.2** If TRR member-only coverage was in effect on the date of the member's death, DEERS will terminate coverage with an effective date coinciding with the date of death. Eligible family members may purchase coverage by completing a TRR request. DMDC will issue letters to survivors advising them of the option to purchase coverage.

#### 4.2 Changes In TRR Coverage

Once TRR coverage is in effect, TRR members, which include TRR-covered survivors, may request the following types of changes.

##### 4.2.1 Type of Coverage Changes

A TRR member/survivor may change TRR type of coverage following procedure for a QLE specified in [paragraph 4.1.2](#) or procedures for open enrollment specified in [paragraph 4.1.3](#). The contractor shall follow procedures specified in [paragraph 5.4](#) for premium adjustments resulting from changes in coverage.

##### 4.2.2 Addition of Family Members to TRR Member and Family Coverage

TRR members/survivors may request to add eligible family members to an existing TRR member-and-family coverage plan at any time, once eligibility for the family is established. Eligibility is established by going to a military personnel office with RAPIDS capability to appropriately update DEERS. The effective date of coverage for the added family member(s) shall follow procedures specified in [paragraphs 4.1.2](#) or [4.1.3](#). The TRR request must be either received by **the MCSC/TOP contractor** or postmarked NLT 60 days after that date.

##### 4.2.3 TRR Newborn/New Child Policy

**4.2.3.1** A newborn/new child will be covered from the date of birth/custody only if, (a) the TRR member registers the newborn/new child in DEERS within 60 days of birth/custody, and (b) the TRR

request is either received **by the MCSC/TOP contractor** or postmarked NLT 60 days after the date of birth/custody. The contractor shall handle claims associated with the child as specified in [paragraph 6.2](#). The contractor shall make adjustments in premiums as specified in [paragraph 5.4](#).

**4.2.3.2** TRR members who reside overseas may have difficulty in obtaining the documentation required to register a newborn/new child in DEERS. As with all other late submissions of completed TRR request forms, the member may submit a request for reconsideration to the appropriate TRICARE Regional Director (RD) (or their designee), or the TRICARE Area Office (TAO) Director consistent with [paragraph 4.5.1](#).

### **4.3 Processing**

**4.3.1** The contractor shall process all TRR transactions through DOES for members or survivors with a DEERS residential address in the contractor's jurisdiction. The contractor shall process TRR requests received along with two months premium payment (as required) NLT 10 calendar days after receipt.

**4.3.2** If the contractor is unable to enroll the member/survivor in DOES due to (a) a 90-day future enrollment limitation, (b) DEERS not reflecting eligibility, (c) the application being incomplete, (d) a missing initial premiums payment, or (e) an underpayment of the initial premium payment; the contractor shall return a copy of the original application and any premium payments to the member, within 10 business days, with an explanation of what is needed for the contractor to accept the application for processing.

### **4.4 Termination Of TRR Coverage**

The contractor shall initiate return of any excess premium amounts paid prorated to the day as indicated NLT 10 business days after the effective date of the termination or after receipt of a Policy Notification Transaction (PNT) notifying the contractor of a termination, whichever is later. The contractor shall also update DEERS with any premium amount refunded within 30 calendar days. The contractor shall include an explanation for the premium refund.

#### **4.4.1 Loss of TRR Eligibility**

The effective date of termination for a member or survivor covered under TRR shall be the effective date of the loss of his or her qualification for TRR coverage. No lockout shall be applied for termination due to loss of TRR eligibility.

##### **4.4.1.1 Sponsor Loss of Eligibility**

When a sponsor's eligibility is terminated at a date other than the anticipated end date, DEERS will send the contractor an unsolicited PNT advising the contractor of the terminated coverage. When a sponsor's eligibility is terminated at the anticipated end date, DEERS will not send the contractor an unsolicited PNT advising the contractor of the terminated coverage.

##### **4.4.1.2 Individual Family Member or Survivor Loss of Eligibility**

In the case of a family member or survivor losing eligibility in DEERS, DEERS will send the contractor an unsolicited PNT advising the contractor to terminate coverage for that individual.

When an individual family member's or survivor's eligibility is terminated at the anticipated end date, DEERS will not send the contractor an unsolicited PNT advising the contractor of the terminated coverage. The contractor shall update the fee system based on the terminated coverage for the family member(s) or survivor(s) as appropriate.

#### **4.4.2 Member Gains Other TRICARE Coverage**

No lockout shall be applied for termination due to a gain of other TRICARE coverage.

**4.4.2.1** If a TRR member gains other TRICARE coverage for a period of 30 days or less, TRR coverage will continue unchanged.

**4.4.2.2** If a TRR member or survivor gains other TRICARE coverage for a period of more than 30 days; DEERS will terminate TRR coverage in accordance with [paragraph 4.4.1.1](#). The contractor must be aware of the fact that DEERS may reflect Active Duty Service Member (ADSM) and Active Duty Family Member (ADFM) TRICARE coverage before the service member actually reports for active duty.

**4.4.2.3** If a TRR member gains other TRICARE coverage via a family member, the member and family members may terminate coverage under TRR without incurring a lockout.

#### **4.4.3 Failure to Make Payment**

**4.4.3.1** Failure to pay monthly premiums in accordance with the procedures in this chapter shall result in termination of coverage. The effective date of termination is the paid-through date. The contractor shall automatically terminate coverage of the TRR member, all covered family members and survivors if the monthly premium payment is not received by the last day of the month following the due date for the monthly premium payment. After the last day of the month, the contractor shall terminate coverage with a termination effective date retroactive to the paid-through date. DMDC sends written notification to the beneficiary of the termination and the reason for the termination. Until the termination action is processed, the contractor may pend any claims received for health care furnished to the retired member, family members and/or survivors during the period for which premiums have yet to be paid, to avoid creating recoupment of health care costs for ineligible beneficiaries. The TRR member, family members and/or survivors will be responsible for the cost of any health care received after the termination date following retroactive termination of coverage. If claims are not pended, the contractor shall initiate recoupment of health care costs following the procedures in [Chapter 10, Section 4](#).

**4.4.3.2** A contractor shall apply a TRR purchase lockout to the Retired Reserve member, family members, and/or survivors. The lockout shall be for a period of 12 months from the effective date of termination. The DMDC written notification of termination (see [paragraph 4.4.3.1](#)) includes notice of the 12 month lockout period.

#### **4.4.4 Member/Survivor Request for Voluntary Termination**

##### **4.4.4.1 Termination of Existing Plan(s)**

The contractor shall accept requests for termination of coverage from TRR members/survivors at anytime. The effective date of termination is either (a) the last day of the month in

which the request was postmarked or received by the MCSC/TOP contractor or (b) the last day of a future month as specified in the request given that the request was postmarked or received by the MCSC/TOP contractor in the month preceding the requested month of termination. The contractor shall apply a TRR purchase lockout to all beneficiaries covered by the TRR plan for a period of 12 months from the effective date of terminations initiated by the TRR member or survivor. The DMDC written notification of termination (see [paragraph 4.4.3.1](#)) includes notice of the 12 month lockout period.

#### 4.4.4.2 Termination of an Individual's Coverage

The contractor shall accept requests for termination of coverage for individual family members or survivors from TRR members/survivors at anytime. The effective date of termination is either (a) the last day of the month in which the request was postmarked or received by the MCSC/TOP contractor, or (b) the last day of a future month as specified in the request given that the request was postmarked or received by the MCSC/TOP contractor in month preceding the requested month of termination, or (c) as otherwise specified. The contractor shall apply a TRR purchase lockout to individual family members or survivors whose TRR coverage was terminated upon request for a period of 12 months from the effective date of terminations initiated by the TRR member or survivor. The DMDC written notification of termination (see [paragraph 4.4.3.1](#)) includes notice of the 12 month lockout period.

#### 4.4.4.3 Cancelled Eligibility and Enrollment

When the contractor receives a PNT for a cancelled enrollment, the contractor will generate a letter notifying the covered member/survivor of the cancellation and refund any unused portion of the premium payment. The contractor shall update DEERS with any premium amount refunded within 30 calendar days. No lockout shall be applied for a cancelled enrollment. The contractor shall include an explanation for the premium refund.

#### 4.4.5 TRR Survivor Coverage Termination

If TRR coverage is continued as described in [paragraph 4.1.4.1](#) and the survivors do not wish to keep the coverage, the survivors must submit a request in writing in accordance with procedures described in [paragraph 4.1.4.1](#) for receipt by the contractor NLT 60 days after the date of death in order to terminate coverage retroactive to the day after the member's death and no lockout is applied. Alternatively, the survivor may request to terminate coverage in accordance with [paragraph 4.4.4](#). Otherwise, DEERS will terminate TRR survivor coverage on the date on which the deceased member of the Retired Reserve would have attained age 60. Refunds of premiums will be handled as specified in [paragraph 4.4](#).

### 4.5 Exceptions

#### 4.5.1 Reconsiderations of Member's and Survivor's Actions

The contractor shall advise TRR members/survivors that all reconsideration requests for a (a) refusal of a late submission of a TRR request or (b) lockouts shall be submitted to the appropriate TRICARE RD or their designee or TAO Director for determination. The TRICARE RD or their designee or the TAO Director will issue decisions within 10 calendar days of receipt for all reconsideration requests. If changes are to be made to a member's/survivor's coverage as a result of a

reconsideration determination, the TRICARE RD, or their designee or the TAO Director will send instructions to the contractor. The contractor shall carry out such instructions NLT 10 days after receipt from the TRICARE RD or their designee or TAO Director. The TRICARE RD or their designee, or the TAO Director may authorize an “override” of information contained on DEERS, pending a system update, based on appropriate documentation regarding eligibility under the law, regulation and policy.

#### **4.5.2 Administrative Issues**

The TRICARE RD, or their designee or TAO Director will notify the contractor when the government determines that an administrative situation occurred that prevented a retired member’s or survivor’s request from being accepted for processing according to submission deadlines specified in this section.

### **5.0 PREMIUM COLLECTION**

The contractor shall perform all premium functions required for TRR. Retired Reserve members or survivors are responsible for all premium payments for the type of coverage elected (i.e., TRR member-only or TRR member-and-family). After enrollment, only monthly premium payments are permitted. Premium-related transactions shall be reported through the enrollment fee payment interface or Catastrophic Cap and Deductible (CC&D) Fee Web (see the TSM, [Chapter 3](#)).

#### **5.1 Jurisdiction For Premium Collection**

**5.1.1** The particular contractor servicing the residential address for the TRR member or survivor shall perform premium collection functions for the TRR member or survivor. The contractor shall identify the financially responsible individual for survivor plans from the survivors actually covered by TRR in descending order of precedence:

- Spouse
- Oldest Enrolled Child (or Legal Guardian as applicable)

**5.1.2** Any time the servicing contractor notices that a new residential address is in the servicing area of another TRICARE contractor, the losing contractor shall notify the TRR member or survivor within 10 calendar days that they need to contact the servicing contractor in their new area to transfer their coverage to the new area. A TRR member or survivor may elect to provide an alternate mailing address, but the servicing contractor shall be based on the TRR member’s or financially responsible survivor’s residential, not alternate mailing address. Any TRR member/financially responsible survivor may transfer regions at any time. The gaining contractor shall perform the premium collections for future payments.

**5.1.3** All unsolicited PNTs for TRR members or survivors will be evaluated to determine if residential address changes require a notification to the TRR member or survivor (see [paragraph 5.1.2](#)).

## 5.2 Premium Collection Processes

**5.2.1** The contractor shall credit the TRR member or survivor for premium payments received. In the case of a start date of coverage at anytime other than the first of a month, the first payment collected by the contractor shall include the prorated amount on a daily basis necessary to synchronize billing to the last day of the month. The daily prorated amount shall be equal to 1/30th of the appropriate premium (rounded to the penny) regardless of how many days are actually in the month. DEERS will automatically prorate the premium due for the mid-month enrollments from the effective date of coverage to the end of that first enrollment month, e.g., from the 18th of the month to the 31st.

**5.2.2** The contractor shall collect monthly premium payments from TRR members or survivors as appropriate and shall report the premium amount paid for those payments to DEERS (see the TSM, [Chapter 3](#)), including any overpayments that are not refunded to the TRR member or survivor. In the event that there are insufficient funds to process a premium payment, the contractor may assess the account holder a fee of up to 20 United States (U.S.) dollars (\$20.00). The contractor shall provide commercial payment methods for TRR premiums that best meet the needs of beneficiaries while conforming to [paragraphs 5.2.3](#) through [5.2.8](#).

**5.2.3** Monthly premiums must be paid through an automated, recurring electronic payment through an Electronic Funds Transfer (EFT) or Recurring Credit/Debit Card (RCC) (i.e., Visa/MasterCard) from a designated financial institution. These are the only acceptable payment methods for the recurring monthly premiums. An EFT payment or a RCC payment shall be processed within the first five business days of the month of coverage. The contractor shall advise TRR member or survivors at the time of EFT/RCC election that an insufficient funds fee of up to \$20 U.S. may be assessed, if sufficient funds are not available.

**5.2.4** TRR members or survivors must make the required initial payment (as specified in [paragraph 4.1](#)) at the time the TRR application is submitted to allow time for the EFT/RCC to be established for subsequent monthly premium payments. The contractor shall accept payment of the first installment by personal check, cashier's check, traveler's check, money order, or credit card (e.g., Visa/MasterCard).

**5.2.5** The contractor shall establish recurring monthly EFTs/RCCs and is responsible for obtaining and verifying the information necessary to do so.

**5.2.6** The contractor shall initiate action to modify EFT/RCC payment amounts to support premium changes.

**5.2.7** When an administrative issue arises that stops or prevents an automated monthly payment from being received by the contractor (e.g., incorrect or transposed number provided by the beneficiary, credit card expired, bank account closed, etc.), the contractor shall grant the TRS member or survivor 30 days after the paid-through date to provide information for a new automated monthly payment method. The contractor may accept payment in accordance with [paragraph 4.1](#) during this 30 day period in order to preserve the TRS member's or survivor's enrollment status.

**5.2.8** The contractor shall directly bill the TRR member or survivor only when a problem occurs in setting up or maintaining the EFT or RCC payment; to include a fee of up to \$20 U.S. due to

insufficient funds. Bills may be sent to the residential or alternate mailing address designated by the TRR member or survivor. All bills shall specify that the premium payment is due for receipt by the contractor no later than the first business day of the month for the month of coverage. Premium payments shall be made payable to the contractor servicing the member's or survivor's coverage as specified in [paragraph 5.1](#). The contractor shall terminate billing once the problem with EFT/RCC payment is resolved.

### **5.3 Annual Premium Adjustment**

**5.3.1** Contractors shall notify current TRR members or survivors in writing of any annual premium adjustments NLT 30 days after the contractors receive notification of the updated premiums.

**5.3.2** For premium adjustments that go into effect at any time other than January the first, the government will provide instructions about notification of TRR members or survivors.

### **5.4 Premium Adjustments From Changes Associated With QLEs**

**5.4.1** When a QLE is processed that changes the premium, the effective date of the premium change shall be the date of the QLE.

**5.4.2** If the change from a QLE results in an increase in the premium, the contractor shall notify the TRR member or survivor of the increase and adjust the next premium amount due, to include any underpaid amount (prorated to the day as specified in [paragraph 5.2](#)), to the effective date of the change.

**5.4.3** If the change from a QLE results in a decrease in the premium, the contractor shall retain any overpaid amount and apply it to subsequent electronic payments until all of the overpayment is exhausted.

### **5.5 Terminations**

The contractor shall initiate the process to refund any premium amounts applied for coverage after the date of termination as specified in [paragraph 4.4](#).

### **5.6 Online Transactions**

In addition to requirements specified in [paragraph 5.0](#) and its subordinate paragraphs, the contractor may provide online capability for TRR members or survivors to conduct business related to premium collection and other applicable administrative services through secure access to the contractor's web site.

## **6.0 CLAIMS PROCESSING**

**6.1** The contractor shall process TRR claims under established TRICARE Standard and TRICARE Extra retiree cost-sharing rules and guidance. Normal TRICARE Other Health Insurance (OHI) processing rules apply to TRR.

**6.2** The contractor shall pend all claims for health care provided to a newborn/new child of a TRR member until the member completes the process specified in [paragraph 4.2.3.1](#). If the contractor becomes aware that a TRR member has an unregistered newborn/new child, the contractor shall notify the TRR member of the requirement to register the new child in DEERS and submit a request form for the newborn/new child NLT 60 days after birth/custody. When the member completes the process specified in [paragraph 4.2.3.1](#), the contractor shall process any claims associated with the child's health care. If the member fails to complete the process as specified in [paragraph 4.2.3.1](#), the contractor shall deny any claims associated with the child's health care.

**6.3** Premium payments made for TRR coverage shall not be applied to the fiscal year deductible or catastrophic cap limit.

**6.4** Non-Availability Statement (NAS) requirements shall apply to TRR members, family members, and survivors in the same manner as for retirees under TRICARE Standard/Extra.

**6.5** If a Retired Reserve member purchases TRR coverage during the same calendar year that the member had a TRICARE Reserve Select (TRS) plan in effect, the catastrophic cap, deductibles and cost shares shall not be recalculated.

**6.6** Medicare is the primary payer for TRICARE beneficiaries who are entitled to Medicare. Claims under the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) will be adjudicated under the rules set forth in the TRICARE Reimbursement Manual (TRM), [Chapter 4, Section 4](#). The MCSCs shall follow procedures established in [Chapter 8, Section 2](#) regarding claims jurisdiction for dual-eligibles.

**6.7** If the contractor receives a PNT notifying them of a retroactive TRR disenrollment the contractor shall initiate recoupment of claims paid if appropriate as specified in [Chapter 10](#).

**6.8** If at anytime the contractor discovers that the Retired Reserve member may be eligible for or enrolled in the FEHBP, the contractor shall report the discovery to the appropriate TRICARE RD or their designee or TAO Director NLT one business day after discovery. As applicable, the contractor shall follow [paragraph 4.4.1](#) and its subordinate paragraphs for loss of TRR qualification. If any other actions are to be taken by the contractor as a result of this discovery, the TRICARE RD or their designee or TAO Director will send instructions to the contractor.

## **7.0 BENEFICIARY EDUCATION AND SUPPORT DIVISION (BE&SD)**

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

### **7.1 Customer Education**

**7.1.1** Materials (i.e., public notices, flyers, informational brochures, web site etc.) will be developed and distributed centrally by Department of Defense (DoD), TRICARE Management Activity (TMA), Office of BE&SD. The contractor shall distribute all informational materials associated with the TRR program to the same extent and through the same means as TRICARE Standard materials are distributed. Copies of the TRICARE handbook and other information materials may be obtained through the usual TMA BE&SD process.

**7.1.2** Upon start of coverage under TRR each contractor shall mail one copy of the TRICARE handbook to each first time TRR member's or survivor's household. The TRR member's or survivor's servicing contractor shall send additional handbooks upon request.

## **7.2 Customer Service**

The contractor shall provide all customer service support in a manner equivalent to that provided TRICARE Standard beneficiaries. When the contractor receives an inquiry involving TRR qualifications, the contractor shall refer the individual to the appropriate RC.

## **8.0 ANALYSIS AND REPORTING**

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

## **9.0 PAYMENTS FOR CONTRACTOR SERVICES RENDERED**

### **9.1 Claims Reporting**

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

### **9.2 Fiduciary Responsibilities**

**9.2.1** The contractor shall act as a fiduciary for all funds acquired from TRR premium collections, which are government property. The contractor shall develop strict funds control processes for its collection, retention and transfer of premium funds to the government. All premium collections received by the contractor shall be maintained in accordance with these procedures.

**9.2.2** Either a separate non-interest bearing account shall be established for the collection and disbursement of TRR premiums or the account used for TRS premium collections shall be used for TRR premiums as well. The contractor shall deposit premium collections to the established account within one business day of receipt.

**9.2.3** The contractor shall wire-transfer the premium collections, net of refund payments, monthly to a specified government account as directed by the TMA Contract Resource Management (CRM) Finance and Accounting Office (F&AO). The government will provide the contractor with information for this government account. The contractor shall notify the TMA CRM F&AO, by e-mail, within one business day of the deposit, specifying the date and amount of the deposit as well as its purpose (i.e. TRR premiums). Premiums for TRS and TRR may be sent as a single wire as long as CRM is notified of the amounts of each type of premium. Collections for delinquency cases that have been transferred to TMA Office of General Counsel-Appeals, Hearings & Claims collection Division (OGC-AC) shall be wire-transferred separately. The contractor shall notify TMA CRM F&AO and TMA OGC-AC by e-mail within one business day of the day of deposit, specifying the sponsor name, sponsor Social Security Number (SSN) (last four digits), payment amount, payment date, date case was transferred to TMA OGC-AC and the date and amount of the deposit.

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

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

- END -



## Administration

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### 1.0 GENERAL

All TRICARE requirements regarding administration shall apply to the TRICARE Overseas Program (TOP) unless specifically changed, waived, or superseded by this section; the TRICARE Policy Manual (TPM), [Chapter 12](#); or the TRICARE contract for health care support services outside the 50 United States and the District of Columbia (hereinafter referred to as the "TOP contract"). See [Chapter 1](#) for additional instructions regarding administration. Specific health care support services required for the performance of this contract are identified in this chapter, in the TPM, [Chapter 12](#), and the TOP contract.

### 2.0 CONTRACT ADMINISTRATION AND INSTRUCTIONS TO CONTRACTOR

**2.1** The provisions of [Chapter 1, Section 2](#) are applicable to the TOP. Additionally, the TOP contractor shall coordinate with the TRICARE Management Activity (TMA) Contracting Officer (CO), the appropriate TMA Contracting Officer Representative (COR), and the appropriate TRICARE Area Office (TAO) Director on any TOP policy or contractual issue that requires additional government clarification or assistance to resolve.

**2.2** The provisions of [Chapter 1, Section 2, paragraph 4.0](#) are superseded as described in [paragraphs 2.2.1](#) through [2.2.3](#).

**2.2.1** A 14 calendar day notice will be provided by the TMA Procurement Contracting Officer (PCO) for all meetings hosted by TMA.

**2.2.2** The TOP contractor shall provide annual representation at two contractor conferences (senior management level) and one Host Nation Provider Representative meeting at TMA. The contractor shall also provide up to four contractor representatives at up to four additional meetings at the direction of the CO per contract year.

**2.2.3** The TOP contractor shall provide representation at quarterly TOP roundtable meetings to be held at TMA-Falls Church with TAO representation.

### 3.0 TRICARE PROCESSING STANDARDS

**3.1** See [Chapter 1, Section 3](#) for instructions regarding TRICARE processing standards.

**3.2** The provisions of [Chapter 1, Section 3, paragraph 3.4.2](#) are not applicable to the TOP contract since there is no requirement in that contract for a dedicated Behavioral Health (BH) provider locator and assistance service.

## **4.0 MANAGEMENT**

The provisions of [Chapter 1, Section 4](#) are applicable to the TOP, except that the provisions of [Chapter 1, Section 4, paragraph 2.3](#) regarding zip code files are only applicable to Puerto Rico.

## **5.0 COMPLIANCE WITH FEDERAL STATUTES**

See [Chapter 1, Section 5](#) for instructions regarding compliance with Federal statutes.

## **6.0 LEGAL MATTERS**

See [Chapter 1, Section 6](#) for instructions regarding legal matters.

## **7.0 TRANSITIONS -- CONTRACT PHASE-IN**

### **7.1 Start-Up Plan**

The provisions of [Chapter 1, Section 7, paragraph 1.1](#) are applicable to the TOP, except that the contractor's comprehensive start-up plan shall be submitted with their contract proposal (instead of 10 calendar days following contract award). A revised start-up plan shall be submitted within 15 calendar days following the interface meetings.

### **7.2 Transition Specifications Meeting**

See [Chapter 1, Section 7, paragraph 1.2](#) for instructions regarding transition specification meeting(s). Separate meetings may be scheduled with each outgoing TOP contractor.

### **7.3 Interface Meetings**

The provisions of [Chapter 1, Section 7, paragraph 1.3](#) are applicable to the TOP, except that the requirement for interface meeting(s) with the outgoing Managed Care Support Contractor (MCSC) is replaced with a requirement for interface meetings with all outgoing overseas contractors. This includes the outgoing South Region MCSC (and its subcontractor for overseas claims processing), the outgoing TRICARE Global Remote Overseas (TGRO) contractor, the outgoing TRICARE Puerto Rico contractor, and all outgoing TAO regional enrollment/marketing contractors.

## **8.0 TRANSITIONS -- START-UP REQUIREMENTS**

**8.1** See [Chapter 1, Section 7, paragraphs 2.1, 2.2, and 2.3](#) for instructions regarding start-up requirements. For purposes of TOP implementation, all references to TRICARE Prime in [paragraph 2.2](#) shall apply to TOP Prime and TOP Prime Remote.

**8.2** Within 30 calendar days following contract award, all Military Treatment Facilities (MTFs) shall provide the TOP contractor with the names and addresses of host nation providers/facilities in the MTF's Preferred Provider Network (PPN). The TOP contractor is not required to duplicate existing networks.

## Beneficiary Education And Support Division (BE&SD)

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### 1.0 GENERAL

**1.1** All TRICARE requirements regarding BE&SD shall apply to the TRICARE Overseas Program (TOP) unless specifically changed, waived, or superseded by the provisions of this section; the TRICARE Policy Manual (TPM), [Chapter 12](#); or the TRICARE contract for health care support services outside the 50 United States and the District of Columbia (hereinafter referred to as the "TOP contract"). See [Chapter 11](#) for additional instructions.

**1.2** Per Department of Defense Instruction (DoDI 6010.21 ("TRICARE Marketing Policy") dated December 18, 2001, TRICARE marketing materials developed by contractors must be coordinated with appropriate Regional Director (RD) and approved by TRICARE Management Activity (TMA). For the TOP contract, this coordination includes the TRICARE Area Office (TAO) Directors. Coordination of local administrative changes is at the local discretion of Military Treatment Facilities (MTFs).

### 2.0 TRICARE SERVICE CENTERS (TSCs)

#### 2.1 Location, Operations, And Staffing

**2.1.1** TSCs are jointly staffed by MTF personnel and TOP contractor personnel. TSCs in the MTFs shall be staffed at a minimum, Monday - Friday (except holidays recognized by the installation) during the administrative hours of the MTF.

**2.1.2** Contractor personnel, the Beneficiary Service Representatives (BSRs), shall be on a full-time basis and qualified to perform all functions of the TSC. The TOP contractor shall implement appropriate business processes to provide full-time TSC coverage if the assigned BSR(s) are unavailable due to planned or unplanned absences (e.g., illness, leave, personal emergencies, etc.) for more than two consecutive business days. Local processes for managing short-term BSR absences (up to two consecutive business days) shall be addressed in the Memorandum of Understanding (MOU) between the affected MTF commander(s) and the TOP contractor.

**2.1.3** The TSC shall meet the standards in [Chapter 1, Section 3](#), as applicable.

#### 2.2 TSC Functions

**2.2.1** The contractor shall establish TSCs to provide all Military Health System (MHS) beneficiaries with information and services as specified below. The contractor shall ensure eligibility for care and enrollment status of beneficiaries before making any arrangements for medical services. (Eligibility for the non-active duty patients is determined by the MTF per [Section 26, paragraph 2.4.4](#).) TSCs shall have an interface with the automated claims processing and enrollment systems to support the functions of the TSC No Later Than (NLT) 30 calendar days prior to the start of the health care delivery.

**2.2.2** The contractor shall establish TSCs that provide all MHS beneficiaries with TOP Prime and TOP Prime Remote enrollment information, access to and referral for care, information on the Point of Service (POS) option, information (including on-line access to the claims processing system for information about the status of a claim), assist beneficiaries with claim problems when the TOP contractor is responsible for processing the claim and continuity-of-care services to all MHS beneficiaries including, but not limited to, active duty personnel, dependents of active duty personnel, retirees and their dependents, survivors, Medicare-eligible beneficiaries and all other categories of individuals eligible to receive MHS services. TSCs shall have a fully operational, on-line interface with the automated claims processing and enrollment systems to support the functions of the TSC NLT 30 calendar days prior to the start of the health care delivery and shall maintain that interface through the life of the contract. The activities of the TSC shall include:

**2.2.2.1 MHS Beneficiary Information**

TSCs shall provide personal assistance to all MHS beneficiaries seeking information about TRICARE Prime, TRICARE Standard, and TRICARE For Life (TFL). The TOP contractor shall ensure that the TSCs are supplied with enrollment and educational information for TRICARE Prime and TRICARE Standard, dual-eligible program and claims submission information, Civilian Health and Medical Program of the Department of Veteran Affairs (CHAMPVA), TRICARE dental programs and all other relevant materials. Through the TSCs, the TOP contractor shall establish mechanisms to advise beneficiaries of care options, including the POS option, and services offered.

**2.2.2.2 Continuity Of Care**

TSCs shall act as the focal point for providing information, referral, and assistance to beneficiaries seeking access to TRICARE services. The contractor personnel located in the TSCs shall maintain day-to-day liaison with MTF officials to promote MTF optimization and ensure effective performance of the access, referral, information, and continuity of care functions.

**2.2.2.3 Enrollment**

Contractor staff in the TSCs shall provide personal assistance to eligible beneficiaries, electing to enroll or disenroll, and permanently assigned active duty personnel enrolling in TRICARE Prime. The TSC shall provide assistance to all MHS beneficiaries, including active duty, Medicare eligibles, and others, in understanding program requirements, by answering questions, adhering to MTF Commanders' and RDs' determinations for Primary Care Manager (PCM) assignment, and following grievance and inquiry procedures in accordance with this manual.

**2.2.2.4 Providers**

TSCs shall maintain up-to-date lists of the providers in the contractor's network. MTF commanders, RDs, and MHS beneficiaries shall be granted access to these lists on an as-needed basis. Contractor staff in the TSCs shall provide lists of Direct Care (DC) PCMs to RDs and MHS beneficiaries when required for PCM selection, if these lists are provided to the contractor staff in the TSC by the MTF.

**2.2.2.5 Claims**

Contractor staff in the TSCs shall assist all TRICARE beneficiaries with all claims issues

when the TOP contractor is responsible for processing the claim. When the TOP contractor is not responsible for processing the claim, the contractor staff in the TSC shall assist the beneficiary in identifying and contacting the organization that is responsible for processing the claim.

#### **2.2.2.6 TRICARE Dental Plans**

Contractor staff in the TSCs shall provide general information on eligibility for the TRICARE Dental Plans (Active Duty Dental Program (ADDP), TRICARE Dental Program (TDP), and TRICARE Retired Dental Program (TRDP)) and how to obtain dental plan information from the appropriate dental contractor. The beneficiaries shall be referred to the appropriate dental contractor for additional information.

### **2.3 Creating And Updating Department of Defense (DoD) Self-Service Logon (DS Logon) Accounts**

DoD affiliates and Department of Veterans Affairs (DVA) affiliates qualify for a DS Logon account. A DS Logon is a secure, self-service logon ID that allows DoD/DVA affiliates to access certain web sites using a single username and password. DoD/DVA affiliates are DoD sponsors, spouses (regardless of age), and dependents (18 and older), and retirees and veterans who have an active affiliation in the Defense Enrollment Eligibility Reporting System (DEERS), which includes Reserve Component (RC) sponsors (including all subcomponents such as the Selected Reserve, Retired Reserve, Individual Ready Reserve (IRR), and Standby Reserve) along with their spouses, and dependents (18 and older). The DoD Self-Service Access Station (DS Access Station) is an online web application developed by the Defense Manpower Data Center (DMDC) for the purpose of creating DS Logon account requests on behalf of DoD/DVA affiliates. When a beneficiary inquiry concerns the DS Logon, the contractor shall refer the caller to the DoD MyAccessCenter application help section at <https://myaccess.dmdc.osd.mil/>.

#### **2.3.1 DS Access Station**

Upon request by DoD/DVA affiliates, TSC personnel shall use the DS Access Station and perform In-Person Proofing (IPP) to generate requests for DMDC to create and update DS Logon accounts following instructions specified in the current version of the DS Logon - Access Station User Guide. DS Access Station is currently available at <https://www.dmdc.osd.mil/appj/dsaccessstation/>. The contractor shall request DS Access Station user authorization for TSC personnel from DMDC through the contractor's DEERS site security manager. A copy of the current DS Logon - Access Station User Guide will be provided upon request.

#### **2.3.2 DS Logon Account Levels**

Two account levels of DS Logon access are available to DoD/DVA affiliates, each with progressing security features and each with a different user-authentication procedure:

##### **2.3.2.1 Basic Account (Level 1)**

This is an entry level user account established online that only provides limited view access to the user's personal information that the user has provided online. This level of account is provided to individuals who have registered online at the eBenefits web site (<http://www.ebenefits.va.gov>) without being in-person proofed. Many applications will not allow access

with a Basic (Level 1) Account.

### **2.3.2.2 Premium Account (Level 2)**

This account is given to a DoD/DVA affiliate who has self-registered using their Common Access Card (CAC) or Defense Financing and Accounting Service (DFAS)/myPay Login ID or who has completed an IPP process with designated representatives such as TSC personnel. To provide enhanced security to the user's personal information, access to most applications including TRICARE-related applications require a Premium (Level 2) Account.

### **2.3.3 Generating DS Logon Requests**

**2.3.3.1** Before generating a request for a Premium Account, TSC personnel shall determine if the requestor has an existing Basic Account. If they do, TSC personnel shall follow DS Logon user guide instructions to generate a request to upgrade the Basic Account to a Premium Account. Upon successful completion of an upgrade, the Premium Account is immediately available for use.

**2.3.3.2** If a Premium Account is created outright rather than being upgraded from a Basic Account, the Premium Account will not be effective and available for use until the requestor receives a letter in postal mail from DMDC and follows the instructions in the letter before the specified deadline to activate the Premium Account. If the requestor does not have an existing Basic Account, TSC personnel shall inform the requestor of the advantages of establishing a Basic Account and provide the requestor with the procedures for obtaining a Basic Account. If the requestor does not wish to create a Basic Account first, TSC personnel shall proceed with the procedures for a new DS Logon request.

### **2.3.4 DS Access Station Users and Confidentiality**

Only users authorized by the DMDC may access the DS Access Station and perform IPP. Furthermore, only authorized DS Access Station users may view any documents presented for IPP or be informed in any way of information available in the DS Access Station. Every authorized user must safeguard the confidentiality of such information at all times to comply with the Privacy Act of 1974. The contractor shall return all documents presented for IPP to the requester and shall not retain any documents. The contractor shall not make photocopies or any other images of documents presented for IPP.

## **3.0 HEALTH CARE FINDER (HCF) SERVICES**

**3.1** TOP HCF functions are performed by TOP contractor personnel located in the TSCs or in contractor-operated call center(s). The TOP contractor shall offer call center operations to support HCF services via toll-free lines 24 hours per day, seven days per week, 365 days per year.

**Note:** The contractor must also offer claims assistance via toll-free lines seven days per week, 365 days per year, between the hours of 2:00 AM and 7:00 PM Central Standard Time (CST). These service hours for claims assistance apply even if claims assistance is provided via the contractor's call center(s).

**3.1.1** HCFs (including MTF/contractor personnel and call centers) are responsible for facilitating access to host nation provider care (including, but not limited to primary care, specialty

care, mental health care, ancillary services, Durable Medical Equipment (DME), and pharmacy services), and for authorizing certain health care services. Additionally, HCFs shall inform beneficiaries of access mechanisms, referral procedures, and rules regarding use of host nation TOP network/non-network providers. They shall also improve patient continuity of care by establishing mechanisms to facilitate necessary consultations, follow-up appointments and the sharing of medical records. TOP HCFs will serve all MHS beneficiaries in the region, regardless of their enrollment status. This includes dual-eligible beneficiaries and beneficiaries residing or enrolled in the 50 United States and the District of Columbia who may require assistance when accessing care in an overseas location.

**3.1.2** For MTF enrollees, the specialty care referral process includes a covered benefit review; entering appropriate authorizations into the contractor's system; locating a qualified network or non-network host nation provider to provide the care on a cashless, claimless basis; providing the beneficiary with a written care authorization and the host nation provider's information; and assisting the beneficiary with establishing an appointment with the host nation provider (upon beneficiary request). The contractor shall also provide information to MTF personnel regarding the status of specialty care referrals and shall work cooperatively with the MTF to assist in obtaining consult results from host nation providers; however, the contractor is not responsible for tracking receipt of consult results.

**3.1.3** For TOP Prime Remote enrollees, the specialty care referral process includes a medical necessity review; a covered benefit review; entering appropriate authorizations into the contractor's system; locating a qualified network or non-network host nation provider to provide the care on a cashless, claimless basis; providing the beneficiary with a written care authorization and the host nation provider's information; and assisting the beneficiary with establishing an appointment with the host nation provider (upon beneficiary request). This process is also applicable to Active Duty Service Members (ADSMs) who are on Temporary Additional Duty/ Temporary Duty (TAD/TDY), in an authorized leave status, or deployed/deployed on liberty in a remote overseas location, and to TRICARE Prime/TRICARE Prime Remote (TPR) enrollees who require urgent specialty care while traveling outside the 50 United States and the District of Columbia.

**3.1.4** Beneficiaries enrolled to the Uniformed Services Family Health Plan (USFHP) and the Continued Health Care Benefit Program (CHCBP) must follow the requirements of those programs when obtaining overseas care.

**3.2** The TOP HCF is responsible for the following functions:

**3.2.1 Referral Assistance for TOP Beneficiaries**

The TOP contractor (working in concert with the MTF Commander) is required to ensure optimal use of MTFs and to foster coordination of all care delivered in the civilian sector and care referred to and from the MTF. The TOP HCF is the primary mechanism for achieving these objectives. The referral services of the TOP HCF are primarily to ensure access to care for enrolled beneficiaries, but the TOP HCF is also available to assist non-enrollees in finding network/non-network host nation providers. For TOP Prime/TOP Prime Remote enrollees, the referral is generally initiated by the beneficiary's PCM. The PCM or beneficiary contacts the TOP HCF for assistance in locating an appropriate host nation provider and to obtain authorization for the care (see [Sections 17](#) and [18](#) for additional information on HCF referral assistance).

### **3.2.2 Referral Assistance for Beneficiaries Enrolled or Residing in the 50 United States and the District of Columbia**

The TOP contractor shall provide referral assistance for TRICARE Prime/TPR enrollees who require urgent or emergent health care while traveling outside the 50 United States and the District of Columbia. These referrals will generally be initiated by the beneficiary, a host nation provider, or an overseas MTF provider. Emergency care never requires preauthorization; however, ADFMs enrolled to TRICARE Prime/TPR may receive urgent and emergency health care services in locations outside the 50 United States and the District of Columbia (to include emergency medical evacuation per [Section 7](#)) on a cashless, claimless basis if the care is coordinated in advance with the TOP contractor. The TOP contractor shall implement guarantee of payment or other business processes to ensure that ADFMs enrolled to TRICARE Prime/TPR may receive urgent or emergency medical services on a cashless, claimless basis upon beneficiary request.

### **3.2.3 Authorizations**

**3.2.3.1** The TOP HCF will authorize care for TPR enrollees; for ADSMs who are on TAD/TDY, in an authorized leave status, or deployed, deployed on liberty in a remote overseas location, and for TRICARE Prime/TPR enrollees who require urgent or emergent health care while traveling outside the 50 United States and the District of Columbia. The contractor shall also ensure that MTF-issued authorizations are entered into all applicable contractor systems. Non-emergent specialty health care received from a host nation provider must be authorized if benefits are to be paid as TOP Prime/TPR.

**3.2.3.2** Care subject to a PCM referral/authorization/Non-Availability Statement (NAS) may receive a clinical review and authorization by the HCF or other designee.

**3.2.4** If an ADFM TOP Prime/TOP Prime Remote enrollee receives care that was not authorized, the care may be covered under the TOP POS option, with POS deductibles and cost-shares. POS provisions also apply to TRICARE Prime/TPR enrollees who receive non-emergency care outside the 50 United States and the District of Columbia without obtaining prior authorization from the TOP contractor. The care must also be otherwise coverable under TRICARE or the claim shall be denied.

**3.2.5** ADSM care that was not referred and authorized may be denied unless it is retroactively authorized by the appropriate service or TAO personnel. POS does not apply to ADSMs.

## **4.0 CUSTOMER SERVICE RESPONSIBILITIES**

TOP customer support shall be provided to TOP RD and TAO staffs, TOP host nation providers, TOP beneficiaries, designated POCs, TOP MTF staffs including Health Benefit Advisors (HBAs)/Beneficiary Counseling and Assistance Coordinators (BCACs)/Debt Collection Assistance Officers (DCAOs), stateside TRICARE Regional Offices (TROs), stateside Managed Care Support Contractors (MCSCs), stateside TRICARE beneficiaries traveling overseas, claims processing contractors, and TMA. TOP contractor customer support service shall include the following:

**4.1** The TOP contractor shall secure at a minimum one dedicated post office box for the receipt of all claims and correspondence from foreign locations per overseas region.

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### Chapter 24, Section 11

#### Beneficiary Education And Support Division (BE&SD)

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**4.2** The TOP contractor shall identify a specific individual and an alternate to assist the TOP RD, TAO Directors, TMA, BCACs and stateside claims processing contractors with the resolution of TOP issues. Issues which cannot be successfully resolved shall be referred to the TOP Contracting Officer's Representative (COR).

**4.3** The TOP contractor shall identify a specific individual and an alternate to assist DCAOs with the resolution of TOP beneficiary debt collection issues.

**4.4** The TOP contractor shall be responsible for establishing and operating a dedicated TRICARE overseas claims/correspondence processing department with a dedicated staff. This department and staff shall be under the direction of a supervisor, who shall function as the contractor's POC for TRICARE overseas claims and related operational and support services. The contractor's department for TRICARE overseas claims shall include at a minimum the following functions/requirements:

**4.4.1** The TOP contractor shall provide toll-free telephone service for claims assistance to TOP beneficiaries and providers seven days a week, 365 days a year, between the hours of 2:00 AM and 7:00 PM CST. Toll-free services must be available from any stateside or overseas location.

**4.4.2** The TOP contractor shall have the ability to translate claims submitted in a foreign language and write in German, Italian, Japanese, Korean, Tagalog (Filipino) and Spanish, or shall have the ability to obtain such translation or writing.

**4.4.3** The TOP contractor shall provide on-line read only access to their claims processing system to the TOP RD, each TOP TAO Director, and the TMA technical representative for TOP claims.

**4.4.4** The TOP contractor shall provide a secure, user-friendly internet portal for receipt of customer claims status inquiries and access to claims status information (to include the ability to view and print Explanation of Benefits (EOBs)).

**4.4.5** The TOP contractor is required to provide, upon TMA or TAO Director request, documentation of claims for auditing purposes.

**4.5** The TOP contractor is required to assist traveling TOP beneficiaries to ensure beneficiary access/receipt of urgent or emergent care in the 50 United States and the District of Columbia. The contractor shall also assist beneficiaries residing or enrolled in the United States or the District of Columbia who require urgent or emergent care while traveling overseas. ADFMs who are enrolled to TRICARE Prime or TPR may receive emergency medical services in locations outside the 50 United States and the District of Columbia (to include emergency medical evacuation) on a cashless, claimless basis if the care is coordinated in advance with the TOP contractor.

**4.6** The contractor shall refer beneficiary, provider, HBAs, and congressional inquiries not related to claims status to TMA Chief, BE&SD.

## **5.0 BENEFICIARY SERVICES**

**5.1** The TOP contractor shall achieve the highest level of beneficiary satisfaction possible in the overseas environment. This shall be accomplished by developing qualified host nation provider networks (complemented by non-network host nation providers as necessary), ensuring timely

access to host nation care, providing TOP information/education/training to beneficiaries and host nation providers, and processing claims in a timely, accurate manner.

**5.2** In addition to the beneficiary education requirements outlined in [Chapter 11, Sections 1 and 2](#), the TOP contractor may be required to conduct beneficiary education/enrollment activities for arriving/deploying units in accordance with the enrollment protocols established in the MOU between the TOP contractor and the MTFs.

**5.3** In addition to the requirements outlined in [Chapter 11, Section 2](#), all beneficiary satisfaction activities (including beneficiary surveys conducted in accordance with [Chapter 11, Section 2](#)) shall be coordinated with the three TAOs to achieve a coordinated, uniform approach to Department of Defense (DoD) customer services overseas.

**5.4** The TOP contractor shall maintain up-to-date lists of host nation network providers, and shall make this information available at all TOP TSCs and via web-based access. Web-based network provider listings shall include information regarding authorization requirements that are applicable to TOP enrollees.

**5.5** The TOP contractor's beneficiary education plan shall address their process for educating TOP beneficiaries regarding care received in the 50 United States and the District of Columbia. At a minimum, this process shall include information regarding referrals/authorizations while stateside, TOP POS policy, and the recommended process for accessing care while stateside. TOP beneficiaries traveling stateside shall be encouraged to utilize MTF care whenever possible. If MTF care is not available, beneficiaries should be encouraged to seek care from a network provider before obtaining care from a non-network provider.

**5.6** The requirement for a quarterly three-day TRICARE training course, as outlined in [Chapter 11, Section 2, paragraph 1.1](#), is superseded for the TOP contractor by a requirement for a total of nine three-day TRICARE training courses per contract option period (two per option period within the TRICARE Eurasia-Africa area; two within the TRICARE Pacific area; two within the TRICARE Latin America/Canada (TLAC) area; and three additional courses that may occur in any stateside or overseas location at the direction of the Contracting Officer (CO)).

**Note:** Only the frequency requirements of [Chapter 11, Section 2, paragraph 1.1](#) are superseded; all other requirements of the referenced paragraph apply to the TOP contractor.

**5.7** The requirement for mailing TRICARE handbooks, as outlined in [Chapter 11, Section 1, paragraph 4.1](#), is superseded for the TOP contractor by a requirement for "on-demand" processes for distributing TRICARE handbooks upon beneficiary request (including, at a minimum, web-based requests, telephone requests, and on-site requests at a TSC).

## **6.0 PROVIDER SERVICES**

**6.1** The TOP contractor shall ensure that all host nation network providers and their support staff have sufficient understanding of the applicable TRICARE program requirements, policies, and procedures to allow them to carry out the requirements of this contract in an efficient and effective manner that promotes beneficiary satisfaction.

**6.2** The TOP contractor shall have the responsibility for developing and delivering TRICARE Program information to host nation providers. The contractor shall determine the requirements for printed products and will develop and deliver these products after obtaining approval from the government. The information in these products will generally be determined by the contractor based on their understanding of the needs of their network providers; however, the government may mandate the inclusion of certain topics or information.

**6.3** Provider education materials shall include information regarding claims processing procedures, claims submission deadlines, and normal claims processing time lines.

**6.4** The government shall ensure provider satisfaction with contractor-provided information by conducting random satisfaction surveys of select network providers.

## **7.0 GRIEVANCES AND GRIEVANCE PROCESSING**

The TOP contractor shall process all grievances related to contractor personnel or contractor actions. The contractor shall also process all grievances related to network or non-network host nation providers or institutions, with a copy provided to the TMA COR and the appropriate TAO.

- END -



- Is not otherwise eligible for care under Chapter 55, 10 USC or Chapter 58, 10 USC Section 1145(a), TAMP; and
- Is not a member of the uniformed services.

### 3.2 Eligibility Of Uniformed Service Sponsor

**3.2.1** Eligibility for TYA is only determined by a proper eligibility response in DEERS. Based on the status of the uniformed service sponsor, the ability to purchase may be limited or not allowed based on the uniformed service sponsor's status and eligibility for medical care under Chapter 55, 10 USC or Chapter 58, 10 USC Section 1145(a). **In addition, young adult dependents must meet all other qualifications shown in paragraph 3.1.**

**3.2.2** Young adult dependents of active duty members (including those called to active duty for more than 30 days) **may qualify** to purchase TYA coverage until the active duty sponsor's date of separation or reaching the age of 26, whichever comes first. Upon the death of an active duty sponsor, dependents eligible for Transitional Survivor coverage may **qualify to** purchase TYA coverage up to the age of 26.

**3.2.3** Young adult dependents of retired **uniformed service sponsors may qualify** to purchase TYA coverage until they reach the age of 26.

**3.2.4** Young adult dependents of uniformed **service** sponsors eligible to purchase TRS or TRICARE Retired Reserve (TRR) are **may qualify** to purchase TYA coverage **only** if the sponsor is enrolled in TRS or TRR. Failure of the uniformed service sponsor to enroll in and maintain enrollment in TRS or TRR or failure to pay TRS or TRR premiums will result in the young adult dependent not being eligible to purchase TYA coverage as of the date of the sponsor's loss of enrollment in TRS or TRR.

**3.2.5** If the Selected Reserve sponsor dies while enrolled in TRS, the young adult dependent **may qualify** to purchase TYA coverage for six months after the date of death of the Selected Reserve sponsor, or until the young adult dependent reaches the age of 26, whichever comes first.

**3.2.6** Young adult dependents of a member of the Retired Reserve, who dies while in a period of TRR coverage, **may qualify** to purchase new or continue existing TYA coverage until the young adult dependent reaches the age of 26. If a member of the Retired Reserve is not covered by TRR on the date of his or her death, his or her surviving dependents do not qualify for TYA coverage until the date on which the deceased member of the Retired Reserve would have attained age 60, at which time they may purchase TYA coverage until reaching the age of 26.

### 4.0 COVERAGE-RELATED PROCEDURES

The contractor shall process coverage-related transactions through the Web Defense Online Enrollment System (**Web DOES**) (TSM, [Chapter 3, Section 1.4](#)). Premium-related transactions shall be reported through the enrollment fee payment interface (see the TSM, [Chapter 3, Section 1.4](#)). The contractor shall perform all premium functions in accordance with [paragraph 5.0](#) and its subordinate paragraphs. The TRICARE Overseas Program (TOP) contractor shall perform these services for young adult dependents residing outside of the 50 United States or the District of Columbia. See the TSM, [Chapter 2, Addendum L](#), for a full list of TYA Health Care Delivery Program

(HCDP) Coverage Code Values.

#### 4.1 Purchasing Coverage

To purchase TYA coverage, young adult dependents may either complete the prescribed paper application or use the Beneficiary Web Enrollment (BWE) application (<http://www.dmdc.osd.mil/appj/bwe/>) and submit it, along with at least an initial payment of three months worth of premiums for either TYA Standard/Extra (see [paragraph 4.1.3](#) for additional retroactive coverage rules) or TYA Prime coverage, within deadlines specified in the following paragraphs. (For enrollments effective on or after October 1, 2012, the initial payment required is two months of premium.) Initially only a fillable form will be available via the BWE tool. Young adult dependents have the option of completing the form online, printing it, and mailing the completed application form. The contractor shall collect completed TYA applications by mail and/or by other means determined by the contractor. If a qualified young adult dependent would like to change coverage from TYA Standard/Extra to TYA Prime, a separate application form must be submitted. TYA application forms submitted before the CO directed effective start date for TYA Prime coverage will be processed as TYA Standard/Extra coverage. If TYA Prime coverage is still desired, the young adult dependent must submit another TYA application form to request Prime coverage when available. If an enrollment lockout is in place (see [paragraph 4.3.2](#)), the contractor may accept and process requests up to 45 days before the end of the 12 month lockout period for new coverage to begin after the 12 month lockout period ends. The contractor shall not process new coverage transactions into Web DOES unless the initial payment received, if eligible, is the correct amount for the type of coverage purchased. The procedures for determining the effective date of coverage are specified in the following paragraphs.

##### 4.1.1 Open Enrollment

A qualified young adult dependent may purchase TYA coverage throughout the year unless locked out from TYA coverage.

###### 4.1.1.1 TYA Standard/Extra Plans

**4.1.1.1.1** The effective date of TYA Standard/Extra coverage shall be the first day of the next month, or the first day of the month requested up to 90 days in the future, provided the request and premium payment required by [paragraph 4.1](#) are received **by the MCSC/TOP contractor** or postmarked by the last day of the month.

**4.1.1.1.2** For applications with a TYA effective date starting on or before May 1, 2011, the contractors shall extend the TYA application deadline until May 31, 2011. For TYA applications received on or after June 1, 2011, [paragraph 4.1.1.1.1](#) will be followed.

###### 4.1.1.2 TYA Prime Plans

**4.1.1.2.1** TYA Prime effective dates will be determined in accordance with [Chapter 6, Section 1, paragraph 4.1.2](#).

**4.1.1.2.2** Young adult dependents may qualify to purchase TOP Prime or TOP Prime Remote plan coverage (see [Chapter 24, Section 5](#)).

#### **4.1.2 Continuation Coverage**

A young adult dependent may purchase TYA coverage with an effective date immediately following the termination of coverage under another TRICARE program, including the CHCBP. The TYA application required by [paragraph 4.1](#) along with an initial payment (see [paragraph 4.1](#)) of premiums, must either be received by the MCSC/TOP contractor, entered into the BWE application, or postmarked NLT 30 days following termination of coverage. See [paragraph 10.0](#) and the TRICARE Policy Manual (TPM), [Chapter 10, Section 4.1](#), for information regarding termination of CHCBP coverage and refund of CHCBP premiums. If the young adult dependent does not meet the requirement for continuation or retroactive coverage, the application will be processed as a new application. If the young adult dependent does not meet the requirement for continuation or retroactive coverage, the application will be processed as an open enrollment application.

#### **4.1.3 Retroactive TYA Standard/Extra Coverage**

A qualified young adult dependent may elect retroactive TYA Standard/Extra coverage effective as of January 1, 2011, if the dependent was eligible as of that date. If retroactive coverage is elected, TYA Standard/Extra premiums must be paid for the time period between January 1, 2011, and the date of the election, along with at least the initial payment (see [paragraph 4.1](#)) of prospective premiums, or as eligible. If retroactive coverage is requested but the young adult dependent was not eligible for TYA Standard/Extra coverage on January 1, 2011, then the date the young adult dependent became eligible for TYA Standard/Extra coverage shall be used as the coverage effective date. Premiums are to be prorated as necessary for the time period between the coverage effective date and the date of election, which includes at least the initial months of prospective coverage, or as eligible. No purchase of retroactive coverage may take place after September 30, 2011. Retroactive coverage is limited to the TYA Standard/Extra benefit only. See [paragraph 10.0](#) and the TPM, [Chapter 10, Section 4.1](#), for information regarding termination of CHCBP coverage and refund of CHCBP premiums.

#### **4.1.4 Changing Coverage Within Same Contractor**

**4.1.4.1** Upon receipt of an application, qualified dependents already enrolled in a TYA plan and who are current in their premium payments may elect to change to another TYA plan for which the qualified dependent is eligible based on the sponsor's eligibility and the geographic location of the qualified young adult dependent. Changes in coverage are effective following the application processing time frames listed in [paragraph 4.1.1](#).

**4.1.4.2** If the premium amount changes, the contractor will adjust future premiums by applying any overages to future TYA premium payments, and adjusting the Electronic Funds Transfer/Recurring Credit/Debit Charge (EFT/RCC) payments so the young adult dependent is not over or undercharged for the coverage requested.

#### **4.1.5 Transfer of Coverage to Another Contractor**

Young adult dependents desiring to transfer TYA coverage to another contractor must submit a new application to the desired contractor. Transfer of TYA coverage to another contractor is only permitted if the young adult dependent is current with their premiums. The gaining contractor shall process transfer requests within 10 calendar days.

## 4.2 Processing

**4.2.1** The contractor shall process all TYA transactions through Web DOES for young adult dependents with a residential address as indicated by the TYA purchaser on the TYA application in the contractor's jurisdiction. The contractor shall process TYA requests received along with at least an initial payment (see [paragraph 4.1](#)) (as required) NLT 10 calendar days after receipt.

**4.2.2** The contractor shall assign Primary Care Managers (PCMs) to purchasers of TYA Prime coverage per [Chapter 6](#).

**4.2.3** If the contractor is unable to enroll the young adult dependent in Web DOES due to (a) a 90-day future enrollment limitation, (b) DEERS not reflecting eligibility, (c) the application being incomplete, (d) a missing initial premiums payment, or (e) an underpayment of the initial premium payment; the contractor shall provide notification to the young adult dependent, initiated within 10 calendar days of receipt of the application, with an explanation of what is needed for the contractor to accept the application for processing and return any premium amounts if appropriate.

## 4.3 Termination Of TYA Coverage

The contractor shall initiate return of any excess premium amounts paid prorated to the day as indicated NLT 10 calendar days after the effective date of the termination or after receipt of a Policy Notification Transaction (PNT) notifying the young adult dependent's contractor of a termination, whichever is later. Premium refunds, to include an explanation of the premium refund, will be sent to young adult dependent's residential address unless an alternate mailing address has been provided. The contractor shall also update DEERS with any premium amount refunded within 30 calendar days.

### 4.3.1 Loss Of TYA Qualification

At any time a young adult dependent ceases to meet all eligibility qualifications, coverage under the TYA program shall terminate. This could be due to the sponsor's losing eligibility for care. The effective date of termination shall be the date upon which the young adult dependent ceased to meet any of the prerequisite qualifications. If a subsequent change in circumstances occurs such as losing eligibility for an eligible employer-sponsored plan, the young adult dependent may qualify again to purchase coverage under the TYA program. Young adult dependents who age out of TYA at age 26 may be eligible to purchase CHCBP coverage (see TPM, [Chapter 10, Section 4.1](#)).

#### 4.3.1.1 Change in Sponsor Status

**4.3.1.1.1** A change in sponsor status (active to retired; active duty to the Reserve Component (RC), etc.), may require the young adult dependent's coverage to be transferred to another TYA coverage plan or cause TYA coverage to be terminated.

## TRICARE Operations Manual 6010.56-M, February 1, 2008

### Appendix A

#### Acronyms And Abbreviations

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TRO-W	TRICARE Regional Office-West
TRPB	TRICARE Retail Pharmacy Benefits
TRR	TRICARE Retired Reserve
TRRx	TRICARE Retail Pharmacy
TRS	TRICARE Reserve Select
TRSA	TRICARE Reserve Select Application
TSC	TRICARE Service Center
TSF	Target of Evaluation Security Functions
TSM	August 2002 TRICARE Systems Manual 7950.1-M February 2008 TRICARE Systems Manual 7950.2-M
TSP	Target of Evaluation Security Policy
TSR	TRICARE Select Reserve
TSRDP	TRICARE Select Reserve Dental Program
TSRx	TRICARE Senior Pharmacy
TSS	TRICARE Senior Supplement
TSSD	TRICARE Senior Supplement Demonstration
TTOP	TRICARE Transitional Outpatient Payment
TTPA	Temporary Transitional Payment Adjustment
TTY	Teletypewriter
TUNA	Transurethral Needle Ablation
TYA	TRICARE Young Adult
UAE	Uterine Artery Embolization
UARS	Upper Airway Resistance Syndrome
UB	Uniform Bill
UBO	Uniform Business Office
UCBT	Umbilical Cord Blood Stem Cell Transplantation
UCC	Uniform Commercial Code Urgent Care Center
UCSF	University of California San Francisco
UIC	Unit Identification Code
UIN	Unit Identifier Number
UM	Utilization Management
UMO	Utilization Management Organization
UMP	User Maintenance Portal
UPIN	Unique Physician Identification Number
UPPP	Uvulopalatopharyngoplasty
URFS	Unremarried Former Spouse
URL	Universal Resource Locator
US	Ultrasound United States
USA	United States of America
USACID	United States Army Criminal Investigation Division
USAF	United States Air Force

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USAO	United States Attorneys' Office
USC	United States Code
USCG	United States Coast Guard
USCO	Uniformed Services Claim Office
USD	Undersecretary of Defense
USD (P&R)	Undersecretary of Defense (Personnel and Readiness)
USDI	Undersecretary of Defense for Intelligence
USFHP	Uniformed Services Family Health Plan
USHBP	Uniformed Services Health Benefit Plan
USMC	United States Marine Corps
USMTF	Uniformed Services Medical Treatment Facility
USN	United States Navy
USPDI	United States Pharmacopoeia Drug Information
USPHS	United States Public Health Service
USPS	United States Postal Service
USPSTF	U.S. Preventive Services Task Force
USS	United Seaman's Service
USTF	Uniformed Services Treatment Facility
UV	Ultraviolet
VA	Veterans Affairs (hospital) Veterans Administration
VAC	Vacuum-Assisted Closure
VAD	Ventricular Assist Device
VAMC	VA Medical Center
VATS	Video-Assisted Thorascopic Surgery
VAX-D	Vertebral Axial Decompression
VD	Venereal Disease
VO	Verifying Office (Official)
VPN	Virtual Private Network
VPOC	Verification Point of Contact
VRDX	Reason Visit Diagnosis
VSAM	Virtual Storage Access Method
VSD	Ventricular Septal Defect
WAC	Wholesale Acquisition Cost
WAN	Wide Area Network
WATS	Wide Area Telephone Service
WC	Worker's Compensation
WebDOES	Web DEERS Online Enrollment System (application)
WEDI	Workgroup for Electronic Data Interchange
WHS	Washington Headquarters Services
WIC	Women, Infants, and Children (Program)
WII	Wounded, Ill, and Injured

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Appendix A

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WLAN	Wireless Local Area Network
WORM	Write Once Read Many
WRAMC	Walter Reed Army Medical Center
WTC	World Trade Center
WTRR	Wire Transfer Reconciliation Report
WTU	Warrior Transition Unit
WWW	World Wide Web
X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome
XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer

2D	Two Dimensional
3D	Three Dimensional

- END -



### **Third Party Billing Agent**

Any entity that acts on behalf of a provider to prepare, submit, and monitor claims, excluding those entities that act solely as a collection agency, as established by [32 CFR 199.2\(b\)](#).

### **Third Party Liability (TPL) Claims**

TPL claims are claims in favor of the Government that arise when medical care is provided to an entitled beneficiary for treatment or injury or illness caused under circumstances creating tort liability legally requiring a third person to pay damages for that care. The Government pursues repayment for the care provided to the beneficiary under the provisions and authority of the Federal Medical Care Recovery Act (FMCRA) (42 USC paragraphs 2651-2653).

### **Third Party Liability (TPL) Recovery**

The recovery by the Government of expenses incurred for medical care provided to an entitled beneficiary in the treatment of injuries or illness caused by a third party who is liable in tort for damages to the beneficiary. Such recoveries can be made from the liable third party directly or from a liability insurance policy (e.g., automobile liability policy or homeowners insurance) covering the liable third party. TPL recoveries are made under the authority of the FMCRA (42 USC paragraph 2651 et sec. Other potential sources of recovery in favor of the Government in TPL situations include, but are not limited to, no fault or uninsured motorist insurance, medical payments provisions of insurance policies, and workers compensation plans. Recoveries from such other sources are made under the authority of 10 USC paragraphs 10790, 1086(g), and 1095b.)

### **Third Party Payer**

An entity that provides an insurance, medical service, or health plan by contract or agreement, including an automobile liability insurance or no fault insurance carrier and a workers compensation program or plan, and any other plan or program (e.g., homeowners insurance, etc.) that is designed to provide compensation or coverage for expenses incurred by a beneficiary for medical services or supplies.

### **Timely Filing**

The filing of TRICARE claims within the prescribed time limits as set forth in [32 CFR 199.7](#).

### **Toll-Free Telephones**

All telephone calls are considered toll-free for the purposes of measuring the standards contained in [Chapter 1, Section 3, paragraph 3.4](#), except for those telephone calls to an **overseas** TRICARE Service Center (TSC).

### **Trading Partner Agreement (HIPAA/Privacy Definition)**

An agreement related to the exchange of information in electronic transactions, whether the agreement is distinct or part of a larger agreement, between each party to the agreement. (For example, a trading partner agreement may specify, among other things, the duties and responsibilities of each party to the agreement in conducting a standard transaction.)

### **Transaction (HIPAA/Privacy Definition)**

The transmission of information between two parties to carry out financial or administrative activities related to health care. It includes the following types of information transmissions:

1. Health care claims or equivalent encounter information.
2. Health care payment and remittance advice.
3. Coordination of benefits.
4. Health care claims status.
5. Enrollment and disenrollment in a health plan.
6. Eligibility for a health plan.
7. Health plan premium payments.
8. Referral certification and authorization.
9. First report of injury.
10. Health claims attachments.
11. Other transactions that may be prescribed by regulation.

### **Transfer Claims**

A claim received by a contractor which is for services received and billed from another contractor's jurisdiction. TRICARE claims and attendant documentation must be referred to the appropriate contractor for processing. Notification shall not be sent to the provider claimant explaining the action taken. Notification shall be sent to the patient claimant explaining the action taken, including the name and address of the correct contractor. Claims for active duty members which are sent to the appropriate Uniformed Service are not considered to be "transfer claims."

### **Transition**

The process of changing contractors who serve a particular area or areas. Transition begins with the Notice of Award to the incoming contractor and is formally completed with the close out procedures of the outgoing contractor, several months after the start work date.

### **Transitional Patients Or Cases**

Patients for whom active care is in progress on the date of a contractor's start work date. If the care being provided is for covered services, the contractor is financially responsible for the portion of care delivered on or after the contractor's start work date.

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