

Contractor Responsibilities

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

1.1 Claims Processing

1.1.1 Claims Processing And Reporting

Regardless of who submits the claim, SHCP claims shall be processed using the same standards and requirements in [Chapter 1](#), unless otherwise stated in this chapter. The contractor for the region in which the patient is enrolled shall process the claim to completion. If the member is not enrolled, the contractor for the region in which the member resides shall process the claim. Claims for inpatient and outpatient medical services shall be processed to completion without application of a cost-share, copayment, or deductible. **The claims filing deadline outlined in [Chapter 8, Section 3, paragraph 1.2](#), does not apply to any Active Duty Service Member (ADSM) SHCP claim or for Active Duty Family Member (ADFM) SHCP claims for authorized In Vitro Fertilization (IVF) treatment based on the sponsor's eligibility as a wounded warrior.**

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

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

1.1.3 Outpatient Care

Outpatient civilian care claims are to be processed according to the patient's enrollment status (see [paragraph 3.0](#)). If the patient is TRICARE eligible, normal TRICARE processing requirements will apply. Additionally, for service determined eligible patients other than active duty, (e.g., Reserved Officer Training Corps (ROTC), former members on the Temporary Disability Retirement List (TDRL), Reserve Component (RC), National Guard, foreign military, etc.) claims will be paid based on an MTF authorization despite the lack of any DEERS indication of eligibility.

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

Claims for care provided under the national DoD/DVA MOA for Spinal Cord Injury (SCI), Traumatic Brain Injury (TBI), and Blind Rehabilitation shall be processed in accordance with [Section 2, paragraph 3.1](#).

1.1.5 Emergency Civilian Hospitalization

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

1.1.6 Temporary Disability Retirement List (TDRL)

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

1.1.7 Comprehensive Clinical Evaluation Program (CCEP)

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

1.1.8 Foreign Member Claims Processing

Foreign military members and their dependents in the United States may be eligible for health care under an approved agreement (e.g., reciprocal health care agreement, North Atlantic Treaty Organization (NATO) Status of Forces Agreement (SOFA), Partnership for Peace (PFP) SOFA). Foreign military members and their dependents on assignment in the United States will be shown on DEERS with a Health Care Coverage Code of "T." Foreign military members who are in the United States on official business may be eligible for care, but may not be reflected on DEERS. Accordingly, claims for foreign force members for care received in the United States will be paid based on an MTF or Military Medical Support Office (MMSO) authorization despite the lack of any DEERS indication of eligibility. Contractors shall process claims received for foreign military members and their dependents as follows:

1.1.8.1 Foreign Military Member

Foreign military members are eligible for civilian outpatient care, but are not eligible for

civilian inpatient care. Any civilian outpatient care for an authorized foreign member must be referred by a MTF or MMSO. For MTF referral requests, the contractor shall accept and follow the referral requirements in [Chapter 8, Section 5](#). If the foreign member works and resides in a geographical area that is a TRICARE Prime Remote (TPR) area, then the MMSO shall issue referrals for outpatient care. Essentially, the same referral processes in place for ADSMs (which includes pending a claim without a referral and forwarding to either an MTF or MMSO for review) shall be followed for foreign military member care.

1.1.8.2 Foreign Military Member Dependent

Family members of foreign military members may be eligible for outpatient civilian care, but are not eligible for inpatient care. Outpatient care, when applicable, is only provided under the TRICARE Standard and/or TRICARE Extra Programs. As long as the family member is registered on DEERS (Health Care Coverage Code of "T") and the DEERS response indicates the family member is eligible for TRICARE Standard Coverage, then the contractor shall process the claim in accordance with TRICARE Standard or TRICARE Extra provisions.

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

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

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

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

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

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

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1.1.10.2 In cases where care cannot be reasonably provided in a timely manner through the VA, the FRC or RCC, working through the Federal Recovery Coordinator Program (FRCP), will facilitate care through MTFs or TRICARE providers. The FRCP will notify the MMSO when the VA cannot reasonably provide an episode of care in a timely manner. MMSO, in turn, will send to the contractor authorization to pay for the episode of care under the SHCP. This authorization will supersede any DEERS eligibility response.

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

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

1.1.10.5 TED records must reflect Enrollment/Health Plan Code "SR - SHCP Referred Care."

1.2 Eligibility Verification

1.2.1 MTF Referred Care

If an MTF referral is on file and the service is either (a) ordinarily covered by TRICARE or (b) covered by TRICARE under paragraph 2.2.5, the contractor shall process the claim in accordance with the provisions in paragraph 1.2.2.2. The contractor shall verify that care provided was authorized by the MTF. If an authorization is not on file, then the contractor shall place the claim in a pending file and verify authorization with the MTF to which the ADSM is enrolled (except for care provided by the DVA under the current national MOA for SCI, TBI, and Blind Rehabilitation, see Section 2, paragraph 3.1). The contractor shall contact the MTF within one working day. If the MTF retroactively authorizes the care, then the contractor shall enter the authorization and notify the claims processor to process the claim for payment. If the MTF determines that the care was not authorized, the contractor shall notify the claims processor and an Explanation of Benefits (EOB) denying the claim shall be initiated. If the contractor does not receive the MTF's response within four working days, the contractor shall, within one working day, enter the contractor's authorization code into the contractor's claims processing system. Claims authorized due to a lack of response from the MTF shall be considered as "Referred Care". Services that would not have ordinarily been covered under TRICARE policy may be authorized for Service members only in accordance with the terms of a waiver approved by the Director, TRICARE Management Activity (TMA), at the request of an authorized official of the uniformed service concerned.

1.2.2 Non-MTF Referred Care

1.2.2.1 Check DEERS Status

If the patient is listed in the DEERS as Direct Care (DC) eligible, process the claim in accordance with the Types of Care paragraph. If, in the process of the DEERS check, the contractor determines the ADSM is enrolled in TPR, then the claim shall be processed as a TPR claim in accordance with Chapter 16 otherwise the claim shall be processed in accordance with the requirements of Chapter 17.

1.2.2.2 Check for Service Point of Contact (SPOC) Preauthorization

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

1.2.2.3 Check Claim For Attached Documentation

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

1.2.2.4 National Guard and Reserve

Claims for National Guard or Reserve sponsors with treatment dates outside their eligibility dates cannot be automatically adjudicated. Claims for ineligible sponsors are to be suspended and routed to MMSO for payment approval or denial. If a payment determination is not received within the 85th day of receipt, the claim is to be denied.

1.2.2.5 Criteria Not Met

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

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

1.3 TPL

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

1.4 Types Of Care

Contractor staff shall receive and accept calls directly from ADSMs requesting authorization for care which has not been MTF referred. If the caller is requesting after hours authorization for care while physically present in the Prime Service Area (PSA) of the MTF to which he/she is enrolled, the care shall be authorized in accordance with the contractor-MTF Memoranda of Understanding (MOU) established between the contractor and the local MTF. If the caller is traveling away from his/her duty station, the care shall be authorized if a prudent person would consider the care to be urgent or emergent. Callers seeking authorization for routine care shall be referred back to their

MTF for instructions. The contractor shall send daily notifications to the ADSMs' enrolled MTF for all care authorized after hours according to locally established business rules.

2.0 COVERAGE

Services that would not have ordinarily been covered under TRICARE policy (including limitations and exclusions) may be authorized for Service members only in accordance with the terms of a waiver approved by the Director, TMA, at the request of an authorized official of the uniformed service concerned. (Reference HA Policy 12-002 "Use of Supplemental Health Care Program Funds for Non-Covered TRICARE Health Care Services and the Waiver Process for Active Duty Service Members").

2.1 TRICARE coverage limits continue to apply to services to non-active TRICARE-eligible covered beneficiaries provided under the SHCP. On occasion care may be referred or authorized for services from a provider of a type which is not TRICARE authorized. The contractor shall not make claims payments to sanctioned or suspended providers. (See Chapter 13, Section 6.) The claim shall be denied if a sanctioned or suspended provider bills for services. MTFs do not have the authority to overturn TMA or Department of Health and Human Services (DHHS) provider exclusions. TRICARE utilization review and utilization management requirements will not apply.

2.2 Upon receipt of an MTF referral/civilian provider referral (for remote Service members/non-enrolled Service members), the contractor shall perform a covered service review. A referral from an MTF or an authorization from a SPOC shall be deemed to constitute member eligibility verification, as well as direction to bypass provider certification and Non-Availability Statement (NAS) rules. The contractor shall take measures as appropriate to enable them to distinguish between an MTF referral and a SPOC authorization.

2.2.1 If the contractor determines that the service, supply, or equipment requested by an MTF referral is covered under TRICARE policy (including paragraph 2.2.5), the contractor shall file an authorization in its system and pay received claims in accordance with the filed authorization. If the contractor determines that the service, supply, or equipment requested by civilian provider referral (for remote Service members/non-enrolled Service members) is covered under TRICARE policy, the contractor shall forward the appropriate documentation to the SPOC for authorization. Upon receipt of the SPOC authorization, the contractor shall file an authorization in its system and pay received claims in accordance with the filed authorization.

2.2.2 If the contractor determines that the requested service, supply, or equipment is not covered by TRICARE policy (including paragraph 2.2.5) but an approved waiver is provided, the contractor shall file an authorization in its system as specified in the TMA approved waiver and pay received claims in accordance with the filed authorization.

2.2.3 If the contractor determines that the requested service, supply, or equipment is not covered by TRICARE policy (including paragraph 2.2.5), the contractor shall decline to file an authorization in its system and deny any received claims accordingly. If the authorization request was received as an MTF referral, the contractor shall notify the MTF (an enrolled MTF if different from the submitting MTF) of the declined authorization with explanation of the reason. If the request was received as a referral from a civilian provider (for a remote Service member/non-enrolled Service member), the contractor shall notify the civilian provider and the remote Service member/non-enrolled Service member of the declined authorization with explanation of the

reason. The notification to a civilian provider and the remote Service member/non-enrolled Service member shall explain the waiver process and provide contact information for the applicable Uniformed Services Headquarters Point of Contact (POC)/Service Project Officers as listed in Chapter 17, Addendum A, paragraph 2.0. No notification to the SPOC is required.

2.2.4 TRICARE benefits may not be extended for complications resulting from non-covered surgeries and treatments performed outside the MTF for a Service member without an approved waiver. If the treatment is a non-covered TRICARE benefit, any follow-on care, including care for complications, will not be covered by TRICARE once the Service member separates from active duty or retires (32 CFR 199.4(e)(9); TPM, Chapter 4, Sections 1.1 and 1.2). The Services will provide appropriate counseling that such follow-on care is the member's personal financial responsibility upon separation or retirement.

2.2.5 Certain services, supplies, and equipment are covered for service members under the SHCP as specified below and no waiver is required:

- Custom-fitted orthoses are covered for Service members on active duty (specified for more than 30 days). The custom-fitted orthotic must be ordered by the appropriate provider and obtained from a TRICARE authorized vendor that specializes in this service. Prefabricated or other types of orthoses available in commercial retail entities are excluded.

2.3 Ancillary Services

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

2.4 Provision Of Respite Care For The Benefit Of Seriously Ill/Injured Active Duty Members

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

2.4.2 ADSMs may qualify for respite care benefits regardless of their enrollment status. ADSMs in the 50 United States and the District of Columbia may qualify if they are enrolled in TRICARE Prime, TPR, or not enrolled and receiving services in accordance with the non-enrolled/non-referred provisions for the use of SHCP funds. ADSMs outside the 50 United States and the District of Columbia may qualify if they are enrolled to TRICARE Overseas Program (TOP) Prime (with enrollment to an MTF), TOP Prime Remote, or not enrolled and receiving services in accordance with the non-enrolled/non-referred provisions for ADSM care overseas (see the TPM, Chapter 12, Section 1.1).

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

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

2.4.4 All SHCP requirements and provisions of [Chapters 16](#) and [17](#) apply to this benefit unless changed or modified by this paragraph. The appropriate chapter for the status of the ADSM shall apply. Contractors shall follow the requirements and provisions of these chapters, to include MTF or MMSO referrals and authorizations, receipt and control of claims, authorization verification, reimbursement and payment mechanisms to providers, reimbursement specifying no cost-share, copay, or deductible to be paid by the ADSM or their lawful spouse, and use of CHAMPUS Maximum Allowable Charges (CMACs)/Diagnosis Related Groups (DRGs) when applicable.

2.4.5 Contractors shall follow the provisions of the TRICARE Systems Manual (TSM), [Chapter 2, Sections 2.8](#) and [6.4](#) regarding the TED special processing code for the ADSM respite benefit. Claims should indicate an appropriate procedure code for respite care (CPT¹ 99600 or HCPCS S9122-S9124) and shall be reimbursed based upon the allowable charge or the negotiated rate.

2.4.6 Respite care services and requirements are as follows:

2.4.6.1 Respite care is authorized for a member of the Uniformed Services on active duty and has a qualifying condition as defined in [Appendix B](#).

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

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

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

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

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

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

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2.4.6.7 The contractor shall follow the reimbursement methodology for the similar respite care benefit found in the TPM, [Chapter 9](#), as modified by ADSM SHCP reimbursement methodology contained in [Chapters 16](#) and [17](#) (for ADSMs located in the 50 United States and the District of Columbia) or TOP reimbursement methodology contained in the TPM, [Chapter 12](#) (for ADSMs located outside the 50 United States and the District of Columbia).

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

2.5 Transitional Care For Service-Related Conditions (TCSRC)

2.5.1 Introduction

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

2.5.2 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.

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 ADMSM is otherwise eligible for TRICARE benefits, they may continue to receive care for the condition, following existing TRICARE guidelines. The former ADMSM may appeal the decision of the DoD Physician in writing to MMSO within 30 calendar days of receipt of the denial by the DoD physician. MMSO will issue a final determination within 30 calendar days of receipt of the appeal. If MMSO determines the condition should be covered under the Section 1637 benefit, coverage will begin on the date MMSO renders the final determination.

2.5.4.4 If the DoD physician determines the individual is eligible for the Section 1637 program, MMSO will provide the enrollment information (Enrollment Start date and condition authorized for treatment) to the member and the contractor responsible for enrollments in the region where the former service member resides. This notice will clearly identify it is for the Section 1637 program. The contractor shall enroll the former service member into the Section 1637 program on DEERS using DEERS Online Enrollment System (DOES) within four business days of receiving the notification from MMSO. This entry will include the Start Date (date condition validated by the DoD physician), an EOC Code, and an EOC Description. The contractor will enter the validated condition covered by the Section 1637 program (received from MMSO) into the contractor's referral and authorization system within eight business days of receipt of the notification from MMSO. The contractor shall actively assist the member using the HCF program in determining the location of final restorative health care for the identified Section 1637 condition. The location of service shall be determined as defined in [paragraph 2.5.4.3](#). The contractor shall instruct the accepting provider on the terms of this final "eval and treat" referral from MMSO and when and where to send clinical results/findings to close out MMSO's files on the Section 1637 eligible member. DEERS shall store the secondary Health Care Delivery Plan (HCDP) code, the date the condition was validated by the DoD physician, the EOC Code, and the EOC Description. DEERS shall return the HCDP code, the start and end dates for the coverage plan, the EOC Code, and the EOC Description with every eligibility query. This program is portable across all contractors.

2.5.4.5 The member in the TCSRC program will obtain the appropriate care for the service-related condition close to their residence, as defined in [paragraphs 2.5.4.3](#) and [2.5.4.4](#). Civilian and VA claims for the specific condition will be processed as if the member were still on active duty, with no copayments required. If the "eval" or "eval and treat" referrals sent to the contractor from MMSO are presented to an MTF for execution, and the MTF accepts, any subsequent MTF generated "defer to network" requests will be accepted, recorded, and claim adjudicated; and this process may be outside the contractor's EOC coding/criteria. The contractor may request clarifications from the MTF on a subsequent "defer to network" request if the referral is for healthcare delivery that is not apparently related to the Section 1637 determined condition.

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

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

2.5.5 Claims Processing And Payment

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

- **Contractor Splits Claim.** If a contractor receives a claim for a member eligible for Section 1637 coverage and the claim includes services not covered by the Section 1637 diagnosis, and the contractor can determine which services are covered under the Section 1637 condition, then the contractor will split the claim into separate claims.
- **Contractor Returns Claim to Provider.** If the claim does not meet the conditions described above, then the contractor will return the claim to the submitter with an explanation that indicates the claim must be split in order to be paid.

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

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

2.5.5.4 Jurisdiction rules for Section 1637 coverage shall be in accordance with [Chapter 8, Section 2](#).

2.5.5.5 The contractors shall pay all claims submitted for the specific service-related condition in the same manner as other active duty claims. There shall be no application of catastrophic cap,

deductibles, cost-shares, copayments or coordination of benefits for these claims. Claims paid for the specific service-related condition under this change should be paid from non-financially underwritten funds.

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

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

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

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

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

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

2.5.6 Definitions

2.5.6.1 Validated Date and Diagnosis

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

2.5.6.2 MMSO

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

2.6 Provisions Of Reproductive Services For The Benefit Of Seriously or Severely Ill Or Injured ADSMs Under The SHCPs

Assisted reproductive services, including sperm retrieval, oocyte retrieval, In-Vitro Fertilization (IVF), artificial insemination, and blastocyst implantation, are available for seriously or severely ill/injured female and male service members (Category II and III). This is a benefit offered based on the condition of the seriously or severely ill/injured service member not the spouse; therefore, the use of the SHCP is authorized.

2.6.1 Policy Guidelines

2.6.1.1 The policy applies to service members, regardless of gender, who have sustained a serious or severe illness/injury while on active duty that led to the loss of their natural procreative ability. It is the intent of this policy to provide IVF services only to consenting male members whose illness or injury prevents the successful delivery of their sperm to their spouse's egg and to consenting female members whose illness or injury prevents their egg from being successfully fertilized by their spouse's sperm, but who maintain ovarian function and have a patent uterine cavity. This includes, but is not limited to, those suffering neurological, physiological, and/or anatomical injuries.

2.6.1.2 The policy provides for the provision of assisted reproductive technologies to assist in the reduction of the disabling effects of the member's qualifying condition. The authority for this policy for care outside of the basic medical benefit is derived from Section 1633 of the 2008 NDAA. This section allows the ADSM to receive services that are outside the definition of "medical care." This benefit is provided through the authorization of the expenditure of SHCP funds and delivery of the needed services in either MTFs that offer assisted reproductive technologies or in the purchased care sector that are outside the medical benefit. Although purchased care is available for this benefit depending on the service member's circumstances not allowing him or her to travel, the use of MTFs shall be encouraged, with members eligible for this benefit given priority for care at MTFs if there is a waiting list. If the member receives care or medications in the civilian sector, participating network providers must be used if available. Preauthorization for every IVF cycle is required.

2.6.1.3 The benefit is limited to permitting a qualified member to procreate with their lawful spouse, as defined in federal statute and regulation.

2.6.1.4 The benefit would apply equally to male and female seriously or severely ill/injured service members (Category II or III). Male members must be able to produce sperm, but need alternative sperm collection technologies as they can no longer ejaculate in a way that allows for egg fertilization. Ill/injured female members require ovarian function and a patent uterine cavity that would allow them to successfully carry a fetus even if unable to conceive naturally (e.g., through damage to their fallopian tubes).

2.6.1.5 Third party donations and surrogacy are not covered benefits. The benefit is designed to allow the member and their dependent spouse to become biological parents through reproductive technologies where the ADSM's illness or injury has made it impossible to conceive naturally.

2.6.1.6 Consent must be able to be given by the ADSM and his or her lawful spouse. Third party consent is not authorized under this policy.

2.6.1.7 The DoD will cost-share the costs of cryopreservation and storage of embryos for up to three years. At the end of three years or when the member separates/retires (whichever comes first), couples are free to continue embryo storage at their own expense if desired. Issues regarding ownership, future embryo use, donation, and/or destruction etc. shall be governed by the applicable state law and shall be the responsibility of the ADSM and his/her lawful spouse and the facility storing the cryopreserved embryos. DoD's role is limited to paying for this benefit when requested by the consenting member. DoD will not have ownership or custody of cryopreserved embryos and will not be involved in the ultimate disposition of excess embryos. Ultimate disposition or destruction of excess embryos will not be cost-shared.

2.6.2 Procedures

2.6.2.1 Prediction of fertility potential (Ovarian Reserve) will be conducted in accordance with the provider clinic's practice guidelines. (This may include a Clomiphene Citrate Challenge Test (CCCT) and evaluation of the uterine cavity.) Beneficiaries with a likelihood of success, based on the specific clinic's guidelines, will be provided IVF cycles under this benefit. Infertility testing and treatment, including correction of the physical cause of infertility, are covered in accordance with the TPM, [Chapter 4, Section 17.1](#).

2.6.2.2 Three completed IVF cycles will be provided for the seriously or severely ill/injured female service member or lawful spouse of the seriously or severely ill/injured male service member. No more than six IVF cycles will be initiated for the seriously or severely ill/injured female service member or legal spouse of the seriously or severely ill/injured male service member. In other words, there may be a total of six attempts to accomplish three completed IVF cycles. If the ill/injured ADSM has used initiated IVF cycles, subsequently remarries and desires this benefit with the new spouse, the number of cycles available is dependent on prior cycles used.

2.6.2.3 Assisted reproductive service centers with capability to provide full services including alternative methods of sperm aspiration will be invited to participate in the TRICARE network by the contractors. (Membership in the American Society for Reproductive Medicine (ASRM), with associated certification(s), is highly recommended for network providers. Reporting outcomes to the Centers for Disease Control and Prevention (CDC) is mandatory.) When a network provider is not available, the benefits provided under this policy may be provided by any TRICARE-authorized provider, including those authorized pursuant to [32 CFR 199.6\(e\)](#).

2.6.2.4 IVF cycles shall be accomplished in accordance with the practice guideline for the provider clinic using gonadotropins which are concentrated mixtures of Follicle Stimulating Hormone (FSH) or FSH and Luteinizing Hormone (LH) given as an injection to stimulate the ovary to produce multiple oocytes in preparation for egg retrieval. These medications will be purchased through the TPharm contract, TRICARE Pharmacy Home Delivery Program, or non-network pharmacy, or MTF.

2.6.2.5 Anesthesia or conscious sedation will be provided for the oocyte retrieval and sperm aspiration in accordance with the TPM, [Chapter 3, Section 1.1](#) and [1.2](#). For males, sperm aspiration through Microsurgical Epididymal Sperm Aspiration (MESA), Percutaneous Epididymal Sperm Aspiration (PESA), or non-surgical fine needle aspiration will be accomplished in conjunction with egg retrieval. Vibratory stimulation or electro-ejaculation may be used if appropriate for the seriously or severely ill/injured service member.

2.6.2.6 Intracytoplasmic sperm injection will be accomplished for all viable oocytes.

2.6.2.7 Embryo transfer in accordance with guidelines provided by the ASRM shall be accomplished in accordance with specific clinic practices at either cleavage stage or blastocyst stage of the embryo.

2.6.2.8 Healthy embryos that progress to an appropriate stage, as assessed by the embryologist, in excess of those used for the fresh embryo transfer may be cryopreserved. Storage of cryopreserved embryos for up to three years will be a covered benefit so long as the member remains eligible for this benefit. Ownership of cryopreserved embryos will be the responsibility of the ADSM and their spouse and documented in accordance with clinic policies.

2.6.2.9 In the event that frozen embryos are available for transfer, TRICARE will authorize frozen embryo transfer cycles to facilitate the utilization of these embryos. Frozen embryo transfers may be accomplished in fresh ovulatory cycles or in medicated transfer cycles in order to provide the optimal uterine environment for embryo implantation.

2.6.3 Process for Participating in Assisted Reproductive Services Program

2.6.3.1 For an ADSM to be eligible, there must be documentation of Category II or III illness or injury designation as defined in Department of Defense Instruction (DoDI) 1300.24.

2.6.3.2 A memorandum must come from the ADSM's PCM or other provider significantly involved in the care of the qualifying condition(s). Certification of the illness or injury category shall be made by the provider and endorsed by the member's service. The memorandum shall include the following:

- ADSM's qualifying diagnosis(es).
- Category (II or III).
- Summary of relevant medical information supporting category designation.
- Name of provider of reproductive services requested to be used.
- Number of initiated IVF cycles.
- Number of cancelled IVF cycles.

2.6.3.3 The memorandum is sent to the member's service for endorsement, and then sent electronically to TMA, Office of the Chief Medical Officer (OCMO) where verification of the member's eligibility for this benefit will be completed. Please send e-mails to: TMASHCPWaiverRequests@tma.osd.mil.

2.6.3.4 This authorization (verification of benefits) shall be forwarded to the appropriate MTF or MMSO as well as the TRICARE Regional Office (TRO), TAO, and TOP Office (TOPO). Preauthorization for care by the MTF or MMSO will be requested from the appropriate contractor. This

preauthorization will allow the use of SHCP funds for this treatment. All bills for the ADSM and spouse should be coded as SHCP bills.

2.6.3.5 In order to verify eligibility, number of attempts (and completed attempts), and all other requirements, all IVF cycles must be preauthorized. OCMO will verify the eligibility of each member for each cycle with a memo. This memo will go through the relevant service back to the MTF or MMSO will request a preauthorization for each cycle.

2.6.3.6 All TED records for this benefit shall include Enrollment/Health Plan Code "SR SHCP - Referred Care" regardless of the enrollment status returned by DEERS. The contractor shall follow all applicable TED coding requirements in accordance with TRICARE System Manual (TSM), [Chapter 2](#).

2.6.3.7 All SHCP requirements and provisions of [Chapter 16](#) and [17](#) apply to this benefit unless changed or modified by this paragraph. The appropriate chapter for the status of the ADSM shall apply. Contractors shall follow the requirements and provisions of these chapters, to include MTF or MMSO referrals and authorizations, receipt and control of claims, authorization verification, reimbursement and payment mechanisms to providers, reimbursement specifying no cost-share, copay, or deductible to be paid by the ADSM or their lawful spouse, and use of CMACs/DRGs when applicable.

2.6.4 Exclusions

2.6.4.1 Third party donations or surrogacy cannot be cost-shared.

2.6.4.2 Cryopreservation of gametes in anticipation of deployment.

2.6.4.3 Services related to gender selection will NOT be cost-shared.

3.0 ENROLLMENT STATUS EFFECT ON CLAIMS PROCESSING

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

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

3.3 Claims for services provided under the current MOU between the DoD (including Army, Air Force, and Navy/Marine Corps facilities) and the DHHS (including the Indian Health Service, Public Health Service, etc.) are not SHCP claims. They should be adjudicated under the claims processing provisions applicable to those specific agreements.

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

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

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

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

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

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

4.0 MEDICAL RECORDS

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

5.0 REIMBURSEMENT

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

5.2 Claims with codes on the TRICARE inpatient only list performed in an outpatient setting will be denied, except in those situations where the beneficiary dies in an emergency room prior to admission. Reference the TRM, [Chapter 13, Section 2, paragraph 3.4](#). Professional providers may submit with modifier CA. No bypass authority is authorized for inpatient only procedure editing. Bypass authority is authorized for codes contained on the No Government Pay List (NGPL) when the service is authorized by the MTF.

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

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

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

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

6.0 END OF PROCESSING

6.1 EOB

An EOB shall be prepared for each supplemental health care claim processed, and copies sent to the provider and the patient in accordance with normal claims processing procedures. For all SHCP claims, the EOB will include the statement that this is a supplemental health care claim, not a TRICARE claim. The EOB will also indicate that questions concerning the processing of the claim must be addressed to the 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 -