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CHANGE 111
6010.56-M
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**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: NEWBORN PRIME ENROLLMENT, SUPPLEMENTAL HEALTH CARE REFERRALS & NEW PRIME ENROLLMENT FORM

CONREQ: 16394

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): The change to the Supplemental Health Care Program (SHCP) ensures a benefit review is completed for each SCHP referral. The review may result in approval or denial, if the request involves a TRICARE non-covered service. An Military Treatment Facility (MTF) Commander or Service Representative can then decide whether or not to submit a waiver. The change also implements the new TRICARE Prime Enrollment, Disenrollment, and Primary Care Manger (PCM) Change Form, DD Form 2876.

EFFECTIVE DATE: Upon direction of the Contracting Officer.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Feb 2008 TPM, Change No. 102.

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

**CHANGE 111
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Enrollment Processing

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, [Disenrollment](#), and Primary Care Manager (PCM) Change Form (one combined form), Department of Defense (DD) Form 2876. 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

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.

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 Section V 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.

information in [Addendum C](#), required by the SPOC for a fitness-for-duty review. The SPOC will respond to the contractor within two working days. When a SPOC referral directs evaluation or treatment of a condition, as opposed to directing a specific service(s), the Managed Care Support Contractor (MCSC) shall use its best business practices in determining the services encompassed within the Episode Of Care (EOC), indicated by the referral. The services may include laboratory tests, radiology tests, echocardiograms, holter monitors, pulmonary function tests, and routine treadmills associated with the EOC. A separate SPOC authorization for these services is not required. If a civilian provider requests additional treatment outside the original EOC, the MCSC shall contact the SPOC for approval. The contractor shall not communicate to the provider or patient that the care has been authorized until the SPOC review process has been completed. The contractor shall use the same best business practices as used for other Prime enrollees in determining EOC when claims are received with lines of care that contain both referred and non-referred lines. Laboratory tests, radiology tests, echocardiogram, holter monitors, pulmonary function tests, and routine treadmills logically associated with the original EOC may be considered part of the originally requested services and do not need to come back to the PCM for approval. Claims received which contain services outside the originally referred EOC on an ADSM must come back to the PCM for approval.

5.3.1.2 If the SPOC determines that the ADSM may receive the care from a civilian source, the SPOC will enter the appropriate code into the authorization/referral system. The contractor shall notify the ADSM of approved referrals. The ADSM may receive the specialty care from a **Military Treatment Facility (MTF)**, a network provider, or a non-network provider according to TRICARE access standards, where possible. In areas where providers are not available within TRICARE access standards, community norms shall apply. (An ADSM may always choose to receive care at an MTF even when the SPOC has authorized a civilian source of care and even if the care at the MTF cannot be arranged within the Prime access standards subject to the member's unit commander [or supervisor] approval.) If the appointment is with a non-network provider, the contractor shall instruct the provider on payment requirements for ADSMs (e.g., no deductible or cost-share) and on other issues affecting claim payment (e.g., the balance billing prohibition). The contractor shall follow [Chapter 8, Section 5](#) when there are additional requests by a MTF for Civilian Health Care (CHC) needs. The contractor shall adjudicate claims for additional MTF requested civilian care in accordance with [Chapter 8, Sections 2 and 5](#).

5.3.1.3 If the contractor does not receive the SPOC's response or request for an extension within two work days, the contractor shall, within one work day after the end of the two work day waiting period, enter the contractor's authorization code into the contractor's claims processing system. The contractor shall document in the contractor's system each step of the effort to obtain a review decision from the SPOC. The first choice for civilian care is with a network provider; if a network provider is not available within Prime access standards, the contractor may authorize the care with a TRICARE-authorized provider. The contractor shall help the ADSM locate an authorized provider.

5.3.1.4 If the SPOC directs the care to a military source, the SPOC will manage the EOC. If the ADSM disagrees with a SPOC determination that the care must be provided by a military source, the ADSM may appeal only through the SPOC who will coordinate the appeal with the Regional Director (RD); the contractor shall refer all appeals and inquiries concerning the SPOC's fitness-for-duty determination to the SPOC.

5.3.1.5 If the ADSM's PCM determines that a specialty referral or test is required on an emergency or urgent basis (less than 48 hours from the time of the PCM office visit) the PCM shall contact the

contractor for a referral and send required information to the SPOC for a fitness for duty review. The ADSM shall receive the care as needed without waiting for the SPOC determination, and the contractor shall adjudicate the claim according to TRICARE Prime provisions. If further specialty care is warranted, the PCM shall request a referral to specialty care. The contractor shall contact the SPOC with a request for an additional SPOC review for the specialty care.

5.3.2 Care Received With No Authorization or Referral

5.3.2.1 The contractor may receive claims for care that require referral, authorization, and SPOC review, that have not been authorized or reviewed. If the claim involves care covered under TRICARE policy, the contractor shall pend the claim and supply the required information (Addendum C) to the SPOC for review. If the SPOC does not notify the contractor of the review determination or ask for an extension for further review within two workdays after submitting the request for coverage determination, the contractor shall then authorize the care. The contractor shall then release the claim for payment, and apply any overrides necessary to ensure that the claim is paid with no fees assessed to the active duty member. However, the contractor shall not make claims payments to sanctioned or suspended providers (see Chapter 13, Section 6).

5.3.2.2 If the contractor determines that the requested service, supply, or equipment is not covered by TRICARE policy (including Chapter 17, Section 3, paragraph 2.2.5) and no TMA approved waiver is provided, the contractor shall decline to file an authorization and shall deny any received claims accordingly. 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.

Note: If the SPOC retroactively determines that the payment should not have been made, the contractor shall initiate recoupment actions according to Chapter 10, Section 4.

6.0 ADDITIONAL INSTRUCTIONS

6.1 Wellness Examinations

The contractor shall reimburse charges for wellness examinations covered under TRICARE Prime (see the TRICARE Policy Manual (TPM), Chapter 7, Section 2.2) without SPOC review. The contractor shall supply information related to requests for follow-up or additional GYN care that requires SPOC review (paragraph 5.2) to the SPOC (see Addendum B).

6.2 Optometry And Hearing Examinations

The ADSM may directly contact the contractor for assistance in arranging for optometry and hearing examinations. The contractor shall refer ADSMs to SPOCs for information on how to obtain eyeglasses, hearing aids, and contact lenses as well as examinations for them, from the Military Health System (MHS) (see Addendum B).

Contractor Responsibilities And Reimbursement

1.0 CONTRACTOR RECEIPT AND CONTROL OF CLAIMS

1.1 The contractor may establish a dedicated post office box to receive claims related to the TRICARE Prime Remote (TPR) Program. This dedicated post office box, if established, may also be the one used for handling Supplemental Health Care Program (SHCP) claims.

1.2 The contractor shall follow appropriate SHCP requirements for claims received for medical care furnished to Active Duty Service Members (ADSMs) not enrolled in the TPR Program.

2.0 CLAIMS PROCESSING

2.1 Jurisdiction

2.1.1 The contractor shall process inpatient and outpatient medical claims for health care services provided worldwide to the contractor's TPR enrollees, except in the case of care provided overseas (i.e., outside of the 50 United States and the District of Columbia). Civilian health care while traveling or visiting overseas shall be processed by the TRICARE Overseas Program (TOP) contractor, regardless of where the beneficiary is enrolled. **The contractor shall process claims for non-covered benefits in accordance with Section 2, paragraph 5.3.2.2.**

2.1.2 The contractor shall forward claims for ADSMs enrolled in TPR in other regions to the contractors for the regions in which the members are enrolled according to provisions in [Chapter 8, Section 2](#).

2.1.3 The contractor shall process claims received for ADSMs who receive care in their regions, but who are not enrolled in TPR, according to the instructions applicable to the SHCP.

2.1.4 The contractor shall forward ADSM dental claims and inquiries to the active duty dental program contractor.

2.2 Claims for Care Provided Under the National DoD/DVA Memorandum of Agreement (MOA) for Spinal Cord Injury (SCI), Traumatic Brain Injury (TBI), and Blind Rehabilitation

2.2.1 Effective January 1, 2007, the contractor shall process claims for ADSM care provided by the DVA for SCI, TBI, and Blind Rehabilitation. Claims shall be processed in accordance with this chapter and the following.

2.2.2 Claims received from a DVA health care facility for ADSM care with any of the following diagnosis codes (principal or secondary) shall be processed as an MOA claim: V57.4; 049.9; 139.0; 310.2; 323.x; 324.0; 326; 344.0x; 344.1; 348.1; 367.9; 368.9; 369.01; 369.02; 369.05; 369.11; 369.15;

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Contractor Responsibilities And Reimbursement

369.4; 430; 431; 432.x; 800.xx; 801.xx; 803.xx; 804.xx; 806.xx; 851.xx; 852.xx; 853.xx; 854.xx; 905.0; 907.0; 907.2; and 952.xx.

2.2.3 The contractor shall verify whether the MOA DVA-provided care has been authorized by Military Medical Support Office (MMSO). MMSO will send authorizations to the contractor by fax. If an authorization is on file, the contractor shall process the claim to payment. The contractor shall not deny claims for lack of authorization. Rather, if a required authorization is not on file, the contractor will place the claim in a pending status and will forward appropriate documentation to MMSO for determination (following the procedures in [Addendum B](#) for MMSO SPOC referral and review procedures).

2.2.4 MOA claims shall be reimbursed as follows:

2.2.4.1 Claims for inpatient care shall be paid using DVA interagency rates. The interagency rate is a daily per diem to cover an inpatient stay and includes room and board, nursing, physician, and ancillary care. These rates will be provided to the contractor by the TRICARE Management Activity (TMA) (including periodic updates as needed). There are three different interagency rates to be paid for rehabilitation care under the MOA. The Rehabilitation Medicine rate will apply to TBI care. Blind rehabilitation and SCI care each have their own separate interagency rate. Additionally, it is possible that two or more separate rates may apply to one inpatient stay. If the DVA-submitted claim identifies more than one rate (with the appropriate number of days identified for each separate rate), the contractor shall pay the claim using the separate rates. (For example, a stay for SCI may include days paid with the SCI rate and days paid at a surgery rate.)

2.2.4.2 Claims for outpatient services shall be paid at the appropriate TRICARE allowable rate (e.g., CHAMPUS Maximum Allowable Charge (CMAC)) with a 10% discount applied.

2.2.4.3 Claims for the following care shall be paid at the interagency rate if one exists and, if not, then at billed charges: transportation; prosthetics; orthotics; durable medical equipment (DME); adjunctive dental care; home care; personal care attendants; and extended care (e.g., nursing home care).

2.2.4.4 Since this is care for ADSMs, normal TRICARE coverage limitations do not apply to services rendered for MOA care. As long as a service has been authorized by MMSO, it will be covered regardless of whether it would have ordinarily not been covered under TRICARE policy.

2.2.5 All TRICARE Encounter Data (TED) records for this care must include Special Processing Code 17 - DVA medical provider claim.

2.3 Time Limitations On Filing ADSM Claims

The claims filing deadline outlined in [Chapter 8, Section 3, paragraph 1.2](#), does not apply to any ADSM claims.

3.0 CLAIM REIMBURSEMENT

3.1 For network providers, the contractor shall pay TPR medical claims at the CHAMPUS allowable charge or at a lower negotiated rate.

3.2 No deductible, cost-sharing, or copayment amounts shall be applied to ADSM claims.

3.3 If a non-participating provider requires a TPR enrollee to make an “up front” payment for health care services, in order for the enrollee to be reimbursed, the enrollee must submit a claim to the contractor with proof of payment and an explanation of the circumstances. The contractor shall process the claim according to the provisions in this chapter. If the claim is payable without SPOC review the contractor shall allow the billed amount and reimburse the enrollee for the 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 enrollee for charges on the claim.

3.4 If the contractor becomes aware that a civilian provider is trying to collect “balance billing” amounts from a TPR enrollee or has initiated collection action for emergency or authorized care, the contractor shall follow contract procedures for notifying the provider that balance billing is prohibited. If the contractor is unable to resolve the situation, the contractor shall pend the file and forward the issue to the SPOC for determination. The SPOC will issue an authorization to the contractor for payments in excess of the applicable TRICARE payment ceilings provided the SPOC has requested and has been granted a waiver from the Deputy Director, TMA, or designee.

3.5 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. The contractor shall then request a waiver of CMAC limitation from the Regional Director (RD), as the designee of the Deputy Director, TMA, before patient referral is made to ensure that the patient does not bear any out-of-pocket expense. The waiver request shall include the patient name, TPR location, services requested (Current Procedural Terminology, 4th Edition [CPT-4] codes), CMAC rate, billed charge, and anticipated negotiated rate. The contractor must obtain approval from the RD before the negotiation can be concluded. The contractors shall ensure that the approved payment is annotated in the authorization/claims processing system, and that payment is issued directly to the provider, unless there is information presented that the ADSM has personally paid the provider.

4.0 THIRD PARTY LIABILITY (TPL)

TPL processing requirements ([Chapter 10](#)) apply to all claims covered by this chapter. However, the contractor shall not delay adjudication action on a claim while awaiting completion of the TPL questionnaire and compilation of documentation. Instead, the contractor shall process the claim(s) to completion. When the contractor receives a completed TPL questionnaire and/or other related documentation, the contractor shall forward the documentation as directed in [Chapter 10](#).

5.0 END OF PROCESSING

The contractor shall issue Explanations of Benefits (EOBs) and provider summary vouchers for TPR claims according to TRICARE Prime claims processing procedures.

6.0 TED VOUCHER SUBMITTAL

The contractor shall report the TPR Program claims on vouchers according to TRICARE Systems Manual (TSM), [Chapter 2, Section 2.3](#). The TED for each claim must reflect the appropriate data element values.

7.0 STANDARDS

All TRICARE Program claims processing standards apply to TPR claims, see [Chapter 1, Section 3](#).

- END -

General

1.0 INTRODUCTION

1.1 The Supplemental Health Care Program (SHCP), with specific exceptions discussed in this chapter, allows for payment of claims for civilian services rendered pursuant to a referral by a provider in a Military Treatment Facility (MTF), as well as for Civilian Health Care (CHC) received by eligible Uniformed Service members. The SHCP exists under authority of 10 USC 1074(c) and [32 CFR 199.16\(a\)\(3\)](#). The use of the SHCP for pay for care referred by MTF providers is governed by Assistant Secretary of Defense (Health Affairs) (ASD(HA)) Policy Memorandum 96-005, "Policy on Use of Supplemental Care Funds by the Military Departments" (October 18, 1995). That policy states, in pertinent part:

"Circumstances where supplemental funds may be used to reimburse for care rendered by non-governmental health care providers to non-active duty patients are limited to those where a medical treatment facility (MTF) provider orders the needed health care services from civilian sources for a patient, and the MTF provider maintains full clinical responsibility for the episode of care. This means that the patient is not disengaged from the MTF that is providing the care."

1.2 SHCP-eligible Service members may include members in travel status (leave, TDY/TAD, permanent change of station), Navy/Marine Corps Service members enrolled to deployable units and referred by the unit Primary Care Manager (PCM) (not an MTF), eligible Reserve Component (RC) personnel, Reserved Officer Training Corps (ROTC) students, cadets/midshipmen, and eligible foreign military.

1.3 The provisions of this Chapter do not apply to services rendered to enrollees in the TRICARE Prime Remote (TPR) program (see [Chapter 16](#)).

1.4 The fact that civilian services have been rendered to an individual who is enrolled to an MTF PCM does not mean that those services were MTF referred care. If a claim is received for an **Active Duty Service Member (ADSM)** MTF enrollee and no authorization is on file, the MTF must be contacted to determine if the care was MTF referred.

2.0 SERVICE POINT OF CONTACT (SPOC)/MILITARY SERVICE PARTICIPATION

2.1 For care that is not referred by an MTF **and is not in an area served by the TRICARE Overseas Program (TOP) contractor**, the SPOC for members of the Army, Air Force, Navy, and Marine Corps will be the Military Medical Support Office (MMSO). The MMSO is established to provide a means to identify, manage, and provide medical oversight of CHC furnished to Service members. MMSO's functions include preauthorization of care when required, medical oversight for specialty care, the coordination and management of civilian routine and emergency hospital admissions. The **United States Coast Guard (USCG)** Public Health Service (PHS), and National Oceanic and Atmospheric

Administration (NOAA) have their own SPOCs for their Service members. A list of Uniformed Service SPOCs is provided in [Addendum A](#). The SPOCs will interact directly with the Managed Care Support Contractor (MCSC) using telephone, facsimile and automation links when available. [Addendum B](#) describes the protocols and procedures for coordination of authorizations with MMSO.

2.2 Contractors will also receive claims for MTF patients who may require medical care that is not available at the MTF (e.g., MRI) and the MTF refers a patient for civilian medical care (this include all civilian care provided to an ADSM MTF enrollee). In these cases, the contractor shall contact the referring MTF for any necessary medical oversight or authorization of care.

3.0 CONTRACTOR RESPONSIBILITIES

3.1 The contractor shall provide payment for inpatient and outpatient services, for MTF-referred civilian care ordered by an MTF provider for an MTF patient for whom the MTF provider maintains responsibility. This includes claims for members on the Temporary Disability Retirement List (TDRL) obtaining required periodic physical exams. After payment of the claim, the contractor shall furnish the Services with information regarding payment of the claim as specified in the contract.

3.2 The contractor shall provide payment for inpatient and outpatient medical services for CHC received by eligible uniformed Service members in accordance with the provisions of this chapter. After payment of the claim, the contractor shall furnish reports as specified in the contract.

4.0 SHCP DIFFERENCES

4.1 ADSMs have no cost-shares, copayments or deductibles. If they have been required by the provider to make "up front" payment they may upon approval be reimbursed in full for amounts in excess of what would ordinarily be reimbursable under TRICARE. Application of Other Health Insurance (OHI) is generally not considered (see [Section 3, paragraph 1.2.3](#)).

4.2 Non-Availability Statement (NAS) requirements do not apply.

4.3 If Third Party Liability (TPL) is involved in a claim, claim payment will not be delayed while the TPL information is developed (see [Section 3, paragraph 1.3](#)).

4.4 The contractor shall provide MTF-referred patients the full range of services offered to TRICARE Prime enrollees.

4.5 If an ADSM intends, while in a terminal leave status, to reside outside of the Prime Service Area (PSA) of the MTF where the ADSM is enrolled, the MTF shall issue to the TRICARE MCSC a single preauthorization for the ADSM to obtain from the Department of Veterans Affairs (DVA) any routine or urgent outpatient primary medical care that should be required anytime during the terminal leave period, except the preauthorization shall not apply to services provided under the terms of the Department of Defense (DoD)/DVA Memorandum Of Agreement (MOA) for "Medical Treatment Provided to Active Duty Service Members with Polytrauma Injury, Spinal Cord Injury, Traumatic Brain Injury or Blindness." Claims from the DVA for services provided under terms of the MOA shall be processed as specified in [Section 2, paragraph 3.0](#). The MCSC shall process a claim received from the DVA for services provided within the scope of the preauthorization using the standards in [Chapter 1](#) unless otherwise stated in this chapter. The claims tracking and retrieval requirements of

[Chapter 1, Section 3, paragraph 2.1](#) apply equally to such SHCP claims. The contractor for the region in which the patient is enrolled shall process the claim to completion.

5.0 SERVICE PROJECT OFFICERS

Each Service will designate a Service Project Officer to be the Service's official POC with TMA and the contractor to resolve any overall service-related matters regarding the program. **The Service Project Officers will be the POC for SHCP waivers.** (Refer to [Addendum A](#) for the list of Service Project Officers).

- END -

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

2.5.4.4 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 -

3.7 The contractor shall follow guidance from the TAO Directors and the MTFs regarding PCM assignment when enrolling beneficiaries into TOP Prime. The MTF enrollment area encompasses a 40-mile radius or a one-hour drive time from the MTF. TOP Prime Remote beneficiaries will be enrolled to the appropriate DMIS code for the beneficiary's remote overseas location. TOP Prime Remote enrollees in Canada will follow guidance applicable to the U.S. and Canada Reciprocal Health Care Agreement, and may be assigned to a Canadian Forces Health Facility for their primary care.

3.8 Newborns/adoptees are deemed to be enrolled for 60 days following birth/adoption when one other family member, to include the sponsor, is enrolled in TOP Prime/TOP Prime Remote. Parents of newborns/adoptees are required to take specific action to enroll the newborn/adoptee within 60 calendar days of birth/adoption. For newborns and newly adopted children who are deemed enrolled, Point of Service (POS) cost-sharing does not apply through the deemed enrollment period, or until an enrollment decision is made by a responsible representative, whichever is earlier. **If the newborn or adoptee is formally enrolled in TOP Prime or TOP Prime Remote within the 60-day period, the date of enrollment will be the date the enrollment form is signed per paragraph 3.6.** If the newborn/adoptee is not formally enrolled during the 60-day period, the newborn/adoptee will revert to TRICARE Standard effective the 61st day, unless the deemed enrollment period has been waived. TAO Directors may extend the deemed enrollment period for newborns/adoptees up to 120 days on a case-by-case or regional basis. TAO Directors shall advise TRICARE Management Activity (TMA) Contracting Officer (CO) in writing when a region-wide enrollment waiver has been authorized. The TMA CO will notify the TOP contractor of any waivers to the 60-day deemed enrollment period in writing at the time the waiver is implemented, and this information shall be incorporated into the Memorandum of Understanding (MOU) between the contractor and the TAO Director(s).

Note: Newborns/adoptees of RC members who are called to active duty for more than 30 consecutive days are eligible for TOP/TRICARE benefits the same as other TRICARE eligible beneficiaries.

3.9 The provisions of [Chapter 6, Section 1](#) and the TPM, [Chapter 10, Section 2.1](#) regarding Prime enrollment fees shall not apply to TOP Prime or TOP Prime Remote. There are no enrollment fees associated with TOP Prime or TOP Prime Remote.

4.0 ENROLLMENT POLICY FOR ADSMs

4.1 Except as described in [paragraph 4.2](#), all ADSMs who are permanently assigned to an overseas duty location must be enrolled into the TOP program that is available in their area. This includes RC ADSMs who are called to active duty for more than 30 consecutive days with a final assignment to an overseas duty station.

4.2 ADSMs assigned to operational forces with assigned organic medical assets may be enrolled to an operational forces' DMIS ID affiliated with its "Parent" DMIS. This includes activated RC members on duty in combatant theaters of operation with existing or imbedded organic medical treatment and support capabilities for health care. Enrollment to a Service or Region-specific operational forces' DMIS for all ADSMs should occur prior to deployment.

5.0 ENROLLMENT POLICY FOR ADFMs

5.1 ADFMs who have Permanent Change of Station (PCS) orders to accompany the sponsor overseas or service-funded orders to relocate overseas without the sponsor are eligible for TOP Prime or TOP Prime Remote enrollment. In order to enroll in these programs, ADFMs must meet the definition of Command Sponsorship in the Joint Federal Travel Regulation (JFTR), Volume I, Appendix A (available at <https://secureapp2/hqda.pentagon.mil/perdiem/>) unless one of the following exceptions exists:

5.1.1 If the ADSM and his/her Command Sponsored ADFM(s) are enrolled in TOP Prime or TOP Prime Remote, and the sponsor is reassigned on unaccompanied PCS orders to a location that does not permit Command Sponsored family members, the family member(s) may retain their TOP enrollment for a period based on the length of the sponsor's unaccompanied orders (but not to exceed two years). In order to retain TOP enrollment in this situation, the family member(s) must continue to be Command Sponsored and may not relocate elsewhere during the sponsor's PCS move.

5.1.2 If the ADFM(s) are authorized to relocate to an overseas location per the sponsor's PCS orders in accordance with JFTR U5222, or per Noncombatant Evacuation Orders without the sponsor, then the ADFM(s) are eligible for enrollment in the appropriate TOP program consistent with their orders.

5.1.3 If the ADFM(s) resided in an overseas location prior to the activation/mobilization of a RC sponsor, then the ADFM(s) are eligible for enrollment in the appropriate TOP program based on the residential mailing address of the sponsor prior to activation/mobilization. The ADFM(s) must have had the same overseas residential address as the sponsor at the time of activation/mobilization.

5.1.4 If the ADFM(s) are currently enrolled in TOP Prime or TOP Prime Remote, and the family has a newborn or adopts a child, then the new family member will be eligible to enroll in the same TOP program.

5.1.5 If the ADFMs are eligible for Transitional Survivor benefits (see Enrollment Policy for Transitional Survivors below).

Note: Command Sponsorship is defined in the JFTR, Volume I, Appendix A at <https://secureapp2.hqda.pentagon.mil/perdiem/>.

5.2 ADFMs who choose to reside overseas but are not Command Sponsored as defined in the JFTR, and who do not meet any of the exceptions listed above, are not eligible for enrollment in TOP Prime or TOP Prime Remote. These ADFMs are eligible for TRICARE Standard, TRICARE Plus (where available) or MTF care on a space-available basis only.

5.3 Eligibility for TOP enrollment normally requires the family to be accompanied by the sponsor; therefore, a family member cannot relocate within the overseas region, relocate to another overseas region, or relocate from a overseas location to an overseas location and transfer enrollment except as specified under the exceptions in this section.

5.4 The TOP contractor shall verify that all of the above requirements are met (including DEERS eligibility check and validation of Command Sponsorship/military orders, if required) prior to enrolling an ADFM into TOP Prime or TOP Prime Remote.

5.5 The process for identifying ADFMs who are Command Sponsored may vary by Service. This is a Service personnel decision and as such, these processes may change over the life of the contract. The TOP contractor may accept any current, valid method of identifying Command Sponsorship to meet the TOP enrollment requirements (e.g., Navy ADFMs who are not listed on the sponsor's orders, but who are in receipt of a letter from the Navy Personnel Services Division (PSD)).

6.0 ENROLLMENT POLICY FOR TRANSITIONAL SURVIVORS

The general provisions of TPM, [Chapter 10, Section 7.1](#) regarding Transitional Survivors shall apply to the TOP. Specific guidelines for Overseas Transitional Survivor benefits are listed below.

6.1 TOP Prime/TOP Prime Remote enrollment policy provisions which require command sponsorship shall not apply to Transitional Survivors whose sponsors died on or after October 7, 2001.

6.2 Transitional Survivors whose sponsors died on or after October 7, 2001 and who choose to remain in an overseas location are eligible for TOP Prime/TOP Prime Remote enrollment during the Transitional Survivor period, regardless of whether they remain at their original residence or relocate to another overseas location. These Transitional Survivors are also eligible for health care benefits under TRICARE Standard.

6.3 Transitional Survivors whose sponsors died on or after October 7, 2001 and who choose to return to the United States from an overseas location are eligible for TRICARE Prime (in TRICARE Prime service areas) or TPRADFM (in remote locations) during the Transitional Survivor benefit period. These Transitional Survivors are also eligible for health care benefits under TRICARE Standard/Extra.

6.4 Transitional Survivors whose sponsors died on or after October 7, 2001 and who choose to move from a stateside location to an overseas location are eligible for TOP Prime or TOP Prime Remote enrollment during the Transitional Survivor benefit period.

6.5 Transitional Survivors whose sponsors died on or after October 7, 2001 are eligible for enrollment and claims reprocessing per TPM, [Chapter 10, Section 7.1](#). Transitional Survivors are also eligible for enrollment fee refunds (if applicable) per TPM, [Chapter 10, Section 7.1](#).

6.6 If the Transitional Survivors are not enrolled in TOP Prime, the Transitional Survivor's priority for appointments at overseas MTFs will be the same as that of ADFMs who are not enrolled in TOP Prime.

6.7 At the end of the Transitional Survivor period, survivors lose their eligibility for enrollment in TOP Prime/TOP Prime Remote (in overseas locations) and TPRADFM (in remote locations) in the 50 United States and the District of Columbia.

7.0 ENROLLMENT PLAN

The TOP contractor, in consultation with the TAO Directors and MTF Commanders, shall develop and implement a TOP enrollment plan. The TOP enrollment plan shall establish enrollment goals and describe the methods to be used to accomplish these goals. The TOP enrollment plan shall be submitted through the TAO Directors to the TMA CO in accordance with the instructions in [Chapter 6, Section 1](#). The TOP enrollment plan shall be submitted not less than 90 calendar days prior to the start of each health care delivery period. At a minimum, the TOP enrollment plan shall include the following:

7.1 A description of the contractor's process for informing beneficiaries about the availability of TOP enrollment options (TOP Prime and TOP Prime Remote).

7.2 A description of any unique conditions and resources which may impact enrollment activities by MTF area and TOP geographic region, along with a description of the contractor's plan for overcoming any potential barriers to effective and efficient enrollment of eligible beneficiaries.

7.3 A description of the contractor's process for verification of eligibility prior to enrollment (including verification of command sponsorship status, when required for enrollment).

7.4 A description of the contractor's process for enrollment of beneficiaries on the DEERS using an automated government-furnished systems application, including the contractor's process for ensuring that enrollment data remains up-to-date and accurate.

7.5 A description of the contractor's process for providing continuous open enrollment for TOP Prime and TOP Prime Remote, automatic re-enrollment, and disenrollment as described in the TPM, [Chapter 10, Sections 2.1 and 3.1](#). The contractor may propose multiple methods of enrollment; however the plan must include the opportunity for enrollment at TRICARE Service Centers (TSCs), at government-specified locations for arriving/deploying units (per [Section 11, paragraph 5.2](#)), via the TOP Point of Contact (POC) program, and by mail.

7.6 The TOP contractor shall provide TOP-enrolled beneficiaries with full and fair disclosure of any restrictions on freedom of choice that apply to TOP enrollees, including the POS option.

8.0 ASSIGNMENT OF PCM

8.1 TOP Prime enrollees will be assigned to a PCM in a local Department of Defense (DoD) MTF. TOP Prime enrollees may not select an MTF Partnership Provider or host nation network or non-network provider for a PCM.

8.2 The MTFs will maintain current PCM lists and will make these lists available to the TOP contractor on a regular basis as determined in the MOU. MTF PCM lists should contain sufficient detail to facilitate new enrollments or PCM reassignments until capacity is optimized per MTF guidance.

8.3 The TOP contractor shall assign TOP enrollees to a PCM at the time of enrollment via the Defense Online Eligibility and Enrollment System (DOES) per the MOU, access standards, and/or other specific government guidance. DOES will only display PCMs with available capacity. TOP Prime beneficiaries must enroll to an overseas DMIS with assignment to an MTF PCM. TOP Prime

Remote beneficiaries must enroll to a civilian PCM, the contractor's call center(s), or a Canadian Forces Health Facility (in Canada). Appointments will be provided within the TRICARE Prime access standards.

8.4 MTF Commanders may establish specific MTF enrollment/empanelment guidelines for their facilities. The TOP contractor shall enroll TOP Prime beneficiaries and assign PCMs according to these MTF guidelines. Upon receipt of a completed TRICARE Enrollment Application, the contractor shall attempt to enroll the beneficiary according to the preferences indicated on the enrollment form (e.g., specific provider, gender or specialty preference). If the beneficiary's PCM preferences are incompatible with MTF enrollment/empanelment guidelines, the beneficiary shall be enrolled according to MTF guidelines. If the preferred PCM is not available (no capacity), the contractor will use the default PCM for that MTF. If there is no PCM capacity in the MTF, the contractor shall contact the MTF for instructions.

8.5 A significant number of MTF PCMs rotate or move each year. This will require the TOP contractor to move the enrollment panels associated with those PCMs. Through a government-provided application, the contractor shall perform batch PCM reassignments based on the parameters established by the MTF. Those parameters include DMIS ID to DMIS ID, PCM ID to PCM ID, Health Care Delivery Plan (HCDP), sex of beneficiary, Unit Identification Code (UIC) (active duty only), age of beneficiary, sponsor Social Security Number (SSN) (for family moves) and name of beneficiary. The contractor will perform MTF PCM reassignment moves within three working days of the effective date of the PCM's reassignment. The contractor will also perform PCM reassignment, as necessary, in response to turnover in host nation PCMs.

8.6 The TOP contractor shall enroll TOP Prime Remote beneficiaries to the appropriate enrollment DMIS ID based on beneficiary location. The contractor shall list the name of the assigned remote location/site or the host nation PCM, as appropriate.

9.0 ENROLLMENT PROCEDURES

9.1 No TRICARE-eligible beneficiary shall be denied enrollment or re-enrollment in, or be required to disenroll from, the TOP Prime/TOP Prime Remote program because of a prior or current medical condition.

9.2 The TOP contractor shall be responsible for enrollment processing and for coordinating enrollment processing with the MTF, the appropriate TAO Director, and DEERS. The contractor shall enter enrollments into DEERS through the National Enrollment Database (NED) according to the provisions of the TSM, [Chapter 3](#). The contractor shall perform the following specific functions related to enrollment processing:

9.2.1 The contractor shall collect TOP Prime enrollment applications at the TSCs or other sites mutually agreed to by the contractor, TAO Director, and the MTF Commander, or by mail or other secure means determined by the contractor. The contractor shall collect TOP Prime Remote service area applications by mail or other secure means determined by the contractor.

9.2.2 At the time of enrollment processing, the contractor shall access DEERS to verify eligibility of applicants and shall update the residential mailing address and any other fields for which they have update capability on DEERS. If the enrollment form does not contain a mailing address, the enrollment form should be developed for a mailing address. Enrollees may submit a temporary

address (e.g., unit address) 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](#). The contractor shall not input temporary addresses not provided by the enrollee. 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 within five calendar days outlining the discrepant information and requesting that the beneficiary contact their military personnel information office for assistance in updating the DEERS record.

9.2.3 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 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](#). A signature from an ADSM, although desired, is not required to complete Prime enrollment as enrollment in Prime is mandatory per TPM, [Chapter 10, Section 2.1, paragraph 1.1](#).

9.3 All TOP enrollees shall be issued enrollment cards per TSM, [Chapter 3, Section 1.4](#).

9.4 TOP Prime/TOP Prime Remote enrollment may occur at any time during the period of TOP eligibility and shall remain effective until the enrollee transfers enrollment to another region, disenrolls, or becomes ineligible for TOP Prime/TOP Prime Remote or the TRICARE program.

9.5 TOP Prime/TOP Prime Remote enrollment may be on an individual or family basis. Single enrollment may be changed to family at any time during the TOP enrollment period. A new TOP enrollment period shall be established for the family.

9.6 Enrollment fees are not required for TOP Prime/TOP Prime Remote.

9.7 ADSMs and ADFMs on PCS assignment in Canada (not at the request of the Canadian government) may enroll in TOP, but must pay up front for all health care and file a claim with the TOP contractor for reimbursement.

10.0 ENROLLMENT OF FAMILY MEMBERS OF E-1 THROUGH E-4

10.1 The provisions of [Chapter 6, Section 1](#) regarding enrollment of family members of E-1 through E-4 shall apply to the TOP, except that TOP Prime/TOP Prime Remote enrollment shall be effective on the date that the application is signed as long as it coincides with dates of eligibility.

10.2 The provisions of [Chapter 6, Section 2](#) regarding enrollment portability shall apply to the TOP, except that stateside-enrolled retirees and retiree family members may not transfer Prime enrollment to an overseas location.

11.0 SPLIT ENROLLMENT

The provisions of [Chapter 6, Section 3](#) regarding split enrollment shall apply to the TOP.

12.0 DISENROLLMENT

12.1 ADFMs shall be disenrolled from TOP Prime/TOP Prime Remote when:

- The enrollee requests disenrollment,
- The enrollee transfers enrollment to a new TRICARE region,
- The enrollee loses eligibility for TOP Prime or TOP Prime Remote,
- The enrollee loses TRICARE eligibility in DEERS, or
- The enrollee has not requested enrollment transfer/disenrollment within 60 calendar days following the end of the overseas tour.

12.2 ADSMs shall be disenrolled from TOP Prime/TOP Prime Remote when:

- The enrollee transfers enrollment to a new TRICARE region,
- The enrollee loses TRICARE eligibility in DEERS, or
- The enrollee has not requested enrollment transfer/disenrollment within 60 calendar days following the end of the overseas tour.

12.3 ADFMs who are enrolled in TOP Prime/TOP Prime Remote may disenroll at any time. They will not be permitted to make another enrollment until after a 12-month period if they have already changed their enrollment status from enrolled to disenrolled twice during the enrollment year (October 1 to September 30) for any reason. ADFMs with sponsors E-1 through E-4 are exempt from these enrollment lock-out provisions. See [Chapter 6, Section 1](#) for guidance regarding enrollment lock-outs.

12.4 ADSMs cannot voluntarily disenroll from TOP Prime or TOP Prime Remote if they remain on permanent assignment in an overseas location where these programs are offered. ADSM enrollment in TOP Prime or TOP Prime Remote continues until they transfer enrollment to another TRICARE region/program or lose eligibility for TOP/TRICARE.

12.5 TOP Prime/TOP Prime Remote enrollees must either transfer enrollment or disenroll within 60 calendar days of the end of the overseas tour when the ADSM departs to a new area of assignment. The TOP contractor shall provide continuing coverage until (1) the enrollment has been transferred to the new location, (2) the enrollee disenrolls, or (3) when enrollment transfer or disenrollment has not been requested by the TOP Prime/TPR enrollee by the 60th day. The TOP contractor will automatically disenroll the beneficiary on the 61st calendar day following the end date of the overseas tour. The ADFM TOP Prime/TPR beneficiary will revert to TRICARE Standard.

13.0 TRICARE ELIGIBILITY CHANGES

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

13.2 The TOP contractor shall include full and complete information about the effects of changes in eligibility and sponsor rank in beneficiary materials and briefings.

- END -

Civilian Health Care (CHC) Of Uniformed Service Members

1.0 GENERAL

1.1 All TRICARE requirements regarding the Supplemental Health Care Program (SHCP) shall apply to the TRICARE Overseas Program (TOP) unless specifically changed, waived, or superseded by this section, 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 17](#) for additional instructions.

1.2 Uniformed service members in an active duty status of greater than 30 days (also known as Active Duty Service Members (ADSMs)) who are on permanent or official duty assignment in a location outside the 50 United States and the District of Columbia must enroll in TRICARE Overseas Program (TOP) Prime or TOP Prime Remote. ADSMs in a temporary duty status and enrolled elsewhere should not transfer their enrollment to TOP Prime or TOP Prime Remote unless it is medically appropriate and will not cause enrollment eligibility disruption to family members' enrollment status. ADSMs are not CHAMPUS-eligible and do not have the option to use TRICARE Standard or the Point of Service (POS) option under TOP Prime or TOP Prime Remote. Uniformed service members who would normally receive care from a host nation provider may be directed to transfer their care to a Military Treatment Facility (MTF). This applies to ADSMs and uniformed service members not in active duty status (Reserve Component (RC) members under Line of Duty (LOD) care). These controls ensure the maintenance of required fitness-for-duty oversight for TOP uniformed service members. Refer to [Section 9](#) for claims processing instructions.

2.0 CONTRACTOR RESPONSIBILITIES

2.1 ADSMs who are enrolled in TOP Prime shall follow the procedures outlined in [Chapter 17](#) for MTF-enrolled ADSMs, except that any references to the Military Medical Support Office (MMSO) should be replaced by a reference to the appropriate regional TRICARE Area Office (TAO) in all overseas locations except the U.S. Virgin Islands **concerning Line of Duty Determinations and except for care delivered under the National Department of Defense (DoD)/Department of Veteran Affairs (DVA) Memorandum of Agreement (MOA) authorization requirements. See paragraph 2.4.3 for National DoD/DVA MOA authorization requirements.** ADSMs who are enrolled in TOP Prime Remote must seek authorization from the TOP contractor for all non-emergent specialty and inpatient care. ADSMs not enrolled in TOP who are on Temporary Additional Duty/Temporary Duty (TAD/TDY), deployed, deployed on liberty, or in an authorized leave status outside the 50 United States and the District of Columbia shall follow referral/authorization guidelines for TOP Prime Remote enrollees.

2.2 If an ADSM seeks host nation care without appropriate authorization, they put themselves at financial risk for claims payment. They are also at risk for potential compromise of medical readiness posture, flight status, or disability benefits, and they may be subject to disciplinary action for disregarding service-specific policy. Lost work time may be charged as ordinary leave.

2.3 The TOP contractor shall ensure a benefit review is done on each SHCP referral and authorization. The TOP contractor shall return deferred-to-network referrals for non-covered services with an explanation of why it was denied. The TOP contractor shall not issue an authorization unless they obtain a copy of an approved waiver. The contractor shall deny all claims for TRICARE non-covered health care services. (Reference Health Affairs (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").

2.3.1 If the contractor determines that the requested service, supply, or equipment is not covered by TRICARE policy and no TMA approved waiver is provided, the contractor shall decline to file an authorization and shall deny any received claims accordingly. If the request was received as an MTF referral, the contractor shall notify the MTF (and 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.

2.3.2 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.

2.4 The provisions of Chapter 17 are changed for the TOP as follows:

2.4.1 The provisions of Chapter 17, Section 2, paragraph 2.0 (Uniformed Services Family Health Plan (USFHP)) are not applicable to the TOP contract. USFHP services are not available outside the 50 United States and the District of Columbia.

2.4.2 Except for the claims for ADSM care provided under the National DoD/DVA MOA, the provisions of Chapter 17, Section 3, paragraph 1.2.1 regarding the timeline for review of SHCP claims by overseas MTFs is extended to 10 calendar days. ADSM claims for covered benefits submitted to the TOP contractor for which an authorization is not on file are to be pended for a determination of whether the care should be authorized. The claim shall be pended and the MTF of enrollment shall be notified that an authorization determination should be accomplished and returned to the TOP contractor within 10 calendar days. If the TOP contractor does not receive the MTF's response within 10 calendar days, the contractor shall move the claim back into active processing within one business day and shall process the claim as if the MTF had authorized the care. Claims authorized due to a lack of response by the MTF shall be considered as "Referred Care", but the contractor must be able to distinguish these claims from MTF-authorized claims. Claims pended under the provisions of this section shall be considered to be excluded claims for the purposes of calculating and reporting claims processing cycle time performance.

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2.4.3 The provisions of [Chapter 17, Section 2, paragraph 3.1](#) regarding claims for care provided under the National DoD/DVA MOA for Spinal Cord Injury (SCI), Traumatic Brain Injury (TBI), Blind Rehabilitation, and Polytrauma are applicable to the TOP and shall be processed in accordance with [Chapter 17, Section 2, paragraph 3.1.3](#). Such care will be authorized by the MMSO for ADSMs under this MOA.

2.4.4 The provisions of [Section 6, paragraph 5.0](#) and [Chapter 8, Section 5](#) apply to TOP SHCP referrals. Additionally, when MTFs submit a referral request for purchased care services for a non-AD sub-population beneficiary eligible for SHCP, the MTF shall utilize the required data elements identified in [Chapter 8, Section 5, paragraph 6.1](#) and shall annotate the referral with "SHCP" in line item 12, "Review Comment". This will ensure that SHCP claims for eligible non-AD sub-population beneficiaries are properly adjudicated.

2.5 When an ADSM leaves a remote TOP assignment as a result of Permanent Change of Station (PCS) or other service-related change of duty status, the following applies in support of medical record accumulation:

2.5.1 For ADSMs leaving remote TOP assignment in Puerto Rico, the PCM shall provide a complete copy of medical records, to include copies of specialty and ancillary care documentation, to ADSMs within 30 calendar days of the ADSM's request for the records. The ADSM may also request copies of medical care documentation (specialty care visits and discharge summaries) on an ongoing, EOC basis.

2.5.2 For ADSMs leaving remote TOP assignments from all overseas areas other than Puerto Rico, ADSMs in those locations should request medical records from the host nation provider(s) who provided health care services during the ADSM's tour of duty. These ADSMs may also request copies of medical care documentation (specialty care visits and discharge summaries) on an ongoing, EOC basis.

2.5.3 Records provided by host nation providers in languages other than English may be submitted to the TOP contractor for translation into English according to the terms of the contract.

2.5.4 Network host nation providers shall be reimbursed for medical records photocopying and postage costs incurred at the rates established in their network provider participation agreements. Non-network host nation providers shall be reimbursed for medical records photocopying and postage costs on the basis of billed charges unless the government has directed a lower reimbursement rate. 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 ADSMs must submit a claim form, with the charges clearly identified, to the contractor for reimbursement.

Note: The purpose of copying medical records is to assist the ADSM in maintaining accurate and current medical documentation. The contractor shall not make payment to a host nation provider who photocopies medical records to support the adjudication of a claim.

2.6 Provision of Respite Care For The Benefit of Seriously Ill or Injured Active Duty Members

2.6.1 The provisions of [Chapter 17, Section 3](#) and the TRICARE Systems Manual (TSM), [Chapter 2, Sections 2.8](#) and [6.4](#) regarding respite care for seriously ill or injured ADSMs are applicable in locations outside the 50 United States and the District of Columbia where TRICARE-authorized Home Health Agencies (HHAs) have been established.

2.6.2 The respite care benefit is applicable to ADSMs enrolled to TOP Prime, TOP Prime Remote, and to any ADSM referred by an overseas MTF or TAO.

2.6.3 All normal ADSM authorization and case management requirements for the TOP apply to the ADSM respite care benefit.

- END -