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**CHANGE 132
6010.56-M
OCTOBER 17, 2014**

**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: TRICARE PRIME REMOTE REVIEW REQUIREMENTS AND SUPPLEMENTAL
HEALTH CARE PROGRAM NON-COVERED SERVICES**

CONREQ: 16840

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change revises and replaces obsolete language, corrects references, updates review requirements between the Defense Health Agency-Great Lakes (DHA-GL) and the Managed Care Support Contractors (MCSCs), and adds Supplemental Health Care Program (SHCP) non-covered services contractor requirements for TRICARE Prime Remote (TPR).

EFFECTIVE DATE: November 17, 2014.

IMPLEMENTATION DATE: December 17, 2014.

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**ATTACHMENT(S): 97 PAGES
DISTRIBUTION: 6010.56-M**

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REMOVE PAGE(S)

CHAPTER 16

Table of Contents, page 1
Section 1, pages 1 - 3
Section 2, pages 1 - 6
Section 3, pages 1 - 3
Section 4, pages 1 - 4
Section 5, page 1
Section 6, pages 1 - 7
Addendum A, pages 1 and 2
Addendum B, pages 1 - 3
Addendum C, pages 1 - 3

CHAPTER 17

Table of Contents, page 1
Section 1, pages 1 - 3
Section 2, pages 1 - 4
Section 3, pages 1 - 22
Addendum A, pages 1 and 2
Addendum B, pages 1 - 3

APPENDIX A

pages 9 - 34

INDEX

pages 1 - 4

INSERT PAGE(S)

Table of Contents, page 1
Section 1, pages 1 - 3
Section 2, pages 1 - 6
Section 3, pages 1 - 3
Section 4, pages 1 - 4
Section 5, page 1
Section 6, pages 1 - 7
Addendum A, pages 1 - 4
Addendum B, pages 1 - 3
★ ★ ★ ★ ★ ★

Table of Contents, page 1
Section 1, pages 1 - 3
Section 2, pages 1 - 4
Section 3, pages 1 - 22
Addendum A, pages 1 and 2
Addendum B, pages 1 - 3

pages 9 - 34

pages 1 - 4

Chapter 16

TRICARE Prime Remote (TPR) Program

Section/Addendum	Subject/Addendum Title
1	General
2	Health Care Providers And Review Requirements
3	Enrollment, Beneficiary Education , And Support Services
4	Contractor Responsibilities And Reimbursement
5	Reports
6	TRICARE Prime Remote For Active Duty Family Member (TPRADFM) Program
A	Points Of Contact (POCs)
B	Specified Authorization Staff (SAS) Review: Protocols And Procedures

General

1.0 INTRODUCTION

The TRICARE Prime Remote (TPR) program provides health care to Service members (including Reserve Component (RC) members activated for more than 30 days) who meet the eligibility criteria specified in 32 CFR 199.16(e)(2) and are enrolled in the program. This chapter applies to operations of the TPR program in remote locations of the United States and the District of Columbia (DC) while the TRICARE Operations Manual (TOM), Chapter 24, Section 18 applies to operations of the TPR program outside of the United States.

2.0 ELIGIBILITY

Contractors have no responsibility for determining eligibility or for deciding in which region a Service member shall enroll. Regional Directors (RDs) will furnish contractors with enrollment information (refer to paragraph 3.0). If a contractor receives a claim for care provided to a Service member who is not enrolled in TPR or who is not enrolled in TRICARE Prime at a Military Treatment Facility (MTF), the contractor shall process the claim according to the applicable guidelines of the Supplemental Health Care Program (SHCP) (Chapter 17).

Note: Service member astronauts assigned to the Johnson Space Center in Houston, Texas must and shall be enrolled in TPR.

3.0 TPR PROGRAM UNITS

The RD will supply the contractor with an electronic directory, updated as needed, that lists, by region, the designated TPR zip codes for the contractor's region(s). The RD will also provide unit listings to the contractor so that the contractor can mail educational materials to the units. In some instances, individual member listings (as opposed to units) may be provided.

4.0 BENEFITS

4.1 Remote Service members enrolled in the TPR program shall receive the benefits of TRICARE Prime, even in areas without contractor networks. Some covered benefits (see Section 2, paragraph 5.3) require review by Specified Authorization Staff (SAS) (identified in Addendum A, paragraph 1.0) so they may identify fitness-for-duty issues. If the contractor determines that a requested or claimed service, supply, or equipment is not covered by TRICARE (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 Service Project Officers as

listed in Chapter 17, Addendum A, paragraph 2.0. No notification to the SAS is required. 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. SAS do not have the authority to overturn TRICARE Management Activity (TMA) or Department of Health and Human Services (DHHS) provider exclusions. See Section 2 for referral and authorization requirements. 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").

4.2 A SAS authorization shall be deemed to constitute referral, authorization, and direction to bypass edits as appropriate to ensure payment of SAS-approved claims. Contractors shall implement appropriate measures to recognize SAS authorization in order to expedite claims processing.

5.0 SAS

Certain Uniformed Service controls and rules apply to Service members due to unique military readiness requirements. SAS (identified in Addendum A, paragraph 1.0) serves as liaison among the Service member, the Service member's Uniformed Service, and the contractor for managing the Service member's health care services. The SAS review referrals for proposed care as well as information about care already received in order to determine impact on an individual's fitness for duty (see Section 2, paragraph 5.3 and Addendum B for referral and review/authorization procedures). SAS, the PCM (if assigned) and the contractor shall work together in making arrangements for the Service member's required examinations. The SAS will provide the protocol, procedures, and required documentation through the contractor to the provider for these examinations. For required care that may not be obtainable in the civilian community, SAS will refer the Service member to an MTF. Refer to Addendum A for the addresses and telephone numbers of the SASs.

6.0 APPEAL PROCESS

6.1 If the contractor, at the direction of the SAS, denies authorization of, or authorization for reimbursement, for a TPR enrollee's health care services, the contractor shall, on the Explanation of Benefits (EOB) or other appropriate document, furnish the enrollee with clear guidance for requesting a reconsideration from or filing an appeal with the SAS (see paragraph 6.2). The SAS will handle only those issues that involve SAS denials of authorization or authorization for reimbursement. The contractor will handle allowable charge issues, grievances, etc.

6.2 If the TPR enrollee disagrees with a denial rendered by the SAS, the first level of appeal will be through the SAS who will coordinate the appeal as appropriate. The enrollee may initiate the appeal by contacting his/her SAS. If the SAS upholds the denial, the SAS will notify the enrollee of further appeal rights with the appropriate Surgeon General's office.

6.3 If the denial is overturned at any level, the SAS will notify the contractor and the Service member.

6.4 The contractor shall forward all written inquiries and correspondence related to SAS denials of authorization, or authorization for reimbursement to the appropriate SAS. The contractor shall refer telephonic inquiries related to SAS denials to the appropriate SAS.

7.0 ACTIVE DUTY FAMILY MEMBERS (ADFM)s AND OTHERS

TRICARE-eligible family members accompanying Service members who are either eligible for or enrolled in the TPR program may enroll in TRICARE Prime Remote for Active Duty Family Members (TPRADFM)s Program in accordance with Section 6.

8.0 TPR PROGRAM DIFFERENCES

In addition to the SHCP differences specified in Chapter 17, Section 1, paragraph 4.0, the following differences apply to the TPR program.

8.1 If the contractor has not established a network of PCMs in a remote area, a TPR designated Service member will still be enrolled without a PCM assigned. The Service member without an assigned PCM will be able to use a local TRICARE-authorized provider for primary health care services without SAS review.

8.2 Point of Service (POS) cost-sharing and deductible amounts do not apply to Service members. If a TPR enrolled Service member receives primary care without a referral or authorization, the enrolling contractor shall process the claim and make payment if the care meets all other TRICARE requirements (i.e., the care is medically necessary, a covered benefit of TRICARE an approved waiver is provided, etc.).

8.3 Annual Service member re-enrollment is not required.

8.4 If the Uniformed Services determine that an active duty member is eligible for the TPR program, enrollment of the member is mandatory, unless there are service-specific issues that merit assignment to a military PCM, or if the Service member elects to waive access standards and enrolls to an MTF (subject to unit commander/supervisor approval).

8.5 If Third Party Liability (TPL) is involved in a claim, Service member claim payment will not be delayed during the development of TPL information from the Service member.

8.6 Enrollment jurisdiction may be based on the location of the military work unit instead of the Service member's residence. This is determined by the Services.

- END -

Health Care Providers And Review Requirements

1.0 NETWORK DEVELOPMENT

The TRICARE Prime Remote (TPR) program has no network development requirements.

2.0 UNIFORMED SERVICES FAMILY HEALTH PLAN (USFHP)

2.1 In addition to receiving claims from civilian providers, the contractor may also receive TPR Program claims from certain USFHP designated providers (DPs). The provisions of TPR will not apply to services furnished by a USFHP DP if the services are included as covered services under the current negotiated agreement between the USFHP DP and Office of the Assistant Secretary of Defense, Health Affairs (OASD(HA)). However, the contractor shall process claims according to the requirements in this chapter for any services not included in the USFHP DP agreement.

2.2 The USFHP, administered by the DPs listed below currently have negotiated agreements that provide the Prime benefit (inpatient and outpatient care). Since these facilities have the capability for inpatient services, they can submit claims that the contractor will process according to applicable TRICARE and TPR reimbursement rules:

- CHRISTUS Health, Houston, TX (which also includes):
 - St. Mary's Hospital, Port Arthur, TX
 - St. John Hospital, Nassau Bay, TX
 - St. Joseph Hospital, Houston, TX
- Martin's Point Health Care, Portland, ME
- Johns Hopkins Health Care Corporation, Baltimore, MD
- Brighton Marine Health Center, Boston, MA
- St. Vincent's Catholic Medical Centers of New York, New York City, NY
- Pacific Medical Clinics, Seattle, WA

3.0 VETERAN'S AFFAIRS

The contractor shall reimburse for services under the current national Department of Defense/Department of Veterans Affairs (DoD/DVA) Memorandum of Agreement (MOA) for "Referral of Active Duty Military Personnel Who Sustain Spinal Cord Injury (SCI), Traumatic Brain Injury (TBI), or Blindness to Veterans Affairs Medical Facilities for Health Care and Rehabilitative Services." (See [Section 4, paragraph 2.2](#) for additional information.) The contractor shall not

reimburse for services provided to TPR enrollees under any local Memoranda of Understanding (MOU) between the DoD (including the Army, Air Force and Navy/Marine Corps facilities) and the Department of Veteran's Affairs (DVA). Claims for these services will continue to be processed by the Military Services. However, the contractor shall process claims according to the requirements in this chapter for any services not included in the local MOU.

4.0 DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) [INDIAN HEALTH SERVICE (IHS), PUBLIC HEALTH SERVICE (PHS), ETC.]

Claims for services not included in the current MOU between the DoD (including the Army, Air Force and Navy/Marine Corps facilities) and the DHHS (including the IHS, PHS, etc.) shall be processed in accordance with the requirements in this chapter.

5.0 REVIEW REQUIREMENTS

5.1 Provision Of Documents

If the **Specified Authorization Staff (SAS)** requests copies of supporting documentation related to care reviews, appeals, claims, etc., the contractor shall send the requested copies to the **SAS** within four work days of receiving the request.

5.2 Primary Care

Service members enrolled in the TPR program can receive primary care services under **TRICARE Prime** without a referral, an authorization, or a fitness-for-duty review by the **SAS** (see **Addendum A**). **Service members** with assigned Primary Care Managers (PCMs) will receive primary care services from their PCMs. **Service members** without assigned PCMs will receive primary care services from TRICARE-authorized civilian providers, where available--or from other civilian providers where TRICARE-authorized civilian providers are not available.

5.3 Care Requiring SAS Review

The following care requires **SAS** review: all inpatient hospitalization, mental health care, invasive medical and surgical procedures (with the exception of laboratory/**diagnostic** services) and **substance abuse**.

5.3.1 Referred Care

5.3.1.1 The requesting provider shall follow the contractor's referral procedures and shall contact the contractor for an authorization. **Upon receipt of a civilian provider referral, the contractor shall perform a covered service review.** If an authorization is required, the contractor shall enter the information in **Addendum B**, required by the **SAS** for a fitness-for-duty review (**paragraph 5.3**). **SAS** will respond to the contractor within two **business** days. When a **SAS** 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. **A SAS authorization for health care includes authorization for any TRICARE covered ancillary or diagnostic services related to the health care authorized (i.e., associated with the EOC).** The contractor shall not communicate to the provider or patient that the care has been authorized until the **SAS** 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 (if assigned) or Primary Care Provider (PCP) for approval.

5.3.1.2 If the SAS determines that the Service member may receive the care from a civilian source, the SAS will enter the appropriate code into the authorization/referral system. The contractor shall notify the Service member of approved referrals. The Service member 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. (A Service member may always choose to receive care at an MTF even when the SAS 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 Service members (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 SAS'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 SAS. 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 Service member locate an authorized provider.

5.3.1.4 If the SAS directs the care to a military source, the SAS will manage the EOC. If the Service member disagrees with a SAS determination that the care must be provided by a military source, the Service member may appeal only through the SAS who will coordinate the appeal as appropriate; the contractor shall refer all appeals and inquiries concerning the SAS's fitness-for-duty determination to the SAS.

5.3.1.5 If the Service member's PCM determines that a specialty referral or test is required on an 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 SAS for a fitness for duty review. The Service member shall receive the care as needed without waiting for the SAS 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 SAS with a request for an additional SAS 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 SAS 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 B](#)) to the SAS for review. If the SAS 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 SAS is required.

Note: If the SAS 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 Comprehensive Health Promotion and Disease Prevention Examinations

The contractor shall reimburse charges for comprehensive health promotion and disease prevention examinations covered under TRICARE Prime (see the TRICARE Policy Manual (TPM), [Chapter 7, Section 2.2](#)) without SAS review.

6.2 Vision And Hearing Examinations

The Service member may directly contact the contractor for assistance in arranging for vision and hearing examinations. The contractor shall refer Service members to SAS for information on how to obtain eyeglasses, hearing aids, and contact lenses as well as examinations for them.

6.3 No PCM Assigned

Service members who work and reside in areas where a PCM is not available may directly access the contractor for assistance in arranging for routine primary care and for urgent specialty or inpatient care with a TRICARE-authorized provider. Since a non-network provider is not required to know the fitness-for-duty review process, it is important that the Service member coordinate all requests for specialty and inpatient care through the contractor. The contractor shall contact the SAS as required for reviews and other assistance as needed.

6.4 Emergency Care

For emergency care, refer to the TPM for guidelines.

6.5 Dental Care

Claims for active duty dental services will be processed and reimbursed by a single separate active duty dental program contractor. Claims for adjunctive dental care will be processed and reimbursed by the MCSC or the TRICARE Overseas Program (TOP) contractor for overseas care.

6.6 Immunizations

The contractor shall reimburse immunizations as primary care under the guidelines in the TRICARE Reimbursement Manual (TRM).

6.7 Ancillary Services

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

7.0 SERVICE MEMBER MEDICAL RECORDS

7.1 For TPR-enrolled **Service members** with assigned PCMs, the contractor shall follow contract requirements for maintaining medical records.

7.2 **Service members** will be instructed by their commands to sign annual medical release forms with their PCMs to allow information to be forwarded as necessary to civilian and military providers. The contractor may use the current "signature on file" procedures to fulfill this requirement ([Chapter 8, Section 4, paragraph 6.0](#)). When a **Service member** leaves an assignment as a result of a Permanent Change of Station (PCS) or other service-related change of duty status, the PCM shall provide a complete copy of medical records, to include copies of specialty and ancillary care documentation, to **Service members** within 30 calendar days of the **Service member's** request for the records. The **Service member** may also request copies of medical care documentation on an ongoing, EOC basis. The contractor shall be responsible for all administrative/copying costs. 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. **Service members** 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. **Service member's** claim forms should be accompanied by a receipt showing the amount paid.

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

7.3 **Service members** without assigned PCMs are responsible for maintaining their medical records when receiving care from civilian providers.

8.0 PROVIDER EDUCATION

The contractor shall familiarize network providers and, when appropriate, other providers with the TPR Program, special requirements for **Service member** health care, and billing procedures (e.g., no cost-share or deductible amounts, balance billing prohibition, etc.). On an ongoing basis, the contractor shall include information on **Service member** specialty care procedures and billing instructions in routine information and educational programs according to contractual requirements.

- END -

Enrollment, Beneficiary Education, And Support Services

1.0 ENROLLMENT

1.1 The **Regional Director (RD)** will, on an as needed basis, but at least semi-annually, provide the contractor with an update to the **TRICARE Prime Remote (TPR)** directory of units whose members are eligible for enrollment in the program according to [Section 1, paragraph 3.0](#).

1.2 An enrollment request, as described above, must be submitted by either the **Service member** or the **Service member's** unit commander for each **Service member** enrolling in the TPR Program. The effective date for TPR Program enrollment is the date the **Service member** or the **Service member's** unit commander submitted the enrollment request.

1.3 **Service member** enrollment in the TPR Program will be for the tour of duty. Enrollment transfers or disenrollments will occur upon change of duty location out of the region, transfer into an Military Treatment Facility (MTF)/clinic Prime Service Area (PSA), retirement, or separation from the service. The **Service member** will be responsible for notifying the contractor when an enrollment transfer is needed. The contractor shall follow enrollment portability and transfer procedures in [Chapter 6, Section 2](#).

- An official enrollment request includes those with (1) an original signature, (2) an electronic signature offered by and collected by the contractor, (3) a verbal consent provided via telephone and documented in the contractor's call notes, or (4) a self attestation by the beneficiary when using the **Beneficiary Web Enrollment (BWE)** system. A **Service member** signature is not required to make enrollment changes using the Enrollment Portability process outlined in [Chapter 6, Section 2, paragraph 1.4](#). A signature is not required to complete the enrollment as enrollment in TPR is mandatory per [paragraph 1.0](#).

1.4 The contractor shall record the **Service member's** TPR enrollment in the Defense Enrollment Eligibility Reporting System (DEERS) via DEERS Online Enrollment System (DOES). The TPR enrollment card is provided by Defense Manpower Data Center (DMDC). When processing TPR enrollment requests from **Service member** astronauts, the contractor shall not assign the astronauts to a network or other TRICARE authorized Primary Care Manager (PCM). The National Aeronautics and Space Administration (NASA) providers shall provide primary care for the **Service member** astronauts and the contractor shall use the PCM (unassigned) procedure when enrolling **Service member** astronauts into the TPR program. The contractor shall coordinate referrals and authorizations from the NASA providers for TPR enrolled **Service member** astronauts in accordance with [Section 2, paragraph 5.2](#) and [its](#) subordinate paragraphs.

2.0 PRIMARY CARE MANAGER (PCM) ASSIGNMENT

At the time of enrollment, a **Service member** will select (or will be assigned) a PCM in the local community, if available. A **Service member** without an assigned PCM may use a local TRICARE-authorized provider for primary care.

3.0 BENEFICIARY EDUCATION

3.1 Enrollment in the TPR Program is mandatory for **Service members** who qualify for the program (see [Section 1, paragraph 2.0](#)); therefore, the Managed Care Support Contractor (MCSC) shall limit educational activities for TPR-enrollees to distributing the informational materials provided by the Government. The RD will determine the initial supply of materials required and the MCSC shall forward materials to the TPR Program Units. The contractor shall include enrollment request options (enrollment forms, BWE transactions, and telephonic requests documented in the contractor's call center notes), for the TPR Program in the **Service member** informational materials.

3.2 Educational issues include the PCM concept (and what procedures to follow when a network PCM is not assigned), how to access care in and out of the area using the contractor, how to access specialty care through the contractor and **Specified Authorization Staff (SAS)**, and information on filing medical claims.

3.3 The Government will provide all TPR enrollees with information about how to obtain self-care manuals. The contractor shall give **TPR-enrolled Service members** and their family members the option of participating in health promotion and wellness programs offered **by the contractor** in MTF PSAs.

3.4 Educational activities in the TPR Program areas shall involve the joint efforts of the service unit of the **Service member**, the **SASs**, the Service Medical Departments, the RD, and the contractor. The contractor shall distribute TMA-supplied educational materials unique to the TPR Program. The contractor is responsible for postage, envelopes, and mailing costs for distributing educational material.

4.0 The contractor shall include TPR Program information and updates as part of all TRICARE briefings. The contractor may propose alternative methods for supplying educational information to **Service members** eligible to enroll in the TPR Program.

5.0 SUPPORT SERVICES

5.1 General

The requirements and standards in [Chapters 1 and 11](#), apply to the TPR Program unless otherwise stated in this chapter.

5.2 Inquiries

The contractor shall designate a point of contact for Government (RD, TRICARE Management Activity (TMA), and Uniformed Service) inquiries related to the TPR Program. The contractor may establish a dedicated unit for responding to inquiries about the TPR Program and the Supplemental Health Care Program (SHCP). The contractor shall respond to all inquiries--written,

telephone, walk-in (overseas only), etc.-- that are not related to dental care or to SAS reviews of medical care. The contractor shall forward all inquiries that specifically address dental care or SAS review of medical care to the active duty dental claims processor or the TPR enrollee's SAS for response. The requirements and standards in [Chapter 1, Section 3](#), apply to TPR inquiries.

5.3 Toll-Free Telephone Service

The contractor shall provide toll-free telephone access for TPR Program beneficiary inquiries. This toll-free access may also serve the SHCP beneficiaries. See [Chapter 1, Section 3](#) for telephone standards. The contractor shall handle provider inquiries through the contractor's provider inquiry system.

- END -

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 Service members 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 **Service members** 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 **Service members** 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 **Service member** 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 **Service member** 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 **Service member** 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;

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 16, Section 4

Contractor Responsibilities And Reimbursement

369.11; 369.15; 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 the **Defense Health Agency-Great Lakes (DHA-GL)**. **DHA-GL** 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 **DHA-GL** for determination.

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 **Service members**, normal TRICARE coverage limitations do not apply to services rendered for MOA care. As long as a service has been authorized by **DHA-GL**, 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 **Service Member Claims**

The claims filing deadline outlined in [Chapter 8, Section 3, paragraph 1.2](#), does not apply to any **Service member** 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 **Service member** 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 **Specified Authorization Staff (SAS)** review, the contractor shall allow the billed amount and reimburse the enrollee for the charges on the claim. If the claim requires **SAS** review the contractor shall pend the claim to the **SAS** for determination. If the **SAS** 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 **SAS** for determination. The **SAS** will issue an authorization to the contractor for payments in excess of the applicable TRICARE payment ceilings provided the **SAS** 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 **Service member** 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 -

Reports

1.0 WORKLOAD AND CYCLE TIME REPORTS

The contractor shall produce monthly workload and cycle time reports for the TPR Program in accordance with the contract deliverable requirements.

2.0 TPR CLAIMS LISTING

Throughout the period of the contract, the contractor shall have the ability to produce, when requested by the TRICARE Management Activity (TMA), an electronic listing of all TPR claims processed to completion for any given month(s). The listing shall include the following data elements: **Specified Authorization Staff (SAS)** Referral Number, TPR Defense Medical Information System Identification (DMIS-ID) code, Internal Control Number (ICN), Service Member's Social Security Number (SSN), and the date the claim was processed to completion (PTC).

- END -

TRICARE Prime Remote For Active Duty Family Member (TPRADFM) Program

1.0 INTRODUCTION

TRICARE Prime Remote for Active Duty Family Member (TPRADFM) provides TRICARE Prime like benefits to certain Active Duty Family Members (ADFM) who reside with the TRICARE Prime Remote (TPR) **enrolled** sponsor in remote locations in the United States and the District of Columbia. It also provides continued TPRADFM eligibility for family members residing at remote locations after the departure of the sponsor for an unaccompanied assignment, and eligibility for family members of Reserve Component (RC) members ordered to active duty. It covers family members of **Service members (on active duty for more than 30 days)** of all seven Uniformed Services in the United States and the District of Columbia. TPRADFM benefits are comparable to TRICARE Prime, including access standards, benefit coverage, and cost-shares. TPRADFM does not apply to ADFM enrollees in areas outside the 50 United States. Such care and claims shall be processed in accordance with the TRICARE Overseas Program (TOP), [Chapter 24](#) and TRICARE Policy Manual (TPM), [Chapter 12](#). The **Defense Health Agency-Great Lakes (DHA-GL)** and the **Specified Authorization Staff (SAS)** are not involved in any part of TPRADFM.

2.0 ELIGIBILITY

To be eligible for enrollment under TPRADFM, family members of **Service members** must meet the following eligibility requirements:

2.1 The **Service member** sponsor is eligible for, and enrolled in TPR and the ADFM resides with the **Service member** in a TPR area, or

2.2 The **Service member** is enrolled to a small government clinic, troop medical clinic, or other facility not capable of primary care management functions. These clinics have been designated by the Services and are located in certain TPR zip codes. These clinics allow active duty enrollment only, and are identified by Defense Medical Information System Identification Codes (DMIS-IDs). A list of applicable DMIS-IDs for the region will be provided to the Managed Care Support Contractor (MCSC) by the Regional Director (RD). The ADFM must reside with the **Service member** who is enrolled in a DMIS-ID Clinic in a TPR area.

2.3 National Guard/Reserve members who are ordered to active duty for a period of more than 30 days are not required to be eligible for, or enrolled, in TPR for their family members to be eligible for TPRADFM. Their family members are eligible for TPRADFM if they meet the criteria of [paragraph 2.6](#).

2.4 If an **Service member** receives a subsequent unaccompanied assignment after the TPR assignment and the family members are not authorized to accompany the member to the next

duty assignment, and they continue to reside in the same TPR location, the family members may remain in TPRADFM for the duration of the subsequent assignment.

2.4.1 ADFMs currently enrolled in TPRADFM, who transition to Transitional Survivor status, may remain enrolled in TPRADFM. See TPM, [Chapter 10, Section 7.1](#) for further information.

2.4.2 All Transitional Survivors may enroll in TPRADFM. At the request of the Transitional Survivor the contractor shall accept and process a new and continued enrollment request (enrollment form, Beneficiary Web Enrollment (BWE) transaction, or telephonic request documented in the contractor's call center notes) submitted by any Transitional Survivor living in, or moving to a TPR area. Enrollment in TPRADFM may continue for Transitional Survivors for the entire Transitional Survivor period. TPRADFM is not available to Survivors as they then become eligible for retiree family member benefits and cost-sharing. For example, after three years the surviving spouse is considered a survivor and, while still eligible for TRICARE, eligibility is at retiree payment rates and rules. Consequently, they are ineligible for TPRADFM which is an active duty program.

2.4.3 Transitional Survivor/Survivor status does not impact eligibility rules. Loss of eligibility as a result of any condition which routinely results in loss of TRICARE eligibility such as reaching age limits, marriage, remarriage, etc. also results in loss of Transitional Survivor/Survivor status.

2.5 "Resides with" is defined as the TPR residence address at which the family resides/resided with the sponsor while the sponsor was enrolled in TPR. Transitional Survivors only have to have a residence address in a TPR area to be eligible to enroll in TPRADFM.

2.6 To be eligible for enrollment under TPRADFM, family members of federalized National Guard/ Reserve members ordered to active duty for a period of more than 30 days must meet the following eligibility requirements:

- The family members reside with the member at the time of activation, and
- The residence address is located in a TPR zip code,
- "Resides with" is defined as the TPR residence address at which the family resides with the activated reservist upon activation.
- The federalized National Guard/Reserve member does not have to be TPR eligible or enrolled. However, for their family members to be eligible for TPRADFM the member must be ordered to active duty for a period of more than 30 days.
- Once enrolled in TPRADFM the family members of the federalized National Guard/ Reserve member, continuing to reside at the TPR residence address, may remain in TPRADFM for the period of active duty of the member, regardless of the subsequent assignment, enrollment location, or residence of the member.
- Family members of the federalized National Guard/Reserve member, continuing to reside at the TPR residence address, may enroll even after the sponsor has deployed/left for a subsequent assignment.

3.0 BENEFITS

ADFM enrolled in TPRADFM are eligible for the Uniform Health Maintenance Organization (HMO) Benefit, even in areas without contractor networks.

4.0 NETWORK DEVELOPMENT

TPRADFM has no network development requirements, except where contractually required. ADFMs enrolled in TPRADFM shall be assigned, or be allowed to select, a Primary Care Manager (PCM) when available through the TRICARE civilian provider network. If a network provider is not available to serve as a primary care provider, the TPRADFM enrollee may utilize any local TRICARE participating or authorized provider for primary care services. Enrolled ADFMs are required to use network providers where available within contractual access standards. If a network provider cannot be identified within the access standards, the enrolled family member shall use a TRICARE authorized provider. Contractors shall assist ADFMs in finding a TRICARE network or authorized provider for specialty care. The beneficiary may be eligible for the Prime travel benefit when referred more than 100 miles for specialty care. If the contractor has not established a network of PCMs in a remote area, a TPR designated ADFM will be enrolled without a PCM assigned. A generic PCM code will be used for TPRADFM enrollees without assigned PCMs. The ADFM without an assigned PCM will be able to use a local TRICARE participating or authorized provider for primary health care services without preauthorization. If a TPRADFM questions whether a service is covered as primary care, they may contact the contractor for assistance.

5.0 UNIFORMED SERVICES FAMILY HEALTH PLAN (USFHP)

If a USFHP is available to ADFMs in a TPR area, the ADFMs have the choice of enrolling in the USFHP, enrolling in TPRADFM, or to remaining in TRICARE Standard. ADFMs choosing to enroll in USFHP will be unable to access care through Military Treatment Facilities (MTFs) or the TRICARE system.

6.0 REFERRALS

6.1 Specialty care requires a referral through the contractor. If the ADFM has a PCM, the PCM shall follow the contractor's referral and authorization procedures. In cases where the ADFM is not enrolled to a PCM, the ADFM, or the ADFM's parent or guardian is responsible for directly contacting the contractor to obtain referrals and authorizations if required. The ADFM should obtain a referral request from their primary care provider which the ADFM would forward to the contractor.

6.2 TPRADFM enrollees are required to obtain a referral and use TRICARE network providers for specialty care where available within TRICARE access standards or pay the POS deductible and cost-share unless an appropriate out-of-network referral is obtained as required under TRICARE Prime.

7.0 PROVIDER EDUCATION

Contractors shall familiarize network providers and, when appropriate, other providers with TPRADFM. The contractor shall propose an educational plan to the RD outlining how providers will become familiar with TPRADFM. The contractor shall provide separate and distinct information to PCMs about the requirements and the special procedures for handling care for TPRADFM (e.g.,

specialty care referral requirements, balance billing limitations, etc.). On an ongoing basis, contractors shall include information on TPRADFM specialty care procedures, benefits, or requirements in routine information and educational programs.

8.0 BENEFICIARY EDUCATION

8.1 Beneficiary education will be a joint effort with the Government providing all beneficiary educational materials for the TPR program.

8.2 The MCSC shall distribute the supplied educational materials, and is responsible for postage, envelopes, and mailing costs for distributing educational materials. The contractor shall give ADFMs the option of participating in health promotion and wellness programs offered in the MTF and Prime program locations. The contractor shall design and conduct, with RD approval, TPRADFM briefings. The contractor shall include TPRADFM information and updates as part of all TRICARE briefings. Ongoing briefings will be on an "as needed" basis and will be coordinated with the RD.

8.3 Enrollment in TPRADFM is optional for ADFMs who qualify for the program; therefore, a contractor shall limit educational activities for TPRADFM enrollees to distributing the materials provided or approved by the Government.

9.0 ENROLLMENT

9.1 When the contractor receives an enrollment request (enrollment form, BWE transaction, or telephonic request documented in the contractor's call center notes) from an ADFM for TPRADFM, the contractor shall ensure the Service member sponsor is eligible for, and enrolled in the TPR program or a DMIS-ID clinic located in TPR designated zip codes. If an ADFM enrollment request is received and the Service member sponsor is either not eligible for TPR, or not enrolled in TPR or a TPR DMIS-ID clinic, the request shall be returned to the sender with a notice that the ADFM is not eligible for TPRADFM and the reason(s) why enrollment was denied. See paragraph 9.5 when a TPRADFM enrollment request is received for a family member of a Reserve Component (RC) member called or ordered to active service for more than 30 days.

9.2 Enrollment in TPRADFM is optional for ADFMs. However, ADFMs must enroll in TPRADFM to receive the TPRADFM benefit. ADFMs who elect not to enroll in TPRADFM may use the TRICARE Standard benefit, or enroll in TRICARE Prime where available, with access standards waived. TPRADFM beneficiaries who elect not to enroll in TPRADFM, and instead receive benefits under the TRICARE Standard and Extra programs must pay the associated TRICARE Standard and Extra cost-shares and deductibles.

9.3 An enrollment request (enrollment form, BWE transaction, or telephonic request documented in the contractor's call center notes) must be submitted to the contractor by either the ADFM or the Service member sponsor for each family member enrolling in TPRADFM. The effective date for TPRADFM enrollment is the first day of the following month, if the request is received by the 20th of the month, or the first day of the second month, if the request is received after the 20th of the month.

- An official enrollment request includes those with (1) an original signature, (2) an electronic signature offered by and collected by the contractor, (3) a verbal consent

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 16, Section 6

TRICARE Prime Remote For Active Duty Family Member (TPRADFM) Program

provided via telephone and documented in the contractor's call notes, or (4) a self attestation by the beneficiary when using the BWE system. A written signature is not required to make enrollment changes when using the Enrollment Portability process outlined in [Chapter 6, Section 2, paragraph 1.4](#).

9.4 The residence address zip code of the TPR eligible or enrolled **Service members** must match with the ADFMs. If the zip codes match, the contractor shall deem the ADFM as eligible for TPRADFM and enroll the ADFM in the program. If the residence address zip codes of the TPR **Service members** and their ADFMs do not match, the ADFMs shall be advised by letter that they are not eligible for enrollment in TPRADFM but they remain eligible for TRICARE Standard, Extra, or Prime as appropriate.

9.5 When the contractor receives an enrollment request (enrollment form, BWE transaction, or telephonic request documented in the contractor's call center notes) for TPRADFM from a family member of a **RC member called or** ordered to active **service** for more than 30 days, the contractor shall ensure the family members are registered as eligible on DEERS.

9.6 The contractor shall match the TPR residence addresses from the enrollment request (enrollment form, BWE transaction, or telephonic request documented in the contractor's call center notes) of the activated federalized National Guard/Reservist member and the family members. If the residence addresses match, to include zip code only match, the contractor shall deem the family members as eligible for TPRADFM and enroll the family member in the program.

9.7 If the TPR residence addresses from the enrollment request (enrollment form, BWE transaction, or telephonic requests documented in the contractor's call center notes) of the activated federalized National Guard/Reserve member and the family members do not match, the family members shall be advised by letter they are not eligible for enrollment in TPRADFM and they shall remain eligible for TRICARE Standard, Extra, or Prime as appropriate.

9.8 Enrollments or disenrollments will occur upon change of duty location out of the remote area, transfer into a MTF/clinic Prime Service Area (PSA), retirement, or separation from the Service. The ADFM or **Service member** is responsible for notifying the contractor when an enrollment transfer is needed. The contractor shall follow enrollment portability and transfer procedures in [Chapter 6, Section 2](#).

9.9 The contractor shall enroll the ADFM in the DEERS Online Enrollment System (DOES) and enter the TPRADFM's enrollment status into DOES. The contractor shall use the DMIS-ID code(s) designated by the RD for that region to enroll ADFMs into TPRADFM (see the TRICARE Systems Manual (TSM)). If the contractor has not established a network of PCMs in a remote area, a TPR designated ADFM will be enrolled without a PCM assigned. A generic PCM code shall be used for TPRADFM enrollees without assigned PCMs. The ADFM without an assigned PCM will be able to use a local TRICARE participating or authorized provider for primary health care services without preauthorization.

9.10 The contractor shall provide TPRADFM enrollment information in the formats indicated in the contract requirements.

10.0 PCM ASSIGNMENT

At the time of enrollment, an ADFM will select (or will be assigned) a PCM within the access standard. The MCSC shall advise the ADFM of the availability of PCMs. If a PCM is not available, the ADFM shall be enrolled to TPRADFM without an identified PCM. An ADFM without an assigned PCM may use any TRICARE-authorized provider for primary care.

11.0 SUPPORT SERVICES

11.1 Inquiries

The contractor shall designate a point of contact for Government (RD, TMA, and Military Service) inquiries related to TPRADFM. The contractor may establish a dedicated unit for responding to inquiries about TPRADFM, or may augment existing TPR service units already serving the **Service members** enrolled in TPR. The correspondence requirements and standards in [Chapter 1, Section 3](#), apply to TPRADFM written inquiries.

11.2 Toll-Free Telephone Service

The contractor shall provide toll-free telephone access for TPRADFM beneficiary inquiries.

12.0 CLAIMS PROCESSING

The regional contractor where the TPRADFM is enrolled shall process all claims for that enrollee, except for care provided overseas (i.e., care outside of the 50 United States and the District of Columbia). Civilian health care while traveling or visiting overseas shall be processed by the TOP contractor, regardless of where the beneficiary is enrolled. POS claims processing provisions do apply. The contractor shall provide TPRADFM claims information in the format for the Monthly Workload Reports and the Monthly Cycle Time Aging reports.

13.0 CLAIM REIMBURSEMENT

13.1 The payment provisions applicable under TPR for **Service members** which allow for additional payment in excess of otherwise allowable amounts to providers who are not TRICARE-authorized or certified do not apply to TPRADFM. Such payments shall not be made unless such payments are otherwise allowed under the payment provisions for unauthorized providers contained in the TPM.

13.2 For network providers, the contractor shall pay TPRADFM claims at the negotiated rate. For participating providers the contractor shall pay up to the CHAMPUS Maximum Allowable Charge (CMAC), or billed charges, whichever is less. Contractors shall follow the requirements in [Chapter 8, Section 5](#) and the TRICARE Reimbursement Manual (TRM), [Chapter 5, Section 1](#), for claims for TPRADFM enrollees receiving care from non-participating providers.

13.3 If a non-participating provider requires a TPRADFM 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.

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 16, Section 6

TRICARE Prime Remote For Active Duty Family Member (TPRADFM) Program

13.4 If the contractor becomes aware that a civilian provider is “balance billing” a TPRADFM enrollee or has initiated collection action for emergency or authorized care, the contractor shall notify the provider that balance billing is prohibited.

13.5 If CMAC rates have been waived for TPR **Service member** enrollees under [Section 4, paragraph 3.5](#), the TPRADFM enrollee shall not be extended the same waived CMAC rates. 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 shall make every effort to obtain the provider’s agreement to accept, as payment in full, a rate within 100% of the 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. By law the contractor shall not negotiate a rate higher than 115% of CMAC for TPRADFM care rendered by a non-participating provider. The contractor shall ensure that the approved payment is annotated in the authorization/claims processing system.

14.0 APPEALS PROCESS

TPRADFM enrollees may appeal denials of authorization or reimbursement through the contractor in accordance with [Chapter 12](#). If the contractor denies authorization or reimbursement for a TPRADFM enrollee’s health care services, the contractor shall, on the Explanation of Benefits (EOB) or other appropriate document, furnish the enrollee with clear guidance for requesting a reconsideration from, or filing an appeal with, the contractor.

15.0 TRICARE ENCOUNTER DATA (TED) SUBMITTAL

The contractor shall report TPRADFM claims under the financially underwritten provisions of the MCS contract.

- END -

Points Of Contact (POCs)

1.0 SPECIFIED AUTHORIZATION STAFF (SAS)

1.1 Army, Air Force, Navy, Marine Corps, And Reserve/National Guard (except Coast Guard Reserve)

For Congressional inquiries:

TRICARE Management Activity
7700 Arlington Blvd, Suite 5101
Falls Church, VA 22042-5101

For all other matters:

Defense Health Agency-Great Lakes
P.O. Box 886999
Great Lakes, IL 60088-6999

Telephone: 1-888-647-6676
Fax: (847) 688-6460

1.2 United States Public Health Service (USPHS) and National Oceanographic And Atmospheric Administration (NOAA):

Medical Affairs Branch
Beneficiary Medical Programs
5600 Fishers Lane, Room 4C-06
Rockville, MD 20857

Telephone for Payment Issues & Care Authorizations: (800) 368-2777
Fax: (800) 733-1303

1.3 Coast Guard and Coast Guard Reserve

Medical Administration
USCG HSWL SC (MA-PA)
300 East Main Street
Norfolk, VA 23510-1000
Telephone: (757) 628-4379

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 16, Addendum A

Points Of Contact (POCs)

2.0 UNIFORMED SERVICES HEADQUARTERS POCs

2.1 Army

HQ, USA MEDCOM
G3/5/7, Patient Admin Division
2748 Worth Road
Fort Sam Houston, TX 78234-6010

Telephone: (210) 221-6113

2.2 Air Force

AFMOA/SGAT
2261 Hughes Ave, Suite 153
JBSA Lackland, TX 78236-1025

Fax: (210) 395-9292, ATTN: AFMOA/SGAT
Unsecured E-Mail: AFMOA.SGAT@us.af.mil
(please note that e-mail sent unencrypted can be vulnerable to unauthorized access)

2.3 Navy/Marine Corps:

Bureau of Medicine and Surgery
Healthcare Operations (M3B1)
7700 Arlington Blvd, Suite 5125
Falls Church, VA 22042-5125

Telephone for TRICARE Officer: (703) 681-8489
Telephone for Financial Issues: (703) 681-9445
Telephone for Patient Administration Issues: (703) 681-9210

2.4 U.S. Coast Guard

Commandant (G-WKH-3)
U.S. Coast Guard
Attn: TRICARE Officer
2100 2nd Street, SW
Washington, DC 20593-0001

Telephone: (202) 267-0846

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 16, Addendum A

Points Of Contact (POCs)

2.5 Army National Guard

NGB-ARS

111 South George Mason Drive

Arlington, VA 22204-1382

Telephone: (703) 607-7140

- END -

Specified Authorization Staff (SAS) Review: Protocols And Procedures

1.0 INTERCONNECTIVITY BETWEEN THE CONTRACTOR AND SAS

1.1 ADP Protocols

1.1.1 The contractor shall provide access for entry and edit of referrals into existing systems supporting this contract. The contractor shall propose one of the following access options:

- Government staff physically located in Great Lakes, IL, accessing the contractor's system, or
- Contractor staff physically located in Great Lakes, IL, accessing the contractor's system, and Government personnel performing a backup role in the event contractor personnel are unavailable due to annual or sick leave or another reason.

1.1.2 For all referrals meeting the criteria for SAS review, the contractor shall provide a status code indicating SAS review is required.

1.1.3 The contractor shall create a standard management listing for all pending referrals requiring SAS review. The listing will be made available on-line to the SAS. The contractor shall propose the design for the listing to the SAS for approval 30 days prior to health care delivery.

1.1.4 The contractor shall provide the capability to edit the status and entry of a 13 digit disposition code indicating if the referral was approved for Military Treatment Facility (MTF) or civilian network treatment (see [paragraph 1.2](#)). This disposition code may be used during the claims adjudication process.

1.1.5 The contractor shall provide the logic to automatically approve the referral if the SAS determination is not received within two work days of referral entry.

1.1.6 The contractor shall provide the telecommunications, hardware, and software necessary for data entry and report printing from the Defense Health Agency-Great Lakes (DHA-GL) location. The contractor shall provide initial and ongoing application training and support on an "as needed" basis.

1.1.7 The contractor shall provide a data dictionary of available data elements to be sent to the DHA-GL automated information system. The contractor shall send all care referral records to the DHA-GL in a tab delimited data flat file. The method of transfer can be File Transfer Protocol (FTP) or an e-mail attachment.

1.1.8 The contractors shall provide the **DHA-GL** read only access to their subcontractor's claims history database. The contractors shall provide the necessary training to the **DHA-GL** staff in order to access the claims history database.

1.2 SAS Referral Data

1.2.1 The format of the referral number will be "DMISYYJJNNNS" where:

1.2.1.1 "DMIS" = the DMIS ID Code of the issuing facility--(5203 = **DHA-GL**);

1.2.1.2 "YY" = the year in which the referral number was issued;

1.2.1.3 "JJJ" = the Julian date on which the referral number was issued;

1.2.1.4 "NNN" = the Facility Sequence Number;

1.2.1.5 "S" = Status (the type of provider)

- "C" = Civilian Care (refer to [Section 2, paragraph 5.3.1.2](#) for referral requirements)
- "M" = Military Care (military MTF or clinic)
- "V" = Veterans' Affairs (VA) Care (VA hospital or medical facility)
- "P" = Care rendered under the Department of Defense/Department of Veterans Affairs (DoD/DVA) Memorandum of Agreement (MOA) for "Referral of Active Duty Military Personnel Who Sustain Spinal Cord Injury, Traumatic Brain Injury, or Blindness to Veterans Affairs Medical Facilities for Health Care and Rehabilitative Services" (refer to [Section 4, paragraph 2.2](#) for referral requirements).

1.2.2 The format of the effective date is "YYYYMMDD" where:

- "YYYY" = the year in which the **SAS** referral is effective;
- "MM" = the month in which the **SAS** referral is effective; and
- "DD" = the day on which the **SAS** referral is effective. A retroactive authorization is indicated by an effective date prior to the issue date.

1.2.3 The format of the expiration date is "YYYYMMDD" where:

- "YYYY" = the year in which the **SAS** referral expires;
- "MM" = the month in which the **SAS** referral expires; and
- "DD" = the day on which the **SAS** referral expires.

1.3 Data Elements

The following data elements are the minimum elements required by **DHA-GL** for determining fitness-for-duty and for determining if care not covered under TRICARE Prime will be covered under TPR. The **DHA-GL** will return the data elements furnished by the contractor when responding to a request for a fitness-for-duty or coverage/benefit determination. If the contractor is asking for a coverage/benefit determination, the contractor shall include the applicable elements marked with asterisks (*) below. If, for example, the contractor cannot authorize the care it is not a **covered** benefit under **TRICARE**, the contractor will include "Not a benefit." If the contractor cannot

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 16, Addendum B

Specified Authorization Staff (SAS) Review: Protocols And Procedures

authorize the care because the care is not medically necessary, the contractor will include **Not medically necessary. If the contractor cannot authorize the care because the provider is not an authorized provider, the contractor shall include ***Provider not authorized.

DATA ELEMENT	CONTRACTOR TO DHA-GL	DHA-GL TO CONTRACTOR
Patient Name	X	X
Patient's DOB	X	X
Patient's Sex	X	X
Contact Date (for retroactive authorizations)	X	X
Service Member SSN	X	X
Service Member Branch of Service	X	X
Duty Status	X	X
PCM Location Code	X	X
DMIS-ID	X	X
Contractor's Authorization Number	X	X
Effective Date of Authorization	X	X
*Not a Benefit	*If applicable	
**Not Medically Necessary	**If applicable	
***Provider Not Authorized	***If applicable	
SAS Fitness-for-Duty Referral Number or Benefit Determination Number		X
Effective Date of SAS Referral		X
Expiration Date of SAS Referral		X
Status of Authorization (may be imbedded number)		X
Number/Frequency of Services Requested for SAS Referral	X	X
Diagnosis	X	X
Procedure Code Range	X	X
Type of Service	X	X
Place of Service	X	X
Free Text (for available clinical information)	X	

- END -

Chapter 17

Supplemental Health Care Program (SHCP)

Section/Addendum	Subject/Addendum Title
1	General
2	Providers Of Care Figure 17.2-1 Disability Pay Schedule
3	Contractor Responsibilities
A	Points Of Contact (POC)
B	Specified Authorization Staff (SAS) Review For Authorization: Protocols And Procedures
C	Memorandum Of Agreement (MOA) Between Department Of Veterans Affairs (DVA) And Department Of Defense (DoD) For Processing Payment For Disability Compensation And Pension Examinations (DCPE) In The Integrated Disability Evaluation System (IDES)
D	Memorandum Of Agreement (MOA) Between Department Of Veterans Affairs (DVA) And Department Of Defense (DoD) For Medical Treatment Provided To Active Duty Service Members (ADSMs) With Spinal Cord Injury (SCI), Traumatic Brain Injury (TBI), Blindness, Or Polytraumatic Injuries

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 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 a Service member MTF enrollee and no authorization is on file, the MTF must be contacted to determine if the care was MTF referred.

2.0 SPECIFIED AUTHORIZATION STAFF (SAS)/MILITARY SERVICE PARTICIPATION

2.1 For care that is **in a TRICARE Prime Remote (TPR) designated area** not referred by an MTF and is not in an area served by the TRICARE Overseas Program (TOP) contractor, the **SAS** will identify, **and coordinate the** CHC furnished to Service members including preauthorization of care when required and **notify the nearest same service MTF for** civilian routine and emergency hospital admissions **so they can assume patient oversight responsibilities**. The **entities performing the SAS functions are identified** in [Addendum A](#).

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 a **Service member** 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 **Service members** have no cost-shares, copayments, **Point of Service (POS) charges**, 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 **There will be no application by the contractor of OHI processing procedures for Service member claims under SHCP.**

4.4 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](#)).

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

4.6 If a **Service member** intends, while in a terminal leave status, to reside outside of the Prime Service Area (PSA) of the MTF where the **Service member** is enrolled, the MTF shall issue to the TRICARE MCSC a single preauthorization for the **Service member** 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.

4.7 Services that would not have ordinarily been covered under TRICARE policy (including limitations and exclusions) may be authorized for Service members 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 ([paragraph 2.0](#)).

4.8 Payment may be made for services furnished by providers who are not TRICARE-authorized or certified ([paragraphs 2.1 and 2.2](#)).

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 -

Providers Of Care

1.0 GENERAL

1.1 The Supplemental Health Care Program (SHCP) payment structure applies to inpatient and outpatient medical claims submitted by civilian institutions, individual professional providers, suppliers, pharmacies, and other TRICARE authorized providers for Civilian Health Care (CHC) rendered to Uniformed Service members and other SHCP-eligible individuals. For Military Treatment Facility (MTF)-referred care, the Managed Care Support Contractor (MCSC) will make referrals to network providers as required by contract.

1.2 For care that is not MTF referred (including care for MTF enrollees), most patients covered by this chapter will have undergone medical care prior to any contact with the Specified Authorization Staff (SAS) (Addendum A) or the MCSC. However, when the patient initiates contact prior to treatment and the SAS has authorized the care being sought, the MCSC will issue authorizations and assist in finding network providers; if a network provider is not available, the referral will be made to a TRICARE authorized provider.

1.3 For service determined eligible patients other than active duty (e.g., Reserve Officer Training Corps (ROTC), Reserve Component (RC), foreign military, etc.), the contractor, upon receiving an authorization from the SAS, will record and enter the authorization to enable appropriate claims processing, and, if necessary, will assist the patient with a network provider or TRICARE-authorized provider (if available).

1.4 Claims for active duty dental services in the 50 United States, the District of Columbia, and U.S. territories and commonwealths will be processed and paid by a single, separate active duty dental program contractor. Claims for adjunctive dental care will be processed and paid by the MCSC (or the TOP contractor for overseas care).

2.0 UNIFORMED SERVICES FAMILY HEALTH PLAN (USFHP)

2.1 In addition to receiving claims from civilian providers, the contractor may also receive SHCP claims from certain USFHP Designated Providers (DPs). The provisions of the SHCP will not apply to services furnished by a USFHP DP if the services are included as covered services under the current negotiated agreement between the USFHP DP and the TRICARE Management Activity (TMA) (this includes care for a USFHP enrollee). However, any services not included in the USFHP DP agreement shall be paid by the contractor in accordance with the requirements in this chapter.

2.2 The USFHP, administered by the DPs listed below currently have negotiated agreements which provide the Prime benefit (inpatient and outpatient care). Since these facilities have the

capability for inpatient services, they can submit claims which will be paid in accordance with applicable TRICARE reimbursement rules under the SHCP:

- CHRISTUS Health, Houston, TX (which also includes):
 - St. Mary's Hospital, Port Arthur, TX
 - St. John Hospital, Nassau Bay, TX
 - St. Joseph Hospital, Houston, TX
- Martin's Point Health Care, Portland, ME
- Johns Hopkins Health Care Corporation, Baltimore, MD
- Brighton Marine Health Center, Boston, MA
- St. Vincent's Catholic Medical Centers of New York, New York City, NY
- Pacific Medical Clinics, Seattle, WA

3.0 DEPARTMENT OF VETERANS AFFAIRS (DVA)

In addition to receiving claims from civilian providers, the contractor may also receive SHCP claims from the DVA. The provisions of the SHCP will not apply to services provided under any Memorandum of Agreement (MOA) for sharing between the Department of Defense (DoD) (including the Army, Air Force, Navy/Marine Corps, and Coast Guard facilities) and the DVA. Claims for these services will continue to be processed by the Services. However, any services not included in any MOA described below shall be paid by the contractor in accordance with the TRICARE Reimbursement Manual (TRM) to include claims referred for beneficiaries on the Temporary Disability Retirement List (TDRL).

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

3.1.1 Effective August 4, 2009, the contractor shall process DVA submitted claims for Service members' treated under the MOA in accordance with this chapter and the following (SCI, TBI MOA; see [Addendum D](#) for a full text copy of the MOA for references purposes only).

3.1.2 Claims received from a DVA health care facility for Service member care shall be processed as an MOA claim based upon the TMA/Defense Health Agency-Great Lakes (DHA-GL) authorization number. As determined by TMA/DHA-GL, all medical conditions shall be authorized and paid under this MOA if a condition of TBI, SCI, Blindness, or Polytrauma exists for the patient. The authorization shall clearly indicate that the care has been authorized under the SCI, TBI, Blindness, and Polytrauma MOA. The authorization shall specify type of care (inpatient, outpatient, etc.) to be given under the referenced MOA and limits of the authorization (inpatient days, outpatient visits, expiration date, etc.). Suggested authorization language to possibly include all care authorized under the SCI, TBI, Blindness, and Polytrauma MOA for inpatient, outpatient and rehabilitative care. TMA/DHA-GL shall send authorizations to the contractor either by fax or by other mutually agreed upon modality.

3.1.3 The contractor shall verify whether the DVA-provided care has been authorized by the TMA/DHA-GL. If an authorization is on file, the contractor shall process the claim to payment. The contractor shall not deny claims for lack of authorization. If a required authorization is not on file, the contractor shall place the claim in a pending status and forward the appropriate documentation to the TMA/DHA-GL identifying the claim as a possible MOA claim for determination (following the procedures in Addendum B for the TMA/DHA-GL SAS referral and review procedures). Additionally, any DVA submitted claim for a Service member with a TBI, SCI, blindness, or polytrauma condition that does not have a matching authorization number shall be pending to the TMA/DHA-GL for payment determination.

3.1.4 MOA claims shall be reimbursed as follows:

3.1.4.1 Claims for inpatient care shall be paid using DVA interagency rates, published in the **Federal Register**. 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 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. All interagency rates except the outpatient interagency rate in the Office of Management and Budget (OMB) Federal Register Notice provided by TMA will be applicable. 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 rate. (For example, a stay for SCI may include days paid with the SCI rate and days billed at a surgery rate.) MCSCs shall verify the DVA billed rate on inpatient claims matches one of the interagency rates provided by TMA. DVA claims for inpatient care submitted with an applicable interagency rate shall not be developed any further (i.e., for revenue codes, diagnosis, etc.) if care has been approved by the TMA/DHA-GL. Claims without an applicable interagency rate shall be denied and an Explanation of Benefits (EOB) shall be issued to the DVA, but not the beneficiary. The claim will need to be resubmitted for payment.

3.1.4.2 Claims for outpatient and ambulatory surgery professional services shall be paid at the appropriate TRICARE allowable rate (e.g., CHAMPUS Maximum Allowable Charge (CMAC)) with a 10% discount applied. For those services without a TRICARE allowable rate, DVA shall be reimbursed at billed charges.

3.1.4.3 The following care services, irrespective of health care delivery setting require authorization from DHA-GL and are reimbursed at billed charges (actual DVA cost) separately from DVA inpatient interagency rates, if one exists:

- Transportation
- Prosthetics
- Non-medical rehabilitative items
- Durable Medical Equipment (DME)
- Orthotics (including cognitive devices)
- Routine and adjunctive dental services
- Optometry
- Lens prescriptions
- Inpatient/outpatient TBI evaluations

- Special diagnostic procedures
- Inpatient/outpatient polytrauma transitional rehabilitation program
- Home care
- Personal care attendants
- Conjoint family therapy
- Ambulatory surgeries
- Cognitive rehabilitation
- Extended care/nursing home care

3.1.4.4 On August 4, 2009, the contractor shall process all claims received on or after this date using the guidelines established under the updated MOA regardless of the date of service. All TRICARE Encounter Data (TED) records for this care shall include Special Processing Code 17 - DVA medical provider claim.

3.1.4.5 If paid at per diem rates, the provisions of [Chapter 8, Section 2, paragraph 7.2](#), apply when enrollment changes in the middle of an inpatient stay. If enrollment changes retroactively, prior payments will not be recouped.

3.2 Claims for Care Provided Under the National DoD/DVA MOA for Payment for Processing Disability Compensation and Pension Examinations (DCPE) in the Integrated Disability Evaluation System (IDES)

The contractor shall reimburse the DVA for services provided under the current national DoD/DVA MOA for "Processing Payment for Disability Compensation and Pension Examinations in the Integrated Disability Evaluation System" (IDES MOA; see [Addendum C](#) for a full text copy of the MOA for reference purposes only). The contractor shall begin processing these claims with dates of care January 1, 2011 and forward. Claims under the IDES MOA shall be processed in accordance with this chapter and the following:

3.2.1 Claims submitted by the DVA on a Centers for Medicare and Medicaid Services (CMS) 1500 Claim Form for a Service member's care with the Current Procedural Terminology (CPT¹) code of 99456 (principal or secondary) shall be processed as a IDES MOA claim.

3.2.2 The contractor shall verify whether services provided under the IDES MOA have been referred and authorized by the MTF. The MTF will generate a single referral request in the Armed Forces Health Longitudinal Technology Application (AHLTA) and submit the referral to the contractor. The referral will specify the total number of Compensation and Pension (C&P) examinations authorized for payment by the contractor. It is not necessary for the referral to identify the various specialists who will render the different C&P examinations. The reason for referral will be entered by the MTF as "**DVA only: Disability Evaluation System (DES) C&P exams for fitness for duty determination - total ___**." The MTF will complete the referral as described in [Chapter 8, Section 5, paragraph 6.1](#) including Note 4.

3.2.3 The DVA will list one C&P examination (CPT¹ code 99456) per the appropriate field of the CMS 1500 Claim Form and indicate one unit such that there is a separate line item for each C&P examination. The DVA can list related ancillary services separately in the appropriate field of the CMS 1500 Claim Form using the appropriate CPT codes.

¹ CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

Contractor Responsibilities

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

1.1 Claims Processing

1.1.1 Claims Processing And Reporting

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

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

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

1.1.3 Outpatient Care

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

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

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

1.1.5 Emergency Civilian Hospitalization

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

1.1.6 Temporary Disability Retirement List (TDRL)

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

1.1.7 Comprehensive Clinical Evaluation Program (CCEP)

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

1.1.8 Foreign Member Claims Processing

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

1.1.8.1 Foreign Military Member

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

civilian inpatient care. Any civilian outpatient care for an authorized foreign member must be referred by a MTF or DHA-GL. 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 DHA-GL shall issue referrals for outpatient care. Essentially, the same referral processes in place for Service members (which includes pending a claim without a referral and forwarding to either an MTF or DHA-GL 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 Service members 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 a Service member 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 a Service member 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.

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 **DHA-GL** when the VA cannot reasonably provide an episode of care in a timely manner. **DHA-GL**, 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 **Service member** 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 **Service member** is listed in the DEERS as **TRICARE Prime, No PCM Selected**, process the claim in accordance with the Types of Care paragraph. If, in the process of the DEERS check, the contractor determines the **Service member** 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 **Specified Authorization Staff (SAS)** Preauthorization

If a **SAS** preauthorization exists, process the claim to completion in accordance with this chapter whether or not the **Service member** 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 **SAS** 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 shall be checked for MTF or SAS authorization before routing to DHA-GL.** Claims for ineligible sponsors are to be suspended and routed to **DHA-GL** 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 **Service members** 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 **Service members'** 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 **SAS** 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 **SAS** 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 **SAS** for authorization. Upon receipt of the **SAS** 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 **SAS** 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/**SAS** 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/**SAS** 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 a **Service member**. See [Appendix B](#) for definitions, terms, and limitations applicable to the respite care benefit.

2.4.2 **Service members** may qualify for respite care benefits regardless of their enrollment status. **Service members** 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. **Service members** 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

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 17, Section 3

Contractor Responsibilities

in accordance with the non-enrolled/non-referred provisions for **Service member** care overseas (see the TPM, [Chapter 12, Section 1.1](#)).

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

2.4.3 There are no cost-shares or copays for **Service member** respite benefits when those services are approved by the member's Direct Care System (DCS) case manager or other appropriate DCS authority (i.e., **DHA-GL SAS**, 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 **Service member** shall apply. Contractors shall follow the requirements and provisions of these chapters, to include MTF or **DHA-GL** 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 **Service member** 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 **Service member** 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 a **Service member's** plan of care includes frequent interventions by the primary caregiver(s).

2.4.6.3 **Service members** 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 (EHC) program described in the TPM, [Chapter 9, Section 15.1](#).

Note: Contractors are not required to enroll **Service members** 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 **Service member's** residence.

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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.

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 [Service member](#) SHCP reimbursement methodology contained in [Chapters 16](#) and [17](#) (for [Service members](#) located in the 50 United States and the District of Columbia) or TOP reimbursement methodology contained in the TPM, [Chapter 12](#) (for [Service members](#) 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 a [Service member](#), a request may be submitted to the [DHA-GL](#), 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 [Service members](#) 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 [Service members](#), 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 [DHA-GL](#) 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 **Service members** 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 **DHA-GL**. 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 **DHA-GL**, 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 **DHA-GL**, 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 **create materials to support beneficiary education** 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 **Service member** on TAMP that believes he/she has a service-related condition which may qualify them for the TCSRC program is to be referred to **DHA-GL** for instructions on how to apply for the benefit.

2.5.4.3 **DHA-GL** will determine if further clinical evaluation/testing of the former **Service member** 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, **DHA-GL** 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.

DHA-GL'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 DHA-GL within 48 hours of the encounter. Once any additional information is received, the DoD physician associated with DHA-GL 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 Service member is otherwise eligible for TRICARE benefits, they may continue to receive care for the condition, following existing TRICARE guidelines. The former Service member may appeal the decision of the DoD Physician in writing to DHA-GL within 30 calendar days of receipt of the denial by the DoD physician. DHA-GL will issue a final determination within 30 calendar days of receipt of the appeal. If DHA-GL determines the condition should be covered under the Section 1637 benefit, coverage will begin on the date DHA-GL renders the final determination.

2.5.4.4 If the DoD physician determines the individual is eligible for the Section 1637 program, DHA-GL 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 DHA-GL. 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 DHA-GL) into the contractor's referral and authorization system within eight business days of receipt of the notification from DHA-GL. 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 DHA-GL and when and where to send clinical results/findings to close out DHA-GL'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

DHA-GL 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 a **Service member**. 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 a **Service member**.

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 [DHA-GL](#).

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 [DHA-GL](#) 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 DHA-GL

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 Service Members 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 Service member 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 **Service member's** illness or injury has made it impossible to conceive naturally.

2.6.1.6 Consent must be able to be given by the **Service member** 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 **Service member** 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 **Service member** 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 **Service member** 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 a **Service member** 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 **Service member'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:

- **Service member'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 **DHA-GL** as well as the TRICARE Regional Office (TRO), TAO, and TOP Office (TOPO). Preauthorization for care by the MTF or **DHA-GL** will be requested from the appropriate contractor. This

preauthorization will allow the use of SHCP funds for this treatment. All bills for the **Service member** 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 **DHA-GL** 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 **Service member** shall apply. Contractors shall follow the requirements and provisions of these chapters, to include MTF or **DHA-GL** 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 **Service member** 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](#).)

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 17, Section 3 Contractor Responsibilities

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 SAS 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 **Service members** in this program, with the additional requirement that **Service members** 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 **Service member** 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 **Service member** 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. **Service members** 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. **Service member'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.

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 17, Section 3

Contractor Responsibilities

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.

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 **Service members** 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 **Service member** 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 **SAS** review the contractor shall allow the billed amount and reimburse the **Service member** for charges on the claim. If the claim requires **SAS** review the contractor shall pend the claim to the **SAS** for determination. If the **SAS** authorizes the care the contractor shall allow the billed amount and reimburse the **Service member** 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 **SAS**, as appropriate, for determination. The referring MTF or **SAS** will issue an authorization to the contractor for payments in excess of CMAC or other applicable TRICARE payment ceilings, provided the referring MTF or **SAS** 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 **SAS**, 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/**SAS** 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/SAS here**):" TRICARE appeal rights shall pertain to outpatient claims for treatment of TRICARE eligible patients. The **SAS** will handle only those issues that involve **SAS** denials of authorization or authorization for reimbursement. The contractor shall handle allowable charge issues, grievances, etc.

6.2.2 If the **Service member** disagrees with a denial of authorization, rendered by **SAS**, the first level of appeal will be through the **SAS** who will coordinate the appeal as appropriate. The **Service member** may initiate the appeal by contacting his/her **SAS**. If the **SAS** upholds the denial, the **SAS** will notify the **Service member** of further appeal rights with the appropriate Surgeon General's office. If the denial is overturned at any level, the **SAS** will notify the contractor and the **Service member**.

6.2.3 The contractor shall forward all written inquiries and correspondence related to **SAS** or MTF denials of authorization or authorization for reimbursement to the appropriate **SAS** or MTF. The contractor shall refer telephonic inquiries related to **SAS** denials to the appropriate **SAS** 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 **SAS**. 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 **SAS** 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 **SAS**, 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, **S**ervice member or the MTF patient, to the referring MTF or the **SAS**, 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 **SAS**. 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 **S**ervice member or MTF patient written inquiries to the referring MTF or the **SAS**, 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 **SAS** upon receipt of the inquiry.

9.0 SHCP AGING CLAIMS REPORT

The Government intends to take action on all referrals to the SAS as quickly as possible. To support this objective, the SAS must be kept apprised of those claims on which the contractor cannot take further action until the SAS has completed its reviews and approvals.

- END -

Points Of Contact (POC)

1.0 SPECIFIED AUTHORIZATION STAFF (SAS)

1.1 Army, Air Force, Navy, Marine Corps, And Reserve/National Guard

For Congressional inquiries:

TRICARE Management Activity
7700 Arlington Blvd, Suite 5101
Falls Church, VA 22042-5126

For all other matters:

Defense Health Agency-Great Lakes
P.O. Box 886999
Great Lakes, IL 60088-6999

Telephone: 1-888-647-6676
FAX: (847) 688-6460

1.2 United States Public Health Service (USPHS) And National Oceanographic And Atmospheric Administration (NOAA)

Medical Affairs Branch
Beneficiary Medical Programs
5600 Fishers Lane, Room 4C-06
Rockville, MD 20857

Payment issues and Care Authorizations: (800) 368-2777
FAX: (800) 733-1303

1.3 Coast Guard

Medical Administration
USCG HSWL SC (MA-PA)
300 East Main Street
Norfolk, VA 23510-1000

Telephone: (757) 628-4379

2.0 UNIFORMED SERVICES HEADQUARTERS/SERVICE PROJECT OFFICERS

2.1 Army

HQ, USA MEDCOM

HP&S, Clinical Services Division

2748 Worth Road, Suite 10

Fort Sam Houston, TX 78234-6113

Telephone: (210) 221-6156

2.2 Air Force

AFMOA/SGAT

2261 Hughes Ave, Suite 153

JBSA Lackland, TX 78236-1025

Unsecured E-mail: AFMOA.SGAT@us.af.mil

(please note that e-mail sent unencrypted can be vulnerable to unauthorized access)

2.3 Navy/Marine Corps

Bureau of Medicine and Surgery

Healthcare Operations (M3B1)

7700 Arlington Blvd, Suite 5125

Falls Church, VA 22042-5125

Telephone for TRICARE Officer: (703) 681-8489

Telephone for Financial Issues: (703) 681-9445

Telephone for Patient Administration Issues: (703) 681-9210

2.4 Coast Guard

United States Coast Guard

Commanding Officer

Health, Safety, and Work-Life Service Center

Attn: Chief, Medical Administration Division

300 East Main Street, Suite 1000

Norfolk, VA 23510-9109

Telephone: (757) 628-4334

- END -

Specified Authorization Staff (SAS) Review For Authorization: Protocols And Procedures

1.0 INTERCONNECTIVITY BETWEEN THE CONTRACTOR AND DEFENSE HEALTH AGENCY- GREAT LAKES (DHA-GL) (THE SAS FOR ARMY, AIR FORCE, NAVY, MARINE CORPS AND COAST GUARD)

1.1 ADP Protocols

1.1.1 The contractor shall provide access for entry and edit of referrals into existing systems supporting this contract. The contractor shall propose one of the following access options:

- Government staff remotely, physically located in Great Lakes, IL, accessing the contractor's system, or
- Contractor staff remotely, physically located in Great Lakes, IL, accessing the contractor's system, and Government personnel performing a backup role in the event contractor personnel are unavailable.

1.1.2 For all referrals meeting the criteria for SAS review, the contractor shall provide a status code indicating SAS review is required.

1.1.3 The contractor shall create a standard management report for all pending referrals requiring SAS review. The contractor shall propose a report design to DHA-GL for approval 30 days prior to health care delivery.

1.1.4 The contractor shall provide the capability to edit the status and entry of a 16 digit disposition code indicating if the referral was approved for civilian network treatment (see [paragraph 1.2](#)). This disposition code may be used during the claims adjudication process.

1.1.5 The contractor shall provide the logic to automatically approve the referral if the SAS determination is not received within two work days of referral entry.

1.1.6 The contractor shall provide the telecommunications, hardware, and software necessary for data entry and report printing from the DHA-GL location. The contractor shall provide application training and support.

1.1.7 The contractor shall provide a data dictionary of available data elements to be sent to the DHA-GL automated information system. The contractor shall send all care referral records to the DHA-GL in a tab delimited data flat file. The method of transfer can be File Transfer Protocol (FTP) or an e-mail attachment.

1.1.8 The contractors shall provide the **DHA-GL** read only access to their subcontractor's claims history database. The contractors shall provide the necessary training to the **DHA-GL** staff in order to access the claims history database.

1.2 SAS Referral Data

1.2.1 The format of the referral number shall be "DMISYYJJNNS" where:

1.2.1.1 "DMIS" = the DMIS ID Code of the issuing facility (5203 = **DHA-GL**);

1.2.1.2 "YY" = the last two digits of the year in which the referral number was issued;

1.2.1.3 "JJJ" = the Julian date on which the referral number was issued;

1.2.1.4 "NNN" = the Facility Sequence Number;

1.2.1.5 "S" = Status (the type of provider)

- "C" = Civilian Care (refer to [Chapter 16, Section 2, paragraph 5.3.1.2](#) for referral requirements)
- "M" = Military Care (medical Military Treatment Facility (MTF) or clinic)
- "V" = Veterans' Affairs (VA) Care (VA hospital or medical facility)
- "P" = Care rendered under the Department of Defense/Department of Veterans Affairs (DoD/DVA) Memorandum of Agreement (MOA) for "Referral of Active Duty Military Personnel Who Sustain Spinal Cord Injury, Traumatic Brain Injury, or Blindness to Veterans Affairs Medical Facilities for Health Care and Rehabilitative Services" (refer to [Section 2, paragraph 3.1](#) for referral requirements).

1.2.2 The format of the effective date is "YYYYMMDD" where:

- "YYYY" = the year in which the **SAS** referral is effective;
- "MM" = the month in which the **SAS** referral is effective; and
- "DD" = the day on which the **SAS** referral is effective. A retroactive authorization is indicated by an effective date prior to the issue date.

1.2.3 The format of the expiration date is "YYYYMMDD" where:

- "YYYY" = the year in which the **SAS** referral expires;
- "MM" = the month in which the **SAS** referral expires; and
- "DD" = the day on which the **SAS** referral expires.

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 17, Addendum B

Specified Authorization Staff (SAS) Review For Authorization: Protocols And Procedures

1.3 Data Elements

The following data elements are the minimum elements required by **DHA-GL** for determining whether to authorize civilian care. The **DHA-GL** will return the data elements furnished by the contractor when responding to a request for authorization determination.

DATA ELEMENT	CONTRACTOR TO DHA-GL	DHA-GL TO CONTRACTOR
Patient Name	X	X
Patient's DOB	X	X
Patient's Sex	X	X
Contact Date (for retroactive authorizations)	X	X
Service Member SSN	X	X
Service Member Branch of Service	X	X
Duty Status	X	X
PCM Location Code	X	X
DMIS-ID	X	X
Contractor's Authorization Number	X	X
Effective Date of Authorization	X	X
*Not a Benefit	*If applicable	
**Not Medically Necessary	**If applicable	
***Provider Not Authorized	***If applicable	
SAS Fitness-for-Duty Referral Number or Benefit Determination Number		X
Effective Date of SAS Referral		X
Expiration Date of SAS Referral		
Status of Authorization (may be embedded number)		X
Number/Frequency of Services Requested for SAS Referral	X	X
Diagnosis	X	X
Procedure Code Range	X	X
Type of Service	X	X
Place of Service	X	X
Free Text (for available clinical information)	X	

- END -

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

DELM	Digital Epiluminescence Microscopy
DENC	Detailed Explanation of Non-Concurrence
DepSecDef	Deputy Secretary of Defense
DES	Data Encryption Standard Disability Evaluation System
DFAS	Defense Finance and Accounting Service
DG	Diagnostic Group
DGH	Denver General Hospital
DHA-GL	Defense Health Agency-Great Lakes (formerly Military Medical Support Office (MMSO))
DHHS	Department of Health and Human Services
DHP	Defense Health Program
DHS	Department of Homeland Security
DIA	Defense Intelligence Agency
DIACAP	DoD Information Assurance Certification And Accreditation Process
DII	Defense Information Infrastructure
DIS	Defense Investigative Service
DISA	Defense Information System Agency
DISCO	Defense Industrial Security Clearance Office
DISN	Defense Information Systems Network
DISP	Defense Industrial Security Program
DITSCAP	DoD Information Technology Security Certification and Accreditation Process
DLAR	Defense Logistics Agency Regulation
DLE	Dialyzable Leukocyte Extract
DLI	Donor Lymphocyte Infusion
DM	Disease Management
DMDC	Defense Manpower Data Center
DME	Durable Medical Equipment
DMEPOS	Durable medical equipment, prosthetics, orthotics, and supplies
DMI	DMDC Medical Interface
DMIS	Defense Medical Information System
DMIS-ID	Defense Medical Information System Identification (Code)
DMLSS	Defense Medical Logistics Support System
DMR	Direct Member Reimbursement
DMZ	Demilitarized Zone
DNA	Deoxyribonucleic Acid
DNA-HLA	Deoxyribonucleic Acid - Human Leucocyte Antigen
DNACI	DoD National Agency Check Plus Written Inquiries
DO	Doctor of Osteopathy Operations Directorate
DOB	Date of Birth
DOC	Dynamic Orthotic Cranioplasty (Band)
DoD	Department of Defense

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

DoD AI	Department of Defense Administrative Instruction
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DoDIG	Department of Defense Inspector General
DoDM	Department of Defense Manual
DoD P&T	Department of Defense Pharmacy and Therapeutics (Committee)
DOE	Department of Energy
DOEBA	Date of Earliest Billing Action
DOES	DEERS Online Enrollment System
DOHA	Defense Office of Hearings and Appeals
DOJ	Department of Justice
DOLBA	Date of Latest Billing Action
DOS	Date Of Service
DP	Designated Provider
DPA	Differential Power Analysis
DPCLO	Defense Privacy and Civil Liberties Office
DPI	Designated Providers Integrator
DPO	DEERS Program Office
DPPO	Designated Provider Program Office
DRA	Deficit Reduction Act
DREZ	Dorsal Root Entry Zone
DRG	Diagnosis Related Group
DRPO	DEERS RAPIDS Program Office
DRS	Decompression Reduction Stabilization
DSA	Data Sharing Agreement
DSAA	Data Sharing Agreement Application Defense Security Assistance Agency
DSC	DMDC Support Center
DSCC	Data and Study Coordinating Center
DS Logon	DoD Self-Service Logon
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSM-III	Diagnostic and Statistical Manual of Mental Disorders, Third Edition
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DSMC	Data and Safety Monitoring Committee
DSMO	Designated Standards Maintenance Organization
DSMT	Diabetes Self-Management Training
DSO	DMDC Support Office
DSPOC	Dental Service Point of Contact
DSU	Data Sending Unit
DTF	Dental Treatment Facility
DTM	Directive-Type Memorandum
DTR	Derived Test Requirements

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

DTRO	Director, TRICARE Regional Office
DUA	Data Use Agreement
DVA	Department of Veterans Affairs
DVAHCF	Department of Veterans Affairs Health Care Finder
DVD	Digital Versatile Disc (formerly Digital Video Disc)
DVD-R	Digital Versatile Disc-Recordable
DWR	DSO Web Request
Dx	Diagnosis
DXA	Dual Energy X-Ray Absorptiometry
E-ID	Early Identification
E-NAS	Electronic Non-Availability Statement
e-QIP	Electronic Questionnaires for Investigations Processing
E&M	Evaluation & Management
E2R	Enrollment Eligibility Reconciliation
EACH	Essential Access Community Hospital
EAL	Common Criteria Evaluation Assurance Level
EAP	Employee-Assistance Program Ethandamine phosphate
EBC	Enrollment Based Capitation
ECA	External Certification Authority
ECAS	European Cardiac Arrhythmia Society
ECG	Electrocardiogram
ECHO	Extended Care Health Option
ECT	Electroconvulsive Therapy
ED	Emergency Department
EDC	Error Detection Code
EDI	Electronic Data Information Electronic Data Interchange
EDIPI	Electronic Data Interchange Person Identifier
EDIPN	Electronic Data Interchange Person Number
EDI_PN	Electronic Data Interchange Patient Number
EEG	Electroencephalogram
EEPROM	Erasable Programmable Read-Only Memory
EFM	Electronic Fetal Monitoring
EFMP	Exceptional Family Member Program
EFP	Environmental Failure Protection
eFRC	Electronic Federal Records Center
EFT	Electronic Funds Transfer Environmental Failure Testing
EGHP	Employer Group Health Plan
E/HPC	Enrollment/Health Plan Code
EHHC	ECHO Home Health Care Extended Care Health Option Home Health Care

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

EHP	Employee Health Program
EHRA	European Heart Rhythm Association
EIA	Educational Interventions for Autism Spectrum Disorders
EID	Early Identification Enrollment Information for Dental
EIDS	Executive Information and Decision Support
EIN	Employer Identification Number
EIP	External Infusion Pump
EKG	Electrocardiogram
ELN	Element Locator Number
ELISA	Enzyme-Linked Immunoabsorbent Assay
E/M	Evaluation and Management
EMC	Electronic Media Claim Enrollment Management Contractor
EMDR	Eye Movement Desensitization and Reprocessing
EMG	Electromyogram
EMTALA	Emergency Medical Treatment & Active Labor Act
ENTNAC	Entrance National Agency Check
EOB	Explanation of Benefits
EOBs	Explanations of Benefits
EOC	Episode of Care
EOE	Evoked Otoacoustic Emission
EOG	Electro-oculogram
EOMB	Explanation of Medicare Benefits
EOP	Explanation of Payment
ePHI	electronic Protected Health Information
EPO	Erythropoietin Exclusive Provider Organization
EPR	EIA Program Report
EPROM	Erasable Programmable Read-Only Memory
ER	Emergency Room
ERA	Electronic Remittance Advice
ERISA	Employee Retirement Income and Security Act of 1974
ESRD	End Stage Renal Disease
EST	Eastern Standard Time
ESWT	Extracorporeal Shock Wave Therapy
ET	Eastern Time
ETIN	Electronic Transmitter Identification Number
EWPS	Enterprise Wide Provider System
EWRAS	Enterprise Wide Referral and Authorization System
F&AO	Finance and Accounting Office(r)
FAI	Femoroacetabular Impingement
FAP	Familial Adenomatous Polyposis

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

FAR	Federal Acquisition Regulations
FASB	Federal Accounting Standards Board
FBI	Federal Bureau of Investigation
FCC	Federal Communications Commission
FCCA	Federal Claims Collection Act
FDA	Food and Drug Administration
FDB	First Data Bank
FDL	Fixed Dollar Loss
Fed	Federal Reserve Bank
FEHBP	Federal Employee Health Benefit Program
FEL	Familial Erythrophagocytic Lymphohistiocytosis
FEV ₁	Forced Expiratory Volume
FFM	Foreign Force Member
FHL	Familial Hemophagocytic Lymphohistiocytosis
FI	Fiscal Intermediary
FIPS	Federal Information Processing Standards (or System)
FIPS PUB	FIPS Publication
FISH	Fluorescence In Situ Hybridization
FISMA	Federal Information Security Management Act
FL	Form Locator
FMCRA	Federal Medical Care Recovery Act
FMRI	Functional Magnetic Resonance Imaging
FOBT	Fecal Occult Blood Testing
FOC	Full Operational Capability
FOIA	Freedom of Information Act
FOUO	For Official Use Only
FPO	Fleet Post Office
FQHC	Federally Qualified Health Center
FR	Federal Register Frozen Records
FRC	Federal Records Center
FSH	Follicle Stimulating Hormone
FSO	Facility Security Officer
FTC	Federal Trade Commission
FTE	Full Time Equivalent
FTP	File Transfer Protocol
FX	Foreign Exchange (lines)
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GAO	General Accounting Office
GAF	Geographic Adjustment Factor
GDC	Guglielmi Detachable Coil

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

GFE	Government Furnished Equipment
GHP	Group Health Plan
GHz	Gigahertz
GIFT	Gamete Intrafallopian Transfer
GIQD	Government Inquiry of DEERS
GP	General Practitioner
GPCI	Geographic Practice Cost Index
GTMCPA	General Temporary Military Contingency Payment Adjustment
H/E	Health and Environment
HAC	Health Administration Center Hospital Acquired Condition
HAVEN	Home Assessment Validation and Entry
HBA	Health Benefits Advisor
HBO	Hyperbaric Oxygen Therapy
HCC	Health Care Coverage
HCDP	Health Care Delivery Program
HCF	Health Care Finder
HCFA	Health Care Financing Administration
HCG	Human Chorionic Gonadotropin
HCIL	Health Care Information Line
HCM	Hypertrophic Cardiomyopathy
HCO	Healthcare Operations Division
HCP	Health Care Provider
HCPC	Healthcare Common Procedure Code (formerly HCFA Common Procedure Code)
HCPCS	Healthcare Common Procedure Coding System (formerly Healthcare Common Procedure Coding System)
HCPR	Health Care Provider Record
HCSR	Health Care Service Record
HDC	High Dose Chemotherapy
HDC/SCR	High Dose Chemotherapy with Stem Cell Rescue
HDE	Humanitarian Device Exemption
HDGC	Hereditary Diffuse Gastric Cancer
HDL	Hardware Description Language
HDR	High Dose Radiation
HEAR	Health Enrollment Assessment Review
HEDIS	Health Plan Employer Data and Information Set
HepB-Hib	Hepatitis B and Hemophilus influenza B
HH	Home Health
HHA	Home Health Agency
HHA PPS	Home Health Agency Prospective Payment System
HHC	Home Health Care
HHC/CM	Home Health Care/Case Management

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

HHRG	Home Health Resource Group
HHS	Health and Human Services
HI	Health Insurance
HIAA	Health Insurance Association of America
HIC	Health Insurance Carrier
HICN	Health Insurance Claim Number
HINN	Hospital-Issued Notice Of Noncoverage
HINT	Hearing in Noise Test
HIPAA	Health Insurance Portability and Accountability Act (of 1996)
HIPEC	Hyperthermic Intraperitoneal Chemotherapy
HIPPS	Health Insurance Prospective Payment System
HIQH	Health Insurance Query for Health Agency
HITECH	Health Information Technology for Economic and Clinical Health
HIV	Human Immunodeficiency Virus
HL7	Health Level 7
HLA	Human Leukocyte Antigen
HMAC	Hash-Based Message Authentication Code
HMO	Health Maintenance Organization
HNPCC	Hereditary Non-Polyposis Colorectal Cancer
HOPD	Hospital Outpatient Department
HPA&E	Health Program Analysis & Evaluation
HPSA	Health Professional Shortage Area
HPV	Human Papilloma Virus
HRA	Health Reimbursement Arrangement
HRG	Health Resource Group
HRS	Heart Rhythm Society
HRT	Heidelberg Retina Tomograph Hormone Replacement Therapy
HSCRC	Health Services Cost Review Commission
HSWL	Health, Safety and Work-Life
HTML	HyperText Markup Language
HTTP	HyperText Transfer (Transport) Protocol
HTTPS	Hypertext Transfer (Transport) Protocol Secure
HUAM	Home Uterine Activity Monitoring
HUD	Humanitarian Use Device
HUS	Hemolytic Uremic Syndrome
HVPT	Hyperventilation Provocation Test
IA	Information Assurance
IATO	Interim Approval to Operate
IAVA	Information Assurance Vulnerability Alert
IAVB	Information Assurance Vulnerability Bulletin
IAVM	Information Assurance Vulnerability Management

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

IAW	In accordance with
IBD	Inflammatory Bowel Disease
IC	Individual Consideration Integrated Circuit
ICASS	International Cooperative Administrative Support Services
ICD	Implantable Cardioverter Defibrillator
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification
ICD-10-PCS	International Classification of Diseases, 10th Revision, Procedure Coding System
ICF	Intermediate Care Facility
ICMP	Individual Case Management Program
ICMP-PEC	Individual Case Management Program For Persons With Extraordinary Conditions
ICN	Internal Control Number
ICSP	Individual Corporate Services Provider
ID	Identification Identifier
IDB	Intradiscal Biacuplasty
IDD	Internal or Intervertebral Disc Decompression
IDE	Investigational Device Exemption Investigational Device
IDEA	Individuals with Disabilities Education Act
IDES	Integrated Disability Evaluation System
IDET	Intradiscal Electrothermal Therapy
IDME	Indirect Medical Education
IdP	Identity Protection
IDTA	Intradiscal Thermal Annuloplasty
IE	Interface Engine Internet Explorer
IEA	Intradiscal Electrothermal Annuloplasty
IEP	Individualized Educational Program
IFC	Interim Final Rule with comment
IFR	Interim Final Rule
IFSP	Individualized Family Service Plan
IG	Implementation Guidance
IgA	Immunoglobulin A
IGCE	Independent Government Cost Estimate
IHC	Immunohistochemistry
IHI	Institute for Healthcare Improvement
IHS	Indian Health Service
IIHI	Individually Identifiable Health Information
IIP	Implantable Infusion Pump

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

IM	Information Management Instant Message/Messaging Intramuscular
IMRT	Intensity Modulated Radiation Therapy
IND	Investigational New Drugs
INR	International Normalized Ratio Intramuscular International Normalized Ratio
INS	Immigration and Naturalization Service
IOC	Initial Operational Capability
IOD	Interface Operational Description
IOLs	Intraocular Lenses
IOM	Internet Only Manual
IOP	Intraocular Pressure
IORT	Intra-Operative Radiation Therapy
IP	Inpatient
IPC	Information Processing Center (outdated term, see SMC)
IPHC	Intraperitoneal Hyperthermic Chemotherapy
IPN	Intraperitoneal Nutrition
IPP	In-Person Proofing
IPPS	Inpatient Prospective Payment System
IPS	Individual Pricing Summary
IPSEC	Secure Internet Protocol
IQ	Intelligence Quotient
IQM	Internal Quality Management
IRB	Institutional Review Board
IRF	Inpatient Rehabilitation Facility
IRR	Individual Ready Reserve
IRS	Internal Revenue Service
IRTS	Integration and Runtime Specification
IS	Information System
ISN	Investigation Schedule Notice
ISO	International Standard Organization
ISP	Internet Service Provider
IT	Information Technology
ITSEC	Information Technology Security Evaluation Criteria
IV	Initialization Vector Intravenous
IVD	In Vitro Diagnostic Ischemic Vascular Disease
IVF	In Vitro Fertilization
JC	Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations (JCAHO))
JCAHO	Joint Commission on Accreditation of Healthcare Organizations

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

JCIH	Joint Committee on Infant Hearing
JCOS	Joint Chiefs of Staff
JFTR	Joint Federal Travel Regulations
JNI	Japanese National Insurance
JTF-GNO	Joint Task Force for Global Network Operations
JUSDAC	Joint Uniformed Services Dental Advisory Committee ⁷
JUSMAC	Joint Uniformed Services Medical Advisory Committee
JUSPAC	Joint Uniformed Services Personnel Advisory Committee
KB	Knowledge Base
KO	Contracting Officer
LAA	Limited Access Authorization
LAC	Local Agency Check
LAK	Lymphokine-Activated Killer
LAN	Local Area Network
LASER	Light Amplification by Stimulated Emission of Radiation
LCD	Local Coverage Determination
LCF	Long-term Care Facility
LCIS	Lobular Carcinoma In Situ
LDL	Low Density Lipoprotein
LDLT	Living Donor Liver Transplantation
LDR	Low Dose Rate
LDT	Laboratory Developed Test
LGS	Lennox-Gastaut Syndrome
LH	Luteinizing Hormone
LLLT	Low Level Laser Therapy
LNT	Lexical Neighborhood Test
LOC	Letter of Consent
LOD	Letter of Denial/Revocation Line of Duty
LOI	Letter of Intent
LOS	Length-of-Stay
LOT	Life Orientation Test
LPN	Licensed Practical Nurse
LSIL	Low-grade Squamous Intraepithelial Lesion
LSN	Location Storage Number
LTC	Long-Term Care
LUPA	Low Utilization Payment Adjustment
LV	Left Ventricle [Ventricular]
LVEF	Left Ventricular Ejection Fraction
LVN	Licensed Vocational Nurse
LVRS	Lung Volume Reduction Surgery
LVSD	Left Ventricular Systolic Dysfunction

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

MAC	Maximum Allowable Charge Maximum Allowable Cost
MAC III	Mission Assurance Category III
MAID	Maximum Allowable Inpatient Day
MAP	MYH-Associated Polyposis
MB&RB	Medical Benefits and Reimbursement Branch
MBI	Molecular Breast Imaging
MCIO	Military Criminal Investigation Organization
MCS	Managed Care Support
MCSC	Managed Care Support Contractor
MCSS	Managed Care Support Services
MCTDP	Myelomeningocele Clinical Trial Demonstration Protocol
MD	Doctor of Medicine
MDI	Mental Developmental Index Multiple Daily Injection
MDR	MHS Data Repository
MDS	Minimum Data Set
MEB	Medical Evaluation Board
MEC	Marketing and Education Committee
MEI	Medicare Economic Index
MEPS	Military Entrance Processing Station
MEPRS	Medical Expense Performance Reporting System
MESA	Microsurgical Epididymal Sperm Aspiration
MET	Microcurrent Electrical Therapy
MFCC	Marriage and Family Counseling Center
MGCRB	Medicare Geographic Classification Review Board
MGIB	Montgomery GI Bill
MH	Mental Health
MHCC	Maryland Health Care Commission
MHO	Medical Holdover
MHS	Military Health System
MHSO	Managing Health Services Organization
MHSS	Military Health Services System
MI	Myocardial Infarction
MI&L	Manpower, Installations, and Logistics
MIA	Missing In Action
MIAP	Multi-Host Internet Access Portal
MIDCAB	Minimally Invasive Direct Coronary Artery Bypass
mild®	Minimally Invasive Lumbar Decompression
MIRE	Monochromatic Infrared Energy
MLNT	Multisyllabic Lexical Neighborhood Test
MMA	Medicare Modernization Act

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

MMEA	Medicare and Medicaid Extenders Act (of 2010)
MMP	Medical Management Program
MMPCMHP	Maryland Multi-Payer Patient-Centered Medical Home Program
MMPP	Maryland Multi-Payer Patient
MMR	Mismatch Repair
MMWR	Morbidity and Mortality Weekly Report
MNR	Medical Necessity Report
MOA	Memorandum of Agreement
MOH	Medal Of Honor
MOMS	Management of Myelomeningocele Study
MOP	Mail Order Pharmacy
MOU	Memorandum of Understanding
MPI	Master Patient Index
MR	Magnetic Resonance Medical Review Mentally Retarded
MRA	Magnetic Resonance Angiography
MRHFP	Medicare Rural Hospital Flexibility Program
MRI	Magnetic Resonance Imaging
MRPU	Medical Retention Processing Unit
MRS	Magnetic Resonance Spectroscopy
MS	Microsoft® Multiple Sclerosis
MSA	Metropolitan Statistical Area
MSC	Military Sealift Command
MSI	Microsatellite Instability
MSIE	Microsoft® Internet Explorer
MSP	Medicare Secondary Payer
MSS	Medical Social Services
MST	Mountain Standard Time
MSUD	Maple Syrup Urine Disease
MSW	Masters of Social Work Medical Social Worker
MT	Mountain Time
MTF	Military Treatment Facility
MUE	Medically Unlikely Edits
MV	Multivisceral (transplant)
MVS	Multiple Virtual Storage
MWR	Morale, Welfare, and Recreation
MYH	mutY homolog
N/A	Not Applicable
N/D	No Default
NAC	National Agency Check

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

NACHA	National Automated Clearing House Association
NACI	National Agency Check Plus Written Inquiries
NACLC	National Agency Check with Law Enforcement and Credit
NADFM	Non-Active Duty Family Member
NARA	National Archives and Records Administration
NAS	Naval Air Station
	Non-Availability Statement
NATO	North Atlantic Treaty Organization
NAVMED	Naval Medical (Form)
NBCC	National Board of Certified Counselors
NCCI	National Correct Coding Initiatives
NCCN	National Comprehensive Cancer Network
NCD	National Coverage Determination
NCE	National Counselor Examination
NCF	National Conversion Factor
NCI	National Cancer Institute
NCMHCE	National Clinical Mental Health Counselor Examination
NCPAP	Nasal Continuous Positive Airway Pressure
NCPDP	National Council of Prescription Drug Program
NCQA	National Committee for Quality Assurance
NCVHS	National Committee on Vital and Health Statistics
NDAA	National Defense Authorization Act
NDC	National Drug Code
NDMS	National Disaster Medical System
NED	National Enrollment Database
NETT	National Emphysema Treatment Trial
NF	Nursing Facility
NG	National Guard
NGPL	No Government Pay List
NHLBI	National Heart, Lung and Blood Institute
NHSC	National Health Service Corps
NICHD	National Institute of Child Health and Human Development
NIH	National Institutes of Health
NII	Networks and Information Integration
NIPRNET	Nonsecure Internet Protocol Router Network
NIS	Naval Investigative Service
NISPOM	National Industrial Security Program Operating Manual
NIST	National Institute of Standards and Technology
NLDA	Nursery and Labor/Delivery Adjustment
NLT	No Later Than
NMA	Non-Medical Attendant
NMES	Neuromuscular Electrical Stimulation

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

NMOP	National Mail Order Pharmacy
NMR	Nuclear Magnetic Resonance
NMT	Nurse Massage Therapist
NOAA	National Oceanic and Atmospheric Administration
NoPP	Notice of Private Practices
NOSCASTC	National Operating Standard Cost as a Share of Total Costs
NP	Nurse Practitioner
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPR	Notice of Program Reimbursement
NPS	Naval Postgraduate School
NPWT	Negative Pressure Wound Therapy
NQF	National Quality Forum
NRC	Nuclear Regulatory Commission
NRS	Non-Routine [Medical] Supply
NSDSMEP	National Standards for Diabetes Self-Management Education Programs
NSF	Non-Sufficient Funds
NTIS	National Technical Information Service
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claims Committee
O/ATIC	Operations/Advanced Technology Integration Center
OA	Office of Administration
OAE	Otoacoustic Emissions
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)
OASD (H&E)	Office of the Assistant Secretary of Defense (Health and Environment)
OASD (MI&L)	Office of the Assistant Secretary of Defense (Manpower, Installations, and Logistics)
OASIS	Outcome and Assessment Information Set
OB/GYN	Obstetrician/Gynecologist
OBRA	Omnibus Budget Reconciliation Act
OCE	Outpatient Code Editor
OCHAMPUS	Office of Civilian Health and Medical Program of the Uniformed Services
OCMO	Office of the Chief Medical Officer
OCONUS	Outside of the Continental United States
OCR	Office for Civil Rights Optical Character Recognition
OCSP	Organizational Corporate Services Provider
OCT	Optical Coherence Tomograph
OD	Optical Disk
OF	Optional Form
OGC	Office of General Counsel

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

OGC-AC	Office of General Counsel-Appeals, Hearings & Claims Collection Division
OGP	Other Government Program
OHI	Other Health Insurance
OHS	Office of Homeland Security
OIG	Office of Inspector General
OMB	Office of Management and Budget
OP/NSP	Operation/Non-Surgical Procedure
OPD	Outpatient Department
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
OR	Operating Room
OSA	Obstructive Sleep Apnea
OSAS	Obstructive Sleep Apnea Syndrome
OSD	Office of the Secretary of Defense
OSHA	Occupational Safety and Health Act
OSS	Office of Strategic Services
OT	Occupational Therapy (Therapist)
OTC	Over-The-Counter
OTCD	Ornithine Transcarbamylase Deficiency
OUSD	Office of the Undersecretary of Defense
OUSD (P&R)	Office of the Undersecretary of Defense (Personnel and Readiness)
P/O	Prosthetic and Orthotics
P&CL	Privacy & Civil Liberties [Office]
P&T	Pharmacy And Therapeutics (Committee)
PA	Physician Assistant
PACAB	Port Access Coronary Artery Bypass
PACO ₂	Partial Pressure of Carbon Dioxide
PAO ₂	Partial Pressure of Oxygen
PAK	Pancreas After Kidney (transplant)
PAP	Papanicolaou
PAS	Privacy Act Statement
PAT	Performance Assessment Tracking
PATH Intl	Professional Association of Therapeutic Horsemanship International
PatID	Patient Identifier
PAVM	Pulmonary Arteriovenous Malformation
PBM	Pharmacy Benefit Manager
PBT	Proton Beam Therapy
PC	Peritoneal Carcinomatosis Personal Computer Professional Component
PCA	Patient Controlled Analgesia
PCDIS	Purchased Care Detail Information System

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

PCI	Percutaneous Coronary Intervention
PCM	Primary Care Manager
PCMBN	PCM By Name
PCMH	Patient-Centered Medical Home
PCMRA	PCM Research Application
PCMRS	PCM Panel Reassignment (Application) PCM Reassignment System
PCO	Procurement (Procuring) Contracting Officer
PCP	Primary Care Physician Primary Care Provider
PCS	Pelvic Congestion Syndrome Permanent Change of Station
PCSIB	Purchased Care Systems Integration Branch
PD	Passport Division
PDA	Patent Ductus Arteriosus Personal Digital Assistant
PDD	Percutaneous (or Plasma) Disc Decompression
PDDBI	Pervasive Developmental Disorders Behavior Inventory
PDDNOS	Pervasive Developmental Disorder Not Otherwise Specified
PDF	Portable Document Format
PDI	Potentially Disqualifying Information
PDQ	Physicians's Data Query
PDR	Person Data Repository
PDS	Person Demographics Service
PDTS	Pharmacy Data Transaction System
PDX	Principal Diagnosis
PE	Physical Examination
PEC	Pharmacoeconomic Center
PEP	Partial Episode Payment
PEPR	Patient Encounter Processing and Reporting
PERMS	Provider Education and Relations Management System
PESA	Percutaneous Epididymal Sperm Aspiration
PET	Positron Emission Tomography
PFCRA	Program Fraud Civil Remedies Act
PFP	Partnership For Peace
PFPWD	Program for Persons with Disabilities
PGD	Preimplantation Genetic Diagnosis
Phen-Fen	Pondimin and Redux
PHI	Protected Health Information
PHIMT	Protected Health Information Management Tool
PHP	Partial Hospitalization Program
PHS	Public Health Service
PI	Program Integrity (Office)

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

PIA	Privacy Impact Assessment (Online)
PIC	Personnel Investigation Center
PIE	Pulsed Irrigation Evacuation
PII	Personally Identifiable Information
PIN	Personnel Identification Number
PIP	Personal Injury Protection Personnel Identity Protection
PIRFT	Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)
PIT	PCM Information Transfer
PIV	Personal Identity Verification
PK	Public Key
PKE	Public Key Enabling
PKI	Public Key Infrastructure
PKU	Phenylketonuria
PLS	Preschool Language Scales
PM-DRG	Pediatric Modified-Diagnosis Related Group
PMPM	Per Member Per Month
PMR	Percutaneous Myocardial Laser Revascularization
PNET	Primitive Neuroectodermal Tumors
PNT	Policy Notification Transaction
POA	Power of Attorney Present On Admission
POA&M	Plan of Action and Milestones
POC	Pharmacy Operations Center Plan of Care Point of Contact
POL	May 1996 TRICARE/CHAMPUS Policy Manual 6010.47-M
POS	Point of Sale (Pharmacy only) Point of Service Public Official's Statement
POV	Privately Owned Vehicle
PPACA	Patient Protection and Affordable Care Act
PPC-PCMH	Physician Practice Connections Patient-Centered Medical Home
PPD	Per Patient Day
PPN	Preferred Provider Network
PPO	Preferred Provider Organization
PPP	Purchasing Power Parity
PPS	Prospective Payment System Ports, Protocols and Services
PPSM	Ports, Protocols, and Service Management
PPV	Pneumococcal Polysaccharide Vaccine
PQI	Potential Quality Indicator Potential Quality Issue

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

PR	Periodic Reinvestigation
PRC	Program Review Committee
PRFA	Percutaneous Radiofrequency Ablation
PRG	Peer Review Group
PRO	Peer Review Organization
ProDUR	Prospective Drug Utilization Review
PROM	Programmable Read-Only Memory
PRP	Personnel Reliability Program
PRPP	Pharmacy Redesign Pilot Project
PSA	Prime Service Area Physician Scarcity Area
PSAB	Personnel Security Appeals Board
PSCT	Peripheral Stem Cell Transplantation
PSD	Personnel Security Division
PSF	Provider Specific File
PSG	Polysomnography
PSI	Personnel Security Investigation
PST	Pacific Standard Time
PT	Pacific Time Physical Therapist Physical Therapy Prothrombin Time
PTA	Pancreas Transplant Alone Percutaneous Transluminal Angioplasty
PTC	Processed To Completion
PTCA	Percutaneous Transluminal Coronary Angioplasty
PTK	Phototherapeutic Keratectomy
PTNS	Posterior Tibial Nerve Stimulation
PTSD	Post-Traumatic Stress Disorder
PVCs	Premature Ventricular Contractions
QA	Quality Assurance
QC	Quality Control
QI	Quality Improvement Quality Issue
QII	Quality Improvement Initiative
QIO	Quality Improvement Organization
QIP	Quality Improvement Program
QLE	Qualifying Life Event
QM	Quality Management
QUIG	Quality Indicator Group
RA	Radiofrequency Annuloplasty Remittance Advice
RADDP	Remote Active Duty Dental Program

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

RAM	Random Access Memory
RAP	Request for Anticipated Payment
RAPIDS	Real-Time Automated Personnel Identification System
RARC	Remittance Advice Remark Code
RC	Reserve Component
RCC	Recurring Credit/Debit Charge Renal Cell Carcinoma
RCCPDS	Reserve Component Common Personnel Data System
RCN	Recoupment Case Number Refund Control Number
RCS	Report Control Symbol
RD	Regional Director Registered Dietitian
RDBMS	Relational Database Management System
RDDDB	Reportable Disease Database
REM	Rapid Eye Movement
RF	Radiofrequency
RFA	Radiofrequency Ablation
RFI	Request For Information
RFP	Request For Proposal
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RhoGAM	RRho (D) Immune Globulin
RIA	Radioimmunoassay
RM	Records Management
RN	Registered Nurse
RNG	Random Number Generator
RO	Regional Office
ROC	Resumption of Care
ROFR	Right of First Refusal
ROM	Read-Only Memory Rough Order of Magnitude
ROMF	Record Object Metadata File
ROT	Read-Only Table
ROTC	Reserved Officer Training Corps
ROVER	RHHI OASIS Verification
RPM	Record Processing Mode
RRA	Regional Review Authority
RRS	Records Retention Schedule
RTC	Residential Treatment Center
rTMS	Repetitive Transcranial Magnetic Stimulation
RUG	Resource Utilization Group

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

RV	Residual Volume Right Ventricle [Ventricular]
RVU	Relative Value Unit
SAAR	System Authorization Access Request
SAD	Seasonal Affective Disorder
SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier
SAFE	Sexual Assault Forensic Examination
SAMHSA	Substance Abuse and Mental Health Services Administration
SAO	Security Assistant Organizations
SAP	Special Access Program
SAPR	Sexual Assault Prevention and Response
SAS	Sensory Afferent Stimulation Specified Authorization Staff (formerly Service Point of contact (SPOC))
SAT	Service Assist Team
SAVR	Surgical Aortic Valve Replacement
SBCC	Service Branch Classification Code
SBI	Special Background Investigation
SCA	Service Contract Act
SCH	Sole Community Hospital
SCHIP	State Children's Health Insurance Program
SCI	Sensitive Compartmented Information Spinal Cord Injury
SCIC	Significant Change in Condition
SCOO	Special Contracts and Operations Office
SCR	Stem Cell Rescue
S/D	Security Division
SD (Form)	Secretary of Defense (Form)
SEP	Sensory Evoked Potentials
SES	Senior Executive Service
SelRes	Selected Reserve
SF	Standard Form
SFTP	Secure File Transfer Protocol
SGDs	Speech Generating Devices
SHCP	Supplemental Health Care Program
SI	Sensitive Information Small Intestine (transplant) Special Indicator (code) Status Indicator
SIDS	Sudden Infant Death Syndrome
SIF	Source Input Format
SII	Special Investigative Inquiry
SI/L	Small Intestine-Live (transplant)
SIOP-ESI	Single Integrated Operational plan-Extremely Sensitive Information

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

SIP	System Identification Profile
SIRT	Selective Internal Radiation Therapy
SIT	Standard Insurance Table
SLP	Speech-Language Pathology
SMC	System Management Center
SN	Skilled Nursing
SNF	Skilled Nursing Facility
SNS	Sacral Nerve Root Stimulation
SOC	Start of Care
SOFA	Status Of Forces Agreement
SOIC	Senior Officer of the Intelligence Community
SON	Submitting Office Number
SOR	Statement of Reasons System of Records
SORN	System of Records Notice
SPA	Simple Power Analysis
SPC	Special Processing Code
SPECT	Single Photon Emission Computed Tomography
SPK	Simultaneous Pancreas Kidney (transplant)
SPR	SECRET Periodic Reinvestigation
SQL	Structured Query Language
SRE	Serious Reportable Event
SSA	Social Security Act Social Security Administration
SSAA	Social Security Authorization Agreement
SSAN	Social Security Administration Number
SSBI	Single-Scope Background Investigation
SSDI	Social Security Disability Insurance
SSL	Secure Socket Layer
SSM	Site Security Manager
SSN	Social Security Number
SSO	Short-Stay Outlier
ST	Speech Therapy
STF	Specialized Treatment Facility
STS	Specialized Treatment Services
STSF	Specialized Treatment Service Facility
SUBID	Sub-Identifier
SUDRF	Substance Use Disorder Rehabilitation Facility
SVO	SIT Validation Office
SVT	Supraventricular Tachycardia
SWLS	Satisfaction With Life Scale
T-3	TRICARE Third Generation

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

TAD	Temporary Additional Duty
TAFIM	Technical Architecture Framework for Information Management
TAH	Total Artificial Heart
TAMP	Transitional Assistance Management Program
TAO	TRICARE Alaska Office TRICARE Area Office
TAR	Total Ankle Replacement
TARO	TRICARE Alaska Regional Office
TAVR	Transcatheter Aortic Valve Replacement
TB	Tuberculosis
TBD	To Be Determined
TBE	Tick Borne Encephalitis
TBI	Traumatic Brain Injury
TC	Technical Component
TCMHC	TRICARE Certified Mental Health Counselor
TCP/IP	Transmission Control Protocol/Internet Protocol
TCSRC	Transitional Care for Service-Related Conditions
TDD	Targeted Disc Decompression
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Program/Plan
TDR	Total Disc Replacement
TDY	Temporary Duty
TED	TRICARE Encounter Data
TEE	Transesophageal Echocardiograph [Echocardiography]
TEFRA	Tax Equity and Fiscal Responsibility Act
TEOB	TRICARE Explanation of Benefits
TEPRC	TRICARE Encounter Pricing (Record)
TEPRV	TRICARE Encounter Provider (Record)
TET	Tubal Embryo Transfer
TF	Transfer Factor
TFL	TRICARE For Life
TFMDP	TRICARE (Active Duty) Family Member Dental Plan
TGRO	TRICARE Global Remote Overseas
TGROHC	TGRO Host Country
TIFF	Tagged Imaged File Format
TIL	Tumor-Infiltrating Lymphocytes
TIMPO	Tri-Service Information Management Program Office
TIN	Taxpayer Identification Number
TIP	Thermal Intradiscal Procedure
TIPS	Transjugular Intrahepatic Portosystemic Shunt
TIS	TRICARE Information Service
TLAC	TRICARE Latin America/Canada

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

TLC	Total Lung Capacity
TMA	TRICARE Management Activity
TMA-A	TRICARE Management Activity - Aurora
TMAC	TRICARE Maximum Allowable Charge
TMCPA	Temporary Military Contingency Payment Adjustment
TMH	Telemental Health
TMI&S	Technology Management Integration & Standards
TMOP	TRICARE Mail Order Pharmacy
TMR	Transmyocardial Revascularization
TMS	Transcranial Magnetic Stimulation
TNEX	TRICARE Next Generation (MHS Systems)
TNP	Topical Negative Pressure
TOB	Type of Bill
TOE	Target of Evaluation
TOL	TRICARE Online
TOM	August 2002 TRICARE Operations Manual 6010.51-M February 2008 TRICARE Operations Manual 6010.56-M
TOP	TRICARE Overseas Program
TOPO	TRICARE Overseas Program Office
TPA	Third Party Administrator
TPC	Third Party Collections
TPharm	TRICARE Pharmacy
TPL	Third Party Liability
TPM	August 2002 TRICARE Policy Manual 6010.54-M February 2008 TRICARE Policy Manual 6010.57-M
TPN	Total Parenteral Nutrition
TPOCS	Third Party Outpatient Collections System
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote Active Duty Family Member
TPRADSM	TRICARE Prime Remote Active Duty Service Member
TPRC	TRICARE Puerto Rico Contract(or)
TPSA	Transitional Prime Service Area
TQMC	TRICARE Quality Monitoring Contractor
TRDP	TRICARE Retiree Dental Program
TRI	TED Record Indicator
TRIAP	TRICARE Assistance Program
TRIP	Temporary Records Information Portal
TRM	August 2002 TRICARE Reimbursement Manual 6010.55-M February 2008 TRICARE Reimbursement Manual 6010.58-M
TRO	TRICARE Regional Office
TRO-N	TRICARE Regional Office-North
TRO-S	TRICARE Regional Office-South
TRO-W	TRICARE Regional Office-West

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

TRPB	TRICARE Retail Pharmacy Benefits
TRR	TRICARE Retired Reserve
TRRx	TRICARE Retail Pharmacy
TRS	TRICARE Reserve Select
TRSA	TRICARE Reserve Select Application
TSC	TRICARE Service Center
TSF	Target of Evaluation Security Functions
TSM	August 2002 TRICARE Systems Manual 7950.1-M February 2008 TRICARE Systems Manual 7950.2-M
TSP	Target of Evaluation Security Policy
TSR	TRICARE Select Reserve
TSRDP	TRICARE Select Reserve Dental Program
TSRx	TRICARE Senior Pharmacy
TSS	TRICARE Senior Supplement
TSSD	TRICARE Senior Supplement Demonstration
TTOP	TRICARE Transitional Outpatient Payment
TTPA	Temporary Transitional Payment Adjustment
TTY	Teletypewriter
TUNA	Transurethral Needle Ablation
TYA	TRICARE Young Adult
UAE	Uterine Artery Embolization
UARS	Upper Airway Resistance Syndrome
UB	Uniform Bill
UBO	Uniform Business Office
UCBT	Umbilical Cord Blood Stem Cell Transplantation
UCC	Uniform Commercial Code Urgent Care Center
UCSF	University of California San Francisco
UIC	Unit Identification Code
UIN	Unit Identifier Number
UM	Utilization Management
UMO	Utilization Management Organization
UMP	User Maintenance Portal
UPIN	Unique Physician Identification Number
UPPP	Uvulopalatopharyngoplasty
URFS	Unremarried Former Spouse
URL	Universal Resource Locator
US	Ultrasound United States
US-CERT	United States-Computer Emergency Readiness Team
USA	United States of America
USACID	United States Army Criminal Investigation Division
USAF	United States Air Force

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

USAO	United States Attorneys' Office
USC	United States Code
USCG	United States Coast Guard
USCO	Uniformed Services Claim Office(r)
USD	Undersecretary of Defense
USD (P&R)	Undersecretary of Defense (Personnel and Readiness)
USDI	Undersecretary of Defense for Intelligence
USFHP	Uniformed Services Family Health Plan
USHBP	Uniformed Services Health Benefit Plan
USMC	United States Marine Corps
USMTF	Uniformed Services Medical Treatment Facility
USN	United States Navy
USPDI	United States Pharmacopoeia Drug Information
USPHS	United States Public Health Service
USPS	United States Postal Service
USPSTF	U.S. Preventive Services Task Force
USS	United Seaman's Service
USTF	Uniformed Services Treatment Facility
UV	Ultraviolet
VA	Veterans Affairs (hospital) Veterans Administration
VAC	Vacuum-Assisted Closure
VAD	Ventricular Assist Device
VAMC	VA Medical Center
VATS	Video-Assisted Thorascopic Surgery
VAX-D	Vertebral Axial Decompression
VD	Venereal Disease
VO	Verifying Office (Official)
VPN	Virtual Private Network
VPOC	Verification Point of Contact
VRDX	Reason Visit Diagnosis
VSAM	Virtual Storage Access Method
VSD	Ventricular Septal Defect
WAC	Wholesale Acquisition Cost
WAN	Wide Area Network
WATS	Wide Area Telephone Service
WC	Worker's Compensation
WebDOES	Web DEERS Online Enrollment System (application)
WEDI	Workgroup for Electronic Data Interchange
WHS	Washington Headquarters Services
WIC	Women, Infants, and Children (Program)
WII	Wounded, Ill, and Injured

TRICARE Operations Manual 6010.56-M, February 1, 2008

Appendix A

Acronyms And Abbreviations

WLAN	Wireless Local Area Network
WORM	Write Once Read Many
WRAMC	Walter Reed Army Medical Center
WTC	World Trade Center
WTRR	Wire Transfer Reconciliation Report
WTU	Warrior Transition Unit
WWW	World Wide Web
X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome
XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer

2D	Two Dimensional
3D	Three Dimensional

- END -

Index

A	Chap	Sec/Add
Acronyms And Abbreviations		Appendix A
Active Duty Dental Care In Remote Overseas Locations	24	10
Additional Supporting Information Pertaining To The Transaction And Code Sets Final Rule	19	A
Administration		
Figures	1	A
Management	1	4
Transitions	1	7
Allowable Charge Reviews	11	7
Ambulance/Aeromedical Evacuation Services	24	7
Appeal Of Factual (Non-Medical Necessity) Determinations	12	5
Appeals And Hearings		
Figures	12	A
General	12	1
TRICARE Overseas Program (TOP)	24	13
Appeals Of Medical Necessity Determinations	12	4
Application Of Deductible And Cost-Sharing	8	7
Applied Behavior Analysis (ABA) Pilot For Non-Active Duty Family Member (NADFM)	18	15
Audits, Inspections, And Reports	20	6
Audits And Inspections	14	1
Reports And Plans	14	2
Special Reports	14	3
Audits, Inspections, Reports, And Plans	24	15
TRICARE Overseas Program (TOP)	24	15
Autism Demonstration Corporate Services Provider (ACSP) Participation Agreement	18	A

B	Chap	Sec/Add
Beneficiary Education And Support Division (BE&SD)	24	11
Beneficiary, Congressional, Media, BCAC, DCAO, And HBA Relations	11	3

C	Chap	Sec/Add
Case Development And Action	13	2
Civilian Health Care (CHC) Of Uniformed Service Members	24	26
Claim Development	8	6
Claim Refund And Collection Procedures	3	3
Claims Adjustments And Recoupments		
Figures	10	A
General	10	1
Claims Filing Deadline	8	3
Claims Processing For Dual Eligibles	20	3
Claims Processing Procedures		
Figures	8	A
General	8	1
TRICARE Overseas Program (TOP)	24	9
Clinical Preventive Services (Prime/Standard)	24	8
Clinical Quality Management Program (CQMP)	7	4
Clinical Support Agreement (CSA) Program	15	3
Collection Actions Against Beneficiaries	11	9
Compliance With Federal Statutes	1	5
Comprehensive Autism Care		
Demonstration	18	18
Participation Agreement	18	B
Continued Health Care Benefit Program (CHCBP)		
Eligibility And Coverage	26	1
TRICARE Overseas Program (TOP)	24	25
Contract Administration And Instructions	1	2
Contractor Relationship With The Military Health System (MHS) TRICARE Quality Monitoring Contractor (TQMC)	7	3
Contractor Responsibilities - SHCP	17	3
Contractor Responsibilities And Reimbursement - TPR	16	4
Correspondence Control, Processing, And Appraisal	11	5
Critical Access Hospital (CAH) Payment Rates	18	7
Customer Service Functions	24	11

