



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY
AURORA, COLORADO 80011-9066

TRICARE
MANAGEMENT ACTIVITY

OD

CHANGE 18
6010.56-M
MARCH 12, 2010

**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: OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) TECHNICAL
CHANGES, FEBRUARY 2010

CONREQ: 14926

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This changes contains OPPS changes to include Active Duty Service Member (ADSM) inpatient procedures performed on an outpatient basis, changes to the observation stay policy, and the addition of new modifiers.

EFFECTIVE DATE: May 1, 2009, unless otherwise indicated.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Feb 2008 TPM, Change No. 27, Feb 2008 TRM, Change No. 26, and Feb 2008 TSM, Change No. 15.


Reta M. Michak
Director, Operations Division

ATTACHMENT(S): 4 PAGES
DISTRIBUTION: 6010.56-M

CHANGE 18
6010.56-M
MARCH 12, 2010

REMOVE PAGE(S)

CHAPTER 17

Section 3, pages 5 through 8

INSERT PAGE(S)

Section 3, pages 5 through 8

1.3 TPL

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

1.4 Types Of Care

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

1.4.1 Emergency Care (As Defined In The TPM)

Subsequent to the eligibility verification process described in [paragraph 1.2](#), the contractor shall pay all emergency claims for eligible uniformed service members. This includes emergency claims for treatment of "dental pain" or a similar diagnosis, to include institutional costs, when no dental procedure is actually performed. If an emergency civilian hospitalization comes to the attention of the contractor, it shall be reported to the SPOC or the MTF to which the active duty member is enrolled. The SPOC or the MTF to which the active duty member is enrolled will have primary case management responsibility, including authorization of care and patient movement for all civilian hospitalizations.

1.4.2 Non-Emergent Care

Subsequent to eligibility verification as described in [paragraph 1.2](#), the contractor shall verify whether the non-emergent medical civilian health care provided was already authorized by the SPOC or the contractor. If there is an authorization on file, the contractor shall process the claim to payment. If a required authorization is not on file for a non-enrollee, then the contractor will place the claim in a pending status and will forward copies of appropriate documentation to SPOC for determination. See [Addendum B](#) for SPOC referral and review procedures.

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

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

2.0 COVERAGE

2.1 Normal TRICARE coverage limitations will not apply to services rendered for supplemental health care for ADSMs. For ADSMs, the Director, TRICARE Management Activity (TMA), at the request of an authorized official of the uniformed service concerned, may authorize coverage for services that would not have ordinarily been covered under TRICARE policy based on that such waiver is necessary to assure adequate availability of health care services to active duty members. TRICARE coverage limits apply to services to TRICARE-eligible covered beneficiaries provided under the SHCP. On occasion care may be referred or authorized for services from a provider of a type which is not TRICARE authorized. The contractor shall not make claims payments to sanctioned or suspended providers. (See [Chapter 13, Section 6](#).) The claim shall be denied if a sanctioned or suspended provider bills for services. MTFs do not have the authority to overturn TMA or Department of Health and Human Services (DHHS) provider exclusions. TRICARE utilization review and utilization management requirements will not apply.

2.2 Unlike a normal TRICARE authorization, an MTF or SPOC authorization shall be deemed to constitute referral, authorization, eligibility verification, and direction to bypass provider certification and Non-Availability Statement (NAS) rules. The contractor shall take measures as appropriate to enable them to distinguish between the two authorization types.

2.3 Ancillary Services

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

2.4 Provision Of Respite Care For The Benefit Of Seriously Ill Or 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 injury or illness while on active duty. The eligibility rules and exclusions contained in [32 CFR 199.5\(e\)\(3\)](#) and [\(5\)](#) do not apply to the provision of respite benefits for an ADSM. See [Appendix B](#) for definitions, terms, and limitations applicable to the respite care benefit.

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

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 17, Section 3

Contractor Responsibilities

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

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

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

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

2.4.6 Respite care services and requirements are as follows:

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

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

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

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

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

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

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

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 ADSM SHCP reimbursement methodology contained in [Chapters 16](#) and [17](#) (for ADSMs located in the 50 United States and the District of Columbia) or TOP reimbursement methodology contained in the TPM, [Chapter 12](#) (for ADSMs located outside the 50 United States and the District of Columbia).

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

2.5 Transitional Care For Service-Related Conditions (TCSRC)

2.5.1 Introduction

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

2.5.2 Prerequisites For TCSRC

In accordance with the NDAA for FY 2008, a member, who is eligible for care under the TAMP, and who has a medical (as defined in [32 CFR 199.2](#)) or adjunctive dental condition believed to be related to their service on active duty may receive extended transitional care for that condition. The diagnosis determination must include the following criteria:

2.5.2.1 To be service-related; and

2.5.2.2 To have been first discovered/diagnosed by the member's civilian or TRICARE health care practitioner during the TAMP period and validated by a DoD physician; and

2.5.2.3 The medical condition requires treatment and can be resolved within 180 days, as determined by a DoD physician, from the date the condition is validated by the DoD physician.

- The period of coverage for the TCSRC shall be no more than 180 days from the date the diagnosed condition is validated by a DoD physician. If a medical condition is identified during the TAMP coverage period, but not validated by a DoD physician until a date after the TAMP coverage period, the start date will be the date that the condition was validated by a DoD physician.
- Service members who are discovered to have a service-related condition, which can not be resolved within the 180 day transitional care period, should be referred by MMSO to the former member's service or to the Veterans Administration (VA) for a determination of eligibility for government provided care.