



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY  
AURORA, COLORADO 80011-9066

TRICARE  
MANAGEMENT ACTIVITY

OD

CHANGE 66  
6010.56-M  
DECEMBER 28, 2011

**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 OVERSEAS PROGRAM (TOP) SUPPLEMENTAL HEALTH CARE PROGRAM (SHCP)

**CONREQ:** 15374

**PAGE CHANGE(S):** See page 2.

**SUMMARY OF CHANGE(S):** This change revises language pertaining to the implementation of the SHCP in locations outside of the 50 United States and the District of Columbia.

**EFFECTIVE DATE:** August 1, 2011.

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

**This change is made in conjunction with Feb 2008 TSM, Change No. 32.**

  
**Reta M. Michak**  
Director, Operations Division

**ATTACHMENT(S):** 14 PAGES  
**DISTRIBUTION:** 6010.56-M

**CHANGE 66**  
**6010.56-M**  
**DECEMBER 28, 2011**

**REMOVE PAGE(S)**

**CHAPTER 17**

Section 1, pages 1 - 3

Section 2, pages 1 and 2

Section 3, pages 5 - 10

**CHAPTER 24**

Section 26, pages 1 and 2

**INSERT PAGE(S)**

Section 1, pages 1 - 3

Section 2, pages 1 and 2

Section 3, pages 5 - 10

Section 26, pages 1 - 3

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

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

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

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

**2.1** For care that is not referred by an MTF, the SPOC for members of the Army, Air Force, Navy, Marine Corps, and Coast Guard will be the Military Medical Support Office (MMSO). The MMSO is established to provide a means to identify, manage and provide medical oversight of CHC furnished to service members. MMSO's functions include preauthorization of care when required, medical oversight for specialty care, the coordination and management of civilian routine and emergency hospital admissions; the initiation or coordination of medical boards; and the coordination of other military personnel-related actions. The Public Health Service (PHS) and

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

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

### **3.0 CONTRACTOR RESPONSIBILITIES**

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

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

### **4.0 SHCP DIFFERENCES**

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

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

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

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

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

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

## **5.0 SERVICE PROJECT OFFICERS**

Each Service will designate a Service Project Officer to be the Service's official POC with TMA and the contractor to resolve any overall service-related matters regarding the program (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 Service Points of Contact (SPOC) (Addendum A) or the MCSC. However, when the patient initiates contact prior to treatment and the SPOC has authorized the care being sought, the MCSC will make referrals to 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 SPOC, will record and enter the authorization to enable appropriate claims processing, and, if necessary, will assist the patient with referral to 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. The provisions of the SHCP will not apply to services furnished by a USFHP designated provider if the services are included as covered services under the current negotiated agreement between the USFHP designated provider and the TRICARE Management Activity (this includes care for a USFHP enrollee). However, any services not included in the USFHP designated provider agreement shall be paid by the contractor in accordance with the requirements in this chapter.

**2.2** The USFHP, administered by the designated providers 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), and Blind Rehabilitation

**3.1.1** The contractor shall reimburse for services provided under the current national DoD/DVA 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." MOA claims shall be processed in accordance with this chapter and the following.

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

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

### **1.2.2.3 Check Claim For Attached Documentation**

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

### **1.2.2.4 National Guard and Reserve**

Claims for National Guard or Reserve sponsors with treatment dates outside their eligibility dates cannot be automatically adjudicated. Claims for ineligible sponsors are to be suspended and routed to MMSO for payment approval or denial. If a payment determination is not received within the 115th day of receipt, the claim is to be denied.

### **1.2.2.5 Criteria Not Met**

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

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

## **1.3 TPL**

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

## **1.4 Types Of Care**

Contractor staff shall receive and accept calls directly from ADSMs requesting authorization for care which has not been MTF referred. If the caller is requesting after hours authorization for care while physically present in the Prime Service Area (PSA) of the MTF to which he/she is enrolled, the care shall be authorized in accordance with the 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. 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), **TOP Prime Remote**, or not enrolled and receiving services in accordance with the non-enrolled/non-referred provisions for ADSM care overseas (see the TPM, [Chapter 12, Section 1.1](#)).

**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

## TRICARE Operations Manual 6010.56-M, February 1, 2008

### Chapter 17, Section 3 Contractor Responsibilities

---

should indicate an appropriate procedure code for respite care (CPT<sup>1</sup> 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.

**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

---

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

former ADSMs, with certain service-related conditions, beyond the TAMP coverage period.

## **2.5.2 Prerequisites For TCSRC**

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

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

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

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

- The period of coverage for the TCSRC shall be no more than 180 days from the date the diagnosed condition is validated by a DoD physician. If a medical condition is identified during the TAMP coverage period, but not validated by a DoD physician until a date after the TAMP coverage period, the start date will be the date that the condition was validated by a DoD physician.
- Service members who are discovered to have a service-related condition, which can not be resolved within the 180 day transitional care period, should be referred by MMSO to the former member's service or to the Veterans Administration (VA) for a determination of eligibility for government provided care.
- Care is authorized for the service-related condition for 180 days from the date the DoD physician validates the service-related condition. For example a service-related condition validated on day 90 of TAMP will result in the following time lines: Care under TAMP for other than the service-related condition terminates on day 180 after the beginning of TAMP coverage. Care for the service-related condition terminates on day 270 in this example (180 days from the day the service-related condition is validated by a DoD physician).

## **2.5.3 Eligibility**

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

**2.5.3.2** A DoD physician must determine that the condition meets the criteria in [paragraph 2.5.2](#). Final validation of the condition must be made by the DoD Physician associated with MMSO. If the determination is made that the member is eligible for this program, the former member shall be entitled to receive medical and adjunctive dental care for that condition, and that condition only, as if they were still on active duty. Enrollment into this program does not affect the eligibility requirements for any other TRICARE program for the former service member or their family members.

**2.5.3.3** Enrollment in the TCSRC includes limited eligibility for MTF Pharmacy, Retail Pharmacy, and TRICARE Mail Order Pharmacy (TMOP) benefits.

**2.5.4 Implementation Steps, Processing For MMSO, And Contractor Requirements And Responsibilities**

The processes and requirements for a member with a possible Section 1637 condition are spelled out in [paragraphs 2.5.4.1](#) through [2.5.4.7](#). These steps, requirements, and responsibilities are applicable to MMSO, the MCSCs, 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 Communications and Customer Service (C&CS) will educate beneficiaries on the Section 1637 benefit. Contractors will collaborate with C&CS in the development of materials that support both beneficiary and provider education.

**2.5.4.2** A former ADSM on TAMP that believes he/she has a service-related condition which may qualify them for the TCSRC program is to be referred to MMSO for instructions on how to apply for the benefit.

**2.5.4.3** MMSO will determine if further clinical evaluation/testing of the former ADSM is needed to validate that the member has a qualifying condition for enrollment into the Section 1637 program. If further clinical evaluation/testing is needed, MMSO will follow existing "defer to network" referral processes and the MCSC 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 MCSC 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 MCSC 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 MCSC shall locate a civilian provider that has both the capability and capacity to accept this referral request within the prescribed ATC standards. The MCSC will execute an active provider locator process (Health Care Finder (HCF)) to support the member's need for this referral request. MMSO's "defer to network" request will be acted on by the MCSC under the normal "urgent/72 hour" requirement. The MCSC 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 MCSC will instruct the accepting provider to return the results of the encounter to MMSO within 48 hours of the encounter. Once any additional information is received, the DoD physician associated with MMSO will make the determination of eligibility for the Section 1637 program. The eligibility determination for coverage under the Section 1637 benefit will be made within 30 calendar days of receiving the member's request, inclusive of the time required to obtain additional information. If the condition does not meet the criteria for enrollment into the Section 1637 program, but the former ADSM is otherwise eligible for TRICARE benefits, they may continue to receive care for the condition, following existing TRICARE guidelines. The former ADSM may appeal the decision of the DoD Physician in writing to MMSO within 30 calendar days of receipt of the denial by the DoD physician. MMSO will issue a final determination within 30 calendar days of receipt of the appeal. If MMSO determines the condition should be covered under the Section 1637 benefit, coverage will begin on the date MMSO renders the final determination.

## Civilian Health Care (CHC) Of Uniformed Service Members

---

### 1.0 GENERAL

**1.1** All TRICARE requirements regarding the Supplemental Health Care Program (SHCP) shall apply to the TRICARE Overseas Program (TOP) unless specifically changed, waived, or superseded by this section, TRICARE Policy Manual (TPM), [Chapter 12](#), or the TRICARE contract for health care support services outside the 50 United States and the District of Columbia (hereinafter referred to as the "TOP Contract"). See [Chapter 17](#) for additional instructions.

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

### 2.0 CONTRACTOR RESPONSIBILITIES

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

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

**2.3** Each TRICARE Area Office (TAO) shall establish processes for ADSM referrals/authorizations in remote locations. These processes may vary by region and shall be documented in the

Memorandum of Understanding (MOU) between the TAO and the TOP contractor. The TOP contractor shall comply with TAO guidance regarding remote-enrolled ADSM referrals/authorizations, to include screening specialty care referrals to assist with the identification of potential fitness-for-duty issues to the designated government Point of Contact (POC).

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

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

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

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

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

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

**2.5.2** For ADSMs leaving remote TOP assignments from all overseas areas other than Puerto Rico, ADSMs in those locations should request medical records from the host nation provider(s) who provided health care services during the ADSM's tour of duty.

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

**TRICARE Operations Manual 6010.56-M, February 1, 2008**

Chapter 24, Section 26

Civilian Health Care (CHC) Of Uniformed Service Members

---

**2.5.4** Network host nation providers shall be reimbursed for medical records photocopying and postage costs incurred at the rates established in their network provider participation agreements. Non-network host nation providers shall be reimbursed for medical records photocopying and postage costs on the basis of billed charges unless the government has directed a lower reimbursement rate. ADSMs who have paid for copied records and applicable postage costs shall be reimbursed for the full amount paid to ensure they have no out-of-pocket expenses. All providers and/or ADSMs must submit a claim form, with the charges clearly identified, to the contractor for reimbursement.

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

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

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

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

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

- END -

