INTRODUCTION

GENERAL

This TRICARE Policy Manual, in conjunction with the TRICARE Reimbursement Manual, contains operational policy necessary to efficiently implement the Code of Federal Regulations at 32 CFR 199. This manual augments the 32 CFR 199 and must be used in conjunction for complete policy information.

This Manual is subordinate to the 32 CFR 199, equal to the TRICARE Reimbursement Manual, and superior to all other TRICARE Management Activity (TMA) administration manuals (TRICARE Operations and TRICARE Systems), and to all TRICARE related verbal and written policy interpretation issued by a TRICARE contractor or Uniformed Service.

Any benefit or program administration issue for which benefit or program operation policy guidance is required should be described, in writing, to: Director, Medical Benefits and Reimbursement Systems, TMA, 16401 E. Centretech Parkway, Aurora, CO 80011-9066.

TRICARE is the Department of Defense's managed health care program for active duty service members, service families, retirees and their families and survivors. TRICARE is a blend of the military's direct care system of hospitals and clinics and the Civilian Health and Medical Program of the Uniformed Services. It represents the best features from the variety of health care delivery alternatives demonstrated by the Department of Defense in the late '80's and early 90's.

A key feature of the Department's managed care implementation is the creation within the United States of 3 Health Services Regions. Within each region, a Military Treatment Facility (MTF) is designated Regional Director for the health care services in the region. The Regional Director, working with all the MTFs within the region, is responsible for organizing and managing health care delivery for all TRICARE and the Military Health System beneficiaries in the region. Supporting the Regional Director is a Managed Care Support contractor (MCS), with responsibility for establishing a network of health care providers to supplement the care available at the MTFs and for performing a variety of health care administrative services on behalf of the Regional Director.

TRICARE MANAGMENT RESPONSIBILITIES

Regional Directors. Are responsible for planning for and delivering services to meet the health needs of the beneficiaries in the region, whether through the MTFs or the contractor. The Regional Director is expected to provide an Administrative Contracting Officer (ACO) and an Alternate Contracting Officer's Representative(s) (ACOR) to monitor and assist in administering the MCS contract. The Regional Director is primarily responsible for oversight and administration of those tasks in the MCS contract that relate to the delivery and management of care.

MTF Commanders. Are responsible for managing health care delivery for the active duty personnel and TRICARE eligibles who are enrolled in Prime with MTF primary care

managers, as well as for providing care to other TRICARE and the Military Health System beneficiaries who are eligible for care in MTFs. If the MTF cannot provide the care to enrollees directly, the MTF Commander and the contractor may enter into a Resource Sharing Agreement or the patient may be referred to a civilian provider who is a member of the contractor's network. The MTF Commander sets priorities for assignment of MTF Primary Care Managers and works directly with the contractor in network development, resource sharing arrangements and similar local initiatives.

TRICARE Dual Eligibility Fiscal Intermediary Contractor (TDEFIC) is responsible for processing all TRICARE claims for services rendered within the fifty United States and the District of Columbia, as well as Puerto Rico, Guam, the United States Virgin Islands, American Samoa and the Northern Mariana Islands, to individuals who have dual eligibility under both TRICARE and Medicare.

Managed Care Support Contractor. The Managed Care Support contractor is responsible for establishing provider networks in those Prime service areas and BRAC sites designated by the Regional Director. The provider networks must include both primary care providers and specialists. The contractor shall ensure that first priority for referral of Prime enrollees for specialty care or inpatient care is the MTF. The contractor processes all Prime, Extra and Standard claims for all beneficiaries, except for TRICARE for Life (TFL), who reside in the Region and performs other tasks specified in the contracts and the manuals. The contractor has a number of responsibilities for support of the Regional Director as well as the MTF.

Administrative Personnel. The Procurement Contracting Officer (PCO) and the Contracting Officer's Representative (COR) are TRICARE Management Activity (TMA) personnel who oversee the functions of the MCS contract, with special emphasis in areas such as claims processing, and who coordinate contract oversight and administration among the variety of Regional Director Administrative Contracting Officer's Representative(s) (ACORs). The procurement contracting officer is the sole authority for directing the contractor or modifying provisions of the contract (some of this authority may be delegated to the Administrative Contracting Officer (ACO) at the Office of the Regional Director).

ASD(HA). Overall policy for TRICARE is established by the Assistant Secretary of Defense for Health Affairs.

TRIPLE OPTION BENEFIT PACKAGE

TRICARE offers beneficiaries three health care options:

1. TRICARE Prime Plan. Beneficiaries who enroll in TRICARE Prime are assigned or select a Primary Care Manager (PCM). A PCM is a provider of primary care, who furnishes or arranges for all health care services required by the Prime enrollee. MTF Commanders have the authority and responsibility to set priorities for enrollment to MTF Primary Care Managers. When MTF's primary care capacity is full, civilian PCMs, who are all part of the contractor's network, are available to provide care to patients.

   a. Expanded benefits. As enrollees of Prime, patients receive clinical preventive services that are provided without cost share for the patient.

b. Reduced cost. Prime enrollees' cost share for civilian services is substantially reduced from that which is applicable under TRICARE Extra and TRICARE Standard. In addition, when a TRICARE Prime enrollee is referred to a non-participating provider, the enrollee is only responsible for the copayment amount, but not for any balance billing amount by the non-participating provider.

2. TRICARE Extra plan. Beneficiaries who do not enroll in Prime may still benefit from using the providers in the contractor's network where possible. On a case by case basis, beneficiaries may participate in TRICARE Extra by receiving care from a network provider. The beneficiary will take advantage of the reduced charges under Extra and a reduction in cost shares. Covered services are the same as under TRICARE Standard.

3. TRICARE Standard plan. The TRICARE Standard plan is identical to the CHAMPUS fee for service program. Its benefits and costs are unchanged from the CHAMPUS program.

GEOGRAPHIC AVAILABILITY

TRICARE is effective throughout the United States. TRICARE Overseas Program Regions are established but operate under different procedures than TRICARE in the United States.

Within a region, the contractor is required to create a provider network and establish TRICARE Prime, Extra and Standard in those MTF Prime service areas and each Base Realignment and Closure (BRAC) site designated by the Regional Director. Additionally, the contractor is encouraged to establish a provider network and offer either Prime or Extra or both in as many non-Prime service areas as patient population (including enrollees in the TRICARE Prime Remote Program) and provider availability make cost-effective. In some parts of some regions, beneficiaries may only have access to TRICARE Standard. If a beneficiary resides in an area not served by a TRICARE provider network, the beneficiary may still choose to travel to a location within the same contract area where there is a network and enroll in Prime at that location. For those beneficiaries, the contractor is not held to the access standards that apply within a Prime service area.

ELIGIBILITY FOR TRICARE

Active Duty Eligibility. All active duty members are considered "automatically enrolled" in TRICARE Prime. They must, however, take action to be enrolled in Prime, and be assigned to a PCM (see the TRICARE Operations Manual for PCM provisions under the TRICARE Prime Remote Program).

Non-Active Duty Eligibility. All individuals entitled to civilian health care under Sections 1079 or 1086 or Title 10, Chapter 55, United States Code, are eligible for TRICARE. These non-active duty individuals, commonly referred to as "TRICARE eligibles", include the spouse and children of active duty personnel, retirees and their spouses and children, and survivors. This group also includes former spouses as defined in Section 1072 (2), of Title 10, Chapter 55, U.S.C. Not included are those individuals who are entitled to care in the direct care system but ordinarily are not entitled to civilian care, such as family member parents and parents-in-law.

TRICARE For Life. Pursuant to Section 712 of the FY 2001 National Defense Authorization Act, Medicare eligible beneficiaries based on age, whose TRICARE eligibility is determined by 10 U.S.C. Section 1086, are eligible for Medicare Part A, and those who are enrolled in Medicare Part B, are eligible for the TRICARE benefit effective October 1, 2001. These beneficiaries are not eligible to enroll in TRICARE Prime.

Supplemental Health Care Program (SHCP) and TRICARE Prime Remote Program. See the TRICARE Operations Manual, Chapters 17 and 18.

Non-DoD TRICARE Eligibles. TRICARE eligibles sponsored by non-DoD uniformed services (the Public Health Service, the United States Coast Guard, and the National Oceanic and Atmospheric Administration) are eligible for TRICARE and may enroll in TRICARE Prime.

NATO Beneficiaries. Family members of active duty members of the armed forces of foreign NATO nations who are eligible for outpatient care under TRICARE may access care under TRICARE Extra and TRICARE Standard only. They are not eligible to enroll in TRICARE Prime.

Prime Enrollment. Eligible beneficiaries must enroll in Prime to receive the expanded benefits and special cost sharing. Even though active duty members are considered to be enrolled automatically, all active duty and non-active duty individuals who wish to take advantage of the full benefits of the Prime program and have their claims adjudicated correctly must take specific action to enroll.

OTHER TRICARE BENEFITS

Included in the TRICARE benefit package is a retail pharmacy network and a mail service pharmacy program.

ADMINISTRATIVE AND EFFECTIVE DATES

Issuance date. The date located on the 1st page of each separate policy issuance. This is the date that the issuance was initially issued by TMA.

Revision date. The revision date is at the bottom of each page that has been revised along with the change number. This is the date that TMA changed the issuance in any way. Each time an issuance is changed, the revised page and/or issuance is given a change number. The revision date and the change number together identify a unique version of the issuance on a specific subject.

Effective date. A date within the body of the text of an issuance which establishes the specific date that a policy is to be applied to benefit adjudication or in program administration. An effective date may be earlier than the issuance or revision date. This date is explicit (e.g., Effective Date: January 1, 1998). The policy effective date takes precedence over the issuance date and the revision date. In the absence of an effective date the policy or instruction is considered to have always been applicable because the newly published policy or instruction confirms the application of existing published program requirements.

Implementation date. The implementation date of a policy or instruction is not noted in the issuance as this date is determined by the terms of the contract modification between TMA and the contractor. Unless otherwise directed by TMA, contractors are not to identify finalized claims for readjudication under revised or new policy. However, the contractor shall readjudicate any denied claim affected by the policy that is brought to the contractor's attention by any source. Pending claims and denied claims in reconsideration shall be adjudicated using the current applicable policy.

To Be Determined (TBD) Dates. For those policies where a TBD date is referenced, the offeror can assume the change will be in effect prior to the first day of health care delivery of the new contract.

BENEFIT POLICY

Benefit policy applies to the scope of services and items which may be considered for cost-sharing by the TRICARE/CHAMPUS within the intent of the CFR Chapter 199.4 and Chapter 199.5.

The current edition of the American Medical Association's Physicians' Current Procedural Terminology (CPT) is incorporated by reference into this Manual to describe the scope of services potentially allowable as a benefit, subject to explicit requirements, limitations, and exclusions, in this Manual or in the 32 CFR 199.

Procedures listed in the CPT and the HCFA Common Procedure Coding System (HCPCS) may be cost-shared only when the contractor determines the procedure is "appropriate medical care" and is "medically or psychologically necessary" and is not "unproven" as defined in the 32 CFR 199.4(g)(15), and the procedure is not explicitly excluded in the TRICARE program.

PROGRAM POLICY

Program policy applies to beneficiary eligibility, provider eligibility, claims adjudication, and quality assurance. Program policy implementation instructions are found in the TRICARE Systems Manual and the TRICARE Operations Manual.

REIMBURSEMENT POLICY

Reimbursement policy sets forth the payment procedures used for reimbursing TRICARE claims. The related implementation instructions for these payment procedures are found in the TRICARE Systems Manual and TRICARE Operations Manual.

The TRICARE Reimbursement Manual provides the methodology for pricing allowable services and items and for payment to specific categories and types of authorized providers. These methods allow the contractor to price and render payment for specific examples of services or items which are not explicitly addressed in the Manual but which belong to a general category or type which is addressed in the Manual.

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