CONTRACTOR RESPONSIBILITIES

1.0. CONTRACTOR RECEIPT AND CONTROL OF SHCP CLAIMS

1.1. Post Office Box

The contractor may establish a dedicated post office box to receive claims and correspondence related to the Supplemental Health Care Program (SHCP). This dedicated box, if established, may be the same post office box which may be established for handling TRICARE Prime Remote and Non-Referred Care claims, as discussed in Chapter 17 and Chapter 19.

1.2. Claims Processing

1.2.1. Claims Processing And Reporting

Regardless of who submits the claim, SHCP claims shall be processed using the same standards 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. The claims tracking and retrieval requirements of Chapter 1, Section 3, paragraph 2.1. apply equally to SHCP claims. Reports on the timeliness of processing supplemental health care claims, as required under paragraph 9.0., are due to each MTF no later than the 15th calendar day of the month following the reporting period.

1.2.2. Civilian Services Rendered To MTF Inpatients

Claims for MTF inpatients referred to a civilian facility or internal resource sharing provider for medical care (test, procedure, or consult) shall be processed to completion without application of a cost-share, co-payment, or deductible. Nonavailability statements 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 DEERS indication of eligibility. These are SHCP claims. SHCP shall not be used for TRICARE For Life beneficiaries referred from an MTF as an inpatient. Such civilian claims shall be processed with Medicare first without consideration of SHCP.

1.2.3. 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., ROTC, Reserve Component, National Guard, Foreign military, etc.) claims will be paid based on an MTF authorization despite the lack of any DEERS indication of eligibility.

1.2.4. Emergency Civilian Hospitalization

If an emergency civilian hospitalization becomes necessary during the test or procedure referred by the MTF and comes to the attention of the contractor, it will be reported to the Patient Administration Department of the referring MTF. The MTF will have primary case management responsibility, including authorization of care and patient movement for all civilian hospitalizations.

1.2.5. 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.

1.2.6. Foreign Claims Processing

1.2.6.1. Process claims received by the contractor for patients covered by reciprocal host nation health care agreements in accordance with the current requirements of the TRICARE Operations Manual and the TRICARE Policy Manual.

1.2.6.2. Forward claims received for personnel permanently assigned to an overseas location to the appropriate overseas claims processor for processing in accordance with the TRICARE Policy Manual, Chapter 12, TRICARE Overseas Program.

1.2.7. Claims Received With Both MTF-Referred And Non-Referred Lines

The contractor shall use the same claims authorization logic as they use for other Prime enrollees when claims are received with lines of care that contain both MTF -Referred and non-referred lines. All ancillary services associated with an outpatient visit shall be considered MTF-Referred.

1.3. Authorization Verification

1.3.1. The contractor shall verify that care provided was authorized by the MTF. If an authorization is not on file, then the contractor shall place the claim in a pending file and verify authorization with the MTF to which the ADSM is enrolled. 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".

1.3.2. For outpatient active duty and non-TRICARE eligible patients, and for all SHCP inpatients, there will be no application by the contractor of the DEERS *Catastrophic Cap and Deductible* Data (*CCDD*), 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.

2.0. COVERAGE

2.1. Normal TRICARE coverage limitations will not apply to services rendered to supplemental health care patients. Services that have been authorized will be covered regardless of whether they would have ordinarily been covered under TRICARE policy. On occasion a referral may be made 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 14, 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 provider exclusions. TRICARE utilization review and utilization management requirements will not apply.

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

2.3. Within the category of SHCP, the contractor shall identify referrals by the MTF for the Comprehensive Clinical Evaluation Program (CCEP). The contractor shall take measures as appropriate to distinguish these claims from other SHCP claims.

2.4. Ancillary Services

An MTF authorization for care includes any ancillary services related to the health care authorized.

3.0. ENROLLMENT STATUS EFFECT ON CLAIMS PROCESSING

3.1. Active duty claims shall be processed without application of a cost-share, co-payment, 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, co-payment, or deductible. These are SHCP claims.

3.3. Claims for TRICARE Prime enrollees who are not in MTF inpatient status shall be processed with the application of the appropriate TRICARE copays. These are TRICARE claims and not SHCP claims.

3.4. Claims for TRICARE eligibles, who are not enrolled in Prime, and who are not in MTF inpatient status, shall be processed in accordance with TRICARE Extra or Standard procedures. These are TRICARE claims and not SHCP claims.

3.5. Claims for services provided under the current Memoranda of Understanding between the Department of Defense (including Army, Air Force, and Navy/Marine Corps facilities) and the Department of Health and Human Services (including the Indian Health Service, Public Health Service, etc.) are not covered. These are not SHCP claims.

3.6. Claims for services not included in the current Memoranda of Understanding between the Department of Defense (including the Army, Air Force and Navy/Marine Corps facilities) and the Department of Health and Human Services shall be processed in accordance with the requirements in this chapter. These are SHCP claims.

3.7. Claims for services provided under the current national and local Memoranda of Understanding between the Department of Defense (including the Army, Air Force and Navy/Marine Corps facilities) and the Department of Veterans' Affairs (DVA) are not covered. These are not SHCP claims.

3.8. Claims for services not included in the current Memoranda of Understanding between the Department of Defense (including the Army, Air Force and Navy/Marine Corps facilities) and the Department of Veterans' Affairs shall be processed in accordance with the requirements in this chapter. These are SHCP claims.

3.9. 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, co-pay or deductible applied to these claims. These are SHCP claims.

3.10. Claims for non-TRICARE eligibles shall be processed for payment solely on the basis of MTF authorization. There will not be a cost share, co-pay or deductible applied to these claims. These are SHCP claims.

3.11. 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.

4.0. MEDICAL RECORDS

The current contract requirements for medical records shall also apply to ADSMs in this program. Narrative summaries and other documentation of care rendered (including laboratory reports and X-rays) shall be given to the ADSM for delivery to his/her PCM and inclusion in his/her military health record. The contractor shall be responsible for all administrative/copying costs. Under no circumstances will the ADSM be charged for this documentation. Network providers shall be reimbursed for medical records photocopying and postage costs incurred at the rates established in their network provider participation agreements. Participating and non-participating providers shall be reimbursed for medical records photocopying and postage costs on the basis of billed charges. ADSMs who have paid for copied records and applicable postage costs shall be reimbursed for the full amount paid to ensure they have no out of pocket expenses. All providers and/or patients must

submit a claim form, with the charges clearly identified, to the contractor for reimbursement. ADSM's claim forms should be accompanied by a receipt showing the amount paid.

5.0. REIMBURSEMENT

5.1. Allowable amounts are to be determined based upon the TRICARE payment reimbursement methodology applicable to the services reflected on the claim, (e.g. DRGs, mental health per diem, CMAC, 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.

5.2. Cost-sharing and deductibles shall not be applied to supplemental health care claims for MTF referred services rendered to uniformed service members, to other MTF referred patients who are not TRICARE eligible, or to patients who receive referred civilian services while remaining in an MTF inpatient status.

5.3. Pending development and implementation of recently enacted legislative authority to waive CMACs under TRICARE, the following interim procedures shall be followed when necessary to assure adequate availability of health care to ADSMs under SHCP. If required services are not available from a network or participating provider within the medically appropriate time frame, the contractor shall arrange for care with a non-participating provider subject to the normal reimbursement rules. The contractor initially shall make every effort to obtain the provider's agreement to accept, as payment in full, a rate within the 100% of CMAC limitation. If this is not feasible, the contractor shall make every effort to obtain the provider's agreement to accept, as payment in full, a rate between 100% and 115% of CMAC. If the latter is not feasible, the contractor shall determine the lowest acceptable rate that the provider will accept and communicate the same to the referring MTF. A waiver of CMAC limitation must be obtained by the MTF from the Regional Director, as the designee of the Chief Operating Officer (COO), TRICARE Management Activity (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 Regional Director, the MTF will notify the contractor who shall then conclude rate negotiations, and notify the MTF when an agreement with the provider has been reached. The contractor shall ensure that the approved payment is annotated in the authorization/claims processing system, and that payment is issued directly to the provider, unless there is information presented that the ADSM has personally paid the provider.

5.4. 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.

5.4.1. 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.

5.4.2. All other claims shall be subject to the appropriate TRICARE copayment and deductible requirements, and to TRICARE payment maximums. Claims for non-enrolled Medicare eligibles shall be returned to the submitting party for filing with the Medicare claims processor.

5.5. In no case shall a uniformed service member who has acted in apparent good faith be required to incur out-of-pocket expenses or be subjected to ongoing collection action initiated by a civilian provider who has refused to abide by TRICARE requirements. (The determination whether a member has acted in good faith rests with the Uniformed Services.) For example, a provider might continue to pursue the service member by "balance billing" for amounts which are clearly in excess of the amount which he had previously agreed to accept as payment in full. When the contractor becomes aware of such situations, they shall initiate contact with the Uniformed Service point of contact (Chapter 18, Addendum A) so that action appropriate to the particular situation can be undertaken. On an exception basis, such action might include specific authorization by the Uniformed Service to pay additional amounts to the provider. In this instance, a waiver from the Chief Operating Officer (COO), TRICARE Management Activity, or a designee, must be initiated by the Uniformed Service for authority to make payment in excess of CMAC or other applicable TRICARE payment ceilings. The contractor and the Government shall act in concert as promptly as possible to issue appropriate payment.

6.0. END OF PROCESSING

6.1. Explanation Of Benefits

An Explanation of Benefits (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 claims pertaining to civilian services rendered to an MTF inpatient and for all other claims for which the MTF has authorized supplemental health care payment, the EOB will include the following statement, "This is a supplemental health care claim, not a TRICARE claim. Questions concerning the processing of this claim must be addressed to the TRICARE Service Center." 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

For supplemental health care claims, the appeals process in Chapter 13, 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 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 here)." TRICARE appeal rights shall pertain to outpatient claims for treatment of TRICARE eligible patients.

7.0. CLAIMS PAYMENTS AND CONTRACTOR REIMBURSEMENT

7.1. Referred Care For MTF Inpatients

Providers, patients or Services (e.g., MTF) shall forward medical claims to the contractor for reimbursement. The contractor shall forward a single consolidated invoice,

with accompanying claims data (only accepted or provisionally accepted by TED) on a monthly basis to the enrolling MTF and its paying office (Defense Finance and Accounting Service [DFAS]. MTFs will forward receiving reports after approval to the DFAS for payment to the contractor.

7.2. MTF Referred Outpatient Care

Providers, patients or Services (e.g., MTF) shall forward medical claims to the contractor for reimbursement. The contractor shall forward a single consolidated invoice with accompanying claims data (only accepted or provisionally accepted by TED), on a monthly basis to the enrolling MTF and its paying office (DFAS). The invoice shall contain claims for uniformed service members and non-TRICARE eligibles with an MTF authorization for payment under supplemental health care. DFAS shall pay the contractor based on approved invoices. Claims for Medicare eligibles will be returned to the submitting party for filing with the Medicare claims processor.

8.0. TED SUBMITTAL

The TED for each claim must reflect the appropriate data element values. The appropriate codes published in the TSM Manual are to be used for supplemental health care claims.

9.0. REQUIRED REPORTS

Summary reports reflecting government dollars paid for supplemental health care claims shall be prepared and submitted to each Service Headquarters every month. Separate reports shall be produced for services rendered to Army National Guard members. All reports described below shall be submitted in electronic media in an Excel format. Payments for CCEP claims shall be reported separately. A separate report of payments on behalf of non-DoD patients shall also be prepared and forwarded to TRICARE Management Activity, Managed Care Support Operations Branch. Summary and detailed reports (also reflecting government dollars paid) for each month will be prepared and submitted to each referring MTF. These reports will be submitted no later than the 15th calendar day of the month following the reporting period. SHCP and CCEP reports will reflect total care paid, and the total dollar amount contained in data elements (paragraphs 9.1.1. through 9.1.3. below), will equal the total amount requested for reimbursement from TMA, Office of Contract Resource Management for each report. For those data elements in items (paragraphs 9.1.1. through 9.1.3. below), which require a count, the contractor must ensure that no workload is double counted. Data elements to include in the reports are:

9.1. Summary Reports By Branch Of Service To Service HQ And TMA (COO)

9.1.1. DMIS ID Code (PCM Location DMIS-ID (Enrollment) Code)

9.1.2. Total Number and Dollar Amount of Claims Paid

9.1.3. Inpatient Dollars Paid - Institutional

9.1.4. Inpatient Dollars Paid - Professional Services

9.1.5. Outpatient Dollars Paid - Clinic Visits (Professional and Ancillary Services)

9.1.6. Outpatient Dollars Paid - Ambulatory Surgeries/Procedures - Professional

9.1.7. Outpatient Dollars Paid - Ambulatory Surgeries/Procedures - Institutional

9.1.8. Total Admissions/Dispositions

9.1.9. Total Bed Days/LOS

9.1.10. Total Ambulatory Surgeries/Procedures, including all Ancillary

9.1.11. Total Outpatient Visits, excluding Ambulatory Surgeries but including all Ancillary related to the outpatient visits

9.1.12. CPT Codes/DRG/ICD-9 Codes

9.1.13. Other items paid

9.2. Detailed Reports For Each MTF

9.2.1. Patient DMIS ID Code (enrollment DMIS)

9.2.2. Referring MTF's DMIS ID code

9.2.3. Patient Name/SSN

9.2.4. Sponsor SSN

9.2.5. Age/Sex/Beneficiary Category (ADSM, ADFM, NADSM, NADFM, TFL, TRICARE ineligibles)

9.2.6. MTF PCM (if available)

9.2.7. Referring provider (if available)

9.2.8. Civilian Provider's Name/Provider ID#

9.2.9. Dates of Care (Outpatient or Inpatient Admission)

9.2.10. Care End Date (FY - Month)

9.2.11. Admitting Diagnoses (Primary/Secondary)

9.2.12. Dispositioning Diagnoses (Primary/Secondary)

9.2.13. CPT Codes/DRG/ICD-9 Codes Related to Inpatient Claim

9.2.14. Total Bed Days/Length of Stay (Inpatient)

9.2.15. Inpatient Institutional $ Paid

9.2.16. Inpatient Professional $ Paid

9.2.17. CPT Codes/ICD-9 Codes Related to Outpatient Claim (including Professional and Ancillary Services)

9.2.18. Outpatient Clinic $ Paid (Including Professional and Ancillary Services)

9.2.19. CPT Codes/ICD-9 Codes Related to Ambulatory Surgery/Procedure Claim (including Professional and Ancillary Services)

9.2.20. Ambulatory Surgery/Procedure $ Paid (Professional)

9.2.21. Ambulatory Surgery/Procedure $ Paid (Institutional)

9.3. Additional Reports

9.3.1. The contractor shall produce monthly workload and timeliness reports for the SHCP. The reports shall cover the period beginning on the first day of the month and closing on the last day of the month. The reports are due on the 15th calendar day of the month following the month being reported.

9.3.2. The contractor shall prepare a cover letter when forwarding reports, which identifies the reports being forwarded, the period being reported, the date the cover letter is prepared by the contractor, and a contractor point of contact should there be any questions regarding the reports.

9.3.3. Workload Reports

9.3.3.1. The contractor shall prepare and submit a monthly SHCP claims workload report for each branch of service (to include Army National Guard separately), as well as one workload report which shows the cumulative totals for all services. The branch of service shall be determined by the service affiliation of the referring MTF and not by the branch of service of the active duty member. The following data shall be included in the workload reports:

- Beginning Inventory of Uncompleted Claims
- Total Number of New Claims Received
- Total Number of Claims Returned
- Total Number of Claims Processed to Completion
- Ending Inventory of Uncompleted Claims

NOTE: Ending inventory of uncompleted claims must equal the beginning inventory of uncompleted claims plus total number of new claims received minus total number of claims returned minus total number of claims processed to completion.

9.3.3.2. The contractor shall send a copy of the monthly Workload Reports to the TMA, Chief, Claims Operations Office and to the Regional Director. The contractor shall also send a

copy of each Service's monthly report to the respective Service Project Officer identified in Chapter 18, Addendum A.

9.3.4. Timeliness Reports

9.3.4.1. The contractor shall prepare and submit a separate monthly cycle time and aging report for SHCP claims, containing the same elements and timeliness breakouts as submitted for other TRICARE claims.

9.3.4.2. The contractor shall send a copy of the SHCP Timeliness Reports to the Regional Director; Chief Financial Officer, TMA; and to the Chief, Special Contracts and Operations Office, TMA.

9.4. SHCP Claims Listing

Throughout the period of the contract, the contractor shall have the ability to produce, when requested by TMA, a hardcopy listing of all SHCP claims processed to completion for any given month(s) to substantiate the contractor's SHCP vouchers to TMA (see Chapter 18, Section 4). The listing shall include the following data elements: referring DMIS ID code, ICN, patient's SSN, and the date the claim was processed to completion. This list shall be presented in ascending DMIS code order.

10.0. CONTRACTOR'S RESPONSIBILITY TO RESPOND TO INQUIRIES

10.1. Telephonic Inquiries

Inquiries relating to the SHCP need not be tracked nor reported separately from other inquiries received by the contractor. All inquiries to the contractor should come from MTFs/claims offices, the Service Project Officers or the TMA. In some instances, inquiries may come from Congressional offices, patients or providers. To facilitate this process, the contractor shall provide 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 TRICARE Prime Remote under Chapter 17 and may be the same line required under Chapter 19. The telephone response standards of Chapter 1, Section 3, paragraph 3.4. shall apply to SHCP telephonic inquiries.

10.1.1. Congressional Telephonic Inquiries

The contractor shall refer any congressional telephonic inquiries to the referring MTF if the inquiry is related to the authorization or non-authorization of a specific claim. If it is a general congressional inquiry regarding the SHCP claims program, the contractor shall respond or refer the caller as appropriate.

10.1.2. Provider And Other Telephonic Inquiries

The contractor shall refer any other telephonic inquiries it receives, including calls from the provider, service member or the MTF patient, to the referring MTF 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.

10.2. Written Inquiries

10.2.1. Congressional Written Inquiries

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. When referring the inquiry to the Service Project Officer, 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.

10.2.2. Provider And Service Member (Or MTF Patient) Written Inquiries

The contractor shall refer provider and service member or MTF patient written inquiries to the referring MTF if the inquiry pertains to the authorization or non-authorization of a specific claim, or to the caller's Service Project Officer if it is a general inquiry regarding the SHCP.

10.2.3. MTF Written Inquiries

The contractor shall provide a final written response to all written inquiries from the MTF within ten work days of the receipt of the inquiry.

11.0. DEDICATED SHCP UNIT

The contractor may at their discretion establish a dedicated unit for all contractor responsibilities related to processing SHCP claims and responding to inquiries about the SHCP. Regardless of the existence of a dedicated unit, the contractor shall designate a point of contact for Government inquiries related to the SHCP.