# CONTRACTOR RESPONSIBILITIES

## 1.0. CLAIMS PROCESSING

**1.1.** The contractor may at its discretion 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 has been established for handling TRICARE Prime Remote and MTF Referred Care claims, as discussed in Chapters 17 and 18.

**1.2.** Regardless of who submits the claim, SHCP claims shall be processed 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 SHCP claims. The contractor for the region in which the patient resides shall process the claim to completion. Reports on the timeliness of processing SHCP claims, as required under paragraph 11.0. are due to the Regional Directors and SPOC no later than the 15th calendar day of the month following the reporting period. Claims for inpatient and outpatient medical services shall be processed to completion without application of a cost-share, co-payment or deductible. Non-availability statements shall not be required.

**1.3.** *Claims for care provided under the national DoD/VA MOA for Spinal Cord Injury, Traumatic Brain Injury, and Blind Rehabilitation shall be processed in accordance with Chapter 19, Section 2, paragraph 2.1.*

## 2.0. FOREIGN CLAIMS PROCESSING

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

## 3.0. ELIGIBILITY VERIFICATION

The contractor shall perform the following screening steps to determine if a claim may be processed to completion under the provisions of this chapter:

### 3.1. Check For MTF Referral Authorization

If an MTF referral is on file, process the claim in accordance with the provisions of Chapter 18.

### 3.2. Check DEERS Status

If the patient is listed in the DEERS as direct care eligible, process the claim in accordance with paragraph 5.0., Types of Care, provided below. If, in the process of the DEERS check, the contractor determines the ADSM is enrolled in TRICARE Prime Remote, then the claim shall be processed as a TRICARE Prime Remote claim in accordance with Chapter 17. The contractor for the region in which the member is enrolled shall process the claim to completion. If the ADSM is enrolled to an MTF, the claim shall be processed in accordance with Chapter 18. If the ADSM is not enrolled (or is a member of the Reserve Component), the claim shall be processed in accordance with this chapter.

### 3.3. Check For SPOC Preauthorization

If a SPOC preauthorization exists, process the claim to completion in accordance with this chapter whether or not the patient is listed in DEERS.

### 3.4. 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.

### 3.5. 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.

### 3.6. 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.

## 4.0. THIRD PARTY LIABILITY

Third party liability (TPL) processing requirements (Chapter 11) 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.

## 5.0. TYPES OF CARE

Contractor staff shall receive and accept calls directly from Active Duty Service Members requesting authorization for care which has not been MTF referred. If the caller is requesting after hours authorization for care while physically present in the Prime service

area of the MTF to which he/she is enrolled, the care shall be authorized in accordance with the MCSC-MTF 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.

### 5.1. Emergency Care (As Defined In The TRICARE Policy Manual)

Subsequent to the eligibility verification process described in paragraph 5.0. above, the contractor shall pay all emergency claims for eligible uniformed Service members. If an emergency civilian hospitalization comes to the attention of the contractor, it shall be reported to the SPOC. The SPOC will have primary case management responsibility, including authorization of care and patient movement for all civilian hospitalizations.

### 5.2. Non-Emergent Care

Subsequent to eligibility verification as described in paragraph 5.0. above, 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 Chapter 19, Addendum B for SPOC referral and review procedures.

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

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

### 5.3. Ancillary Services

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

## 6.0. COVERAGE

**6.1.** Normal TRICARE coverage limitations will not apply to services rendered to SHCP eligible uniformed service members covered by this chapter. Services that have been authorized by the SPOC will be covered regardless of whether they would have ordinarily been covered under TRICARE policy. Occasionally, care may be authorized which was not rendered by a TRICARE authorized provider. Contractors 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. SPOCs do not have the authority to overturn TMA or Department of Health and Human Services provider exclusions. Customary TRICARE utilization review and utilization management requirements will not apply.

**6.2.** Unlike a normal TRICARE authorization, a SPOC authorization shall be deemed to constitute referral, authorization, eligibility verification, and direction to bypass provider certification and NAS rules. Contractors shall take measures as appropriate to enable them to distinguish between the two authorization types.

## 7.0. 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 shall 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 will 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 will 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.

## 8.0. REIMBURSEMENT

**8.1.** 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. Cost sharing and deductibles shall not be applied to SHCP claims.

**8.2.** 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 one 100% of CMAC limitation. If this is not feasible, the contractor shall make every effort to obtain the provider's agreement to accept, as payment in full, a rate between 100 and 115% of CMAC. If the latter is not feasible, the contractor shall determine the lowest acceptable rate that the provider will accept. The contractor shall then request a waiver of CMAC limitation from the Regional Director, 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. The waiver request shall include the patient name, ADSM's location, services requested (CPT-4) codes, CMAC rate, billed charge, and anticipated negotiated rate. The contractor must obtain approval from the Regional Director before the negotiation can be concluded. The contractors shall ensure that the approved payment is annotated in the authorization/claims processing system, and that payment is

issued directly to the provider, unless there is information presented that the ADSM has personally paid the provider.

**8.3.** Eligible uniformed service members 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. If the claim is payable without SPOC review the contractor shall allow the billed amount and reimburse the ADSM for charges on the claim. If the claim requires SPOC review the contractor shall pend the claim to the SPOC for determination. If the SPOC authorizes the care the contractor shall allow the billed amount and reimburse the ADSM for charges on the claim.

**8.4.** In no case shall a uniformed service member be subjected to "balance billing" or ongoing collection action by a civilian provider for emergency or authorized care. If the contractor becomes aware of such situations that they cannot resolve they shall pend the file and forward the issue to the SPOC for determination. The SPOC will issue an authorization to the contractor for payments in excess of CMAC or other applicable TRICARE payment ceilings, provided the SPOC has requested and has been granted a waiver from the Chief Operating Officer (COO), TRICARE Management Activity, or designee.

## 9.0. END OF PROCESSING

### 9.1. Explanation Of Benefits

An appropriate Explanation of Benefits (EOB) shall be prepared for each supplemental health care claim processed, and copies sent to the provider and the patient (uniformed service member) in accordance with normal claims processing procedures. The EOB will also 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 SPOC." Any standard TRICARE EOB messages which are applicable to the claim are also to be utilized, e.g., "No authorization on file."

### 9.2. Appeal Process

**9.2.1.** If the contractor, at the direction of the Service Point of Contact (SPOC), denies authorization of, or authorization for reimbursement, for an ADSMs health care services, the contractor shall, on the Explanation of Benefits or other appropriate document, furnish the ADSM with clear guidance for requesting a reconsideration from or filing an appeal with the SPOC. The SPOC will handle only those issues that involve SPOC denials of authorization or authorization for reimbursement. The contractor shall handle allowable charge issues, grievances, etc.

**9.2.2.** An ADSM will appeal SPOC denials of authorization or authorization for reimbursement through the SPOC--not through the contractor. If the ADSM disagrees with a denial, the first level of appeal will be through the Service Point of Contact who will coordinate the appeal with the appropriate Regional Director. The ADSM may initiate the appeal by contacting his/her Service Point of Contact or by calling the Military Medical Support Office (MMSO) at 1-888-647-6676. If the SPOC upholds the denial, the SPOC will notify the ADSM of further appeal rights with the appropriate Surgeon General's office. If the denial is overturned at any level, the SPOC will notify the contractor and the ADSM.

**9.2.3.** The contractor shall forward all written inquiries and correspondence related to SPOC denials of authorization or authorization for reimbursement to the appropriate SPOC. The contractor shall refer telephonic inquiries related to SPOC denials to 1-888-MHS-MMSO.

## 10.0. TED VOUCHER SUBMITTAL

The contractor shall report the SHCP claims on TED vouchers according to the provisions in Chapter 3, Section 3.

## 11.0. REPORTS FOR SHCP

### 11.1. Required Reports

**11.1.1.** Reports reflecting government dollars paid for all SHCP claims will be prepared and submitted to the SPOC and each Regional Director every month by branch of service. The contractor shall produce separate reports for services furnished to members of the Army National Guard and a separate report for services rendered to members of the Air Force National Guard. Contractors shall submit all reports described below in electronic media in an Excel format. The contractor shall also prepare a separate report of payment on behalf of non-DoD patients. The contractor shall forward this report to TRICARE Management Activity, Managed Care Support Operations Branch. The contractor shall submit these reports no later than the 15th calendar day of the month following the reporting period. These reports will reflect total care paid, and the total dollar amount contained in data elements paragraphs 11.1.3.1. through 11.1.3.13., below, and will equal the total amount submitted to TRICARE Management Activity, Contract Resource Management Directorate as vouchers and approved for check release. For those data elements in items paragraphs 11.1.3.1. through 11.1.3.13., below, which require a count, the MCS contractor must ensure that no workload is double-counted.

**11.1.2.** Aggregated quarterly reports will be prepared and submitted to each Service Headquarters. These reports will be submitted no later than the 15th calendar day of the month following the close of each fiscal quarter.

**11.1.3.** Data elements to include in the reports are:

**11.1.3.1.** DMIS ID Code – enrollment MTF

**11.1.3.2.** Total Number and Dollar Amount of Claims Paid

**11.1.3.3.** Inpatient Dollars Paid - Institutional

**11.1.3.4.** Inpatient Dollars Paid - Professional Services

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

**11.1.3.6.** Outpatient Dollars Paid - Ambulatory Surgeries/ Procedures - Professional Services

**11.1.3.7.** Outpatient Dollars Paid - Ambulatory Surgeries/ Procedures - Institutional

**11.1.3.8.** Total Admissions/Dispositions

**11.1.3.9.** Total Bed Days/LOS

**11.1.3.10.** Total Ambulatory Surgeries/Procedures, including all Ancillary

**11.1.3.11.** Total Outpatient Visits, Excluding Ambulatory Surgeries but including all Ancillary related to the outpatient visits

**11.1.3.12.** CPT Codes/DRG/ICD-9 Codes

**11.1.3.13.** Other Items Paid

### 11.2. Additional Reports

The contractor shall produce monthly workload and timeliness reports for the SHCP. The reports 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. The contractor shall prepare a cover letter when forwarding reports, which shall identify 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.

### 11.2.1. Workload Reports

The contractor shall prepare and submit a monthly SHCP claims workload report for each branch of service (to include Army National Guard, and Air Force National Guard separately), as well as one workload report which shows the cumulative totals for all services. The contractor shall send a copy of the Workload Reports to the TMA, Chief, Special Contracts and Operations Office. The contractor shall also send a copy of each Service's monthly report to the respective Service Project Officer identified in Chapter 19, Addendum A and to the SPOC. 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.

### 11.2.2. Timeliness Reports

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. The contractor shall send a copy of the SHCP Timeliness Reports

to the Regional Directors; Chief Financial Officer, TMA; and to the Chief, Special Contracts and Operations Office, TMA.

### 11.2.3. Aging Claims Report

The government intends to take action on all referrals to the SPOC as quickly as possible. To support this objective, the SPOC must be kept apprised of those claims on which the contractor cannot take further action until the SPOC has completed its reviews and approvals. Therefore, no less frequently than once per week, the contractor shall forward to the SPOC a report listing those claims which have been pended awaiting SPOC action, and the age of those claims. The age breakouts reported in that report may be based upon the same categories as reported in the monthly cycle time and aging reports sent to TMA (Chapter 15, Addendum A, Figure 15-A-2). In the alternative, they may be configured based upon existing workload management reports used internally by the contractor or its subcontractor. The weekly report to the SPOC may consist simply of a copy of the relevant portion of such an internal report if the contractor or its subcontractor currently utilizes one.

### 11.2.4. 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 contractors SHCP vouchers to TMA. 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.

## 12.0. CONTRACTOR'S RESPONSIBILITY TO RESPOND TO INQUIRIES

### 12.1. Telephonic Inquiries

Inquiries relating to the SHCP need not be tracked nor reported separately from other inquiries received by the MCS contractor. All inquiries to the contractor should come from the MTFs/claims offices, the Service Project Officers, the TMA, or SPOC. However, inquiries may be received from congressional representatives, providers and/or patients. 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 18. The telephone response standards of Chapter 1, Section 3, paragraph 3.4. shall apply to SHCP telephonic inquiries.

### 12.1.1. Congressional Telephonic Inquiries

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

### 12.1.2. Provider And Other Telephonic Inquiries

The contractor shall refer provider and any other telephonic inquiries it receives, including calls from the Service member to the SPOC if the inquiry is related to the authorization or non-authorization of a specific claim. The contractor shall respond as appropriate to general inquiries regarding the SHCP.

## 12.2. Written Inquiries

### 12.2.1. Congressional Written Inquiries

The contractor shall refer written congressional inquiries to the SPOC if the inquiry is related to the authorization or non-authorization of a specific claim or episode of treatment. When referring the inquiry, the contractor shall attach a copy of all supporting documentation related to the inquiry. If it is a general congressional inquiry regarding the SHCP, the contractor shall refer the inquiry to the TMA. The contractor shall refer all congressional written inquiries within 72 hours of identifying the inquiry as relating to the SHCP. When referring the inquiry, the contractor shall also send a letter to the congressional office informing them of the action taken and providing them with the name, address and telephone number of the individual or entity to which the congressional correspondence was transferred.

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

The contractor shall refer provider and service member written inquiries to the SPOC.

### 12.2.3. MTF Written Inquiries

The contractor shall refer all written inquiries from the MTF to the SPOC upon receipt of the inquiry.

## 13.0. 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.