Contractor Responsibilities

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1.0 CONTRACTOR RECEIPT AND CONTROL OF SUPPLEMENTAL HEALTH CARE PROGRAM (SHCP) CLAIMS

1.1 Claims Processing

1.1.1 Claims Processing And Reporting

Regardless of who submits the claim, SHCP claims shall be processed using the same standards and requirements 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. If the Service member is not enrolled, the contractor for the region in which the Service member resides shall process the claim. Claims for inpatient and outpatient medical services shall be processed to completion without application of a cost-share, copayment, or deductible. The claims filing deadline outlined in Chapter 8, Section 3, does not apply to any Service member SHCP claim or for Active Duty Family Member (ADFM) SHCP claims for authorized In Vitro Fertilization (IVF) treatment based on the sponsor's eligibility as a wounded warrior.

1.1.2 Civilian Services Rendered To Military Treatment Facility (MTF)/Enhanced Multi-Service Market (eMSM) Inpatients

Claims for MTF/eMSM inpatients referred to a civilian facility for medical care (test, procedure, or consult) shall be processed to completion without application of a cost-share, copayment, or deductible. Costs for transportation of current MTF/eMSM 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/eMSM authorization despite the lack of any Defense Enrollment Eligibility Reporting System (DEERS) indication of eligibility, these are SHCP claims. SHCP shall not be used for TRICARE For Life (TFL) beneficiaries referred from an MTF/eMSM as an inpatient. Such civilian claims shall be processed through Medicare first without consideration of SHCP.

1.1.3 Outpatient Care

Outpatient civilian care claims are to be processed according to the patient's enrollment or eligibility status (see paragraph 3.0). If the patient is shown as eligible in DEERS, normal claims processing requirements will apply. Additionally, for service determined eligible patients other than

active duty, (e.g., Reserve Officer Training Corps (ROTC), former members on the Temporary Disability Retirement List (TDRL), Reserve Component (RC), National Guard, foreign military members, etc.), claims will be paid based on an MTF/eMSM authorization despite the lack of any DEERS indication of eligibility.

1.1.4 Department of Defense (DoD)/Department of Veterans Affairs (DVA) Memorandum of Agreement (MOA)

Claims for care provided under the national DoD/DVA MOA for Spinal Cord Injury (SCI), Traumatic Brain Injury (TBI), and Blind Rehabilitation shall be processed in accordance with Section 2, paragraph 3.1.

1.1.5 Emergency Civilian Hospitalization

If an emergency civilian hospitalization becomes necessary during the test or procedure referred by the MTF/eMSM, or a hospitalization of a Service member comes to the attention of the contractor, it will be reported to the referring MTF/eMSM or the enrolled MTF/eMSM if not referred. The MTF/eMSM will have primary case management responsibility, including authorization of care and patient movement for all civilian hospitalizations.

1.1.6 Temporary Disability Retirement List (TDRL)

Claims for periodic physical exams for participants on the TDRL will be processed based on the MTF/eMSM authorization. These claims are SHCP claims, but will be maintained and tracked separately from other SHCP claims. It is the responsibility of the MTF/eMSM to identify TDRL referrals to the contractor at the time of authorization. SHCP funds shall not be used to treat the conditions which caused the Service member to be placed on the TDRL or for conditions discovered during the physical examination. The TRICARE Encounter Data (TED) record for each TDRL physical exam claim must reflect the Enrollment/Health Plan Code **SR** and the Special Processing Code (SPC) **DE**.

1.1.7 Comprehensive Clinical Evaluation Program (CCEP)

Claims for participants in the CCEP will be processed based on the MTF/eMSM authorization. These claims are SHCP claims, but will be maintained and tracked separately from other SHCP claims. It is the responsibility of the MTF/eMSM to identify CCEP referrals to the contractor at the time of authorization.

1.1.8 Foreign Military Member and Family Member Claims Processing

Foreign military members and their family members in the United States (U.S.) may be eligible for health care under an approved agreement (e.g., reciprocal health care agreement, North Atlantic Treaty Organization (NATO) Status of Forces Agreement (SOFA), or Partnership for Peace (PfP) SOFA). Foreign military members and their family members on assignment in the U.S. will be shown on DEERS with a Health Care Coverage Member Category Code of **T**. Foreign military members who are in the US on official business may be eligible for care, but may not be reflected on DEERS. Accordingly, claims for foreign military member's outpatient care provided in the U.S. shall be paid based on an MTF/eMSM or Specified Authorization Staff (SAS) authorization despite the lack of any DEERS indication of eligibility. Contractors shall process claims received for foreign military members and their family members as follows:

1.1.8.1 Foreign Military Member

Foreign military members are eligible for civilian outpatient care, but are not eligible for civilian inpatient care (see the TRICARE Policy Manual (TPM), Chapter 1, Section 1.1). Any civilian outpatient care for an authorized foreign military member must be referred by an MTF/eMSM or SAS. For MTF/eMSM referral requests, the contractor shall accept and follow the referral requirements in Chapter 8, Section 5. If the foreign military member works and resides in a TRICARE Prime Remote (TPR) area, then the SAS will issue referrals for outpatient care. Essentially, the same referral processes in place for Service members (which includes pending a claim without a referral and forwarding to either an MTF/eMSM or SAS for review) shall be followed for foreign military member care. Authorized civilian outpatient care claims for foreign military members are processed with no copayment or cost-share. If the member has double coverage (not including national health plan coverage from his or her home country), the double coverage provisions in the TRICARE Reimbursement Manual (TRM), Chapter 4, apply to these claims. Foreign military members are not required nor are they eligible to enroll in any TRICARE plan for their civilian outpatient claims to be paid by TRICARE.

1.1.8.2 Family Members of Foreign Military Members

Family members of foreign military members may be eligible for outpatient civilian care, but are not eligible for inpatient care (see the TPM, Chapter 1, Section 1.1). If the family member is registered and shown as eligible in DEERS (Health Care Coverage Member Category Code of **T**), then the contractor shall process the claim with TRICARE Standard/Extra cost-shares (through December 31, 2017) or TRICARE Select Group B ADFM cost-shares (starting January 1, 2018) (see the TRM, Chapter 2, Section 2) as appropriate. If the family member has double coverage (not including national health plan coverage from his or her home country), the double coverage provisions in the TRM apply.

1.1.9 Claims Received With Both MTF/eMSM-Referred And Non-Referred Lines

1.1.9.1 The contractor shall use its best business practices in determining Episode of Care (EOC) when claims are received with lines of care containing both -referred and non-referred (directs evaluation or treatment of a condition) lines. Laboratory tests, radiology tests, echocardiogram, holter monitors, pulmonary function tests, and routine treadmills logically associated with the referred EOC may be considered part of the originally requested services and do not need additional MTF/eMSM approval. Claims received which contain services outside the originally referred EOC on a Service member must come back to the MTF/eMSM for approval.

1.1.9.2 Non-mental health SHCP requests will have a benefit review only. The contractor will not do a medical necessity review. Medical necessity reviews will be provided by the MTF/eMSM or civilian referring provider.

1.2 Eligibility Verification

1.2.1 MTF/eMSM Referred Care

If an MTF/eMSM referral is on file and the service is either ordinarily covered by TRICARE or covered by TRICARE under paragraph 2.2.4, the contractor shall process the claim in accordance with the provisions in paragraph 1.2.2.2. The contractor shall verify that care provided was authorized by the MTF/eMSM. If an authorization is not on file, then the contractor shall place the claim in a pending file and verify authorization with the Service member's MTF/eMSM (except for care provided by the DVA/

Veterans Health Administration (VHA) under the current national MOA for SCI, TBI, and Blind Rehabilitation, see Section 2, paragraph 3.1). If the claim is for a breast pump, a prescription is required and the prescription must indicate whether it is for a manual, standard electric, or heavy-duty hospital grade breast pump. If the claim is for a manual or standard electric pump, no additional MTF/eMSM authorization is required. If the claim is for a heavy-duty hospital grade pump, a prescription is required and a referral must be on file. If no referral is on file, the contractor shall contact the MTF/eMSM for authorization as described below. Claims for breast pump supplies do not require a prescription or MTF/eMSM referral/authorization. The contractor shall contact the MTF/eMSM within one working day. If the MTF/eMSM 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/eMSM 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 a response within four working days from the MTF's/eMSM's response, 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/eMSM shall be considered as "Referred Care". Services that would not have ordinarily been covered under TRICARE policy shall be authorized for Service members only in accordance with the terms of a waiver approved by the Director, Defense Health Agency (DHA), at the request of an authorized official of the Uniformed Service concerned or SAS as appropriate, except for exemptions under paragraph 2.2.4.

1.2.2 Non-MTF/eMSM Referred Care

1.2.2.1 Check DEERS Status

If the Service member is listed in DEERS as TRICARE Prime, No Primary Care Manager (PCM) Selected, process the claim in accordance with paragraph 1.4 (Types of Care). If the DEERS check indicates the Service member is enrolled in TPR, then the claim shall be processed as a TPR claim in accordance with Chapter 16. Otherwise the claim shall be processed in accordance with the requirements of Chapter 17.

1.2.2.2 Check for SAS Preauthorization

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

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 SAS 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 shall be checked for MTF/eMSM or SAS authorization before routing to SAS. Claims for ineligible sponsors are to be suspended and routed to SAS for payment approval or denial. If a payment determination is not received within the 85th 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 shall 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 Federal Recovery Coordination Program (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 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 Service members requesting authorization for care which has not been MTF/eMSM referred. If the caller is requesting after hours authorization for care while physically present in the Prime Service Area (PSA) of the MTF/eMSM to which he/she is enrolled, the care shall be authorized in accordance with the contractor-MTF/eMSM Memoranda of Understanding (MOU) established between the contractor and the local MTF/eMSM. 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/eMSM for instructions. The contractor shall send daily notifications to the Service members' enrolled MTF/eMSM for all care authorized after hours according to locally established business rules.

2.0 COVERAGE

Except as authorized by this section, services that would not have ordinarily been covered under TRICARE policy (including limitations and exclusions) may be authorized for Service members only in accordance with the terms of a waiver approved by the Director, DHA, at the request of an authorized official of the Uniformed Service concerned, or by SAS. (Reference HA Policy 12-002 "Use of Supplemental Health Care Program Funds for Non-Covered TRICARE Health Care Services and the Waiver Process for Active Duty Service Members".) TRICARE coverage limits continue to apply to services to non-active duty TRICARE-eligible covered beneficiaries provided under the SHCP.

Note: No waiver (regardless of basic benefit standards) is required for care being received under the DoD/VA MOA or for emergent care at non-authorized facilities.

2.1 On occasion, under the SHCP, care may be referred or authorized for services from a provider of a type which is not TRICARE authorized. This is limited to emergent cases, care under the DoD/VA MOA,

or with a DHA waiver. 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/eMSMs do not have the authority to overturn DHA or Department of Health and Human Services (DHHS) provider exclusions. TRICARE utilization review and utilization management requirements will not apply.

- On occasion Service members may be referred or authorized for emergency services from a facility which is not TRICARE authorized (see the TRM, Chapter 1, Section 29, paragraph 2.1). The Service member must be transferred to an authorized facility when a bed becomes available and it is safe (as determined by the Service member's current provider and accepting provider) to transfer the Service member. There is no time standard. Continued stay at an unauthorized facility beyond the emergent requirement requires a waiver under the SHCP. The Service member will be held harmless during this process.

2.1.1 In determining whether a given service or supply would not have ordinarily been covered under TRICARE policy, the contractor shall:

2.1.1.1 Deny health care services and supplies that are specifically excluded from coverage, as reflected in the TRICARE Manuals and on the No Government Pay List (NGPL);

2.1.1.2 Ensure application of any published frequency limitations, coverage criteria, and/or other TRICARE published criteria; and

2.1.1.3 Allow coverage for care provided under current Demonstration authority.

2.1.2 In making the determination required by paragraph 2.1, the contractor is not required to determine medical necessity. A referral from an MTF/eMSM or an authorization from a SAS shall be deemed authorization for coverage of the private sector care.

2.1.3 Similarly, an MTF/eMSM referral or SAS authorization for private sector care that is not specifically excluded from coverage, including the off-label use of an Food and Drug Administration (FDA) approved drug, device, or medical procedure for which no published exclusion exists, shall constitute authorization to process the claim for payment. MTF/eMSM referral or SAS authorization or civilian provider requests for authorization for care that is considered by the contractor to be unproven per the TPM, Chapter 1 shall be processed unless the request is for a specific published exclusion or all-inclusive limitation.

2.2 Upon receipt of an MTF/eMSM referral/civilian provider referral (for remote Service members/ non-enrolled Service members), the contractor shall perform a coverage review. A referral from an MTF/eMSM or an authorization from a SAS shall be deemed to constitute Service member eligibility verification, as well as direction to bypass provider authorization/certification (in emergency cases only) rules. The contractor shall take measures as appropriate to enable them to distinguish between an MTF/eMSM referral and a SAS authorization.

2.2.1 If the contractor determines that the service, supply, or equipment requested by an MTF/ eMSM referral is covered under TRICARE policy (including paragraph 2.2.4), the contractor shall file an authorization in its system and pay received claims in accordance with the filed authorization. If the contractor determines that the service, supply, or equipment requested by civilian provider referral (for remote Service members/non-enrolled Service members) is covered under TRICARE policy, the

contractor shall forward the appropriate documentation to the SAS for authorization. Upon receipt of the SAS authorization, the contractor shall file an authorization in its system and pay received claims in accordance with the filed authorization.

2.2.2 If the contractor determines that the requested service, supply, or equipment is not covered by TRICARE policy (including paragraph 2.2.4) but an approved waiver is provided, the contractor shall file an authorization in its system as specified in the DHA approved waiver and pay received claims in accordance with the filed authorization.

2.2.3 If the contractor determines that the requested service, supply, or equipment is not covered by TRICARE policy (including paragraph 2.2.4), the contractor shall decline to file an authorization in its system and deny any received claims accordingly. If the authorization request was received as an MTF/eMSM referral, the contractor shall notify the MTF/eMSM (an enrolled MTF/eMSM if different from the submitting MTF/eMSM) of the declined authorization with explanation of the reason. If the request was received as a referral from a civilian provider (for a remote Service member/non-enrolled Service member), the contractor shall notify the civilian provider and the remote Service member/non-enrolled Service member of the declined authorization with explanation of the reason. The notification to a civilian provider and the remote Service member/non-enrolled Service member shall explain the waiver process and provide contact information for the applicable Uniformed Services Headquarters Point of Contact (POC)/Service Project Officers as listed in Addendum A, paragraph 2.0. No notification to the SAS is required.

2.2.4 Certain services, supplies, and equipment are covered for Service members under the SHCP as specified below and no waiver is required:

2.2.4.1 Custom-fitted orthoses are covered for Service members on active duty. The custom-fitted orthosis must be ordered by the appropriate provider and obtained from a TRICARE authorized vendor that specializes in this service. Prefabricated or other types of orthoses available in commercial retail entities are excluded. Specifically, this benefit refers to custom fitted orthotics (e.g., foot inserts for plantar fasciitis, flat feet, or similar diagnoses).

2.2.4.2 Hearing Aids

2.2.4.2.1 Hearing device/prosthetics, cochlear and other implant systems and accessories must be procured by the MTF/eMSM for those Service members who reside in a Prime Service Area (PSA) with audiology services.

2.2.4.2.2 Service members residing outside of a PSA, or where MTFs/eMSMs lack the audiology services necessary for hearing aid procurement, shall be referred to a network provider for hearing aid procurement, fittings, and/or adjustments through the SHCP without a waiver. Except for TPR enrollees, the referral must document the lack of MTF/eMSM audiology services. All services must be preauthorized.

2.2.4.3 Continuous Positive Airway Pressure (CPAP) Batteries And Portable Devices

2.2.4.3.1 CPAP batteries for both standard and portable devices and adaptive equipment are covered.

2.2.4.3.1.1 The request shall document that the Active Duty Service Member (ADSM) is on deployment status and is not within one year of retirement/separation.

2.2.4.3.1.2 A replacement battery shall be provided if the current battery is no longer functional after normal use or damaged during deployment at no fault of the ADSM as documented in the request.

2.2.4.3.1.3 If the battery is lost or damaged because of ADSM personal negligence, SHCP funds shall not be used to replace the battery.

2.2.4.3.2 Portable CPAP devices are covered.

2.2.4.3.2.1 The following criteria shall be met and documented on the referral:

2.2.4.3.2.1.1 The ADSM has a diagnosis of Obstructive Sleep Apnea (OSA); and

2.2.4.3.2.1.2 The ADSM travels on official business at least three days per month or is being deployed.

2.2.4.3.2.1.3 The device must have humidification and battery capability.

2.2.4.3.2.1.4 If the ADSM already has a standard CPAP device a portable device shall be authorized if criteria are met.

2.2.4.3.2.1.5 Upon initial referral for a CPAP device a portable device shall be authorized if criteria are met. A standard CPAP device shall not be authorized in addition to a portable device.

2.2.4.3.2.2 Portable CPAP devices shall be coded using Healthcare Common Procedure Coding System (HCPCS) code E1399 and shall be reimbursed based upon the billed charge.

2.2.4 Ambulance Fees

2.2.4.4.1 In some localities that do not provide an Advanced Life Support (ALS) ambulance, a Basic Life Support (BLS) ambulance will be dispatched, and a separate call is made to an ALS responder to meet the BLS ambulance at the scene. Under current TRICARE policy, there must be a contract between the BLS ambulance provider and the ALS responder in order to pay for both claims. When there is not a contract between both ambulance service providers, the contractor shall reimburse the BLS ambulance provider under normal TRICARE reimbursement policy, and additionally reimburse the ALS responder claim.

2.2.4.4.2 There may be situations where an ambulance responds to an emergency call and provides evaluation/treatment without transport, as the person either refuses transport or it is unnecessary to transport after assessment and treatment. This is sometimes referred to as "response and evaluation/treatment but no transport" or "treat and release." For Service members, the contractor shall reimburse a claim submitted by an ambulance provider or first responder if there was a response and evaluation/treatment, but no transport.

2.2.4.4.3 For services provided on or after September 13, 2018, see TRM, Chapter 1, Section 14.

2.2.4.5 Maintenance of Wakefulness Test (MWT) for Obstructive Sleep Apnea (OSA)

Where there is a military need to determine the effectiveness of treatment in regards to sleepiness for a Service member with a diagnosis of OSA, an MWT is covered when all of the following criteria are met:

2.2.4.5.1 The MWT referral documents the Service member has been diagnosed with OSA and has received at least 30 days of described treatment, for example Continuous Positive Airway Pressure (CPAP).

2.2.4.5.2 The referral documents that the nearest military treatment facility with a Sleep Disorder Center and Sleep Lab cannot accommodate the request for MWT.

2.2.4.5.3 For members treated with Positive Airway Pressure (PAP), the referral will include Service specific PAP treatment compliance requirements such as number of hours used on percentage of nights since initiation of treatment.

2.2.4.5.4 The MWT shall be performed by a network/civilian sleep facility that is American Academy of Sleep Medicine (AASM) certified.

2.2.4.5.5 Prior to conducting the MWT, the sleep lab shall document PAP usage and compare to Service specific compliance requirements.

2.2.4.5.6 If compliance requirements are met the sleep lab can proceed with the MWT.

2.2.4.5.7 If compliance requirements are not met the sleep lab will not proceed with the MWT and report the results to the referring provider.

2.2.4.5.8 For members treated with surgical therapy, an MWT will only be performed if they have had a post-operative polysomnography confirming an Apnea Hypopnea Index (AHI) less than five per hour documented on the referral.

2.2.4.6 Multiple Prostheses

2.2.4.6.1 Multiple prostheses shall be covered for ADSMs with major limb amputation(s). This includes amputations at or above the ankle and/or wrist including partial hand or foot amputations. Additional prostheses may be necessary based on the ADSM's fitness, duties and deployment requirements.

2.2.4.6.2 Every limb with an amputation may require multiple prostheses.

2.2.4.6.3 All ADSMs who have sustained an amputation(s) shall undergo an initial assessment (in person or telephonically) at one of the following Advanced Rehabilitation Center (ARC) locations: The Center for the Intrepid, San Antonio Military Medical Center, San Antonio, Texas; Walter Reed National Military Medical Center, Bethesda, Maryland; or the Comprehensive Combat and Complex Casualty Care, Naval Medical Center, San Diego, California. See Chapter 8, Section 5.

2.2.4.6.4 The ARC will:

2.2.4.6.4.1 Determine the appropriateness and availability of a transfer/admission to the ARC for additional prostheses.

2.2.4.6.4.2 If ARC is unable to accommodate the referral, the ARC will assist the provider in determining the specific type of prostheses required (e.g., for running, swimming, or navigating uneven terrain) for the referral to a civilian network providers.

2.2.4.6.4.3 Track all ADSMs with major amputations and prosthetic prescriptions.

2.2.4.6.5 Replacement prostheses will be covered when the treating physician determines that an ADSM's physiological condition changes or that the device is lost, irreparably damaged, or replacement is necessary. An assessment by the ARC is not necessary for replacements.

2.2.4.6.6 Prostheses covered in accordance with paragraph 2.2.4.6.5 shall be provided regardless of remaining time on active duty subject to the ADSM's fitness and duty requirements.

2.2.4.6.7 TRICARE covers one permanent prosthesis at a time unless the beneficiary requires a bilateral prosthesis. See the TPM, Chapter 8, Section 4.1. Upon the ADSM's retirement, TRICARE's coverage policy will apply regarding repair and replacement of one prosthetic device. TRICARE coverage will not extend to any additional prostheses. ADSMs who separate or retire may seek replacement and repairs from the ARCs or Veterans Health Administration (VHA), as eligible.

2.2.4.6.8 Addendum D contains the MOA Between DVA And DoD For Medical Treatment Provided To Service Members With SCI, TBI, Blindness, Or Polytraumatic Injuries. Acquired conditions referred to DVA/VHA medical facilities/programs referenced in the MOA or similar private sector programs are exempt from the SHCP waiver process and will be reimbursed under normal TRICARE reimbursement policy. Referrals for programs, DME, or other authorized treatment for acquired conditions will not be processed by DHA-Great Lakes (DHA-GL), but shall be processed in alignment with the conditions of the MOA. Acquired conditions include:

2.2.4.6.8.1 Acquired Brain Injuries (ABIs) (e.g., cardiovascular accident, brain cancer, aneurysm, brain arteriovenous malformation). This includes ABIs due to International Classification of Diseases, 10th Revision (ICD-10) codes including S06 (other than those already covered under the MOA as TBI), A87.9, F01.50, F02.80, F02.81, F03.90, F03.91, F07.81, G00.9, G03.0, G03.1, G03.9, G04.00, G05.3, G05.4, G06.0, G06.1, G06.2, G08, G09, G92, G93.0, G93.1, I60.00, I60.01, I60.02, I60.10, I60.11, I60.12, I60.2, I60.30, I60.31, I60.32, I60.4, I60.50, I60.51, I60.52, I60.6, I60.7, I60.8, I60.9, I61.9, I62.00, I62.1, I63.019, I63.119, I63.139, I63.20, I63.219, I63.22, I63.239, I63.30, I63.40, I63.50, I63.59, I67.89, I69.810, I69.811, I69.812, I69.813, I69.814, I69.815, I69.818, I69.819, I69.898, I69.910, I69.911, I69.912, I69.913, I69.914, I69.915, I69.918, I69.919, I69.928, P10.1, P10.3, P10.8, P10.9, P52.4, P52.5, P52.6, P52.8, P52.9, R09.0, R09.01, R09.02, R41.2, R41.3, R41.82, T75.1, T75.1XXA, T75.1XXD, T75.1XXS.

2.2.4.6.8.2 Acquired blindness (e.g., blindness caused by diabetes, infections, glaucoma or other non-traumatic injury). This includes ICD-10 codes under Blindness and Low Vision (H54).

2.2.4.6.8.3 Non-traumatic spinal cord disorders (e.g., conditions due to infection, loss of blood supply, compression caused by cancer, or degeneration of the spinal vertebrae). This includes ICD-10 codes under deforming dorsopathies (M40-M43), spondylopathies (M45-49) and other dorsopathies (M50-M54).

2.2.4.7 Laser Therapy for Pseudofolliculitis Barbae (PFB) of the Face and Neck

2.2.4.7.1 Laser therapy is covered in the civilian sector to ensure medical readiness of ADSMs with a diagnosis of PFB of the face and neck when all of the following criteria are met and documented on the referral:

2.2.4.7.1.1 There is a safety risk in operational, maintenance and training environments where the wearing of breathing protection may be required.

2.2.4.7.1.2 The ADSM has been diagnosed with PFB of the face and neck and has failed conservative therapy.

2.2.4.7.1.3 The ADSM's PCM has referred the case to a MTF/eMSM dermatologist for an in-person, telephone or telehealth consultation.

2.2.4.7.1.4 The MTF/eMSM dermatologist has recommended laser therapy and the laser therapy is not available at the MTF/eMSM.

2.2.4.7.2 The MTF/eMSM dermatologist will assess each case to limit inappropriate referrals, encourage laser therapy in MTFs/eMSMs, and ensure referred care is consistent with any Service-specific polices on PFB. The MTF/eMSM dermatologist may establish local policies to streamline this process.

2.2.4.7.3 The contractor shall ensure the laser therapy in the civilian sector is provided by a dermatologist.

2.2.4.8 Coronavirus 2019 (COVID-19) Testing for Asymptomatic (ADSMs)

COVID-19 in-vitro diagnostic tests using FDA approved, cleared or authorized Nucleic Acid Amplification (NAA) tests which includes the Reverse Transcription Polymerase Chain Reaction (RT-PCR) test is covered for asymptomatic ADSMs when ordered by a TRICARE authorized provider. The TRICARE Overseas Program (TOP) contractor is authorized to follow the established guidelines/standards of care for COVID-19 testing for the country, host-nation, and/or regional health authority (e.g., World Health Organization (WHO)), where the patient is treated. (See the TPM, Chapter 12, Section 1.2.)

2.3 Non-Waiverable Health Care Services

2.3.1 Bariatric surgery.

2.3.2 Chiropractic services outside of the MTF/eMSM.

2.4 Specifically Defined Health Care

2.4.1 Ancillary Services

The Regulation governing SHCP requires each service be authorized, with very limited exceptions. For purposes of SHCP claims processing, an MTF/eMSM referral/SAS authorization for care will be deemed to include authorization of any TRICARE-covered ancillary services directly and clearly related to the specific EOC authorized (e.g., evaluation or treatment of a specific medical condition).

Any questions of whether a particular service is related to the EOC already authorized should be resolved by means of seeking MTF/eMSM referral/SAS authorization for the service in question.

2.4.2 Benefit Coverage Comparable To The Extended Care Health Option (ECHO) For Seriously Ill Or Injured Service Members

2.4.2.1 Under 10 USC 1074(c)(4)(A) and (B), seriously ill/injured Service members shall receive services comparable to those provided to dependents of Service members under 10 USC 1079(d) and (e), the TRICARE ECHO Program. Statutory authority for these benefits for retirees ended December 31, 2012. Former Service members that utilized this benefit will continue to be covered by this provision for benefits received before December 31, 2012 (e.g., anti-rejection medication for a limb transplant). The contractors shall ensure all TED requirements outlined in the TRICARE Systems Manual (TSM), Chapter 2 are met including appropriate use of SPC **PF** to identify TED records for care rendered under the ECHO benefit for seriously ill or injured Service members.

2.4.2.2 There are no cost-shares, copayments, or financial caps for any of these ECHO-like benefits when these services are authorized. There is no requirement to register in the Exceptional Family Member Program (EFMP). There is no time limit with disability/illness requirement. These benefits shall be preauthorized, to include documentation of Category II/III designation per Department of Defense Instruction (DoDI) 1300.24; and, documentation that the Service member has been referred to a Medical Evaluations Board (MEB).

2.4.2.3 The following categories of care listed under 10 USC 1079(e) are authorized (see 10 USC 1079(e)(1-7):

2.4.2.3.1 Diagnosis.

2.4.2.3.2 Inpatient, outpatient, and comprehensive Home Health Care (HHC) supplies and services which may include cost effective and medically appropriate services other than part-time or intermittent services, as these terms are currently used under the TRICARE ECHO Program.

2.4.2.3.3 Training, rehabilitation, special education, and assistive technology devices.

2.4.2.3.4 Institutional care in private nonprofit, public, and state institutions and facilities and, if appropriate, transportation to and from such institutions and facilities.

2.4.2.3.5 Home health services, including custodial care in conjunction with authorized home health services.

2.4.2.3.6 Seriously ill or injured Service members are defined as Category II or III per DoDI 1300.24.

2.4.2.3.6.1 Category II:

- Has a serious injury or illness.
- Is unlikely to return to duty within a time specified by his or her military department.

- May be medically separated from the military.

2.4.2.3.6.2 Category III:

- Has a severe or catastrophic injury or illness.
- Is highly unlikely to return to duty.
- Will most likely be medically separated from the military.

2.4.2.4 The Service member's primary care provider or primary specialty care provider shall document and provide the Service member's category status on a referral as well as documentation of a referral to an MEB. Preauthorization is required. If the documentation supports the category designation of Category II/III, the Service member is eligible for benefits comparable to ECHO. Using the Government furnished web-based enrollment application, the contractor shall apply the ECHO Health Care Delivery Plan (HCDP) code of 400 to the Service member. The provider's documentation of Category II/III status is the authorizing document allowing the contractor to apply the ECHO HCDP code to the Service member. The contractor shall ensure all TED requirements outlined in the TSM, Chapter 2 are met, including appropriate use of SPC **PF** to identify TED records for care rendered under the ECHO benefit for seriously ill or injured Service members.

2.4.2.5 The contractor shall collaborate with all DVA/VHA case managers along with the Service member's healthcare team to ensure continuity of care and transition to DVA/VHA care and management upon retirement or separation.

2.4.2.6 As much as practical, these benefits should mirror the ECHO Program and be coordinated between the contractor and the health care team. Benefits for these Service members arise from any physiological disorder or condition or anatomical loss affecting one or more body system and which precludes the person with the disorder, condition, or anatomical loss from unaided performance of at least one of the following major life activities: breathing, cognition, hearing, seeing, and ability to bathe, dress, eat, groom, speak, stair use, toilet use, transferring, and walking. Benefits include services for rehabilitative, habitative care as well as Durable Equipment (DE) and DME.

2.4.2.7 Designation of comparable to ECHO benefits for Service members.

2.4.2.7.1 Requests for benefits under the comparable to ECHO will come from the Service member's PCM or specialty provider with documentation of the category description (II/III) along with documentation to support that category description.

2.4.2.7.2 Documentation of a referral to an MEB must be provided.

2.4.2.8 Provision Of Respite Care

2.4.2.8.1 The eligibility rules and exclusions contained in 32 CFR 199.5(b)(3) and (5) do not apply to the provision of respite benefits for a Service member. See Appendix A for definitions, terms, and limitations applicable to the respite care benefit.

2.4.2.8.2 Seriously ill or injured Service members shall qualify for respite care benefits regardless of their enrollment status. Service members in the 50 U.S. and the District of Columbia shall 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. Service members outside the 50 U.S.

and the District of Columbia shall qualify if they are enrolled to TOP Prime (with enrollment to an MTF/eMSM), TOP Prime Remote, or not enrolled and receiving services in accordance with the non-enrolled/non-referred provisions for Service member care overseas (see TPM, Chapter 12, Section 1.1).

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

2.4.2.8.3 There are no cost-shares or copays for Service member respite benefits when those services are approved by the Service member's Direct Care System (DCS) case manager or other appropriate DCS authority (i.e., SAS, the enrolled or referring MTF/eMSM, TRICARE Area Office (TAO), or Community Care Units (CCUs)).

2.4.2.8.4 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 Service member shall apply. Contractors shall follow the requirements and provisions of these chapters, to include:

- MTF/eMSM or SAS 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 Service member or their lawful spouse; and
- Use of CHAMPUS Maximum Allowable Charges (CMACs)/Diagnosis Related Groups (DRGs) when applicable.

2.4.2.8.5 The contractor shall follow the provisions of the TSM, Chapter 2, Sections 2.8 and 6.4 regarding the TED SPC for the Service member respite benefit. Claims should indicate an appropriate procedure code for respite care (CPT 99600 or HCPCS S9122-S9124) and shall be reimbursed based upon the allowable charge or the negotiated rate.

2.4.2.8.6 Respite care services and requirements are as follows:

2.4.2.8.6.1 Respite care is authorized for a Service member of the Uniformed Services on active duty and has a qualifying condition as defined in Appendix A.

2.4.2.8.6.2 Respite care is available if a Service member's plan of care includes frequent interventions by the primary caregiver(s).

2.4.2.8.6.3 Service members 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.

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

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

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

2.4.2.8.6.6 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.

2.4.2.8.6.7 The contractor shall follow the reimbursement methodology for the similar respite care benefit found in the TPM, Chapter 9, as modified by Service member SHCP reimbursement methodology contained in Chapters 16 and 17 (for Service members located in the 50 U.S. and the District of Columbia) or TOP reimbursement methodology contained in the TPM, Chapter 12 (for Service members located outside the 50 U.S. and the District of Columbia).

2.4.2.8.7 Should other services or supplies not outlined above, or those otherwise available under the TRICARE program, be considered necessary for the care or treatment of a Service member, a request shall be submitted to the SAS, MTF/eMSM, or TAO for authorization of payment. When preauthorization is possible it shall be done.

2.4.2.9 Customized Hand Crank Bikes

2.4.2.9.1 There is a cap of $5,500.

2.4.2.9.2 Bike must be custom fitted for the Service member's unique injury.

2.4.2.9.3 Must be preauthorized and evidence of a Category II/III illness or injury must accompany the request. No request should be for more than the $5,500 cap.

2.4.2.10 Custodial Care

2.4.2.10.1 Limited to 30 days if Service member has not been referred to an MEB.

2.4.2.10.2 At the MTF/eMSM case manager's request, the appropriate regional Medical Director, Clinical Operations Division (COD), TRICARE Health Plans may extend an additional 30 days if Service member is due to return to duty at the end of the additional 30 days.

2.4.2.10.3 Any additional extensions must be with a waiver from the Director, DHA for those Service members that have not been referred to a MEB.

2.4.2.10.4 For Service members who have been referred to an MEB, authorization is valid until Service member retires, separates, or returns to duty. No waiver is required.

2.4.2.10.5 May be provided in the home or authorized provider/facility. Use of an unauthorized provider/facility would require a waiver.

2.4.2.10.6 Custodial care services may be provided up to 24/7. The health care team will periodically review Service member's care plan to revise amount of custodial care required.

2.4.2.10.7 The Service member's health care team will determine the requirements of the Service member for Custodial Care, including the number of hours and duration of the service and will adjust these requirements accordingly as the Service member's requirements change.

2.4.2.10.8 As required the contractors shall collaborate with DoD and DVA/VHA case managers along with the Service member's health care team to ensure continuity of care and transition to DVA/VHA care and management upon retirement or separation.

2.4.2.10.9 Care must be preauthorized with documentation of Category II/III illness or injury and other inclusion criteria in this section accompanying the request.

2.4.2.11 Cryopreservation And Reproductive Services

2.4.2.11.1 Policy Guidelines For Cyropreservation Of Sperm/Oocytes/Embryos For Service Members With A Diagnosis Of Cancer

2.4.2.11.1.1 Service member must be either Category II or III as a result of their cancer at the time of retrieval. The Service member must be scheduled to undergo a gonadotoxic treatment for their cancer.

2.4.2.11.1.1.1 For females cyropreservation of eggs at age 49 or under at the time of retrieval.

2.4.2.11.1.1.2 For males cyropreservation of sperm at 61 or under at time of retrieval.

2.4.2.11.1.2 Are on a period of active duty greater than 30 days and are scheduled to remain on active duty for the duration of the retrieval and freezing process.

2.4.2.11.1.3 Have capacity to provide informed consent (i.e., third party consent is not authorized).

Note: Prior surgical sterilization does not disqualify a Service member from participating.

2.4.2.11.1.4 Mature Oocyte Retrieval

2.4.2.11.1.4.1 Referral by PCM (or referral by primary care provider for TPR enrollees) or specialist involved in a Service member's cancer care is required for each cycle. No more than three completed retrieval cycles are covered. Services and supplies covered for mature oocyte retrieval include the following.

2.4.2.11.1.4.1.1 Consultation and subsequent office visits as indicated.

2.4.2.11.1.4.1.2 Laboratory tests and ultrasound imaging as indicated.

2.4.2.11.1.4.1.3 Provider-administered medications as indicated for oocyte retrieval.

2.4.2.11.1.4.1.4 Self-administered medications as indicated for oocyte retrieval are covered under Chapter 23.

2.4.2.11.1.4.1.5 Surgical retrieval and anesthesia.

2.4.2.11.1.4.1.6 Medically necessary services and supplies associated with complications.

2.4.2.11.1.4.2 The benefit is limited to the retrieval of 20 oocytes or three completed cycles, whichever occurs first. There may be a total of four attempts to accomplish three completed cycles.

2.4.2.11.1.4.3 Additional retrieval beyond one cycle shall be authorized by the contractor only if the cumulative number of oocytes retrieved of all previous cycles is less than 20. For instance, if 12 oocytes are retrieved in the first cycle, the contractor may approve a second cycle. If 11 more oocytes are retrieved in the second cycle, the contractor shall not approve a third cycle.

2.4.2.11.1.5 Sperm Collection And Retrieval

2.4.2.11.1.5.1 Referral by PCM (or referral by primary care provider for TPR enrollees) or specialist involved in a Service member's cancer care is required. If indicated, invasive procedures for sperm retrieval beyond simple collection of semen (or urine for retrograde ejaculation) must be specified in the referral. Services and supplies covered for sperm collection and retrieval includes the following.

2.4.2.11.1.5.1.1 Consultation and subsequent office visits as indicated.

2.4.2.11.1.5.1.2 Laboratory tests as indicated including semen analysis.

2.4.2.11.1.5.1.3 Provider-administered medications as indicated for sperm retrieval.

2.4.2.11.1.5.1.4 Self-administered medications indicated for sperm retrieval are covered under Chapter 23.

2.4.2.11.1.5.1.5 Invasive procedures for sperm retrieval (e.g., electro-ejaculation, epididymal aspiration) likely to produce viable sperm.

2.4.2.11.1.5.1.6 Medically necessary services and supplies associated with complications.

2.4.2.11.1.5.2 The benefit is limited to either two simple specimen collections or one invasive procedure for sperm retrieval.

2.4.2.11.1.6 Cryopreservation

2.4.2.11.1.6.1 Services and supplies associated with cryopreservation of all mature oocytes and sperm retrieved, and embryos.

2.4.2.11.1.6.2 Storage Of Retrieved/Collected Oocyte/Sperm And Embryos

Note: The 36 month limitations in paragraphs 2.4.2.11.1.6.2.1 and 2.4.2.11.1.6.2.2 are temporarily waived for qualified ADSMs whose coverage ended or will end between the date of the declaration of the COVID-19 national emergency on March 1, 2020, until 90 days following the declared end of the national emergency by the President of the United States. All other coverage criteria still apply.

2.4.2.11.1.6.2.1 Storage is covered for 36 months from date of first retrieval of all mature oocytes and sperm. The cost of storage is incurred on the first day of the initial period of storage and the first day of any subsequent year of storage.

2.4.2.11.1.6.2.2 The Service member is responsible for all costs incurred after 36 months or when the Service member separates/retires (whichever comes first). Arrangements for disposition are the responsibility of Service members subject to state regulation on disposal and abandonment of frozen specimens.

2.4.2.11.1.6.2.3 The contractor shall ensure that oocytes, sperm, and embryos shall be stored at facilities listed and registered in accordance with 21 CFR 1271.

2.4.2.11.1.6.3 Ownership And Disposition

Issues regarding ownership, future use, donation, and/or destruction shall be governed by applicable state law and shall be the responsibility of the Service member and their lawful spouse and the facility storing the cryopreserved oocytes/sperm/embryos. DoD's role is limited to paying for this benefit when requested by the consenting Service member. DoD will not have ownership or custody of cryopreserved oocytes/sperm/embryos. DoD will not be involved in the ultimate disposition of excess cryopreserved oocytes/sperm/embryos. Ultimate disposition or destruction of excess cryopreserved oocytes/sperm/embryos is not separately reimbursed.

2.4.2.11.2 Policy Guidelines For Assisted Reproductive Technology (ART)

2.4.2.11.2.1 The policy provides for the provision of ART which includes embryo cryopreservation and storage, to assist in the reduction of the disabling effects of the Service member's qualifying condition. The authority for this policy for care outside of the basic medical benefit is derived from Section 1633 of the 2008 National Defense Authorization Act (NDAA). This section allows the Service member to receive services that are outside the definition of "medical care." This benefit is provided through the authorization of the expenditure of SHCP funds and delivery of the needed services in either MTFs/eMSMs that offer assisted reproductive technologies or in the purchased care sector that are outside the medical benefit. Although purchased care is available for this benefit depending on the Service member's circumstances not allowing him or her to travel, the use of MTFs/eMSMs shall be encouraged, with Service members eligible for this benefit given priority for care at MTFs/eMSMs if there is a waiting list. If the Service member receives care or medications in the civilian sector, participating network providers shall be used if available. Preauthorization for every IVF cycle is required.

2.4.2.11.2.2 Assisted reproductive services, including sperm retrieval, oocyte retrieval, IVF, artificial insemination, and blastocyst implantation is offered based on the condition of the seriously or severely ill/injured Service member not the spouse; therefore, the use of the SHCP is authorized.

2.4.2.11.2.3 The benefit is limited to permitting a qualified Service member to procreate with their lawful spouse, as defined in federal statute and regulation.

2.4.2.11.2.4 Consent must be able to be given by the Service member and his or her lawful spouse. Third party consent is not authorized under this policy.

2.4.2.11.2.5 Third party donations and surrogacy are not covered benefits. The benefit is designed to allow the Service member and their spouse to become biological parents through reproductive technologies.

2.4.2.11.3 Cancer

2.4.2.11.3.1 The policy applies to Service members, regardless of gender, who are seriously or severely ill (Category II, III) as a result of their cancer and will or have undergone cancer therapy that may have effected their fertility. The Service member will use their cryopreserved sperm/oocytes or embryos for the ART services such as IVF.

Note: The 36 month limitations in paragraphs 2.4.2.11.3.2 and 2.4.2.11.3.3 are temporarily waived for qualified ADSMs whose coverage ended or will end between the date of the declaration of the COVID-19 national emergency on March 1, 2020, until 90 days following the declared end of the national emergency by the President of the United States. All other coverage criteria still apply.

2.4.2.11.3.2 The ART benefit will be available for 36 months from the date of sperm or oocyte retrieval.

2.4.2.11.3.3 If the Service member proceeds with embryo cryopreservation and storage during this 36 month period, these services will be covered only during the 36 month period.

2.4.2.11.4 Transportation, shipping and handling costs of oncocryopreserved sperm and oocytes shall be covered when:

2.4.2.11.4.1 Relocating the specimen from a local cryobank to a local fertility clinic; or

2.4.2.11.4.2 Relocating the specimen from a cryobank to a distant fertility clinic closer to where the Service member currently resides.

2.4.2.11.5 Urogenital Trauma

2.4.2.11.5.1 The policy applies to Service members, regardless of gender, who have sustained a serious or severe illness/injury while on active duty that led to the loss of their natural procreative ability. It is the intent of this policy to provide ART services, including embryo cryopreservation and storage without limitation while on active duty, only to consenting male Service members whose illness or injury to their urogenital system prevents the successful delivery of their sperm to their spouse's egg and to consenting female Service members whose illness or injury to their urogenital system prevents their egg from being successfully fertilized by their spouse's sperm, but who maintain ovarian function and have a patent uterine cavity. This includes, but is not limited to, those suffering neurological, physiological, and/or anatomical injuries.

2.4.2.11.5.2 Male Service members must be able to produce sperm, but need alternative sperm collection technologies as they can no longer ejaculate in a way that allows for egg fertilization. Ill/injured female Service members require ovarian function and a patent uterine cavity that would allow them to successfully carry a fetus even if unable to conceive naturally (e.g., thorough damage to their fallopian tubes).

2.4.2.11.5.3 Embryo cryopreservation and storage will be covered as long as the Service member remains on active duty.

2.4.2.11.5.4 The Service member is responsible for all storage costs when the Service member separates/retires. Arrangements for disposition are the responsibility of Service members subject to state regulation on disposal and abandonment of frozen specimens.

2.4.2.11.6 Procedures

2.4.2.11.6.1 Prediction of fertility potential (Ovarian Reserve) shall be conducted in accordance with the provider clinic's practice guidelines. (This may include a Clomiphene Citrate Challenge Test (CCCT) and evaluation of the uterine cavity.) Beneficiaries with a likelihood of success, based on the specific clinic's guidelines, shall be provided IVF cycles under this benefit. Infertility testing and treatment, including correction of the physical cause of infertility, are covered in accordance with the TPM, Chapter 4, Section 17.1.

2.4.2.11.6.2 Three completed IVF cycles shall be provided for the seriously or severely ill/injured female Service member or lawful spouse of the seriously or severely ill/injured male Service member. No more than six IVF cycles shall be initiated for the seriously or severely ill/injured female Service member or legal spouse of the seriously or severely ill/injured male Service member. There may be a total of six attempts to accomplish three completed IVF cycles. If the ill/ injured Service member has used initiated IVF cycles, subsequently remarries and desires this benefit with the new spouse, the number of cycles available is dependent on prior cycles used.

2.4.2.11.6.3 Assisted reproductive service centers with capability to provide full services including alternative methods of sperm aspiration will be invited to participate and accept payment at the network discount rate. (Membership in the American Society for Reproductive Medicine (ASRM), with associated certification(s), is highly recommended for network providers. Reporting outcomes to the Centers for Disease Control and Prevention (CDC) is mandatory.) When a network provider is not available, the benefits provided under this policy may be provided by any TRICARE-authorized provider, including those authorized pursuant to 32 CFR 199.6(e).

2.4.2.11.6.4 IVF cycles shall be accomplished in accordance with the practice guideline for the provider clinic using gonadotropins which are concentrated mixtures of Follicle Stimulating Hormone (FSH) or FSH and Luteinizing Hormone (LH) given as an injection to stimulate the ovary to produce multiple oocytes in preparation for egg retrieval. These medications shall be purchased through the TPharm contract (to include home delivery, non-network retail pharmacy, and network retail pharmacy options) or MTF/eMSM.

2.4.2.11.6.5 Anesthesia or conscious sedation will be provided for the oocyte retrieval and sperm aspiration in accordance with the TPM, Chapter 3, Section 1.1 and 1.2. For males, sperm aspiration through Microsurgical Epididymal Sperm Aspiration (MESA), Percutaneous Epididymal Sperm Aspiration (PESA), or non-surgical fine needle aspiration will be accomplished in conjunction with egg retrieval. Vibratory stimulation or electro-ejaculation may be used if appropriate for the seriously or severely ill/injured Service member.

2.4.2.11.6.6 Intracytoplasmic sperm injection will be accomplished for all viable oocytes.

2.4.2.11.6.7 Embryo transfer in accordance with guidelines provided by the ASRM shall be accomplished in accordance with specific clinic practices at either cleavage stage or blastocyst stage of the embryo.

2.4.2.11.6.8 Healthy embryos that progress to an appropriate stage, as assessed by the embryologist, in excess of those used for the fresh embryo transfer may be cryopreserved.

2.4.2.11.6.9 In the event that frozen embryos are available for transfer, TRICARE will authorize frozen embryo transfer cycles to facilitate the utilization of these embryos. Frozen embryo transfers may be accomplished in fresh ovulatory cycles or in medicated transfer cycles in order to provide the optimal uterine environment for embryo implantation.

2.4.2.11.7 Process For Participating In Assisted Reproductive Services Program

2.4.2.11.7.1 For a Service member to be eligible, there must be documentation of Category II or III illness or injury designation as defined in DoDI 1300.24.

2.4.2.11.7.2 The referral to the contractor will contain the following information:

- Service member's qualifying diagnosis(es);
- Category (II or III);
- Summary of relevant medical information supporting category designation;
- Name of provider of reproductive services requested to be used;
- Number of initiated IVF cycles; and
- Number of cancelled IVF cycles.

2.4.2.11.7.3 All TED records for this benefit shall include Enrollment/Health Plan Code "**SR** SHCP - Referred Care" regardless of the enrollment status returned by DEERS. The contractor shall follow all applicable TED coding requirements in accordance with TSM, Chapter 2.

2.4.2.11.7.4 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 Service member shall apply. Contractors shall follow the requirements and provisions of these chapters, to include MTF/eMSM or SAS 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 Service member or their lawful spouse, and use of CMACs/DRGs when applicable.

2.4.2.11.8 Exclusions

2.4.2.11.8.1 Third party donations or surrogacy cannot be cost-shared.

2.4.2.11.8.2 Cryopreservation of gametes in anticipation of deployment.

2.4.2.11.8.3 Services related to gender selection will NOT be cost-shared.

2.4.2.12 Incontinence Supplies

Personal incontinence supplies (i.e., diapers) that support skin integrity and prevent deterioration of skin due to incontinence are covered. Also covered are other types of incontinence supplies such as diaper creams, bed pads, etc. that are necessary for skin protection.

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 Service members during the Transitional Assistance Management Program (TAMP) coverage period. This change does not create a new class of beneficiaries, but expands/extends the period of TRICARE eligibility for certain former Service members, 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 Service 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 The condition is service-related; and

2.5.2.2 Discovered/diagnosed by the Service 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, from the date the condition is validated by the DoD physician.

- The period of coverage for 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 the condition was validated by a DoD physician.

- Service members who are discovered to have a service-related condition, which cannot be resolved within the 180 day transitional care period, should be referred by SAS to the former Service member's Service or to the DVA/VHA for a determination of eligibility for Government provided care.

- Care is authorized for the service-related condition(s) 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 Service members 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 a DoD Physician associated with SAS. If the determination is made that the former Service member is eligible for this program, the former Service member shall be entitled to receive medical and adjunctive dental care for that condition only as if they were still on active duty. Enrollment into this program does not affect eligibility requirements for any other TRICARE program for the former Service member or their family members.

2.5.3.3 Enrollment in TCSRC includes limited eligibility for MTF/eMSM Pharmacy, Retail Pharmacy, TRICARE Pharmacy (TPharm) contract, and TRICARE Pharmacy Home Delivery Program benefits.

2.5.4 TCSRC Implementation Steps

The processes and requirements for a former Service member with a possible Section 1637 program condition are detailed in paragraphs 2.5.4.1 through 2.5.4.7. These steps, requirements, and responsibilities are applicable to SAS, the contractor, TRICARE civilian providers, and the Armed Forces.

2.5.4.1 DHA Communications will create materials to support beneficiary education on the Section 1637 benefit. Contractors shall collaborate with DHA Communications in the development of educational materials for both beneficiaries and providers.

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

2.5.4.3 SAS reviews all TCRSC applications and determines if further clinical evaluation/testing of the former Service member is required. If further clinical evaluation/testing is needed. SAS will follow existing "defer to network" referral processes.

2.5.4.3.1 The contractor shall execute the referral and authorization to support health care delivery in the area in where the former Service member resides as follows:

2.5.4.3.2 If a DoD MTF/eMSM is within the one hour drive time Access To Care (ATC) standards and has the capabilities, they have first right of refusal.

2.5.4.3.3 If there is no MTF/eMSM or the MTF/eMSM does not have the capacity, then the contractor shall ascertain if a DVA/VHA medical facility (as a network provider) is within ATC standards and the facility has the necessary capabilities and capacity. The contractor shall pay these claims in the same manner as other active duty claims.

2.5.4.3.4 If neither an MTF/eMSM of DVA/VHA are available, the contractor shall locate a civilian provider that has both the capability and capacity to accept this referral request within the prescribed ATC standards. The contractor shall execute an active provider locator process (Health Care Finder (HCF)) to support the former Service member's need for this referral request. SAS's "defer to network" request shall be acted on by the contractor under the normal "urgent/72 hour" requirement.

2.5.4.3.5 The contractor shall inform the former Service member of the provider location and contact information so the former Service member can schedule an appointment. The contractor shall pay these claims in the same manner as other active duty claims.

- The contractor shall instruct the accepting provider to return the results of the encounter to SAS within 48 hours of the encounter.

2.5.4.3.6 Once the additional information is received, the DoD physician associated with SAS makes the determination of eligibility for the Section 1637 program. An eligibility determination for coverage under the Section 1637 will be made within 30 calendar days of receiving the former Service member's request, inclusive of the time required to obtain additional information.

- If the coverage is denied, the former Service member may appeal the decision in writing to SAS within 30 calendar days of receipt of the denial. SAS will issue a final determination within 30 calendar days of receipt of the appeal. If SAS determines the condition should be covered under the Section 1637 program, coverage will begin on the date SAS renders the final determination.

2.5.4.4 If SAS determines the individual is eligible for the Section 1637 program, they will provide the enrollment information (Enrollment Start date and condition authorized for treatment) to the former Service member and the contractor responsible for enrollments in the region where the former Service member resides.

2.5.4.4.1 The notice will clearly identify it is for the Section 1637 program. The contractor shall enroll the former Service member into the Section 1637 program on DEERS using Government furnished web-based system/application within four business days of receiving the notification from SAS. This entry shall include the Start Date (date condition validated by the DoD physician); an EOC Code; and an EOC Description. The contractor shall enter the validated condition covered by the Section 1637 program (received from SAS) into the contractor's referral and authorization system within eight business days of receipt of the notification from SAS.

2.5.4.4.2 The contractor shall actively assist the former Service member using the HCF program to determine the location of final restorative health care for the identified Section 1637 condition. The location of service shall meet ATC standards.

2.5.4.4.3 The contractor shall instruct the accepting provider on the terms of this final "eval and treat" referral from SAS along with when and where to send clinical results/findings necessary to close out SAS's files. DEERS will store the secondary Health Care Delivery Plan (HCDP) code, the date the condition was validated by the DoD physician, the EOC Code, and the EOC Description. DEERS shall return the HCDP code, the start and end dates for the coverage plan, the EOC Code, and the EOC Description with every eligibility query. This program is portable across all contractors.

2.5.4.5 Civilian and VHA claims for the specific condition will be processed as if the Service member were still on active duty, with no copayments required. If the "eval" or "eval and treat" referrals sent to the contractor from SAS are presented to an MTF/eMSM for execution, and the MTF/eMSM accepts, any subsequent MTF/eMSM generated "defer to network" requests will be accepted, recorded, and claim adjudicated; and this process may be outside the contractor's EOC coding/criteria. The contractor may request clarifications from the MTF/eMSM on a subsequent "defer to network" request if the referral is for healthcare delivery that is not apparently related to the Section 1637 determined condition.

2.5.4.6 The Section 1637 benefit shall be terminated 180 days after the validated diagnosis is made by the DoD physician, no matter the status of the service-related condition. Following the termination

of the Transitional Care period, further care for this service-related condition may be provided by the DVA/VHA.

2.5.4.7 Personnel on active duty for longer than 30 calendar days will have their Section 1637 coverage terminated by DEERS. Personnel scheduled to report for active duty (Early Alert Status), may have both the Section 1637 HCDP and HCDP 001 (for Active Duty). Once the active duty period actually begins, Section 1637 coverage will be terminated. If active duty orders are cancelled prior to entry on active duty, Section 1637 coverage will continue until the original end date. There is no reinstatement of the terminated Section 1637 coverage.

2.5.5 Claims Processing And Payment

2.5.5.1 The Section 1637 HCDP code may be present with any other HCDP code. During claims processing, if the TCSRC HCDP is received from DEERS, the contractor shall first determine if the claim being processed is for the Section 1637 condition or not. If the claim is for the specific service-related condition, the claim shall be processed and paid as if the Service member were an active duty Service member. The contractor shall determine if the claim is for an MTF/eMSM directed "defer to network" request for the Section 1637 condition which may not relate to the EOC codes determined by the contractor. If the claim is not for the covered condition, the claim shall be processed following the standard TRICARE procedures. If the claim includes services for the Section 1637 covered condition, and additional services, the contractor shall assess the claim's status and take one of the following actions:

2.5.5.1.1 Contractor Splits Claim

If a contractor receives a claim for a Service member eligible for Section 1637 coverage and the claim includes services not covered by the Section 1637 diagnosis, and the contractor can determine which services are covered under the Section 1637 condition, then the contractor shall split the claim into separate claims.

2.5.5.1.2 Contractor Returns Claim to Provider

If the claim does not meet the conditions described above, then the contractor shall return the claim to the submitter with an explanation that indicates the claim must be split in order to be paid.

2.5.5.2 Where a beneficiary has had clinical evaluation(s)/tests performed in order to determine eligibility for Section 1637 program coverage and has paid for those clinical evaluation(s)/tests out-of-pocket, the contractor shall process any claim(s) received for such clinical evaluation(s)/tests and shall pay any such claim as if the Service member were an active duty Service member.

2.5.5.3 Service members with multiple service-related conditions will have multiple Section 1637 enrollments. Each condition may have the same or different begin and end dates.

2.5.5.4 Jurisdiction rules for Section 1637 program coverage shall be in accordance with Chapter 8, Section 2.

2.5.5.5 The contractors shall pay all claims submitted for the specific service-related condition in the same manner as other active duty claims. There shall be no application of catastrophic cap, deductibles, cost-shares, copayments or coordination of benefits for these claims. Claims paid for the

specific service-related condition under this change should be paid from non-financially underwritten funds.

2.5.5.6 Claims paid for medical care under the 180 day TAMP program, for other than the service-related condition, shall continue to be paid as an ADFM beneficiary under TRICARE with application of appropriate cost-shares and deductibles for these claims. The Section 1637 benefit does not extend the duration of the TAMP period beyond 180 days.

2.5.5.7 If the contractor is unable to determine if the care received is covered by the Section 1637 diagnosis, the claim is to be pended while the contractor obtains further clarification from SAS.

2.5.5.8 Pharmacy transactions at retail network pharmacies are processed on-line using the HIPAA data transaction standard of the National Council for Prescription Drug Programs (NCPDP). Under this standard, claims are adjudicated real time for eligibility along with clinical and administrative edits at the point of sale which includes cost-share determinations based on the Service member's primary HCDP code.

2.5.5.8.1 Enrolled Service members determined to be eligible for pharmacy services based on their primary HCDP code will pay appropriate cost-shares as determined by their primary HCDP code and will submit a paper claim to the pharmacy contractor to seek reimbursement of these costs shares. Enrollment documentation that includes the specific condition for Section 1637 enrollment shall be submitted with their claim. The pharmacy contractor shall verify eligibility in DEERS and determine coverage of the prescription based on the specific condition detailed in the supporting documentation.

2.5.5.8.2 Enrolled Service members determined to not be eligible for pharmacy services based on their primary HCDP code will pay out-of-pocket for the total cost of the prescription and then submit a paper claim to the pharmacy contractor for reimbursement. The pharmacy contractor shall verify eligibility in DEERS and determine coverage of the prescription based on the specific condition detailed in the supporting documentation.

2.5.5.8.3 In situations where the supporting document submitted by the former Service member to the pharmacy contractor does not provide sufficient detail of their covered condition, the pharmacy contractor shall contact SAS to obtain appropriate documentation of their covered condition needed to make a coverage determination and process the claim.

2.6 Advanced Rehabilitation Centers

See Chapter 8, Section 5, paragraph 2.8.

3.0 ENROLLMENT STATUS EFFECT ON CLAIMS PROCESSING

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

3.2 Claims for TRICARE Prime enrollees who are in MTF/eMSM inpatient status shall be processed without application of a cost-share, copayment, or deductible. These are SHCP claims.

3.3 Claims for services provided under the current MOU between the DoD (including Army, Air Force, and Navy/Marine Corps facilities) and the DHHS (including the Indian Health Service, Public Health Service, etc.) are not SHCP claims. They shall be adjudicated under the claims processing provisions applicable to those specific agreements.

3.4 Claims for services provided under any local MOU between the DoD (including the Army, Air Force, and Navy/Marine Corps facilities) and the DVA/VHA are not SHCP claims. They shall be adjudicated under the claims processing provisions applicable to those specific agreements. (Claims for services provided under the current national MOA for SCI, TBI, and Blind Rehabilitation are covered, see Section 2, paragraph 3.1.)

3.5 Claims for participants in the CCEP shall be processed for payment solely on the basis of MTF/eMSM authorization. There will not be a cost-share, copayment, or deductible applied to these claims. These are SHCP claims.

3.6 Claims for non-TRICARE eligibles shall be processed for payment solely on the basis of MTF/eMSM or SAS authorization. There shall not be a cost-share, copayment, or deductible applied to these claims. These are SHCP claims.

3.7 Outpatient claims for non-TRICARE Medicare eligibles shall be returned to the submitting party for filing with the Medicare claims processor. These are not SHCP or TRICARE claims.

3.8 Claims for TDRL participants shall be processed for payment in accordance with DoD/HA Policy Letter dated March 30, 2009, Subject: Policy Guidance for Use of Supplemental Health Care Program Funds to Pay for Required Physical Examinations for Members on the Temporary Disability Retirement List. There shall not be a cost-share, copayment, or deductible applied to these claims. These are SHCP claims. SHCP funds shall only be applied to the exam. SHCP funds shall not be used to treat the condition which caused Service member to be placed on the TDRL or for conditions discovered during the exam.

3.9 Claims from Service members enrolled in the FRCP shall be processed without application of a cost-share, copayment, or deductible. These are SHCP claims.

4.0 MEDICAL RECORDS

The current contract requirements for medical records shall also apply to Service members in this program, with the additional requirement that Service members shall also be given copies directly. Narrative summaries and other documentation of care rendered (including laboratory reports and X-rays) shall be given to the Service member 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 Service member 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. Service members 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. Service member's claim forms should be accompanied by a receipt showing the amount paid.

5.0 REIMBURSEMENT

5.1 Allowable amounts shall 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, Outpatient Prospective Payment System (OPPS), 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 unless a CMAC/DRG exists. Cost-sharing and deductibles shall not be applied to supplemental health care claims.

5.2 Claims with codes on the TRICARE inpatient only list performed in an outpatient setting shall be denied, except in those situations where the beneficiary dies in an emergency room prior to admission. Reference the TRM, Chapter 13, Section 2, paragraph 3.4. Professional providers may submit with modifier **CA**. No bypass authority is authorized for inpatient only procedure editing.

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 Service members 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/eMSM. A waiver of CMAC limitation will be obtained by the MTF/eMSM from the Director, TROs, as the designee of the Chief Operating Officer (COO), DHA, 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 Director, TROs, the MTF/eMSM will notify the contractor who shall then conclude rate negotiations, and notify the MTF/eMSM 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 Service member has personally paid the provider. In the case of non-MTF/eMSM referred care, the contractor shall submit the waiver request to the Director, TROs.

5.4 Eligible uniformed Service members and/or referred patients who have been required by the provider to make "up front" payment at the time services are rendered shall be required to submit a claim to the contractor with an explanation and proof of such payment. For eligible uniformed Service members, if the claim is payable without SAS review the contractor shall allow the billed amount and reimburse the Service member for charges on the claim. If the claim requires SAS review the contractor shall pend the claim to the SAS for determination. If the SAS authorizes the care the contractor shall allow the billed amount and reimburse the Service member for charges on the claim.

- Supplemental health care claims for uniformed Service members and all MTF/eMSM inpatients receiving referred civilian care while remaining in an MTF/eMSM 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.

5.5 In no case shall a uniformed Service member be subjected to "balance billing" or ongoing collection action by a civilian provider for referred, 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 referring MTF/eMSM or SAS, as appropriate, for determination. The referring MTF/eMSM or SAS will issue an authorization to the contractor for payments in excess of CMAC or other applicable TRICARE payment ceilings, provided the referring MTF/eMSM or SAS has requested and has been granted a waiver from the COO, DHA, or designee.

6.0 END OF PROCESSING

6.1 EOB

An 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 SHCP claims, the EOB shall include the statement that this is a supplemental health care claim, not a TRICARE claim. The EOB shall also indicate that questions concerning the processing of the claim must be addressed to the contractor or SAS, as appropriate. Any standard TRICARE EOB messages which are applicable to the claim shall also be utilized, e.g., "No authorization on file."

6.2 Appeal Rights

6.2.1 For supplemental health care claims, the appeals process in Chapter 12, 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/eMSM/SAS 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/eMSM name/SAS here)**." TRICARE appeal rights shall pertain to outpatient claims for treatment of TRICARE eligible patients. The SAS will handle only those issues that involve SAS denials of authorization or authorization for reimbursement. The contractor shall handle allowable charge issues, grievances, etc.

6.2.2 If the Service member disagrees with a denial of authorization, rendered by SAS, the first level of appeal will be through the SAS who will coordinate the appeal as appropriate. The Service member may initiate the appeal by contacting his/her SAS. If the SAS upholds the denial, the SAS will notify the Service member of further appeal rights with the appropriate Surgeon General's office. If the denial is overturned at any level, the SAS will notify the contractor and the Service member.

6.2.3 The contractor shall forward all written inquiries and correspondence related to the SAS or MTF/eMSM denials of authorization or authorization for reimbursement to the appropriate SAS or MTF/eMSM. The contractor shall refer telephonic inquiries related to SAS denials to the appropriate SAS or MTF/eMSM.

7.0 TRICARE ENCOUNTER DATA (TED) SUBMITTAL

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

8.0 CONTRACTOR'S RESPONSIBILITY TO RESPOND TO INQUIRIES

8.1 Telephonic Inquiries

Inquiries relating to the SHCP need not be tracked nor reported separately from other inquiries received by the contractor. Most SHCP inquiries to the contractor should come from MTFs/eMSMs/claims offices, the Service Project Officers, DHA, or the SAS. In some instances, inquiries may also come from Congressional offices, patients, or providers. To facilitate responsiveness to SHCP inquiries, the contractor shall provide MTFs/eMSMs/claims offices, the Service Project Officers, DHA, and the SAS 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 contract for toll-free and other service phone lines. It may be the same line as required in support of TPR under Chapter 16. The telephone response standards of Chapter 1, Section 3, shall apply to SHCP telephonic inquiries.

8.1.1 Congressional Telephonic Inquiries

The contractor shall refer any Congressional telephonic inquiries to the referring MTF/eMSM or the SAS, as appropriate, 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.

8.1.2 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/eMSM patient, to the referring MTF/eMSM or the SAS, as appropriate, 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.

8.2 Written Inquiries

8.2.1 Congressional Written Inquiries

For MTF/eMSM-referred care, the contractor shall refer written Congressional inquiries to the Service Project Officer of the referring MTF's/eMSM's branch of service if the inquiry is related to the authorization or non-authorization of a specific claim. For non-MTF/eMSM referred care, the inquiry shall be referred to the SAS. 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 Director, DHA. 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.

8.2.2 Provider And Service Member (Or MTF/eMSM Patient) Written Inquiries

The contractor shall refer provider and Service member or MTF/eMSM patient written inquiries to the referring MTF/eMSM or the SAS, as appropriate, if the inquiry pertains to the authorization or non-authorization of a specific claim. The contractor shall respond as appropriate to

general written inquiries regarding the SHCP.

8.2.3 MTF/eMSM Written Inquiries

8.2.3.1 The contractor shall provide a final written response to all written inquiries from the MTF/ eMSM within 10 work days of the receipt of the inquiry, or if appropriate, refer the inquiry to the SAS upon receipt of the inquiry.

8.2.3.2 The Government intends to take action on all referrals to the SAS as quickly as possible. To support this objective, the SAS must be kept apprised of those claims by telephone, e-mail or fax on which the contractor cannot take further action until the SAS has completed its reviews and approvals.

9.0 EFFECTIVE DATES

9.1 April 21, 2017, for oncofertility and cryopreservation for seriously ill Service members diagnosed with cancer.

9.2 September 28, 2018, for removal of 36 month limitation on the cryopreservation and storage of embryos for seriously ill/injured Service members with a diagnosis of urogenital trauma. Public Law 115-245, Section 8129.

9.3 January 24, 2019, for portable CPAP devices for Service members with OSA who meet the established criteria.

9.4 February 22, 2019, for coverage of shipping and handling costs of cryopreserved sperm and oocytes for seriously ill Service members with a cancer diagnosis.

9.5 May 8, 2019, for coverage of multiple prostheses for ADSMs with major limb amputation(s).

9.6 November 1, 2019, for FDA approved COVID-19 in vitro diagnostic tests, using RT-PCR for asymptomatic ADSMs. Authority valid through August 31, 2021.

9.7 May 20, 2020, for coding and reimbursement of portable CPAP devices.

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