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TRICARE
MANAGEMENT ACTIVITY

PRO

CHANGE 155
6010.49-M
APRIL 19, 2000

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR OPERATIONS MANUAL

The TRICARE Management Activity has authorized the following change(s) to 6010.49-M, reissued July 1992.

REMOVE AND INSERT PAGE(S): See pages 2 through 4.

SUMMARY OF CHANGE(S): This change added the requirement that the Health Integrity and Protection Bank must be notified when a provider is released from a network provider agreement due to adverse cause; deleted Program for Persons with Disabilities as one of the TRICARE benefits for TAMP; states the enrollment fee and the revised effective dates for the Pharmacy Redesign Pilot Program; revised VA reimbursement for pharmacy drug claims; clarified POS provisions in referral to specialty and inpatient services; deleted a requirement under Additional Criteria for Selection of Non-Physician Mental Health Providers; added clarification on services and supplies authorized in error; and added designation of providers as a non-appealable issue. For a detailed list of additional administrative changes, see pages 5 through 8.

EFFECTIVE DATE AND IMPLEMENTATION: Upon direction of the Contracting Officer.

This change is made in conjunction with Policy Manual Change No. 13.


Mary C. Boykin
Chief, Office of Program Requirements

ATTACHMENT(S): 262 PAGES
DISTRIBUTION: 6010.49-M

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SUMMARY OF CHANGES

PART ONE

CHAPTER 1

1. Page 1.1.IV-3. Added word "Patient" and corrected a reference.
2. Page 1.1.VIII-5. Revised language.
3. Page 1.1.VIII-6. Clarified "joint responsibility" for maintenance of provider files.
4. Page 1.1.VIII-10. Updated OPM cross-references.

CHAPTER 3

1. Page 1.3.III-3. Clarified what constitutes routine correspondence.
2. Page 1.3.IV-5. Removed reference to TMA Form 744; added reference to Section G.

CHAPTER 4

1. Page 1.4.A-5. Replaced "Delinquent" with "Outstanding".

PART TWO

CHAPTER 1

1. Pages 2.1.II-1 and 2. Added language that was previously deleted where dental claims for active duty service members in TRICARE Prime Remote are to be sent; Clarified instructions for Supplying Out-of-Area Provider Information.
2. Page 2.1.III-1. Clarified the meaning of "Receipt".
3. Pages 2.1.VI-1 and 2. Clarified language.
4. Page 2.1.VI-4. Deleted "Claimcheck" and revised language.
5. Page 2.1.VI-6. Reference corrected.
6. Page 2.1.VI-8. Editorial changes.
7. Page 2.1.VI-13. Deleted sentence stating "EOBs and vouchers must not be used for purposes other than conveying the results of a final determination, unless specifically directed by the contracting officer; i.e., they are not substitutes for letters."
8. Page 2.1.VI-21. Added "or TRICARE Service Center (TSC)".
9. Page 2.1.VI-24. Updated Internet address and clarified language.
10. Page 2.1.VI-25. Editorial changes.
11. Page 2.1.B-1. Changed previously deleted paragraphs to "Reserved".
12. Page 2.1.C-1. Added "Sample Format for Quarterly Rebundling Report" for it was inadvertently removed in a previous change.

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1. Page 2.2.I-1. Clarified “Definition of Authorized Provider”.

CHAPTER 4

1. Page 2.4.I-5. Deleted Section I.B.6 “Rounding of Prevailing Charges”.
2. Page 2.4.III-2. Added language that was previously deleted for contractor responsibilities.

CHAPTER 5

1. Page 2.5.III-5. Clarified content of letter sent to beneficiary.
2. Page 2.5.IV.7. Clarified content of letter sent to beneficiary.
3. Page 2.5.IV-12. Deleted last three sentences in Section IV.C.8.c.
4. Page 2.5.A-16. Deleted “cc to Beneficiary”.

CHAPTER 7

1. Page 2.7.VI-9. Added the requirement that the Health Integrity and Protection Bank must be notified when a provider is released from a network provider agreement due to adverse cause.

CHAPTER 8

1. Page 2.8.IV-1. Added “blockage rate”.
2. Page 2.8.V-2. Added paragraph on “Grievance Processing Jurisdiction”.
3. Page 2.8.VIII-2. Clarified the type of contacts to be reported.

CHAPTER 11

1. Added and revised acronyms and definitions.

CHAPTER 16

1. Page 2.16.I-1. Deleted Program for Persons with Disabilities as one of the TRICARE benefits for TAMP.

CHAPTER 20

1. Page 2.20.Q-5 and 9. Formalized the previous notification to the contractors dated February 2, 2000, which stated that the enrollment fee was to be determined and the effective dates would be delayed for the Pharmacy Redesign Pilot Program.

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CHAPTER 21

1. Page 2.21.I-2. Revised VA reimbursement for pharmacy drug claims.

PART THREE

CHAPTER 1

1. Page 3.1.I-2. Clarified contractor requirements.
2. Page 3.1.I-8. Corrected reference.
3. Page 3.1.I-9. Replaced “civilian providers” with “PCMs”.
4. Pages 3.1.II-1 through 3. Updated Policy Manual references and clarified POS provisions in referral to specialty and inpatient services.
5. Page 3.1.B-3. Deleted one of the requirements for “Additional Criteria for Selection of Non-physician Mental Health Providers”.

CHAPTER 2

1. Page 3.2.I-2. Deleted “(which include PRIMUS/NAVCARE clinics)”.
2. Page 3.2.III-1. Added “during the same time frame” to the paragraph.
3. Page 3.2.III-3. Added a DFARS clause.
4. Page 3.2.A-1. Deleted “(including at PRIMUS/NAVCARE clinics)”.

CHAPTER 3

1. Page 3.3.I-1. Typographical correction.
2. Page 3.3.II-1. Deleted “socioeconomic status (rank)”.

CHAPTER 4

1. Page 3.4.I-1. Deleted language and re-arranged sentence sequence.
2. Page 3.4.II-1. Updated Policy Manual references.
3. Page 3.4.II-2. Updated Policy Manual references and replaced “maximum capacity is reached” with “capacity is optimized”.
4. Page 3.4.II-4. Added language clarification on disenrollment for those failing to pay quarterly enrollment fee.
5. Page 3.4.II-6. Updated Policy Manual references.
6. Page 3.4.VI-3. Replaced “TRICARE” with “MHS”.

CHAPTER 7

1. Page 3.7.I-1. Added clarification to what will be considered an initial determination.
2. Pages 3.7.I-4 & 5. Added language on “Services and Supplies Authorized in Error.”

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3. Page 3.7.II-1. Editorial changes.
4. Page 3.7.II-2. Revised language.
5. Page 3.7.II-3. Clarification added on when a beneficiary's letter to the Member of Congress may be accepted as an appeal; Clarified who may receive information when denial of payment for claimed services is being appealed.
6. Page 3.7.II-5. Deleted "pre" from "preauthorization".
7. Page 3.7.II-7. Replaced "Preauthorization" with "Preadmission".
8. Page 3.7.III-1. Clarification added to what is an appealable issue.
9. Page 3.7.III-3. Added "Designation of Providers" as a non-appealable issue; Added language stating that an untimely request for reconsideration shall be considered routine correspondence.
10. Page 3.7.III-6. Deleted "the NQMC or".
11. Page 3.7.V-1. Replaced "suggested" with "required".
12. Page 3.7.A-1. Deleted Figure 3.7.A-1.
13. Page 3.7.A-2. Revised language as to when the consent will expire; Revised the "Prohibition on Rediscovery" language.
14. Page 3.7.A-9. Replaced "termination" with "sanction".

CHAPTER 8

1. Page 3.8.1-5. Revised language which excludes Active Duty Service Member claims from review for possible double coverage.