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TRICARE
MANAGEMENT ACTIVITY

PRD

CHANGE 55
6010.51-M
SEPTEMBER 28, 2007

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE OPERATIONS MANUAL (TOM)

The TRICARE Management Activity has authorized the following addition(s)/
revision(s) to 6010.51-M, reissued August 2002.

CHANGE TITLE: REFERRALS/PREAUTHORIZATIONS/
AUTHORIZATIONS

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change modifies requirements for processing
referrals and preauthorizations/authorizations from the MTFs. This change also
provides additional instruction for use of the referral report that is MTF-generated
and transmitted to the MCSCs.

EFFECTIVE DATE: Prior to the end of FY 2007.

IMPLEMENTATION DATE: Thirty days from effective date.

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Director, Program Requirements Division

ATTACHMENT(S): 5 PAGES
DISTRIBUTION: 6010.51-M

CHANGE 55
6010.51-M
September 28, 2007

REMOVE PAGE(S)

CHAPTER 8

Section 5, pages 3 through 7

INSERT PAGE(S)

Section 5, pages 3 through 7

In the case of residents of a region, geographically distant family therapy must be certified by the contractor in order for cost-sharing to occur.

4.2. If a claim for admission or extension is submitted and no authorization form is on file, the claim shall not be paid. For network claims, the contractor may deny or develop in accordance with its agreements with network providers. For non-network claims, the contractor shall deny the claim.

4.3. For any claims submitted for inpatient care at other than the residential treatment center, the contractor shall pay the claim if the care was medically necessary. Claims for RTC care during the period of time the beneficiary was receiving care from another inpatient facility shall be denied. If the residential treatment center has been paid and a claim for inpatient hospital care is received and the care was medically necessary, the contractor must pay the inpatient hospital claim and recover the payment from the residential treatment center.

5.0. FORMER SPOUSE WITH PRE-EXISTING CONDITION

The former spouse will be on DEERS under his/her own Social Security Number.

6.0. GRANDFATHERED CUSTODIAL CARE CASES

A list of the beneficiaries who qualified for custodial care benefits prior to June 1, 1977, has been furnished to the contractor with instructions to flag the file for those beneficiaries on the list who are within its region. Claims received for those beneficiaries, for which no authorization is on file, are to be suspended and the contractor shall notify the TMA, Beneficiary and Provider Services Division. Refer to [32 CFR 199.4](#).

7.0. INTERIM REFERRAL AND AUTHORIZATION PROCESS

7.1. The interim referral and authorization management process shall be implemented and operated until such time as the government issues a change order directing the implementation of an alternate authorization and referral management system. Following implementation of this interim process, MTFs and *Managed Care Support Contractors (MCSCs)* may elect to work together to develop alternative means of accomplishing referrals and authorizations, with approval of the contracting officer. Any such development and the subsequent implementation of any alternative shall be without cost to the government.

7.2. The contractor shall process referrals in accordance with the following:

7.2.1. Referrals From The MTF To The *Contractor*

Referrals from the MTF shall include all of the following information, at a minimum, unless otherwise specified. Contractors shall receive the MTF referral via fax (or by other electronic means agreed upon by the MTF and the MCSC). The MTF is not required to provide diagnosis or procedure codes. The MCSC shall translate the narrative descriptions into standard diagnosis and procedure codes.

TRICARE OPERATIONS MANUAL 6010.51-M, AUGUST 1, 2002

CHAPTER 8, SECTION 5

REFERRALS/PREAUTHORIZATIONS/AUTHORIZATIONS

REQUIRED DATA ELEMENT*	DESCRIPTION/PURPOSE/USE
Request Date/Time	DD MMM YY hhmm
Request Priority	STAT/24-hour/ASAP/Today/72-hour/Routine
Requester	
<i>Referring Provider</i> Name	Name of PCM/MTF individual provider making request
<i>Referring Provider NPI</i>	<i>HIPAA National Provider Identifier (NPI) - Type 1 (Individual)</i>
<i>Referring MTF</i>	Name of <i>Military Treatment Facility (MTF)</i>
<i>Referring MT NPI</i>	<i>HIPAA National Provider Identifier - Type 2 (Organizational)</i>
PATIENT INFO	
Sponsor SSN	
Patient ID	EDI_PN (from DEERS) if available
Patient Name	Full Name of Patient (if no EDI_PN available)
Patient DOB	Date of Birth (required if patient not on DEERS)
Patient Gender	
Patient Address	Full Address of Beneficiary (including zip)
<i>Patient Telephone Number</i>	<i>If available - Telephone Number (including area code)</i>
CLINICAL INFO	
Patient Primary Provisional Diagnosis	Description
Reason for Request	Sufficient Clinical Info to Perform MNR
SERVICE	
Service 1 - Provider	<i>Specialty</i> of Service Provider
Service 1 - Provider Sub-Specialty	Additional Sub-Specialist Info if Needed (Free Text Clarifying Info Entered with Reason for Request) e.g., Pediatric Nephrologist
Service 1 - By Name Provider Request if Applicable - First and Last Name	Optional Info Regarding Preferred Specialist Provider (Free Text)
Service 1 - Service Type	Inpatient, Specialty Referral, DME Purchase/Rental, Other Health Service, et al DME Provider to do CMN
Service 1 - Service Quantity (optional)	Number of Visits, Units, etc.
CHCS Generated Order Number (DMIS-YYMMDD-XXXXX)	<i>Unique Identifier Number (UIN). The UIN is the DMIS (of the referring facility identified in the "Referring MTF" field on this request) --Date in format indicated-- Consult Order Number from CHCS.</i>

REQUIRED DATA ELEMENT*	DESCRIPTION/PURPOSE/USE
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Special Instructions:

NOTE 1: **Above data elements are required unless otherwise noted as "Optional."*

NOTE 2: *Use of the NPI is required in accordance with the HHS NPI Final Rule by May 23, 2007 or upon Service direction and/or direction of the Contracting Officer (CO). Implementation requirements may be found at Chapter 21, Section 4 of this Manual.*

7.2.1.1. The contractor shall use the CHCS generated order number (DMIS-YYMMDD-XXXXX) as a unique identifier. *The first four digits of the UIN is the DMIS of the referring facility only.* Using the unique identifier, the contractor will locate related referrals, authorizations, and claims, and track consult results.

Contractor generated MTF reports shall be modified to accommodate the unique identifier *and NPI* as needed. The unique identifier shall also be used for all related customer service inquiries. *UINs and NPIs* will be attached to all MTF referrals and will be portable across all regions of care. *The contractor shall capture the NPIs from the referral transmission report and forward the NPI to the referred-to provider on all referrals.*

7.2.1.2. The MCSC where care is rendered will apply their best business practices when authorizing care for referrals to their network and will retain responsibility for managing requests for additional services or inpatient concurrent stay reviews associated with the original referral as well as changes to the speciality provider identified to deliver the care. The MCSC authorizing the care shall forward the referral/authorization information, including the range of codes authorized (i.e., episode of care) and the name, *the NPI* and demographic information of the speciality provider to the MCSC for the region to which the patient is enrolled. Claims submitted by the provider will be processed by the MCSC for the region to which the patient is enrolled using the referral/authorization information provided by the out-of-region MCSC.

7.2.1.3. The contractor shall screen the information provided and return, by fax or other electronic means acceptable to the MTF and the MCSC, incomplete requests within one business day. The return of a referral to the MTF is considered processed to completion. One business day is defined as the work day following the day of transmission at the close of business at the location of the receiving entity. A business day is Monday through Friday, excluding federal holidays.

7.2.1.4. The contractor shall verify that the services are a TRICARE benefit through appropriate medical review and screening to ensure that the service requested is reimbursable through TRICARE. The contractor's medical review shall be in accordance with the contractor's best business practices. This process does not alter the TRICARE Operations Manual (TOM), TRICARE Policy Manual (TPM), or TRICARE Systems Manual (TSM) provisions covering active duty personnel or TFL beneficiaries.

7.2.1.5. The MCSC shall advise the patient, referring MTF, and receiving provider of all approved referrals. The MTF single Point Of Contact (POC) shall be advised via fax or other electronic means acceptable to the MTF and the MCSC. (The MTF single POC may be an individual or a single office with more than one telephone number.) The notice to the beneficiary shall contain the unique identifier and information necessary to support

obtaining ordered services or an appointment with the referred to provider within the access standards. The notice shall also provide the beneficiary with instructions on how to change their provider, if desired. *If the MCSC is made aware the beneficiary changed the provider listed on the referral, the MCSC will make appropriate modifications to MTF issued referral (to revise the provider the beneficiary was referred to by the MTF). The revised referral shall contain the same level of data as the initial MTF referral. The revised referral will be issued to the current provider, with a copy to the MTF.* For Same Day and 72-hour referrals no beneficiary notification shall be issued. The MCSC shall notify the provider to whom the beneficiary is being referred of the approved services, to include clinical information furnished by the referring provider.

7.2.1.6. If services are denied, the MCSC shall notify the patient and shall advise the patient of their right to appeal consistent with the TOM. The MCSC shall also notify the referring single MTF POC by fax of the initial denial.

7.2.1.7. For services beyond the initial authorization, the MCSC shall use its best practices in determining the extent of additional services to authorize. The MCSC shall not request a referral from the MTF but shall provide the MTF, through the MTF's single POC, a copy of the authorization and clinical information that served as the basis for the new authorization.

7.2.1.8. The MCSC shall provide the consult results to a single POC at the MTF in accordance with contract requirements. Returned results shall include the patient's name, *name of the rendering provider*, and the consult order number (*CHCS generated order number*) assigned by the MTF.

7.2.2. Referrals From The Contractor To The MTF

Referrals subject to the right of first refusal provision from the civilian sector shall be processed in accordance with the following procedures.

7.2.2.1. The contractor shall fax, or other electronic means acceptable to the MTF and the MCSC, the referral to the single MTF POC. The request shall contain the minimum data set described *in paragraph 7.2.1. (with the exception of the UIN)* plus the civilian provider's fax number, telephone number, and mailing address. This data set shall be provided to the MTF in plain text with or without diagnosis or procedure codes.

7.2.2.2. The MTF will respond via fax or other electronic means acceptable to the MTF and the MCSC, generally within one business day, as defined in [paragraph 7.2.2.1.](#) above, from receipt of the request to the single POC provided in the MOU by the contractor. When no response is received from the MTF in response to the right of first refusal request in one business day as defined above, the contractor shall process the referral request as if the MTF declined to see the patient. Monthly, no later than the 10th calendar day in the following month, the contractor shall provide each MTF with a report of the number of referrals forwarded based on the Right of First Refusal provision, the number accepted by the MTF, the number individually rejected by the MTF, and the number rejected by the MTF as a result of the automatic rejection after 1 business day.

7.2.2.3. The contractor shall contact the MTF POC for the coordination of Same Day and Seventy-two Hour referrals in accordance with the MTF MOU. In general, the MTF will respond within 30 minutes of notification. When no response is received from the MTF

within 30 minutes, the contractor shall process the referral request as if the MTF declined to see the patient.

7.2.2.4. The Right of First Refusal will be forwarded for only those beneficiaries residing within the Prime Service Area access standards and for whom the MTF has indicated the desire to receive referral request based on specialty or selective diagnosis code or procedure codes, and/or enrollment category. Right of First Refusal requests shall be provided prior to the MCSCs medical necessity and covered benefit review to afford the MTF the opportunity to see the patient prior to any decision.

7.2.2.5. In instances where the MTF elects to accept the patient, the MTF will advise the MCSC within one business day, as defined above in [paragraph 7.2.2.1](#). The MCSC will notify the beneficiary of the MTF's acceptance and provide instructions for contacting the MTF to obtain an appointment.

7.2.3. Provision Of Reports

7.2.3.1. The contractor shall ensure that network specialty providers provide clearly legible specialty care consultation or referral reports, operative reports, and discharge summaries to the beneficiary's initiating provider within 10 working days of the initial referral visit, procedure(s), follow-up clinic visits (when a report to the referring provider is considered clinically warranted), and after the final authorized visit. The contractor will ensure a report from the initial specialty encounter is returned to the initiating provider within 10 working days 98% of the time. The preferred method of delivery to MTF providers is electronic and will be addressed in the Memorandum Of Understanding (MOU). Each MTF will establish a single POC for the receipt of the required documents. (The MTF single POC may be an individual or a single office with more than one telephone number.) In urgent/emergent situations, a preliminary report of a specialty consultation shall be conveyed to the beneficiary's initiating provider within 24 hours (unless best medical practices dictate less time is required for a preliminary report) by telephone, fax or other means with a formal written report provided within the standard 98% of the time. All consultation or referral reports, operative reports, and discharge summaries shall be provided to the provider who initiated the referral within 30 calendar days. If the accreditation standards organization has a more stringent specialty referral-reporting requirement, the contractor shall adhere to that standard.

7.2.3.2. The requirements specified in [paragraph 7.2.3.1](#) above, apply to all referrals for professional services provided by a health care provider (as defined in 32 CFR 199) to assist the initiating provider in the diagnosis and treatment of a patient, including, for example, imaging studies (reports by the interpreting radiologist), physical therapy, occupational therapy, and speech therapy. The performance requirement does not apply to referrals for non-professional services such as durable medical equipment or laboratory studies.

