Chapter 16 Section 2

# Health Care Providers And Review Requirements

## 1.0 NETWORK DEVELOPMENT

The TRICARE Prime Remote (TPR) program has no network development requirements.

## 2.0 UNIFORMED SERVICES FAMILY HEALTH PLAN (USFHP)

**2.1** In addition to receiving claims from civilian providers, the contractor may also receive TPR Program claims from certain USFHP designated providers (DPs). The provisions of TPR will not apply to services furnished by a USFHP DP if the services are included as covered services under the current negotiated agreement between the USFHP DP and Office of the Assistant Secretary of Defense, Health Affairs (OASD(HA)). However, the contractor shall process claims according to the requirements in this chapter for any services not included in the USFHP DP agreement.

**2.2** The USFHP, administered by the DPs listed below currently have negotiated agreements that provide the Prime benefit (inpatient and outpatient care). Since these facilities have the capability for inpatient services, they can submit claims that the contractor will process according to applicable TRICARE and TPR reimbursement rules:

- CHRISTUS Health, Houston, TX (which also includes):

  St. Mary's Hospital, Port Arthur, TX
  St. John Hospital, Nassau Bay, TX
  St. Joseph Hospital, Houston, TX

- Martin's Point Health Care, Portland, ME

- Johns Hopkins Health Care Corporation, Baltimore, MD

- Brighton Marine Health Center, Boston, MA

- St. Vincent's Catholic Medical Centers of New York, New York City, NY

- Pacific Medical Clinics, Seattle, WA

## 3.0 VETERAN'S AFFAIRS

The contractor shall reimburse for services under the current national Department of Defense/Department of Veterans Affairs (DoD/DVA) Memorandum of Agreement (MOA) for "Referral of Active Duty Military Personnel Who Sustain Spinal Cord Injury (SCI), Traumatic Brain Injury (TBI), or Blindness to Veterans Affairs Medical Facilities for Health Care and Rehabilitative Services." (See Section 4, paragraph 2.2 for additional information.) The contractor shall not

reimburse for services provided to TPR enrollees under any local Memoranda of Understanding (MOU) between the DoD (including the Army, Air Force and Navy/Marine Corps facilities) and the Department of Veteran's Affairs (DVA). Claims for these services will continue to be processed by the Military Services. However, the contractor shall process claims according to the requirements in this chapter for any services not included in the local MOU.

## 4.0 DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) [INDIAN HEALTH SERVICE (IHS), PUBLIC HEALTH SERVICE (PHS), ETC.]

Claims for services not included in the current MOU between the DoD (including the Army, Air Force and Navy/Marine Corps facilities) and the DHHS (including the IHS, PHS, etc.) shall be processed in accordance with the requirements in this chapter.

## 5.0 REVIEW REQUIREMENTS

### 5.1 Provision Of Documents

If the Service Point of Contact (SPOC) requests copies of supporting documentation related to care reviews, appeals, claims, etc., the contractor shall send the requested copies to the SPOC within four work days of receiving the request.

### 5.2 Primary Care

Active Duty Service Members (ADSMs) enrolled in the TPR program can receive primary care services under the Uniform HMO Benefit without a referral, an authorization, or a fitness-for-duty review by the ADSM's SPOC (see Addendum A). ADSMs with assigned Primary Care Managers (PCMs) will receive primary care services from their PCMs. ADSMs without assigned PCMs will receive primary care services from TRICARE-authorized civilian providers, where available--or from other civilian providers where TRICARE-authorized civilian providers are not available. If a contractor receives claims for primary care services that are not covered under TRICARE and/or that are furnished to a TPR enrollee by a provider who is not TRICARE-authorized or certified, the contractor shall pend the claim and supply required information (Addendum D) to the SPOC for coverage determination (refer to Section 1, paragraph 4.0 for additional information). If the SPOC does not notify the contractor of the review determination or ask for an extension for further review within two workdays after submitting the request for a coverage determination, the contractor shall enter the designated authorization code into their system and release the claim for payment.

### 5.3 Non-Emergency Specialty Care, All Inpatient Care, Mental Health Care, And Other Care

The following care requires SPOC review: non-emergency specialty care, claims for prescriptions for controlled substances (network pharmacies shall fill the prescription and the contractor shall forward claim information to the SPOC on the monthly report for a retrospective review), all inpatient hospitalization, mental health care, and invasive medical and surgical procedures (with the exception of laboratory services) furnished in ambulatory settings. The contractor shall not, however, delay claim processing for a SPOC review determination.

### 5.3.1 Referred Care

**5.3.1.1** The requesting provider shall follow the contractor's referral procedures and shall contact the contractor for an authorization. If an authorization is required, the contractor shall enter the information in Addendum D, required by the SPOC for a fitness-for-duty review. The SPOC will respond to the contractor within two working days. When a SPOC referral directs evaluation or treatment of a condition, as opposed to directing a specific service(s), the Managed Care Support Contractor (MCSC) shall use its best business practices in determining the services encompassed within the Episode Of Care (EOC), indicated by the referral. The services may include laboratory tests, radiology tests, echocardiograms, holter monitors, pulmonary function tests, and routine treadmills associated with the EOC. A separate SPOC authorization for these services is not required. If a civilian provider requests additional treatment outside the original EOC, the MCSC shall contact the SPOC for approval. The contractor shall not communicate to the provider or patient that the care has been authorized until the SPOC review process has been completed. The contractor shall use the same best business practices as used for other Prime enrollees in determining EOC when claims are received with lines of care that contain both referred and non-referred lines. Laboratory tests, radiology tests, echocardiogram, holter monitors, pulmonary function tests, and routine treadmills logically associated with the original EOC may be considered part of the originally requested services and do not need to come back to the PCM for approval. Claims received which contain services outside the originally referred EOC on an ADSM must come back to the PCM for approval.

**5.3.1.2** If the SPOC determines that the ADSM may receive the care from a civilian source, the SPOC will enter the appropriate code into the authorization/referral system. The contractor shall notify the ADSM of approved referrals. The ADSM may receive the specialty care from an MTF, a network provider, or a non-network provider according to TRICARE access standards, where possible. In areas where providers are not available within TRICARE access standards, community norms shall apply. (An ADSM may always choose to receive care at an MTF even when the SPOC has authorized a civilian source of care and even if the care at the MTF cannot be arranged within the Prime access standards subject to the member's unit commander [or supervisor] approval.) If the appointment is with a non-network provider, the contractor shall instruct the provider on payment requirements for ADSMs (e.g., no deductible or cost-share) and on other issues affecting claim payment (e.g., the balance billing prohibition).

**5.3.1.3** If the contractor does not receive the SPOC's response or request for an extension within two work days, the contractor shall, within one work day after the end of the two work day waiting period, enter the contractor's authorization code into the contractor's claims processing system. The contractor shall document in the contractor's system each step of the effort to obtain a review decision from the SPOC. The first choice for civilian care is with a network provider; if a network provider is not available within Prime access standards, the contractor may authorize the care with a TRICARE-authorized provider. The contractor shall help the ADSM locate an authorized provider.

**5.3.1.4** If the SPOC directs the care to a military source, the SPOC will manage the EOC. If the ADSM disagrees with a SPOC determination that the care must be provided by a military source, the ADSM may appeal only through the SPOC who will coordinate the appeal with the Regional Director (RD); the contractor shall refer all appeals and inquiries concerning the SPOC's fitness-for-duty determination to the SPOC.

**5.3.1.5** If the ADSM's PCM determines that a specialty referral or test is required on an emergency or urgent basis (less than 48 hours from the time of the PCM office visit) the PCM shall contact the contractor for a referral and send required information to the SPOC for a fitness for duty review. The ADSM shall receive the care as needed without waiting for the SPOC determination, and the contractor shall adjudicate the claim according to TRICARE Prime provisions. If further specialty care is warranted, the PCM shall request a referral to specialty care. The contractor shall contact the SPOC with a request for an additional SPOC review for the specialty care.

### 5.3.2 Care Received With No Authorization or Referral

**5.3.2.1** The contractor may receive claims for care that require referral, authorization, and SPOC review, that have not been authorized or reviewed. If the claim involves care covered under TPR, the contractor shall pend the claim and supply the required information (Addendum D) to the SPOC for review. If the SPOC does not notify the contractor of the review determination or ask for an extension for further review within two workdays after submitting the request for coverage determination, the contractor shall then authorize the care. The contractor shall then release the claim for payment, and apply any overrides necessary to ensure that the claim is paid with no fees assessed to the active duty member. However, the contractor shall not make claims payments to sanctioned or suspended providers (see Chapter 13, Section 6).

**5.3.2.2** If the contractor determines that the services on the claim are not covered under TRICARE Prime and/or that the provider of care is not TRICARE-authorized, or is not certified, the contractor shall pend the claim and supply required information (Addendum D) to the SPOC for a coverage determination as well as for a fitness-for-duty screening (refer to Addendum B) for information and examples of covered services). If the SPOC does not notify the contractor of the review determination or ask for an extension for further review within two workdays after submitting the request for a coverage determination, the contractor shall then authorize the care. The contractor shall then release the claim for payment and apply any overrides necessary to ensure that the claim is paid. However, the contractor shall not make claims payments to sanctioned or suspended providers (see Chapter 13, Section 6).

**Note:** If the SPOC retroactively determines that the payment should not have been made, the contractor shall initiate recoupment actions according to Chapter 10, Section 4.

## 6.0 ADDITIONAL INSTRUCTIONS

### 6.1 Wellness Examinations

The contractor shall reimburse charges for wellness examinations covered under TRICARE Prime (see the TRICARE Policy Manual (TPM), Chapter 7, Section 2.2) without SPOC review. The contractor shall supply information related to requests for follow-up or additional GYN care that requires SPOC review (paragraph 5.2) to the SPOC (see Addendum B).

### 6.2 Optometry And Hearing Examinations

The ADSM may directly contact the contractor for assistance in arranging for optometry and hearing examinations. The contractor shall refer ADSMs to SPOCs for information on how to obtain eyeglasses, hearing aids, and contact lenses as well as examinations for them, from the Military Health System (MHS) (see Addendum B).

### 6.3 No PCM Assigned

ADSMs who work and reside in areas where a PCM is not available may directly access the contractor for assistance in arranging for routine primary care and for urgent specialty or inpatient care with a TRICARE-authorized provider. Since a non-network provider is not required to know the fitness-for-duty review process, it is important that the ADSM coordinate all requests for specialty and inpatient care through the contractor. The contractor shall contact the SPOC as required for reviews and other assistance as needed.

### 6.4 Emergency Care

For emergency care, refer to the TPM for guidelines.

### 6.5 Dental Care

Claims for all dental services, including adjunctive dental care will be processed and reimbursed by a single separate active duty dental claims processor. Addendum C provides guidelines for dental claims and inquiries. (See Section 4, paragraph 2.2 for adjunctive dental care provided under the National DoD/DVA MOA.)

### 6.6 Immunizations

The contractor shall reimburse immunizations as primary care under the guidelines in the TRICARE Reimbursement Manual (TRM).

### 6.7 Ancillary Services

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

## 7.0 ADSM MEDICAL RECORDS

**7.1** For TPR-enrolled ADSMs with assigned PCMs, the contractor shall follow contract requirements for maintaining medical records.

**7.2** ADSMs will be instructed by their commands to sign annual medical release forms with their PCMs to allow information to be forwarded as necessary to civilian and military providers. The contractor may use the current "signature on file" procedures to fulfill this requirement (Chapter 8, Section 4, paragraph 6.0). When an ADSM leaves an assignment as a result of a Permanent Change of Station (PCS) or other service-related change of duty status, the PCM shall provide a complete copy of medical records, to include copies of specialty and ancillary care documentation, to ADSMs within 30 calendar days of the ADSM's request for the records. The ADSM may also request copies of medical care documentation on an ongoing, EOC basis. The contractor shall be responsible for all administrative/copying costs. Network providers shall be reimbursed for medical records photocopying and postage costs incurred at the rates established in their network provider participation agreements. Participating and non-participating providers shall be reimbursed for medical records photocopying and postage costs on the basis of billed charges. ADSMs who have paid for copied records and applicable postage costs shall be reimbursed for the full amount paid to ensure they have no out of pocket expenses. All providers and/or patients must submit a claim

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

**Note:** The purpose of the copying of medical records is to assist the ADSM in maintaining accurate and current medical documentation. The contractor shall not make payment to the provider who photocopies medical records to support the adjudication of a claim.

**7.3** ADSMs without assigned PCMs are responsible for maintaining their medical records when receiving care from civilian providers.

## 8.0 PROVIDER EDUCATION

The contractor shall familiarize network providers and, when appropriate, other providers with the TPR Program, special requirements for ADSM health care, and billing procedures (e.g., no cost-share or deductible amounts, balance billing prohibition, etc.). On an ongoing basis, the contractor shall include information on ADSM specialty care procedures and billing instructions in routine information and educational programs according to contractual requirements.

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