

Referrals/Preauthorizations/Authorizations

1.0 REFERRALS

1.1 The contractor is responsible for reviewing all requests for referrals. The contractor shall not mandate an authorization, to include a medical necessity or utilization management determination, before referring a patient for an evaluation by a network Primary Care Manager (PCM) to obtain a referral prior to referring a beneficiary to a specialist. The contractor shall review the referral request, and if it is determined that the services being requested are not a TRICARE benefit, the beneficiary shall be informed that the services are excluded from coverage, and will not be paid by TRICARE, if obtained.

1.2 The TRICARE beneficiary must be “held harmless” in cases where the network provider fails to request a referral and the contractor either denies payment or applies the Point Of Service (POS) option. If the referral involves services rendered by a non-network provider, “hold harmless” cannot apply, as “hold harmless” only applies to network providers. Once the patient is evaluated by the specialist, the contractor may require an authorization before the services are provided or the procedure performed. In those instances where a contractor requires authorization of services in addition to those listed in [Chapter 7, Section 2](#), such authorization must be available to and appealable by all beneficiaries, whether enrolled or not. Within Prime Service Areas (PSAs), the Military Treatment Facilities (MTFs) have the Right of First Refusal (ROFR) for all referrals, as determined by the Memorandum of Understanding (MOU) between the contractor and each MTF.

1.3 Urgent Care Referrals

Urgent care services are medically necessary services required for an illness or injury that would not result in further disability or death if not treated immediately, but does require professional attention within 24 hours. If urgent treatment is required by a TRICARE Prime enrollee after hours, while traveling away from their residence, or whose PCM is otherwise unavailable, the enrollee may contact their regional contractor (or designated provider) for assistance finding an appropriate facility/provider before receiving non-emergent care from a provider other than the PCM. If they do not coordinate urgent care with their PCM or regional contractor, the care may be covered under the POS option, resulting in higher out-of-pocket costs. If an enrollee is traveling overseas, he or she shall call the TRICARE Overseas Program (TOP) Regional Call Center for the region in which he or she is traveling to coordinate urgent care.

2.0 PREAUTHORIZATIONS/AUTHORIZATIONS

2.1 The contractor is responsible for reviewing all requests for authorization. Issuance of authorizations shall not be used to restrict freedom of choice of the TRICARE Standard beneficiary who chooses to receive care from authorized non-network providers, except as required under [Chapter 7, Section 2](#).

2.2 The contractor is required to advise beneficiaries, sponsors, providers, and other responsible persons of those benefits requiring authorization before payment may be made and inform them of the procedures for requesting the authorization. Although beneficiaries are required to obtain authorization prior to receiving payment for the care listed at [Chapter 7, Section 2](#), authorization may be requested following the care. Whether the authorization is requested before or after care, all qualified care shall be authorized for payment. The contractor shall emphasize the need for concerned persons to contact a Beneficiary Counseling Assistance Coordinator (BCAC)/Health Benefits Advisor (HBA) or the contractor for assistance.

2.3 Because of the high risk that many services requiring special authorization may be denied, the contractor shall offer preauthorization for the care to all TRICARE beneficiaries who reside within its jurisdiction. The contractor shall process all requests for such authorization whether submitted by the beneficiary, sponsor or provider requesting authorization on behalf of the beneficiary.

2.4 The contractor shall issue notification of preauthorization/authorization or waiver to the beneficiary or parent/guardian or a minor or incompetent adult, the provider, and to its claims processing staff. Notification may be made in writing by letter, or on a form developed by the contractor. These forms and letters are all referred to as TRICARE authorization forms. The contractor shall not issue an authorization for acute, inpatient mental health care for more than seven calendar days at a time.

2.5 The contractor shall document authorizations. The contractor must also maintain an automated authorization file or an automated system of flagging to ensure claims are processed consistent with authorizations. The contractor shall verify that the beneficiary, sponsor, provider, and service or supply information submitted on the claim are consistent with that authorized and that the care was accomplished within the authorized time period.

2.6 Prime enrollees receiving emergency care or authorized care from non-network, non-participating providers shall be responsible for only the Prime copayment. On such claims, contractors shall allow the amount the provider may collect under TRICARE rules; i.e., if the charges on a claim are subject to the balance billing limit (refer to the TRICARE Reimbursement Manual (TRM), [Chapter 3, Section 1](#) for information on balance billing limit), the contractor shall allow the lesser of the billed charges or the balance billing limit (115% of allowable charge). If the charges on a claim are exempt from the balance billing limit, the contractor shall allow the billed charges. Refer to the TRM, [Chapter 2, Section 1](#) for information on claims for certain ancillary services.

2.7 The requirement that a TRICARE Prime enrollee obtain a referral/authorization from their PCM to receive the H1N1 immunization from a non-network, TRICARE-authorized provider has been temporarily waived from October 1, 2009 to May 1, 2010. During this period, Prime enrollees may obtain the H1N1 immunization from a non-network TRICARE-authorized provider without prior authorization or PCM referral. POS cost-shares normally associated with non-referred care obtained by Prime enrollees from non-network providers without appropriate authorization will not apply during this period.

3.0 FAILURE TO COMPLY WITH PREAUTHORIZATION - PAYMENT REDUCTION

During claims processing, provider payments shall be reduced for failure to comply with the preauthorization requirements for certain types of care. See the TRM, [Chapter 1, Section 28](#), for

more information.

4.0 PSYCHIATRIC RESIDENTIAL TREATMENT CENTERS (RTCs)

4.1 Before any claims for RTC care may be paid, an authorization must be on file. The dates of service on the claim form and the name of the facility plus the Employer Identification Number (EIN) with suffix must correspond with the dates of the approval and the facility indicated on the authorization. If the beneficiary resides outside of the contractor's region, the contractor responsible for payment shall pay the claims at the rate determined by the Defense Health Agency (DHA). When the contractor issues an RTC authorization, it shall flag its files to preclude payment of any family or collateral therapy that is billed in the name of the RTC patient. That cost is the responsibility of the RTC, unless, as part of its negotiated agreement, the contractor agrees to a separate payment for such care. Under the DHA-determined rates, family therapists may bill separately from the RTC (outside the all-inclusive rate) only if the therapy is provided to one or both of the parents residing a significant distance from the RTC. 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 RTC, 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 RTC 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 RTC.

5.0 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 DHA, Beneficiary Education and Support Division (BE&SD). Refer to [32 CFR 199.4](#).

6.0 REFERRAL AND AUTHORIZATION PROCESS

The contractor shall process referrals in accordance with the following:

6.1 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 Managed Care Support Contractor (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. The contractor shall ensure that care received outside the MTF and referred by the MTF (for MTF enrollees) is properly entered into the

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contractor's claims processing system to ensure the appropriate adjudication of claims.

REQUIRED DATA ELEMENT*	DESCRIPTION/PURPOSE/USE
Request Date/Time	DD MMM YY hhmm
Request Priority	STAT/24-hour/ASAP/Today/72-hour/Routine
Requester	
Referring Provider Name	Name of PCM/MTF individual provider making request
Referring Provider National Provider Identifier (NPI)	Health Insurance Portability and Accountability Act (HIPAA) NPI - Type 1 (Individual)
Referring MTF	Name of MTF
Referring MTF NPI	HIPAA NPI - Type 2 (Organizational)
PATIENT INFORMATION	
Sponsor Social Security Number (SSN)	
Patient ID	Electronic Data Interchange Patient Number (EDI_PN) (from DEERS) if available
Patient Name	Full Name of Patient (if no EDI_PN available)
Patient Date of Birth (DOB)	Date of Birth (required if patient not on DEERS)
Patient Gender	
Patient Address	Full Address of Beneficiary (including zip)
Patient Telephone Number	If available - Telephone Number (including area code)
CLINICAL INFORMATION	
Patient Primary Provisional Diagnosis	Description
Reason for Request	Sufficient Clinical Info to Perform Medical Necessity Report (MNR)
SERVICE	
Service 1 - Provider	Specialty 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, Durable Medical Equipment (DME) Purchase/Rental, Other Health Service, et al DME Provider to do Certificates of Medical Necessity (CMN)
Service 1 - Service Quantity (optional)	Number of Visits, Units, etc.
Composite Health Care System (CHCS) Generated Order Number (Defense Medical Information System (DMIS)-YYMMDD-XXXXX)	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.
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 Health and Human Services (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 19, Section 4 .	
Note 3: When issuing a preauthorization for an ADSM while in terminal leave status to obtain medical care from the Department of Veterans Affairs (DVA), as required by Chapter 17, Section 1, paragraph 4.6 , the MTF shall make special entries for data elements as follows:	
Patient Primary Provisional Diagnosis	Condition of a routine or urgent nature as specified by the patient at a future date.

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REQUIRED DATA ELEMENT*	DESCRIPTION/PURPOSE/USE
SERVICE (CONTINUED)	
Reason for Request	Provide preauthorization for outpatient treatment by the DVA for routine or urgent conditions while the active duty patient is in a terminal leave status.
Service 1 - Provider	Any DVA provider.
Service 1 - By Name Provider Request if Applicable - First and Last Name	DVA provider only.
Note 4: When issuing an authorization for the DVA to provide a Compensation and Pension (C&P) examination for a service member as required by Chapter 17, Section 2, paragraph 3.2.2 , the MTF shall make special entries for data elements as follows:	
Patient Primary Provisional Diagnosis	V68.01 - Disability Examination
Reason for Request	DVA only: Integrated Disability Evaluation System (IDES) C&P Examinations for Fitness for Duty Determination
Service 1 - Provider	Any DVA Provider
Service 1 - By Name Provider Request if Applicable - First and Last Name	DVA Provider Only
Service 1 - Service Quantity	Number of C&P Examinations Authorized

Special Instructions:

This blanket preauthorization is only for routine and urgent outpatient primary medical care provided by the DVA while the patient is in a terminal leave status. Terminal leave for this patient concludes at midnight on DD MMM YY.

6.1.1 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. 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.

6.1.2 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 (EOC)) and the name, the NPI, and demographic information of the speciality provider to the MCSC for the region to which the patient is enrolled. If the patient is enrolled overseas, the MCSC will provide the same service and information required above to the TOP contractor. If a CONUS Prime retiree/retiree family member receives authorization to obtain care overseas from an MCSC, the MCSC shall forward the authorization information to the TOP contractor to ensure appropriate adjudication of the claim. Claims submitted by the provider will be processed by the MCSC or the TOP contractor according to [Chapter 8, Section 2](#).

6.1.3 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.

6.1.4 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 TRICARE For Life (TFL) beneficiaries.

6.1.5 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, 24-hour, 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.

6.1.6 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.

6.1.7 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.

6.2 Referrals From The Contractor To The MTF

Referrals subject to the ROFR provision from the civilian sector shall be processed as follows:

6.2.1 The MCSC shall fax, or send via other electronic means acceptable to the MTF and MCSC, the referral to the single MTF POC. The request shall contain the minimum data set described in [paragraph 6.1](#) (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. This transmission will generally take place within one business day. A business day is Monday through Friday, excluding Federal holidays.

6.2.1.1 Referrals to the MTF shall be classified as follows:

6.2.1.1.1 Urgent referrals are those that must be accepted or declined by the MTF within 90 minutes. If the MTF fails to respond within that time period, the referral is considered a passive denial and the patient is directed to the network by the MCSC.

6.2.1.1.2 Routine referrals are those that must be accepted or declined by the MTF within two business days. If the MTF fails to respond within that time period, the referral is considered a passive denial and the patient is directed to the network by the MCSC.

6.2.2 The MTF will respond via fax or other electronic means acceptable to the MTF and the MCSC as defined in [paragraph 6.2.1](#), to the single POC provided in the MOU by the MCSC. When no response is received from the MTF within the time frames specified above, the MCSC shall process the referral request as if the MTF declined to see the patient. The MCSC shall provide each MTF with a report of the number of referrals forwarded based on the ROFR provision.

6.2.3 ROFR requests will be forwarded for Prime beneficiaries if the MTF has indicated the desire to receive referral request based on specialty or selective diagnosis code or procedure codes, and/or enrollment category. ROFR 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.

6.2.4 In instances where the MTF elects to accept the patient, the MTF will advise the MCSC as defined in [paragraph 6.2.1](#). The MCSC will notify the beneficiary of the MTF's acceptance and provide instructions for contacting the MTF to obtain an appointment.

7.0 EXIGENT CASES REQUIRING IMMEDIATE COORDINATION WITH REGIONAL OFFICE

In cases involving serious medical conditions or other instances where time is of the essence, the contractor shall initiate an expedited review and suspend case processing if the care does not satisfy TRICARE benefit criteria. The contractor shall notify the TRICARE Regional Office (TRO) as soon as possible of its findings and forward the entire case file to the TRO for review. The case shall remain suspended until the TRO notifies the contractor of the DHA's determination. The types of cases that may require immediate TRO coordination include, but are not limited to, the following:

- Life-threatening illness
- Rare disease
- Treatment of cancer patients
- Treatment of very ill children
- Organ transplant

- END -

