



DEFENSE
HEALTH AGENCY

HPOB

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS
16401 EAST CENTRETECH PARKWAY
AURORA, CO 80011-9066

**CHANGE 169
6010.56-M
FEBRUARY 11, 2016**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE OPERATIONS MANUAL (TOM), FEBRUARY 2008**

The Defense Health Agency has authorized the following addition(s)/revision(s).

CHANGE TITLE: INTEGRATED DISABILITY EVALUATION SYSTEM

CONREQ: 17510

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change directs the contractors to make revisions to the way they process claims for Compensation & Pension exams provided by the Veteran Affairs to Service Members.

EFFECTIVE DATE: March 11, 2016.

IMPLEMENTATION DATE: March 11, 2016.

This change is made in conjunction with Feb 2008 TSM, Change No. 82.

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Digitally signed by
ARENDALE JOHN LOUIS II.1150775368
DN: c=US, o=U.S. Government, ou=DoD,
ou=PKI, ou=TMA,
cn=ARENDALE JOHN LOUIS II.1150775368
Date: 2016.02.08 10:01:43 -0700

**John L. Arendale
Section Chief, Health Plan
Operations Branch (HPOB)
Defense Health Agency (DHA)**

**ATTACHMENT(S): 9 PAGES
DISTRIBUTION: 6010.56-M**

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT.

CHANGE 169
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REMOVE PAGE(S)

CHAPTER 8

Section 5, pages 5 and 6

CHAPTER 16

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CHAPTER 17

Section 2, pages 3 through 5

INSERT PAGE(S)

Section 5, pages 5 and 6

Section 2, pages 3 through 6

Section 2, pages 3 through 5

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Chapter 8, Section 5

Referrals/Preauthorizations/Authorizations

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 or Z02.71 - 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 MM YY. The referral in Note 4 shall be considered a blanket authorization for any DVA provider to conduct the authorized number C&P exams and associated ancillary services.	

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](#).

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Chapter 8, Section 5

Referrals/Preauthorizations/Authorizations

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.

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 (if assigned) or Primary Care Provider (PCP) for approval.

5.3.1.2 If the SAS determines that the Service member may receive the care from a civilian source, the SAS will enter the appropriate code into the authorization/referral system. The contractor shall notify the Service member of approved referrals. The Service member may receive the specialty care from a Military Treatment Facility (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. (A Service member may always choose to receive care at an MTF even when the SAS 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 Service members (e.g., no deductible or cost-share) and on other issues affecting claim payment (e.g., the balance billing prohibition). The contractor shall follow Chapter 8, Section 5 when there are additional requests by a MTF for Civilian Health Care (CHC) needs. The contractor shall adjudicate claims for additional MTF requested civilian care in accordance with Chapter 8, Sections 2 and 5.

5.3.1.3 If the contractor does not receive the SAS'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 SAS. 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 Service member locate an authorized provider.

5.3.1.4 If the SAS directs the care to a military source, the SAS will manage the EOC. If the Service member disagrees with a SAS determination that the care must be provided by a military source, the Service member may appeal only through the SAS who will coordinate the appeal as appropriate; the contractor shall refer all appeals and inquiries concerning the SAS's fitness-for-duty determination to the SAS.

5.3.1.5 If the Service member's PCM determines that a specialty referral or test is required on an 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 SAS for a fitness for duty review. The Service member shall receive the care as needed without waiting for the SAS 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 SAS with a request for an additional SAS 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 SAS review, that have not been authorized or reviewed. If the claim involves care covered under

TRICARE policy, the contractor shall pend the claim and supply the required information ([Addendum B](#)) to the SAS for review. If the SAS 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](#)).

Note: Claims for care provided under the National DoD/DVA MOA for Payment for Processing Disability Compensation and Pension Examinations (DCPE) in the Integrated Disability Evaluation System (IDES) shall follow the requirements specified in [Chapter 17, Section 2, paragraph 3.2.5](#).

5.3.2.2 If the contractor determines that the requested service, supply, or equipment is not covered by TRICARE policy (including [Chapter 17, Section 3, paragraph 2.2.5](#)) and no [Defense Health Agency \(DHA\)](#) approved waiver is provided, the contractor shall decline to file an authorization and shall deny any received claims accordingly. 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 [Chapter 17, Addendum A, paragraph 2.0](#). No notification to the SAS is required.

Note: If the SAS 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 Comprehensive Health Promotion and Disease Prevention Examinations

The contractor shall reimburse charges for comprehensive health promotion and disease prevention examinations covered under TRICARE Prime (see the TRICARE Policy Manual (TPM), [Chapter 7, Section 2.2](#)) without SAS review.

6.2 Vision And Hearing Examinations

The Service member may directly contact the contractor for assistance in arranging for vision and hearing examinations. The contractor shall refer Service members to SAS for information on how to obtain eyeglasses, hearing aids, and contact lenses as well as examinations for them.

6.3 No PCM Assigned

Service members 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 Service member coordinate all requests for specialty and inpatient care through the contractor. The contractor shall contact the SAS 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 active duty dental services will be processed and reimbursed by a single separate active duty dental program contractor. Claims for adjunctive dental care will be processed and reimbursed by the MCSC or the TRICARE Overseas Program (TOP) contractor for overseas care.

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

7.0 SERVICE MEMBER MEDICAL RECORDS

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

7.2 Service members 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 a Service member 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 Service members within 30 calendar days of the Service member's request for the records. The Service member 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. 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.

Note: The purpose of the copying of medical records is to assist the Service member 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 Service members 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 **Service member** 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 **Service member** specialty care procedures and billing instructions in routine information and educational programs according to contractual requirements.

- END -

3.1.3 The contractor shall verify whether the DVA-provided care has been authorized by the DHA/DHA-GL. If an authorization is on file, the contractor shall process the claim to payment. The contractor shall not deny claims for lack of authorization. If a required authorization is not on file, the contractor shall place the claim in a pending status and forward the appropriate documentation to the DHA/DHA-GL identifying the claim as a possible MOA claim for determination (following the procedures in Addendum B for the DHA/DHA-GL SAS referral and review procedures). Additionally, any DVA submitted claim for a Service member with a TBI, SCI, blindness, or polytrauma condition that does not have a matching authorization number shall be pending to the DHA/DHA-GL for payment determination.

3.1.4 MOA claims shall be reimbursed as follows:

3.1.4.1 Claims for inpatient care shall be paid using DVA interagency rates, published in the Federal Register. The interagency rate is a daily per diem to cover an inpatient stay and includes room and board, nursing, physician, and ancillary care. These rates will be provided to the contractor by the DHA (including periodic updates as needed). There are three different interagency rates to be paid for rehabilitation care under the MOA. The Rehabilitation Medicine rate will apply to TBI care. Blind rehabilitation and SCI care each have their own separate interagency rate. Additionally, it is possible that two or more separate rates will apply to one inpatient stay. All interagency rates except the outpatient interagency rate in the Office of Management and Budget (OMB) Federal Register Notice provided by DHA will be applicable. If the DVA-submitted claim identifies more than one rate (with the appropriate number of days identified for each separate rate), the contractor shall pay the claim using the separate rate. (For example, a stay for SCI may include days paid with the SCI rate and days billed at a surgery rate.) MCSCs shall verify the DVA billed rate on inpatient claims matches one of the interagency rates provided by DHA. DVA claims for inpatient care submitted with an applicable interagency rate shall not be developed any further (i.e., for revenue codes, diagnosis, etc.) if care has been approved by the DHA/DHA-GL. Claims without an applicable interagency rate shall be denied and an Explanation of Benefits (EOB) shall be issued to the DVA, but not the beneficiary. The claim will need to be resubmitted for payment.

3.1.4.2 Claims for outpatient and ambulatory surgery professional services shall be paid at the appropriate TRICARE allowable rate (e.g., CHAMPUS Maximum Allowable Charge (CMAC)) with a 10% discount applied. For those services without a TRICARE allowable rate, DVA shall be reimbursed at billed charges.

3.1.4.3 The following care services, irrespective of health care delivery setting require authorization from DHA-GL and are reimbursed at billed charges (actual DVA cost) separately from DVA inpatient interagency rates, if one exists:

- Transportation
- Prosthetics
- Non-medical rehabilitative items
- Durable Equipment (DE) and Durable Medical Equipment (DME)
- Orthotics (including cognitive devices)
- Routine and adjunctive dental services
- Optometry
- Lens prescriptions
- Inpatient/outpatient TBI evaluations

- Special diagnostic procedures
- Inpatient/outpatient polytrauma transitional rehabilitation program
- Home care
- Personal care attendants
- Conjoint family therapy
- Ambulatory surgeries
- Cognitive rehabilitation
- Extended care/nursing home care

3.1.4.4 On August 4, 2009, the contractor shall process all claims received on or after this date using the guidelines established under the updated MOA regardless of the date of service. All TRICARE Encounter Data (TED) records for this care shall include Special Processing Code 17 - DVA medical provider claim.

3.1.4.5 If paid at per diem rates, the provisions of [Chapter 8, Section 2, paragraph 7.2](#), apply when enrollment changes in the middle of an inpatient stay. If enrollment changes retroactively, prior payments will not be recouped.

3.2 Claims for Care Provided Under the National DoD/DVA MOA for Payment for Processing Disability Compensation and Pension Examinations (DCPE) in the Integrated Disability Evaluation System (IDES)

The contractor shall reimburse the DVA for services provided under the current national DoD/DVA MOA for "Processing Payment for Disability Compensation and Pension Examinations in the Integrated Disability Evaluation System" (IDES MOA; see [Addendum C](#) for a full text copy of the MOA for reference purposes only). The contractor shall process claims with dates of **service October 1, 2014**, and forward. Claims under the IDES MOA shall be processed in accordance with this chapter and the following:

3.2.1 Claims submitted by **any DVA facility/provider** for a Service member's care with the Current Procedural Terminology (CPT¹) code of 99456, **International Classification of Diseases, 9th Revision (ICD-9) diagnostic code of V68.01, or International Classification of Diseases, 10th Revision (ICD-10) diagnostic code of Z02.71 (Disability Examination)** shall be processed as a IDES MOA claim. **IDES MOA claims are SHCP claims.**

3.2.2 The MTF will generate a single referral and submit the referral to the contractor. **Although the MTF referral may specify a particular DVA facility/provider to provide the IDES MOA services, the contractor shall consider the referral as a blanket authorization to process claims from any billing DVA facility/provider for authorized/DCPE exams and associated ancillary services under the IDES MOA. The MTF will complete the referral as described in [Chapter 8, Section 5, paragraph 6.1 including Note 4](#).** The referral will specify the total number of Compensation and Pension (C&P) examinations authorized for payment by the contractor. It is not necessary for the referral to identify the various specialists who will render the different C&P examinations. The reason for referral will be entered by the MTF as **"DVA only: Disability Evaluation System (DES) C&P exams for fitness for duty determination - total ___."**

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Providers Of Care

3.2.3 The DVA will list one C&P examination (CPT² code 99456) per the appropriate field of the claim form and indicate one unit such that there is a separate line item for each C&P examination. Related ancillary services may be billed on the same claim form or on a separate claim form identified by the single diagnosis of ICD-9/ICD-10 diagnostic code, V68.01/Z02.71 (Disability Examination).

3.2.4 If an IDES MOA claim is received from the DVA (paragraph 3.2.1) and an authorization to any DVA provider is on file, the contractor shall process the claim to payment (see Section 2, paragraph 2.2). One C&P examination fee will be paid for each referred and authorized C&P examination up to the total number of C&P examinations authorized by the referring MTF.

3.2.5 If an IDES MOA claim is received from the DVA (paragraph 3.2.1) and no authorization is on file, the contractor shall verify that the claim contains CPT² procedure code 99456 and/or ICD-9/ICD-10 code V68.01/Z02.71, and process the claim to payment. The contractor shall provide a monthly report of the number of IDES MOA claims received without authorization. Details for content and submission of this report are contained in the contract, DD Form 1423, Contract Data Requirement List (CDRL).

3.2.6 Claims for C&P exams shall be paid as SHCP using the pricing provisions agreed upon in the IDES MOA. CPT² procedure code 99456 shall be used and will be considered to include all parts of each C&P examination, except ancillary services. Claims for related ancillary services shall be paid at the appropriate TRICARE allowable rate (e.g., CMAC) with a 10% discount applied.

FIGURE 17.2-1 DISABILITY PAY SCHEDULE

EFFECTIVE DATE	C& P DISABILITY EXAM (99456 ²)	ANCILLARY SERVICES
01/01/2011	\$515.00	CMAC - 10%

3.2.7 All TED records for this care shall include Special Processing Code **DC** - Compensation and Pension Examinations-DVA, Special Processing Code **17** - VA Medical Provider Claim, and Enrollment Health Plan Code **SR** - SHCP-Referred Care.

3.2.8 Claims for care provided prior to October 1, 2014, have been paid in full under a separate agreement. The contractor shall process all claims with dates of service from October 1, 2014, forward as outlined above. The contractor shall reject IDES claims and requests to adjust/reprocess IDES claims with dates of service before October 1, 2014.

- END -

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