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TRICARE  
MANAGEMENT ACTIVITY

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FOR  
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The TRICARE Management Activity has authorized the following addition(s)/revision(s).

**CHANGE TITLE:** REVISION TO THE URGENT CARE REFERRALS HEALTH CARE FINDER  
(HCF) INITIATIVE

**CONREQ:** 15481

**PAGE CHANGE(S):** See page 2.

**SUMMARY OF CHANGE(S):** This change updates the Military Treatment Facilities (MTFs) selected for the Urgent Care Referrals HCF Initiative.

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

  
**Reta M. Michak**  
**Director, Operations Division**

**ATTACHMENT(S):** 4 PAGES  
**DISTRIBUTION:** 6010.56-M

**CHANGE 64**  
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**REMOVE PAGE(S)**

**CHAPTER 8**

Section 5, pages 1 - 4

**INSERT PAGE(S)**

Section 5, pages 1 - 4

## Referrals/Preauthorizations/Authorizations

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### 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

TRICARE Prime enrollees must initially seek all urgent care from their PCM. If the PCM is unable to provide a primary care service, or if the enrollee requires specialty care, the PCM is responsible for referring the enrollee to another more qualified TRICARE authorized provider. For civilian PCMs and MTF providers with “defer/refer to network” requests, the PCM/MTF provider must notify the contractor that a referral is being made.

**1.3.1** In an effort to provide better access for after-hours and out-of-area urgent care needs, the contractor shall implement an initiative to re-test the Health Care Finder (HCF) capability to facilitate access to urgent care and potentially decrease Emergency Room (ER) usage for truly non-emergent care needs. An evaluation of the initiative will be accomplished one year after implementation. Three MTFs from each region (one from each Service) have been selected for this initiative. MTFs selected for the North Region include [Joint Base-McGuire-Dix-Lakehurst](#), Fort Lee, and Patuxent River Naval Air Station (NAS). MTFs selected for the South Region include Dyess AFB, Fort Stewart, and Naval [Branch Health Clinic, Albany](#). MTFs selected for the West Region include Luke AFB, Fort Riley, and Naval Station [Fallon](#).

**1.3.2** For the aforementioned MTFs, the contractor, through HCF functionality, shall receive and accept calls directly from eligible MTF Prime enrollees requesting authorization for urgent care

which has not been MTF-referred due to after-hours or out-of-area scenarios. Both urgent and emergent requests by a beneficiary shall be authorized to ensure that a POS charge is not inadvertently charged for a beneficiary's perceived emergent need that on claim adjudication is actually an urgent care need based on TRICARE Policy Manual (TPM), Chapter 2, Section 6.1 and 32 CFR 199.

**1.3.2.1** If the caller is an MTF Prime enrollee requesting after-hours authorization for care while physically present in the PSA of the MTF to which he/she is enrolled, the care shall be authorized in accordance with the MOU established between the designated MTF and the appropriate regional contractor.

**1.3.2.2** If the caller is traveling out of his/her PSA (anywhere in the Continental United States (CONUS), including Hawaii and Alaska), the care shall be authorized and provider locator services shall be provided if a prudent person would consider the care request to be urgent. If the requested care authorization is outside the contractor's own region, the contractor is to communicate with the contractor with responsibility for the care delivery per paragraph 6.1.2.

**1.3.2.3** HCFs assisting beneficiaries with urgent care needs are not required to have professional clinical qualifications. The contractor will ensure that the HCF lines are manned at a minimum from 3:00 pm to 8:00 pm on weekdays, 8:00 am to 8:00 pm on weekends, holidays and days the MTFs are closed at the discretion of the MTF commander. Callers seeking authorization for routine care shall be referred back to their MTF of enrollment for instructions.

**1.3.3** Contractors shall ensure that after-hours urgent care authorizations are entered into the claims processing system, so that POS provisions are not applied to a service for which the HCF has issued an urgent care authorization. On the MTF's next business day, the contractor shall send notification to the appropriate designated MTF which shows all urgent care authorizations approved for that MTF's Prime enrollees. At a minimum, information shall include:

- Patient Name;
- Patient Date of Birth (DOB);
- Patient Address;
- DEERS Benefits Number;
- Chief Complaint;
- Type of Request (after-hours or out-of-area);
- Date Authorization Issued;
- Authorization Number; and
- Provider Authorized To (if available).

## 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 TRICARE Management Activity (TMA). 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 TMA-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 TMA, Beneficiary and Provider Services (BPS) Division. 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 contractor's claims processing system to ensure the appropriate adjudication of claims.