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TRICARE  
MANAGEMENT ACTIVITY

OD

CHANGE 8  
6010.56-M  
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**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL  
FOR  
TRICARE OPERATIONS MANUAL (TOM)**

The TRICARE Management Activity has authorized the following addition(s)/revision(s) to 6010.56-M, issued February 2008.

**CHANGE TITLE:**      **PREAUTHORIZATION FOR VETERANS AFFAIRS (VA) CARE FOR ACTIVE DUTY SERVICES MEMBERS (ADSMs) ON TERMINAL LEAVE**

**PAGE CHANGE(S):**    See page 2.

**SUMMARY OF CHANGE(S):**    This change requires all routine or urgent outpatient primary medical care by the VA to ADSMs on terminal leave to be preauthorized by the Military Treatment Facility (MTF). This change brings this manual up-to-date with published Change 79 (June 1, 2009) to the August 2002 TRICARE Operations Manual 6010.51-M.

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

**Reta Michak**  
**Director, Operations Division**

**ATTACHMENT(S):**    **7 PAGES**  
**DISTRIBUTION:**     **6010.56-M**

**CHANGE 8**  
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**REMOVE PAGE(S)**

**CHAPTER 8**

Section 5, pages 3 through 6

**CHAPTER 17**

Section 1, pages 1 and 2

**INSERT PAGE(S)**

Section 5, pages 3 through 6

Section 1, pages 1 through 3

# TRICARE Operations Manual 6010.56-M, February 1, 2008

## Chapter 8, Section 5

### Referrals/Preauthorizations/Authorizations

**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 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.

<b>REQUIRED DATA ELEMENT*</b>	<b>DESCRIPTION/PURPOSE/USE</b>
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)

**TRICARE Operations Manual 6010.56-M, February 1, 2008**

Chapter 8, Section 5

Referrals/Preauthorizations/Authorizations

REQUIRED DATA ELEMENT*	DESCRIPTION/PURPOSE/USE
<b>PATIENT INFORMATION</b>	
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)
<b>CLINICAL INFORMATION</b>	
Patient Primary Provisional Diagnosis	Description
Reason for Request	Sufficient Clinical Info to Perform Medical Necessity Report (MNR)
<b>SERVICE</b>	
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 4.5](#), 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.
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.

**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.

## TRICARE Operations Manual 6010.56-M, February 1, 2008

### Chapter 8, Section 5

#### Referrals/Preauthorizations/Authorizations

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**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. 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.

**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 in accordance with the following procedures.

**6.2.1** The contractor shall fax, or send via 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 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.

**6.2.2** 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 6.2.1](#), 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 ROFR request in one business day as defined above, the contractor shall process the referral request as if the MTF declined to see the patient. The contractor shall provide each MTF with a report of the number of referrals forwarded based on the ROFR provision.

**6.2.3** The contractor shall contact the MTF POC for the coordination of same day and 72-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.

**6.2.4** The ROFR will be forwarded for only those beneficiaries residing within the PSA 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. 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.

**6.2.5** In instances where the MTF elects to accept the patient, the MTF will advise the MCSC within one business day, 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.

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## General

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### 1.0 INTRODUCTION

**1.1** The Supplemental Health Care Program (SHCP), with specific exceptions discussed in this chapter, allows for payment of claims for civilian services rendered pursuant to a referral by a provider in a Military Treatment Facility (MTF), as well as for Civilian Health Care (CHC) received in the United States by eligible Uniformed Service members. The SHCP exists under authority of 10 USC 1074(c) and [32 CFR 199.16\(a\)\(3\)](#). The use of the SHCP for pay for care referred by MTF providers is governed by Assistant Secretary of Defense (Health Affairs) (ASD(HA)) Policy Memorandum 96-005, "Policy on Use of Supplemental Care Funds by the Military Departments" (October 18, 1995). That policy states, in pertinent part:

"Circumstances where supplemental funds may be used to reimburse for care rendered by non-governmental health care providers to non-active duty patients are limited to those where a medical treatment facility (MTF) provider orders the needed health care services from civilian sources for a patient, and the MTF provider maintains full clinical responsibility for the episode of care. This means that the patient is not disengaged from the MTF that is providing the care."

**1.2** Eligible Active Duty Service Members (ADSMs) may include members in travel status (leave, TDY/TAD, permanent change of station), Navy/Marine Corps service members enrolled to deployable units and referred by the unit Primary Care Manager (PCM) (not an MTF), eligible Reserve Component (RC) personnel, Reserved Officer Training Corps (ROTC) students, cadets/midshipmen, and eligible foreign military.

**1.3** The provisions of this Chapter do not apply to services rendered to enrollees in the TRICARE Prime Remote program (see [Chapter 16](#)) or to ADSMs enrolled overseas (see [Chapter 24](#)).

**1.4** The fact that civilian services have been rendered to an individual who is enrolled to an MTF PCM does not mean that those services were MTF referred care. If a claim is received for an ADSM MTF enrollee and no authorization is on file, the MTF must be contacted to determine if the care was MTF referred.

### 2.0 SERVICE POINT OF CONTACT (SPOC)/MILITARY SERVICE PARTICIPATION

**2.1** For care that is not referred by an MTF, the SPOC for members of the Army, Air Force, Navy, Marine Corps, and Coast Guard will be the Military Medical Support Office (MMSO). The MMSO is established to provide a means to identify, manage and provide medical oversight of CHC furnished to service members. MMSO's functions include preauthorization of care when required, medical oversight for specialty care, the coordination and management of civilian routine and emergency hospital admissions; the initiation or coordination of medical boards; and the coordination of other military personnel-related actions. The Public Health Service (PHS) and

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National Oceanic and Atmospheric Administration (NOAA) have their own SPOCs for their service members. A list of Uniformed Service SPOCs is provided in [Addendum A](#). The SPOCs will interact directly with the Managed Care Support Contractor (MCSC) using telephone, facsimile and automation links when available. [Addendum B](#) describes the protocols and procedures for coordination of authorizations with MMSO.

**2.2** Contractors will also receive claims for MTF patients who may require medical care that is not available at the MTF (e.g., MRI) and the MTF refers a patient for civilian medical care (this include all civilian care provided to an ADSM MTF enrollee). In these cases, the contractor shall contact the referring MTF for any necessary medical oversight or authorization of care.

### **3.0 CONTRACTOR RESPONSIBILITIES**

**3.1** The contractor shall provide payment for inpatient and outpatient services, for MTF-referred civilian care within the 50 United States and the District of Columbia ordered by an MTF provider for an MTF patient for whom the MTF provider maintains responsibility. After payment of the claim, the contractor shall furnish the Services with information regarding payment of the claim as specified in the contract.

**3.2** The contractor shall provide payment for inpatient and outpatient medical services for CHC received in the 50 United States and the District of Columbia by eligible uniformed service members in accordance with the provisions of this chapter. After payment of the claim, the contractor shall furnish reports as specified in the contract.

### **4.0 SHCP DIFFERENCES**

**4.1** ADSMs have no cost-shares, copayments or deductibles. If they have been required by the provider to make "up front" payment they may upon approval be reimbursed in full for amounts in excess of what would ordinarily be reimbursable under TRICARE. Application of Other Health Insurance (OHI) is generally not considered (see [Section 3, paragraph 1.2.3](#)).

**4.2** Non-Availability Statement (NAS) requirements do not apply.

**4.3** If Third Party Liability (TPL) is involved in a claim, claim payment will not be delayed while the TPL information is developed (see [Section 3, paragraph 1.3](#)).

**4.4** The contractor shall provide MTF-referred patients the full range of services offered to TRICARE Prime enrollees.

**4.5** If an ADSM intends, while in a terminal leave status, to reside outside of the Prime Service Area (PSA) of the MTF where the ADSM is enrolled, the MTF shall issue to the TRICARE MCSC a single preauthorization for the ADSM to obtain from the Department of Veterans Affairs (DVA) any routine or urgent outpatient primary medical care that should be required anytime during the terminal leave period, except the preauthorization shall not apply to services provided under the terms of the Department of Defense (DoD)/DVA Memorandum Of Agreement (MOA) for "Medical Treatment Provided to Active Duty Service Members with Polytrauma Injury, Spinal Cord Injury, Traumatic Brain Injury or Blindness." Claims from the DVA for services provided under terms of the MOA shall be processed as specified in [Section 2, paragraph 3.0](#). The MCSC shall process a claim received from the DVA for services provided within the scope of the preauthorization using the standards in

Chapter 1 unless otherwise stated in this chapter. The claims tracking and retrieval requirements of Chapter 1, Section 3, paragraph 2.1 apply equally to such SHCP claims. The contractor for the region in which the patient is enrolled shall process the claim to completion.

## 5.0 SERVICE PROJECT OFFICERS

Each Service will designate a Service Project Officer to be the Service's official POC with TMA and the contractor to resolve any overall service-related matters regarding the program (refer to [Addendum A](#) for the list of Service Project Officers).

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