



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY  
AURORA, COLORADO 80011-9066

TRICARE  
MANAGEMENT ACTIVITY

**MB&RB**

**CHANGE 142  
6010.54-M  
JUNE 24, 2011**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL  
FOR  
TRICARE POLICY MANUAL (TPM), AUGUST 2002**

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

**CHANGE TITLE: SKILLED NURSING FACILITY (SNF) CARE PREAUTHORIZATION  
REQUIREMENT FOR DUAL ELIGIBLE BENEFICIARIES**

**CONREQ: 15000**

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

**SUMMARY OF CHANGE(S): This change adds language requiring preauthorization for SNF care for TRICARE dual eligibles in the U.S. and U.S. territories beginning on day 101, when TRICARE becomes primary payer.**

**EFFECTIVE DATE: April 1, 2010.**

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

**This change is made in conjunction with Aug 2002 TOM, Change No. 123 and Aug 2002 TRM, Change No. 134.**

**Ann N. Fazzini  
Chief, Medical Benefits and  
Reimbursement Branch**

**ATTACHMENT(S): 6 PAGE(S)  
DISTRIBUTION: 6010.54-M**

**CHANGE 142**  
**6010.54-M**  
**JUNE 24, 2011**

**REMOVE PAGE(S)**

**CHAPTER 1**

Section 7.1, pages 1 and 2

**CHAPTER 12**

Section 8.1, pages 1 and 2

Section 10.1, pages 1 and 2

**INSERT PAGE(S)**

Section 7.1, pages 1 and 2

Section 8.1, pages 1 and 2

Section 10.1, pages 1 and 2

## SPECIAL AUTHORIZATION REQUIREMENTS

ISSUE DATE: August 4, 1988

AUTHORITY: [32 CFR 199.4\(a\)\(12\)](#), [32 CFR 199.5\(h\)\(3\)](#) and [32 CFR 199.15\(b\)\(4\)](#)

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### I. POLICY

Unless otherwise specifically excepted, the adjudication of the following types of care is subject to the following authorization requirements:

- A. Adjunctive dental care must be preauthorized.
- B. Dental anesthesia and institutional benefit must be preauthorized. See [Chapter 8, Section 13.2, paragraph II.E.](#)
- C. Extended Care Health Option (ECHO) benefits must be authorized in accordance with [Chapter 9, Section 4.1.](#)
- D. Effective October 1, 1991, preadmission and continued stay authorization is required before nonemergency inpatient mental health services may be cost-shared (includes Residential Treatment Center (RTC) care and alcoholism detoxification and rehabilitation). Effective September 29, 1993, preadmission and continued stay authorization is also required for all care in a Partial Hospitalization Program (PHP).
- E. Effective November 18, 1991, psychoanalysis must be preauthorized.
- F. The Executive Director, [TRICARE Management Activity \(TMA\)](#), or designee, may require preauthorization of admission to inpatient facilities.
- G. Organ and stem cell transplants are required to be preauthorized. For organ and stem cell transplants, the preauthorization shall remain in effect as long as the beneficiary continues to meet the specific transplant criteria set forth in this Policy Manual, or until the approved transplant occurs.
- H. Effective for dates of service **June 1, 2010**, Skilled Nursing Facility (SNF) care received in the U.S. and U.S. territories must be preauthorized for TRICARE dual eligible beneficiaries. The TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) contractor will preauthorize SNF care beginning on day 101, when TRICARE becomes primary payer. For those beneficiaries inpatient on the effective date, a preauthorization will be required August 1, 2010. See the TRICARE Operations Manual (TOM), [Chapter 7, Section 2](#) and the TRICARE Reimbursement Manual (TRM), [Chapter 8, Section 2.](#)

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CHAPTER 1, SECTION 7.1

SPECIAL AUTHORIZATION REQUIREMENTS

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I. Each TRICARE Regional Managed Care Support Contractor (MCSC) may require additional care authorizations not identified in this section. Such authorization requirements may differ between regions. Beneficiaries and providers are responsible for contacting their contractor for a listing of additional regional authorization requirements.

NOTE: When a beneficiary has “other insurance” that provides primary coverage, preauthorization requirements in paragraph I.I. will not apply. Any medically necessary reviews the MCSC believes are necessary, to act as a secondary payor, shall be performed on a retrospective basis. The conditions for applying this exception are the same as applied to the Non-Availability Statement (NAS) exception in Chapter 1, Section 6.1, paragraph III.A.

J. Provider payments are reduced for the failure to comply with the preauthorization requirements for certain types of care. See the TRM, Chapter 1, Section 28.

II. EXCEPTIONS

A. For Dual Eligible beneficiaries, these requirements apply when TRICARE is primary payer. As secondary payer, TRICARE will rely on and not replicate Medicare’s determination of medical necessity and appropriateness in all circumstances where Medicare is primary payer. In the event that TRICARE is primary payer for these services and preauthorization was not obtained, the contractor will obtain the necessary information and perform a retrospective review.

B. The requirement that a TRICARE Prime enrollee obtain a referral/authorization from their Primary Care Manager (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. Point Of Service (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.

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## AUTHORIZATION REQUIREMENTS

ISSUE DATE:

AUTHORITY: [32 CFR 199.17](#)

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### I. POLICY

Each TOP TRICARE Area Office (TAO) Director may require authorizations. Such authorization requirements may differ between TOP regions. Beneficiaries and providers are responsible for contacting their TOP TAO Director or Health Care Finder (HCF) for a listing of TOP regional authorization requirements. Unless otherwise specifically excluded in this chapter, the adjudication of the following types of care requires TOP authorization/preauthorization.

A. Overseas Extended Care Health Option (ECHO) benefits must be authorized by the TOP TAO Director or designee, prior to receiving the ECHO benefit.

B. TOP non-enrollees do not require pre-authorization/authorization for care except for non-emergent inpatient mental health services (pre-admission and continued stay).

C. TOP Prime enrollees (other than TGRO/TPRC) are required to obtain authorization for care rendered in the following countries: Belgium, Germany, Guam, Iceland, Italy, Japan, Korea, Portugal (Azores), Spain, Turkey and the United Kingdom. Determination of overseas countries requiring authorization for care will be made by the appropriate overseas TAO Director or designee.

D. TOP **Active Duty Service Member (ADSM)** urgent/emergent care received in the continental United States (CONUS) does not require authorization. Authorization is required for all non-emergent/urgent care received in CONUS, including non-emergent/urgent inpatient mental health care. TOP ADSM claims for non-emergent/urgent care obtained in CONUS should only be paid when accompanied by the appropriate payment authorization forms (SF1034 or NAVMED6320/10).

E. TOP enrolled **Active Duty Family Members (ADFM)**s are not required to obtain authorization for CONUS non-emergent/non-urgent care except for CONUS non-emergent/urgent inpatient mental health care.

F. For TOP Prime ADFMs and TOP Standard beneficiaries, CONUS non-emergent inpatient mental health pre-authorizations/authorizations will be performed by the mental health review contractor. Claims for drugs, radiological diagnostics (excluding **Magnetic Resonance Imaging (MRI)** and **Positron Emission Tomography (PET)** scans), and ancillary

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CHAPTER 12, SECTION 8.1

AUTHORIZATION REQUIREMENTS

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services obtained from OCONUS providers are exempt from the TOP authorization requirements.

G. TRICARE Global Remote Overseas (TGRO) and TRICARE Puerto Rico Contract (TPRC) healthcare contractor claims do not require authorization by the overseas claims processing contractor responsible for processing overseas claims.

H. Effective for dates of service **June 1, 2010**, Skilled Nursing Facility (SNF) care received in the U.S. and U.S. territories must be preauthorized for TRICARE dual eligible beneficiaries. The dual eligible contractor will preauthorize SNF care beginning on day 101, when TRICARE becomes primary payer.

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## PAYMENT POLICY

ISSUE DATE:

AUTHORITY: [32 CFR 199.17](#)

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### I. POLICY

A. With the exception of all hospital inpatient and professional charges in Philippines and Panama subject to the foreign fee schedule, Puerto Rico, and prescription drugs, reimbursement of all other TOP beneficiary claims for overseas health care shall be based upon the billed charges. (See [Chapter 12, Section 11.1](#), TRICARE Reimbursement Manual (TRM), Chapter 1, [Sections 34](#) and [35](#), for additional guidelines). Puerto Rico claims shall be reimbursed following continental United States (CONUS) reimbursement guidelines.

B. Payment of Skilled Nursing Facility (SNF) claims from Puerto Rico and the U.S. Territories (Guam, the U.S. Virgin Islands, and American Samoa) shall be processed as routine foreign claims and shall be subject to the Prospective Payment System (PPS), as required under Medicare in accordance with the Social Security Act. These SNFs will be subject to the same rules as applied to SNFs in the U.S. (see the TRM, [Chapter 8](#)):

1. Preauthorization is not a requirement for SNF care. TRICARE contractors, at their discretion, may conduct concurrent or retrospective review for Standard and TRICARE for Life (TFL) patients when TRICARE is the primary payer. The review required for the lower 18 Resource Utilization Groups (RUGs) for services prior to October 1, 2010, and the lower 14 RUGs for services on/after October 1, 2010, are a requirement for all TRICARE patients when TRICARE is primary (see TRM, [Chapter 8, Section 2, paragraph IV.C.16.](#)). There will be no review for Standard or TFL patients where TRICARE is the secondary payer. The existing referral and authorization procedures for Prime beneficiaries will remain unaffected.

2. Beneficiaries in the lower 18 or 14 RUGs depending on date of service do not automatically qualify for SNF coverage. These beneficiaries will be individually reviewed to determine whether they meet the criteria for skilled services and the need for skilled services (see the TRM, [Chapter 8, Section 2](#)). If these beneficiaries do not meet these criteria, the SNF PPS claim shall be denied.

3. The TRICARE Managed Care Support Contractor (MCSC), South Region (hereinafter known as “overseas claims processing contractor”), at their own discretion, may collect MDS assessment data per the TRM, [Chapter 8, Section 2](#). **The TOP contractor assumed responsibilities for all overseas claims effective September 1, 2010.**

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CHAPTER 12, SECTION 10.1

PAYMENT POLICY

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4. The overseas claims processing contractor shall be responsible to enter into participation agreements with SNFs in Puerto Rico, Guam, the U.S. Virgin Islands, and American Samoa.

5. The overseas claims processing contractor, at their own discretion, may conduct any data analysis to identify aberrant SNF PPS providers or those providers who might inappropriately place TRICARE beneficiaries in a high RUG. The contractor shall also assist the TRICARE Area Office (TAO) Directors in obtaining/providing SNF data, for conducting any SNF PPS data analysis they deem necessary.

C. Balance billing provisions do not apply to TOP beneficiary claims for TOP overseas health care paid as billed.

D. For health care rendered in Puerto Rico and in the U.S., reimbursement for all TOP beneficiary care shall follow the TRICARE payment policies except as outlined in [paragraph I.E.](#)

E. Non-assigned provider claims for active duty service member (ADSM) CONUS health care shall be paid following normal TRICARE CONUS reimbursement rules for institutional and non-institutional care. The contractor shall make every effort to obtain the provider's agreement to accept, as payment in full, first a rate within the 100% CHAMPUS Maximum Allowable Charge (CMAC) limitation and then second, a rate between 100 and 115% of CMAC. If the latter is not feasible, the contractor shall determine the lowest acceptable rate that the provider will accept. The contractor shall then request a waiver of CMAC limitation from the TAO Director, as the designee of the Chief Operating Office (COO), TRICARE Management Activity (TMA), to ensure that the patient does not bear any out-of-pocket expense. The waiver request shall include the patient name, ADSM's location, services requested (CPT-4) codes, CMAC rate, billed charge, and anticipated negotiated rate. The contractor must obtain approval from the TAO Director before the negotiation can be concluded. The contractors shall ensure that the approval payment is annotated in the authorization/claims processing system, and that payment is issued directly to the provider, unless there is information presented that the ADSM has personally paid the provider.

1. TOP ADSM who have been required by the provider to make "up front" payment at the time services are rendered will be required to submit a claim to the contractor with an explanation and proof of such payment. If the claim is payable, the contractor shall allow the billed amount and reimburse the ADSM for charges on the claim. After processing the claim, the contractor shall initiate recoupment action from the non-participating provider for any amount above the maximum allowed by law.

2. In no case shall a uniformed service member be subjected to "balance billing" or ongoing collection action by a civilian provider for emergency or authorized care. If the contractor becomes aware of such situations that they cannot resolve, they shall pend the file and forward the issue to the appropriate TAO Director. The appropriate TAO Director will issue an authorization to the contractor for payments in excess of CMAC or other applicable TRICARE payment ceilings, provided the TAO Director has requested and has been granted a waiver from the COO, TMA, or designee.