CHAPTER 1
SECTION 6.1

NONAVAILABILITY STATEMENT (DD FORM 1251) FOR INPATIENT CARE

ISSUE DATE: February 16, 1983
AUTHORITY: 32 CFR 199.4(a)(9) and 32 CFR 199.7(a)(7)

I. DEFINITION

A valid Nonavailability Statement (NAS) is an official Department of Defense document (DD Form 1251 (Figure 1-6.1-1)) issued by the commander (or a designee) of a Uniformed Services Medical Treatment Facility (MTF) which certifies that a specific medical service was not available to a non-enrolled beneficiary at, or through, the MTF at the time the beneficiary sought the service.

II. POLICY

A. Effective for admissions on or after December 28, 2003, the NAS requirement is eliminated except for mental health admissions. A claim shall not be paid for nonemergency inpatient mental health care rendered to a non-enrolled beneficiary who resided at the time the care was rendered within a U.S. Postal Service Zip Code area listed as a part of an MTF catchment area in the zip code directory, unless the NAS authorization resides on the Enterprise Wide Referral and Authorization System (EWRAS) or the claim is accompanied by a valid NAS or, in the case of an electronic media claim (EMC) or CMS 1450 UB-40 claim, there is an endorsement on the claim that the NAS is on file with the provider. See paragraph III. EXCEPTIONS, below. For overseas NAS procedures, authorization and referral requirements, including requirements for EWRAS, see Chapter 12, Section 2.1 and 12.1.

B. NAS for Maternity Care. For any maternity episode wherein the first prenatal visit occurs on or after December 28, 2003, no NAS is required. For a maternity episode wherein the first prenatal visit occurs between October 5, 1999 through December 27, 2003, for a beneficiary who lives in an MTF catchment area zip code and who is not enrolled in TRICARE Prime, an NAS shall be required for TRICARE/CHAMPUS cost-share of nonemergency health care services related to outpatient prenatal, outpatient or inpatient delivery, and outpatient postpartum care subsequent to the visit which confirms the pregnancy. Maternity services provided in a birthing center or at home shall also require an NAS for those maternity episodes wherein the first prenatal visit occurs between October 5, 1999 through December 27, 2003. An NAS shall not be required for a beneficiary who has other health insurance for primary coverage. The maternity NAS shall be subject to the same requirements as provided in paragraph II.A.

C. NAS for Newborns. No NAS will be required for newborns with admission or birth date of December 28, 2003, or after. For newborns with date of birth or admission prior to December 28, 2003, see paragraph II.G.4.

D. An NAS is not an authorization for TRICARE benefits. An NAS in no way authorizes the listed service or services as a TRICARE benefit.

E. Requirements for NAS. The policy in effect at the time the care is rendered apply in determining the applicable requirements for the NAS. The authority for issuing an NAS is limited to an MTF commander (or the commander's designee). The DoD Instruction 6015.23, "Delivery of Healthcare at Military Treatment Facilities: Foreign Service Care: Third-Party Collection; Beneficiary Counseling and Assistance Coordinators (BCACs)" (Figure 1-6.1-2) applies to NAS for inpatient mental health care.

F. Waiver to NAS Elimination Requirement. With the exception of maternity care, the ASD(HA) may require NASs for other than mental health services when:

1. Significant costs would be avoided by performing specific procedures at the affected MTFs, or

2. Specific procedures must be provided at the affected MTFs to ensure proficiency levels of the practitioners, or

3. The lack of NAS data would significantly interfere with TRICARE contract administration.

In exercising the above authority, the ASD(HA) must give 60-day notice to the Armed Services Committees of the House and the Senate and publish a notice in the Federal Register. The MTF, the TRICARE Region, and the contractors must publicize any NAS requirements to the affected beneficiaries.

G. NAS Validity.

1. An NAS is valid for a medically necessary hospital admission which occurs within 30 calendar days of issuance. The NAS shall remain valid from the date of admission until 15 days after discharge for any follow-on treatment which is directly related to the admission.

2. An NAS is valid for the adjudication of TRICARE claims for all related care otherwise authorized which is received from a civilian source while the beneficiary resided within the MTF catchment area which issued the NAS.

3. For **maternity** episodes wherein the first prenatal visit occurs between October 5, 1999 to December 27, 2003, or before March 26, 1998, for the purposes of NAS validity, the date of admission is the date when the patient entered into the prenatal care program with a civilian provider. For these episodes, the maternity NAS should be issued no earlier than 30 days before the first prenatal visit. The maternity NAS shall remain valid until 42 days following termination of the pregnancy.

4. For newborns with date of birth or admission before December 28, 2003. For **newborn care**, in the event that a non-enrolled newborn infant remains in the hospital continuously after the discharge of the mother, the mother's NAS shall be deemed valid for the infant in the same hospital for up to 15 days after the mother's discharge. Beyond this 15-day limit, a claim for nonemergency inpatient care requires a valid NAS in the infant's name. Also, see paragraph III.H.

5. Chronic care admissions before December 28, 2003. In cases of multiple inpatient admissions for the same diagnosis, an NAS may be issued for an entire episode of treatment, valid for a one year period from the date of issuance (e.g., inpatient chemotherapy or dialysis, etc.).

H. A retroactively issued NAS is issued only if the services listed could not have been rendered in the MTF, or it would have been medically inappropriate to have sought MTF admission at the time services were delivered in the civilian sector.

I. Knowledge of NAS requirement. A beneficiary is responsible for determining if an NAS is required for his or her area of residence and for obtaining one, if required, by first seeking nonemergency care in the responsible MTF.

J. Traveling Beneficiary. The requirement for an NAS applies to a nonemergency mental health admission while the non-enrolled beneficiary is away from his or her residence.

K. Related Claims. A copy of the NAS valid for a specific mental health admission is required for any inpatient services claim (institutional, professional or ancillary service claim) related to that admission or the claim must be associated with the previously submitted inpatient hospital claim and its required NAS.

III. EXCEPTIONS

A. When a beneficiary has "other health insurance" that provides primary coverage, an NAS is not required for nonemergency services provided to a beneficiary who resides within an MTF catchment area. The conditions for applying this provision are:

1. The "other health insurance" must be primary under the provisions of TRICARE Reimbursement Manual, Chapter 4, Section 1.

2. Documentation that the "other health insurance" processed the claim and of the exact amount paid must be submitted with the TRICARE claim.

3. For NAS purposes, the "other health insurance" must be a medical-hospital-surgical plan which at least covers inpatient hospitalization of the beneficiary.

4. For non-enrolled newborns with date of birth or admission before December 28, 2003. When the mother's "other health insurance" does not cover the newborn, an NAS will not be required for the first three days of newborn care. If a newborn becomes a patient in his or her own right, the NAS requirement applies. Also, see paragraph III.H.

B. Emergency. An NAS is not required to adjudicate a claim for an emergency. See Chapter 2, Section 6.1 to determine what constitutes an emergency.

C. CHAMPVA. Civilian Health and Medical Program of the Veterans Administration (CHAMPVA) beneficiaries are not subject to the NAS requirements since they are not eligible for MTF care.

D. Active-duty-mother's newborn with date of birth or admission before December 28, 2003. If an active duty service member is admitted and gives birth in a civilian hospital, the newborn infant is deemed to be enrolled in Prime for 120 days and there will be no NAS required while the infant is deemed to be enrolled in Prime.

E. Illegitimate Newborn of Active-Duty Father and Ineligible Mother with Date of Birth or Admission Before December 28, 2003. The NAS requirements for the illegitimate newborn (who qualifies as an eligible TRICARE beneficiary) of an active-duty father and an ineligible mother are the same as for newborns of active duty mothers (see paragraph III.D.).

F. Illegitimate Newborn of Retiree Father and Ineligible Mother with Date of Birth or Admission Before December 28, 2003. If the ineligible mother is admitted and gives birth in a civilian hospital, an NAS for the illegitimate non-enrolled newborn (who qualifies as an eligible TRICARE beneficiary) is not required if the newborn's stay does not exceed 3 days.

G. Specific Programs.

An NAS is not required for care rendered by the following providers or programs:

- External Resource-Sharing
- Extended Care Health Option (ECHO)
- Residential Treatment Centers (RTC)
- Skilled Nursing Facilities (SNF)
- Student Infirmaries
- Substance Use Disorder Rehabilitation Facilities (SUDRF)

H. An NAS is not required for beneficiaries who are enrolled in TRICARE Prime even when these beneficiaries use the POS option. Prime enrollees are subject to the referral and authorization requirement.

NOTE: Newborns born into active duty service member families or retiree families where one parent/family member is enrolled in TRICARE Prime are deemed enrolled in Prime for 60 days and no NAS is required for such newborns. The TRICARE Regional Director of each TRICARE Regional Office and Deputy Director of each TRICARE Area Office are granted the authority to extend the deemed period up to 120-days, on a case-by-case or regional basis.

FIGURE 1-6.1-1 DD 1251 (SAMPLE)

UNIFORMED SERVICES MEDICAL TREATMENT FACILITY **NONAVAILABILITY STATEMENT (NAS)**	REPORT CONTROL SYMBOL

Privacy Act Statement

AUTHORITY: 44 USC 3101, 41 CFR 101 et seq., 10 USC 1066 and 1079, and EO 9397, November 1943 (SSN).

PRINCIPAL PURPOSE: To evaluate eligibility for civilian health benefits authorized by 10 USC, Chapter 55, and to issue payment upon establishment of eligibility and determination that the medical care received is authorized by law. The information is subject to verification with the appropriate Uniformed Service.

ROUTINE USE: CHAMPUS and its contractors use the information to control and process medical claims for payment; for control and approval of medical treatments and interface with providers of medical care; to control and accomplish reviews of utilization; for review of claims related to possible third party liability cases and initiation of recovery actions; and for referral to Peer Review Committees or similar professional review organizations to control and review providers' medical care.

DISCLOSURE: Voluntary; however, failure to provide information will result in denial of, or delay in payment of, the claim.

1. NAS NUMBER *(Facility) (Yr-Julian) (Seq. No.)*	2. PRIMARY REASON FOR ISSUANCE *(X one)*	
		a. PROPER FACILITIES ARE TEMPORARILY NOT AVAILABLE IN A SAFE OR TIMELY MANNER
3. MAJOR DIAGNOSIC CATEGORY FOR WHICH NAS IS ISSUED *(Use code from reverse)*		b. PROFESSIONAL CAPABILITY IS TEMPORARILY NOT AVAILABLE IN A SAFE OR TIMELY MANNER
		c. PROPER FACILITIES OR PROFESSIONAL CAPABILITY ARE PERMANENTLY NOT AVAILABLE AT THIS FACILITY
		d. IT WOULD BE MEDICALLY INAPPROPRIATE TO REQUIRE THE BENEFICIARY TO USE THE MTF *(Explain in Remarks)*

4. PATIENT DATA		
a. NAME *(Last, First, Middle Initial)*	b. DATE OF BIRTH *(YYMMDD)*	c. SEX
d. ADDRESS *(Street, City, State, and ZIP Code)*	e. PATIENT CATEGORY *(X one)*	f. OTHER NON CHAMPUS HEALTH INSURANCE *(X one)*
	(1) Dependent of Active Duty	
	(2) Dependent of Retiree	(1) Yes, but only CHAMPUS Supplemental
	(3) Retiree	
	(4) Survivor	(2) Yes *(List in Remarks)*
	(5) Former Spouse	(3) No

5. SPONSOR DATA *(if you marked 4e(3) Retiree above, print "Same" in 5a.)*	
a. NAME *(Last, First, Middle Initial)*	b. SPONSOR'S OR RETIREE'S SOCIAL SECURITY NO.

6. ISSUING OFFICIAL DATA		
a. NAME *(Last, First, Middle Initial)*	b. TITLE	
c. SIGNATURE	d. PAY GRADE	e. DATE ISSUED *(YYMMDD)*

7. REMARKS *(Indicate block number to which the answer applies.)*

DD Form 1251, JUL 91

Outside the United States and Puerto Rico, previous editions may be used until exhausted
Inside the United States and Puerto Rico, previous editions are obsolete

FIGURE 1-6.1-1 DD 1251 (SAMPLE) (CONTINUED)

INSTRUCTIONS TO THE PATIENT
Concerning use by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)

1. The medical care requested is not available to you at a Uniformed Services Medical Treatment Facility (USMTF) in this area.

2. This form does NOT guarantee that CHAMPUS will cost share your care.

a. If you receive medical care from civilian sources and such care is determined to be authorized care under CHAMPUS, it will be cost shared by the Government to the extent that the program permits, provided such care is not obtained in a facility which discriminates in its admission and treatment practices on the basis of race, color, or national origin.

b. If you receive medical care from civilian sources and it is determined that all or part of the care is not authorized under CHAMPUS, the GOVERNMENT WILL NOT PAY for the unauthorized care.

c. The determination of whether medical care you receive from civilian sources is covered under CHAMPUS can not be made at this time because this determination depends, among other things, upon the care you actually receive and not upon the statement regarding your condition or diagnosis made on this form.

3. This form must be presented with your Uniformed Services Identification and Privilege Card when you obtain civilian medical care. For your claim to be processed, you must be enrolled in the Defense Enrollment Eligibility Reporting System (DEERS).

4. This form is valid only for medical care requested from and determined not available at a Uniformed Services medical treatment facility in this area.

5. An NAS shall normally be valid only for a hospital admission or the indicated outpatient procedure within 30 days of issuance for the specialty code noted on the NAS. For inpatient care, it will remain valid from the date of admission until 15 days after discharge for any other required treatment that is directly related to the original admission, with the following exceptions:

a. In maternity cases, the date of admission is the date when the patient entered into the prenatal care program with a civilian provider, and the maternity NAS shall remain valid for 42 days following termination of the pregnancy. A retroactive NAS may be issued for maternity care, but not a chronic care NAS.

b. If a newborn infant remains in the hospital continuously after the discharge of a CHAMPUS eligible mother, the mother's NAS shall be valid for the infant in the same hospital for up to 15 days after the mother's discharge. Beyond this 15 day limit, the beneficiary must request the issuing facility to make a determination on the availability of care for the infant and to issue an NAS for the infant if the requirements of these instructions are met.

c. If an active duty service member gives birth in a civilian hospital and there are charges for the care of the infant, an NAS is required for the infant if the infant's stay is for four or more days. (At that point, the infant is considered to be a new CHAMPUS eligible patient in his or her own right.)

d. If you do not use this form within 30 days, or if you have questions about the expiration of the form, you should check with you local Health Benefits Advisor (HBA) prior to your admission to the hospital. If you do not use this form, return it to the issuing Uniformed Services medical treatment facility.

6. If you have further questions regarding this form or your CHAMPUS benefits, you should talk with your local Health Benefits Advisor, the CHAMPUS Fiscal Intermediary for your area, or the Beneficiary and Provider Relations Division, Office of CHAMPUS, Aurora, Colorado 80045-6900.

I HAVE REVIEWED AND UNDERSTAND, THE ABOVE INSTRUCTIONS

PATIENT'S SIGNATURE

INSTRUCTIONS FOR COMPLETING DD FORM 1251

This form can be issued only in accordance with the provisions of DoDI 6015.10, "Issuance of Nonavailability Statements," as implemented by the issuing facility's host Service (AR 40-121, NAVMEDCOMINST 6320.3 AFR 168.9, PHS General Circular No. 6, CGCOMDTINST 6320.11b.NOAA CO.4).

The issuing officer or designee should brief the recipient on the instructions to the Patient on the front of this form. However, if the patient is not enrolled in DEERS, and the HBA has reason to believe the individual is entitled to care, issue a "conditional" NAS and advise the patient that the claim will not be considered until the DEERS enrollment is complete.

If the NAS is being issued retroactively (after the date the patient was admitted to the hospital), the last three digits of the NAS Number, Block 1, must be between 900 and 999 and an explanation provided in Block 7, "Remarks." If this condition is not met, the CHAMPUS Fiscal Intermediary will reject the claim.

1. Enter an NAS Number.
   - The first four digits are the Defense Medical Information System (DMIS) facility identifier.
   - The next four digits represent the date the form is issued. It consists of the last digit of the year plus the Julian Date. (For example, if the date is 1 January 1988, these digits would be 8001.)
   - The final three digits are the facility sequence number:
     - Numbers 000 through 699 may be assigned in accordance with the implementing instructions of the issuing facility's host Service.
     - Numbers 700 through 799 are assigned to retroactive chronic care.
     - Numbers 800 through 899 are assigned to NASs issued for chronic care and are valid for one year from date of issuance.
     - Numbers 900 through 999 are assigned to NAS's issued retroactively.
2. Made the appropriate box.
3. Enter the code for the major diagnostic category for which the NAS is being issued from the following list. For further information on what goes into each category, consult the Diagnostic Related Group (DRG) Definitions Manual.

   01 Diseases and Disorders of the Nervous System
   02 Diseases and Disorders of the Eye
   03 Diseases and Disorders of the Ear, Nose and Throat

3. Codes (Cont'd)

   04 Diseases and Disorders of the Respiratory System
   05 Diseases and Disorders of the Circulatory System
   06 Diseases and Disorders of the Digestive System
   07 Diseases and Disorders of the Hepatobiliary System and Pancreas
   08 Diseases of the Musculoskeletal System and Connective Tissue
   09 Diseases of the Skin, Subcutaneous Tissue and Breast
   10 Endocrine, Nutritional and Metabolic Diseases
   11 Diseases and Disorders of the Kidney and Urinary Tract
   12 Diseases and Disorders of the Male Reproductive System
   13 Diseases and Disorders of the Female Reproductive System
   14 Pregnancy, Childbirth and the Puerperium
   15 Normal Newborns and Other Neonates with Certain Conditions Originating in the Perinatal Period
   16 Diseases and Disorders of the Blood and Blood-Forming Organs and Immunological Disorders
   17 Myeloproliferative Disorders and Poorly Differentiated Neoplasms
   18 Infectious and Parasitic Diseases (Systemic and Unspecified Sites)
   19 Mental Diseases and Disorders
   20 Alcohol/Drug Use and Alcohol/Drug Induced Organic Disorders
   21 Injuries, Poisonings, and Toxic Effect of Drugs
   22 Burns
   23 Factors Influencing Health Status and Other Contacts with Health Services
   60 Pediatrics (over 28 days of age)
   61-74 Selected Outpatient Procedures

4a-e. Self -explanatory.

4f. Mark the appropriate box. If `f(2), Yes," is marked, specify the name of the insurance company and the policy number. if available, in Block 7, "Remarks."

5a. Enter the Sponsor's name. If the sponsor is the patient, enter "Same." 5b is self-explanatory.

6a-d. Self-explanatory.

6e. This date should be the same as the date in Block 1 but written in YYMMDD format.

7. Enter remarks as required by these instructions and implementing instructions.

DD Form 1251, JUL 91 (Back)

FIGURE 1-6.1-2 DELIVERY OF HEALTH CARE AT MILITARY TREATMENT FACILITIES (MTFS)

Department of Defense
INSTRUCTION

NUMBER 6015.23
October 30, 2002

ASD(HA)

SUBJECT: Delivery of Healthcare at Military Treatment Facilities: Foreign Service care; Third-Party Collection; Beneficiary Counseling and Assistance Coordinators (BCACs)

References: (a) DoD Instruction 6015.23, "Delivery of Healthcare at Military Treatment Facilities (MTFs)," December 9, 1996 (hereby canceled)
(b) DoD Directive 5136.1, "Assistant Secretary of Defense (Health Affairs)," May 27, 1994
(c) Chapter 55 and Sections 1079(a), 1073, 1095, and 2559 of title 10, United States Code
(d) DoD 5025.1-M, "DoD Directives System Procedures," current edition
(e) through (i), see enclosure 1

1. REISSUANCE AND PURPOSE

This Instruction:

1.1. Reissues reference (a) to implement policy, assign responsibilities and prescribe procedures on provisions of care in the delivery of healthcare at military treatment facilities (MTFs) in the Military Health System.

1.2. Implements policy, assigns responsibilities and prescribes procedures:

1.2.1. On international military reciprocal healthcare agreements.

1.2.2. Under DoD Directive 5136.1 (reference (b)).

1.2.3. On Beneficiary Counseling and Assistance Coordinator responsibilities in accordance with 10 U.S.C. 1095e (reference (c)).

1.3. Authorizes DoD 6015.1-M, "Classification Nomenclature and Definitions Relating to Fixed and Non-fixed MTFs" and DoD 6010.15-M, "Military Treatment Facility Uniform Business Office (UBO)," in accordance with DoD 5025.1-M (reference (d)).

2. APPLICABILITY

This Instruction applies to the Office of the Secretary of Defense, the Military Departments, the Chairman of the Joint Chiefs of Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities in the Department of Defense (hereafter referred to collectively as "the DoD Components").

3. POLICY

It is DoD policy that:

FIGURE 1-6.1-2 DELIVERY OF HEALTH CARE AT MILITARY TREATMENT FACILITIES (MTFS)

3.1. The Secretary of Defense, under Title 10 U.S.C. 1073 (reference (c)), generally administers programs and activities of Chapter 55 of reference (c) for the Armed Forces; under his jurisdiction, the Secretary of Transportation administers such programs and activities for the Coast Guard when the Coast Guard is not operating as a Service in the Navy; and the Secretary of Health and Human Services administers such programs and activities for the Commissioned Corps of the National Oceanic and Atmospheric Administration and for the Commissioned Corps of the U.S. Public Health Service. Reference (b) delegates the Secretary of Defense's authority to the Assistant Secretary of Defense for Health Affairs.

3.2. Under 10 U.S.C. 2559 (reference (c)), the Department of Defense shall make MTF inpatient medical care available without cost (except for a subsistence charge, if it applies) to the foreign force members and their dependents in the United States from countries that have international reciprocal healthcare agreements with the Department of Defense (as determined by the Assistant Secretary of Defense for Health Affairs) and where comparable care is made available to a comparable number of U.S. Military personnel and their dependents in the foreign country. Foreign force members eligible for inpatient care under these criteria are also eligible for supplemental care similar to that which is available for non-active duty patients receiving care in military treatment facilities.

3.3. Foreign force members and their dependents in the United States who do not meet the criteria in paragraph 3.2., and who are otherwise eligible for and receive MTF inpatient and outpatient medical care, must reimburse that facility for such care at the appropriate DoD reimbursement rate.

3.4. Foreign military members and their dependents in the United States who are not covered by an international reciprocal healthcare agreement shall be offered DoD healthcare to the extent authorized by the regulations of the Military Departments.

3.5. Foreign governments may submit requests for international reciprocal healthcare agreements to the Assistant Secretary of Defense for Health Affairs. The request must include:

3.5.1. A description of the foreign country's military healthcare; and

3.5.2. The numbers of foreign military members and dependents expected to be covered by the agreement.

3.6. Foreign personnel subject to North Atlantic Treaty Organization Status of Forces Agreement (SOFA) or countries under the Partnership For Peace SOFA, their dependents and diplomatic personnel accompanying the forces, may receive medical and dental care in Uniformed Service facilities. Outpatient care in facilities of the Uniformed Services is provided at no cost to the covered personnel or sponsoring agency; inpatient care is provided at the appropriate DoD-established reimbursement rate. CHAMPUS/TRICARE Standard coverage is only available for outpatient care.

3.7. The MTF or Unit Commander shall establish and maintain a business office that encompasses Third-Party Collection, Medical Affirmative Claims, and Medical Services Account Programs. The business office shall:

3.7.1. Collect those funds from third-party payers to the fullest extent allowed by law and 32 CFR 220 (reference (e)).

FIGURE 1-6.1-2 DELIVERY OF HEALTH CARE AT MILITARY TREATMENT FACILITIES (MTFS)

3.7.2. Deposit all Third-Party Collection (TPC) Program funds into the appropriations supporting the MTF where the billed service was provided in the fiscal year in which collections were made. These collections shall be available to the local facility of the Uniformed Services responsible for the collections and shall be over and above the facility's direct budget amount in accordance with Title 10, section 1095, Subchapter A, Part II, Chapter 55 (reference (c)).

3.7.2.1 Funds collected under the TPC Program shall be used, except for amounts needed to finance collection activities, to enhance healthcare services.

3.7.2.2 Collect funds through Medical Services Accounts and Medical Affirmative Claims programs. These funds shall be deposited into the appropriations supporting the facility of the Uniformed Service in accordance with DoD and Service-specific guidance.

3.8. MTFs shall issue a non-availability statement (NAS) to non-enrolled (i.e., Standard or Extra) TRICARE beneficiaries for authorized non-emergency inpatient care. In some areas, the Managed Care Support Contractors may issue NASs after reaching a formal agreement with the local MTF Commander (or Commanders) and the appropriate Lead Agent Office. NAS may be issued only when the care required is not available from an MTF and the catchment area includes the beneficiary's current address. Occasionally, the MTF Commander (or designee) may decide it is medically inappropriate for the beneficiary to use the MTF (e.g., a transportation support problem) and issue the NAS on that basis. NAS issuance procedures shall be consistent with NAS requirements in 32 CFR 199.7 (reference (f)).

3.9. In accordance with 10 U.S.C 1095e (reference (c)) and prescribed herein, Lead Agents and MTF Commanders shall establish full-time Beneficiary Counseling and Assistance Coordinator (BCAC) positions at Lead Agent Offices, and either full-time or collateral duty positions at MTFs, as the MTF Commander determines.

4. RESPONSIBILITIES

4.1. The Assistant Secretary of Defense for Health Affairs (ASD(HA)) shall:

4.1.1. Modify, supplement, and monitor compliance with this Instruction.

4.1.2. Determine parity, negotiate, and conclude the requests for reciprocal healthcare agreements.

4.1.3. Be responsible for:

4.1.3.1 Coordinating proposed international reciprocal healthcare agreements with the Under Secretary of Defense for Policy, Under Secretary of Defense (Comptroller), General Counsel of the Department of Defense, and appropriate other DoD Components;

4.1.3.2 Providing copies of concluded agreements to appropriate DoD Components;

4.1.3.3 Furnishing guidance concerning application of the agreements.

4.1.4. Determine that comparable care is available to a comparable number of United States force members and their dependents in the foreign country concerned and that an appropriate international agreement exists with the foreign country.

4.1.5. Act on recommendations for international reciprocal healthcare agreements foreign governments submit, and negotiate and conclude any necessary international agreements, consistent with DoD Directive 5530.3 (reference (g)).

4.1.6. Set policies concerning NASs and catchment areas.

FIGURE 1-6.1-2 DELIVERY OF HEALTH CARE AT MILITARY TREATMENT FACILITIES (MTFS)

4.2. The Secretaries of the Military Departments shall:

4.2.1. Be responsible for reviewing procedures that the Military Departments establish to ensure compliance with this Instruction.

4.2.2. Comply with international reciprocal healthcare agreements.

4.2.3. Budget for the medical and dental care it anticipates furnishing to eligible foreign personnel under its sponsorship in non-military and U.S. Government facilities, other than military. They shall also use payment procedures and rates they use for U.S. personnel.

4.2.4. Ensure that each Commander of an MTF submit, to their respective biometrics agencies, workload information, including live births, admissions and dispositions, days of care, visits, and ancillary services, by the fifth of the next month. The biometrics agencies review it and, if necessary, work with the site to correct it. The MTF shall release the report by the fifteenth of the following month.

4.2.5. Act on requests for changes in clinical services at MTFs as recommended by respective military command authorities and inform the regional Lead Agent regarding these decisions.

4.2.6. Ensure that each Commander of an MTF designates a BCAC, and Alternate BCAC, either full time or as a collateral duty.

4.3. The Director, TRICARE Management Activity (TMA) shall:

4.3.1. Ensure each Lead Agent designates a full-time BCAC and an Alternate BCAC.

4.3.2. Assume responsibility to coordinate with the Services regarding any modifications to that portion of this Instruction dealing with BCAC support.

4.3.3. Ensure toll-free telephone communication between beneficiaries and Lead Agent BCACs.

4.3.4. Ensure Lead Agent BCACs receive the most current TRICARE policy information to help address beneficiary issues and concerns.

4.3.5. Ensure that Lead Agent BCACs receive customer service training.

4.3.6. Ensure that appropriate directorates within TMA provide Lead Agent BCACs with current TRICARE policy information and customer service training.

5. PROCEDURES

5.1. NAS

5.1.1. A NAS is not required when there is a medical emergency, when a beneficiary has another health insurance plan that provides primary coverage for the cost of their medical services, or when the beneficiary is enrolled in TRICARE Prime. For TRICARE Prime enrollees, the primary care manager or healthcare finder shall write a referral. The MTFs, OCONUS Lead Agents, the Military Medical Support Office, or regional managed care support contractors issue a "valid care authorization."

5.1.1.1 Electronically issued NASs shall be valid for thirty (30) days. All issued NASs shall be reported on the Defense Eligibility Enrollment Reporting System or Composite Health Care System.

5.1.1.2 The MTF Commander (or senior designated physician) may issue a NAS retroactively for medical care provided by civilian sources.

FIGURE 1-6.1-2 DELIVERY OF HEALTH CARE AT MILITARY TREATMENT FACILITIES (MTFS)

5.1.2. The MTF Commander (or senior designated physician) shall determine the availability of equitable services provided within the MTF. A decision regarding the medical necessity of each beneficiary's request for inpatient care is not to be a consideration in the issuance of a NAS. The timeframe to issue a NAS, once requested, is the same as the pre-authorization review timeline standards specified in the managed care support contracts.

5.1.3. The first-level appeal for decisions surrounding NAS issuance is the MTF Commander, the second-level appeal is the TRICARE Lead Agent, and the third and final level of appeal is the Service Surgeon General of the sponsor's Service.

6. INFORMATION REQUIREMENTS

The patient care data collected for compliance with this requirement shall be reported using the Report Control Symbol of RCS DD-HA(AR)1453, in accordance with DoD 8910.1-M (reference (h)). Definitions of the data elements and codes must be the same for all three Military Services. New facilities must be given identification codes by the OASD(HA) and properly identified when initially reporting their data. The reporting requirement identified at subparagraph 4.2.4. is exempt from licensing in accordance with section 6 of DoD Directive 8910.1 (reference (i)).

7. EFFECTIVE DATE

This Instruction is effective immediately.

William Winkenwerder, Jr., MD
Assistant Secretary of Defense (Health Affairs)

Enclosures - 2

E.1. References, continued

E.2. Roles and Responsibilities for Beneficiary Counseling and Assistance Coordinators

FIGURE 1-6.1-2 DELIVERY OF HEALTH CARE AT MILITARY TREATMENT FACILITIES (MTFS)

E1. ENCLOSURE 1
REFERENCES, continued

(e) Title 32, Code of Federal Regulations, Part 220, "Collection from Third-Party Payers of Reasonable Costs of Healthcare Services," current edition

(f) Title 32, Code of Federal Regulations, Part 199, "Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)," current edition

(g) DoD Directive 5530.3, "International Agreements," June 11, 1987

(h) DoD 8910.1-M, "DoD Procedures for Management of Information Requirements," November 28, 1986

(i) DoD Directive 8910.1, "Management and Control of Information Requirements," June 11, 1993,

FIGURE 1-6.1-2 DELIVERY OF HEALTH CARE AT MILITARY TREATMENT FACILITIES (MTFS)

E2. ENCLOSURE 2
ROLES AND RESPONSIBILITIES FOR
BENEFICIARY COUNSELING AND ASSISTANCE COORDINATORS (BCACs)

E2.1. GENERAL RULES

As developed between the Services and TMA, BCACs shall carry out their responsibilities and fulfill their generalized roles to:

E2.1.1. Serve as beneficiary advocates and problem solvers, providing dedicated service to all MHS beneficiaries.

E2.1.2. Receive inquiries directly from beneficiaries, the DoD Components, other Agencies, and various interested parties

E2.1.3. Coordinate with appropriate points of contact throughout the MHS, including Managed Care Support Contractor (MCSC) points of contact, to best meet beneficiary needs for information or assistance.

E2.1.4. Help resolve issues by openly communicating with all involved parties.

E2.1.5. Ensure TRICARE information and assistance with accessing healthcare services is available across the TRICARE system for eligible beneficiaries.

E2.1.6. Help beneficiaries resolve concerns when they are not satisfied with services from other parties.

E2.1.7. Counsel beneficiaries and clarify information on their TRICARE benefit (including such options as TRICARE Prime Remote, TRICARE For Life, Dental Programs, and other Demonstrations/ Projects, etc.) and consult with others as necessary.

E2.1.8. Work with functional experts to provide enrollment, beneficiary counseling, and claims processing information. BCACs shall describe or seek clarification on eligibility requirements and benefits based on the category of beneficiary seeking assistance.

E2.1.9. Respond, as directed, to beneficiary, provider, and congressional inquires on TRICARE matters.

E2.1.10. Address access to healthcare complaints, ensuring that beneficiaries get the appropriate benefits and services to which they are entitled

E2.2. OPERATIONAL ACTIVITES

E2.2.1. Lead Agent BCACs shall:

E2.2.1.1. Be responsible for working beneficiary issues that cross regional boundaries.

E2.2.1.2. Disseminate current and correct information on TRICARE regulations and policies to MTF BCACs as needed to facilitate MTF BCACs' ability to perform their jobs.

E2.2.1.3. Act as liaisons to resolve issues with MTF BCACs, MCSCs, Fiscal Intermediaries, the Services, and other concerned parties, when such issues are not resolved at the local level.

E2.2.2. BCACs shall:

FIGURE 1-6.1-2 DELIVERY OF HEALTH CARE AT MILITARY TREATMENT FACILITIES (MTFS)

E2.2.2.1. Follow-up on and troubleshoot problems beneficiaries have processing claims, enrolling in programs, and receiving authorization for services or other system problems that are exceedingly complicated, unduly delayed, or inappropriately handled.

E2.2.2.2. Bring identified systemic problems to the appropriate Lead Agent or MTF point of contact to address.

E2.2.2.3. Analyze, research, and resolve TRICARE inquires, regardless of how they were received; i.e., written, telephonic, and/or electronic (e-mail).

E2.2.2.4. Provide information and assistance based on personal, written, or telephone inquiries and address inpatient and outpatient care based on TRICARE program elements.

E2.2.2.5. Maintain statistical data and generate reports to Lead Agent Directors and/or MTF Commanders on workload volume and categories of issues they encountered.

E2.2.2.6. Use information gleaned from reports to make suggestions for developing and marketing beneficiary education efforts to improve understanding of issues.

E2.2.2.7. Maintain formal documentation process for tracking problem resolution.

E2.2.2.8. Ensure external communications are consistent with the strategies and objectives established by Lead Agents.

E2.3. CONTACTS REQUIRED FOR BCAC DUTIES

BCACs shall:

E2.3.1. Facilitate ongoing, appropriate, and effective communication with Lead Agent Offices, MTF BCACs, TRICARE Service Centers (TSCs), MCSCs, and others when coordinating on and resolving issues.

E2.3.2. Coordinate with staff subject matter experts on issues, as necessary.

E2.3.3. Keep the military chain of command, the Services, and TMA informed of ongoing issues and special cases.

E2.3.4. Maintain a continuing cooperative relationship with various agencies, including Offices of the Lead Agent; the Service Surgeon General offices; MTFs, TSCs, MCSC regional and corporate offices; TRICARE Management Activity; Social Security Administration; Centers for Medicare and Medicaid Services; Department of Veterans Affairs; Dental Agencies; Fiscal Intermediaries and/or Claims Processing Offices; and Congressional field offices.

E2.4. CLAIMS ASSISTANCE

BCACs shall:

E2.4.1. Provide or directly communicate information on healthcare services that TRICARE covers and excludes and convey how these benefits and policies integrate with other healthcare sources.

E2.4.2. Explain a beneficiary's costs and responsibilities when enrolling in TRICARE Prime or accessing services under the TRICARE Extra or Standard options.

FIGURE 1-6.1-2 DELIVERY OF HEALTH CARE AT MILITARY TREATMENT FACILITIES (MTFS)

E2.4.3. Help beneficiaries understand the TRICARE claims process, including information on resolving unpaid healthcare claims, pre-authorization requirements, and third-party liability.

E2.4.4. Help resolve DEERS eligibility and enrollment problems.

E2.5. APPEALS AND GRIEVANCES

E2.5.1. Lead Agent BCACs shall:

E2.5.1.1. Handle issues received from beneficiaries, MTFs, or TSCs that staff there has not been able to resolve.

E2.5.1.2. Work directly with beneficiaries who feel they have exhausted the MHS/MCSC system and/or have become dissatisfied with services they received.

E2.5.2. BCACs shall:

E2.5.2.1. Explain appeals and grievance procedures and advise beneficiaries on the appropriate use of these procedures.

E2.5.2.2. Refer cases to points of contact that can provide detailed and specific information on how to access TRICARE services and what steps beneficiaries can take if not satisfied with services received.

E2.6. KNOWLEDGE AND SKILLS

The Lead Agent BCAC requires the following:

E2.6.1. Expert knowledge of the TRICARE program policies and reference manuals.

E2.6.2. In-depth knowledge, experience, and training to handle and solve complex issues that arise when addressing healthcare benefits.

E2.6.3. Tact, diplomacy, and restraint in counseling and explaining entitlements, benefits, and responsibilities to all beneficiaries.

E2.6.4. Understanding of the MHS and TRICARE program elements.

E2.6.5. Mastery of oral and written communication skills and customer service principles, methods, practices, and techniques and analytic methods, including using research tools, analysis, and interpersonal relations practices.

E2.6.6. Practical knowledge and understanding of TRICARE contract language, regional healthcare issues and initiatives, and other Federal health benefits programs.

E2.6.7. Knowledge of basic principles and practices relating to the entire military healthcare delivery system.

E2.6.8. Knowledge of TRICARE healthcare claims processing regulations, procedures, and policies to ensure payment of legitimate claims.

E2.6.9. Knowledge of region-specific TRICARE contracts relating to authorized benefits and requirements needed to obtain healthcare.

E2.7. COMPLEXITIES ASSOCIATED WITH THE BCAC POSITION

The BCAC shall:

E2.7.1. Have a thorough understanding of the TRICARE benefit, related regional contracts, and MTF and/or Service-specific regulations, including practical knowledge of TRICARE special benefit programs and general understanding of the MHS.

FIGURE 1-6.1-2 DELIVERY OF HEALTH CARE AT MILITARY TREATMENT FACILITIES (MTFS)

E2.7.2. Remain abreast of continual updates/changes to the variety of health benefits programs available to beneficiaries at the appropriate OASD(HA), TMA, regional, and MTF level.

E2.7.3. Be able to organize, prioritize, complete, and track multiple complaints, issues, and projects.

E2.7.4. Exercise a great deal of initiative, independence, and considerable judgment in interpreting issues and adapting existing practices and precedents, using these skills when developing approaches that integrate all aspects of TMA's objectives to establish a unified beneficiary services program.

E2.7.5. Prioritize and reconcile benefit issues, working through different sources/agencies.

E2.7.6. Use Guidelines and Regulations that are often complex and under continuous change, cover many different programs, and may require extensive interpretive judgment.

E2.8. RESOURCES AVAILABLE TO BCACs

E2.8.1. The BCACs most frequently use OASD(HA)/TRICARE policy and program documents, managed care support contracts, DoD documents, Directives, Manuals, and Service-level instructions. They also use:

E2.8.1.1. General policy statements and statutory mandates, such as general guidance in DoD Instructions pertaining to correspondence.

E2.8.1.2. Applicable TMA Operations and Policy Manuals, including the appropriate Code of Federal Regulations.

E2.8.2. MTF Commanders shall define, under the guidance of their respective Military Departments, specific details regarding MTF BCAC roles and responsibilities.

E2.9. OPERTIONAL ACTIVITES PERFORMED BY BCACs

E2.9.1. The BCAC, whom the beneficiary contacts, assumes responsibility for the issue and/or inquiry from the time of initial contact until the issue is resolved.

E2.9.2. BCACs shall assign a case identifier to each beneficiary case, using a Service and/or TMA-developed database or program. BCACs shall track cases, categorizing caseload by data elements and timeliness of resolution.

E2.9.2.1. After the Lead Agent BCAC assigns a case identifier and the data is entered, BCACs shall determine whether the issue shall be resolved at the Lead Agent or other level, i.e., MTF, Services, TMA, or MCSC, forwarding appropriate cases as necessary. MTF's BCACs shall follow these same procedures.

E2.9.2.2. Lead Agent BCACs shall annotate confirmation of case acceptance and identification of the responsible action point of contact for cases referred out to others. MTF Commanders and MTF BCACs shall develop internal processes to ensure tracking of all cases.

E2.9.2.3. Lead Agent BCACs shall assist and ensure cases referred to other action offices meet identified resolution timeline requirements. MTF Commanders and MTF BCACs shall establish internal procedures to achieve the same result.

FIGURE 1-6.1-2 DELIVERY OF HEALTH CARE AT MILITARY TREATMENT FACILITIES (MTFS)

E2.9.3. BCACs shall comply with case completion time requirements as follows: Resolve "Priority" cases, i.e., those cases forwarded on behalf of a beneficiary by OASD(HA), TMA, members of Congress or those otherwise designated as Priority by the Lead Agent/MTF Commander, within ten (10)-calendar days. Resolve Routine issues within thirty (30)-calendar days. BCACs may modify the established case resolution timelines to meet compliance standards.

E2.10. CASE CLOSURE

The BCAC accepting a specific case shall notify the beneficiary of case closure and determine beneficiary satisfaction with case outcome via an oral, written, or automated process.

E2.11. COORDINATION

BCACs are responsible for coordinating data and generating reports on beneficiary issue caseloads.

E2.11.1. Lead Agent and MTF BCACs shall provide data input based on established methodology to support MHS-wide reporting. TMA (Communications and Customer Service) will create and distribute regional and Service-specific reports, based on data input received through coordination with the Services.

E2.11.2. Lead Agent BCACs shall generate regional or MTF-specific ad hoc reports as required by Lead Agent Directors and/or MTF Commanders to meet specific needs.

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