CHAPTER 2
SECTION 4

POINT OF SERVICE OPTION

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I. DESCRIPTION

The Point of Service Option applies under TRICARE Prime only. It gives TRICARE Prime enrollees the freedom to obtain services from any civilian provider. Under the Point of Service Option, when Prime enrollees self-refer to a civilian authorized provider other than their Primary Care Manager (PCM), TRICARE Standard coverage requirements apply unless otherwise stated in this section.

II. POLICY

A. Self referred non-emergency specialty or inpatient care provided to a TRICARE Prime enrollee either within or outside the network, which is neither provided by the patient's PCM or referred by the PCM, nor authorized by the Health Care Finder, may be reimbursed under the Point of Service option if it is a benefit under TRICARE Standard.

B. Contractors shall apply Prime copayments, not Point of Service cost-sharing provisions when PCMs, network providers and/or Health Care Finders do not follow established referral/authorization procedures. For example, if the contractor processes a claim without evidence of an authorization and/or a referral under Point of Service provisions, and the contractor later verifies that the PCM or other appropriate provider referred the beneficiary for the care, the contractor shall adjust the claim under Prime provisions. The contractor need not identify past claims, however the contractor shall adjust these claims as they are brought to their attention.

C. On a case-by-case basis, following stabilization of the patient, the contractor or MTF Commander may require a TRICARE Prime beneficiary to transfer to a network facility or the MTF. The contractor shall provide written notice to the beneficiary (or responsible party) advising them of the impending transfer to a network facility or MTF. If the beneficiary elects to remain in the non-network facility, and the facility is exempt from the TRICARE/CHAMPUS DRG-based payment system, Point of Service cost-sharing will begin 24-hours following receipt of the written notice. If the non-network facility is subject to the TRICARE/CHAMPUS DRG-based payment system, then Point of Service cost-sharing will be based on the total DRG allowed amount. Neither the contractor nor the MTF Commander may require a transfer until such time as the transfer is deemed medically safe.

D. Point of Service deductible and cost-share amounts follow for TRICARE Prime enrollees:

1. Enrollment year deductible for outpatient claims (deductible amounts do not apply to inpatient claims): $300 per individual; $600 per family.

2. Beneficiary cost-share for inpatient and outpatient claims: 50 percent of the allowable charge after the deductible has been met.

E. Point of Service deductible and cost-share amounts are NOT creditable to the enrollment year catastrophic cap and they are not limited by the cap.

F. Contractors shall credit Point of Service deductible and cost-share amounts to the $1,000/$3,000 fiscal year catastrophic cap for Prime enrollees. The cap, however, does not apply to POS claims; i.e., a TRICARE Prime enrollee shall pay deductible and cost-share amounts for Point of Service claims even after his/her out-of-pocket expenses exceed either the fiscal year or enrollment year catastrophic cap amount. The government will pay no more than 50% of the allowable charge for any care covered under the Point of Service option.

G. Point of Service deductible and cost-sharing do not apply to the claims for care received by certain newborn and newly adopted children who have been automatically enrolled in TRICARE Prime.

H. TRICARE Prime enrollees have no NAS requirements, even under the Point of Service Option. Prime enrollees who wish to use the POS option may seek specialized treatment services (STSs) without evaluation by the STS facility (STSF), without Health Care Finder authorization, and without an STSF NAS. As provided in the OPM, Chapter 19, the STS program will terminate no later than June 1, 2003.

I. All TRICARE coverage provisions apply to Point of Service claims with the exceptions noted in this section.

III. EXCEPTIONS

A. TRICARE Prime enrollees are entitled to receive the first eight mental health sessions without PCM referral or preauthorization. If the care is provided by a network provider, the claim is to be processed under TRICARE Prime rules. The network provider will notify the Health Care Finder of the care and obtain authorization on behalf of the beneficiary. This authorization is only to permit claims processing and does not include or represent a clinical review. Point of Service cost sharing applies to claims for the first eight (8) mental health sessions provided by a non-network provider.

B. The TRICARE Prime Clinical Preventive Services do not require preauthorization or authorization. Most of the services covered as Clinical Preventive Services are provided directly or ordered by the patient's PCM. In those cases that patients can self-refer for services (i.e., eye examinations), patients must use network providers. If the patient does not use a network provider, payment will be made under the Point of Service option ONLY for services that are otherwise covered under TRICARE Standard.

C. Point of Service cost-sharing and deductible amounts do not apply if an enrollee has other health insurance that provides primary coverage, i.e., the other health insurance must be primary under the provisions of Chapter 4, Section 1; and documentation that the other insurance processed the claim and of the exact amount paid must be submitted with the TRICARE claim. TRICARE Prime provisions apply for this type of claim.

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