REFERRALS/*PREAUTHORIZATIONS/*AUTHORIZATIONS

1.0. REFERRALS

1.1. The National Defense Authorization Act for Fiscal Year 2001, Conference Report 106-945, Section 728, states in part, "...no contract for managed care support under the TRICARE Program... shall require a primary care or specialty care provider to obtain prior authorization before referring a patient to a specialty care provider that is part of the network ..." The contractor is responsible for reviewing all requests for referrals. The contractor shall not require an authorization, to include a medical necessity or utilization management determination, before referring a patient for an evaluation by a network 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 plan. 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, the MTFs have the right of first refusal for all referrals, as determined by the MOUs between the contractor and each MTF.

2.0. *PREAUTHORIZATIONS/*AUTHORIZATIONS

2.1. The contractor is responsible for reviewing all requests for authorization. Within TRICARE Standard, issuance of authorizations shall not be used to restrict freedom of choice of the beneficiary who chooses to receive care from authorized non-network providers.

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 their Health Benefits Advisor 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. Preauthorizations/authorizations shall be electronically transferred to the MTF in HIPAA compliant manner.

2.4. The contractor shall issue notification of preauthorization/authorization or waiver to the beneficiary or parent/guardian or a minor or incompetent, 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.

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.

4.0. PSYCHIATRIC RESIDENTIAL TREATMENT CENTERS

4.1. Before any claims for residential treatment center 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 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 residential treatment center patient. That cost is the responsibility of the residential treatment center, 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 residential treatment center (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 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. FORMER SPOUSE WITH PRE-EXISTING CONDITION

The former spouse will be on DEERS under his/her own Social Security Number.

6.0. 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 Division. Refer to 32 CFR 199.4.