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.

2.6. *Prime enrollees receiving emergency care or authorized care from non-network, non-participating providers shall be responsible for only the Prime copayment. On such claims, contractors shall allow the amount the provider may collect under TRICARE rules; i.e., if the charges on a claim are subject to the balance billing limit (refer to the TRICARE Reimbursement Manual, Chapter 3, Section 1 for information on balance billing limit), the contractor shall allow the lesser of the billed charges or the balance billing limit (115% of allowable charge). If the charges on a claim are exempt from the balance billing limit, the contractor shall allow the billed charges. Refer to the TRICARE Reimbursement Manual, Chapter 2, Section 1 for information on claims for certain ancillary services.*

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.

7.0. INTERIM REFERRAL AND AUTHORIZATION PROCESS

7.1. The interim referral and authorization management process shall be implemented and operated until such time as the government issues a change order directing the implementation of an alternate authorization and referral management system. Following implementation of this interim process, MTFs and MCSCs may elect to work together to develop alternative means of accomplishing referrals and authorizations, with approval of the contracting officer. Any such development and the subsequent implementation of any alternative shall be without cost to the government.

7.2. The contractor shall process referrals in accordance with the following:

7.2.1. Referrals From The MTF To The MCSC

For referrals from the MTF, the contractor shall receive a fax (or by other electronic means agreed upon by the MTF and the MCSC) containing the following information. The MTF is not required to provide diagnosis or procedure codes. The MCSC shall translate the narrative descriptions into standard diagnosis and procedure codes.

DATA ELEMENT	DESCRIPTION/PURPOSE/USE
Request Date/Time	DD MMM YY hhmm

DATA ELEMENT	DESCRIPTION/PURPOSE/USE
Request Priority	STAT/24-hour/ASAP/Today/72-hour/Routine
Requester	
Requestor Name	Name of PCM/MTF individual provider or clinic making request
Requesting Facility (MTF)	Name of MTF facility
	PATIENT INFO
Sponsor SSN	Required
Patient ID	EDI_PN (from DEERS) if available
Patient Name	Full Name of Patient (if no EDI_PN available)
Patient DOB	Date of Birth (required if patient not on DEERS)
Patient Gender	
Patient Address	Full Address of Beneficiary (including zip)
	CLINICAL INFO
Patient Primary Provisional Diagnosis	Description
Reason for Request	Sufficient Clinical Info to Perform MNR
	SERVICE
Service 1 - Provider	Required - Speciality 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, DME Purchase/Rental, Other Health Service, et al DME Provider to do CMN
Service 1 - Service Quantity (optional)	Number of Visits, Units, etc.
CHCS Generated Order Number (DMIS-YYMMDD-XXXXX)	
Special Instructions:	

7.2.1.1. The contractor shall use the CHCS generated order number (DMIS-YYMMDD-XXXXX) as a unique identifier. Using the unique identifier, the contractor will locate related referrals, authorizations, and claims, and track consult results. Contractor generated MTF reports shall be modified to accommodate the unique identifier as needed. The unique identifier shall also be used for all related customer service inquiries. *Unique Identifier Numbers (UINs) will be attached to all MTF referrals and will be portable across all regions of care. 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) and the name 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.

7.2.1.2. 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.

7.2.1.3. 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 TFL beneficiaries.

7.2.1.4. 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. For Same Day and 72-hour referrals a beneficiary notification is not required. The MCSC shall also notify the provider to whom the beneficiary is being referred of the approved services, to include clinical information furnished by the referring provider.

7.2.1.5. 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.

7.2.1.6. 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.

7.2.1.7. The MCSC shall provide the consult results to a single POC at the MTF in accordance with contract requirements. Returned results shall include the patient's name and the consult order number assigned by the MTF.

7.2.2. Referrals From The Contractor To The MTF

Referrals subject to the right of first refusal provision from the civilian sector shall be processed in accordance with the following procedures.

7.2.2.1. The contractor shall fax, or 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 above 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.

7.2.2.2. 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 7.2.2.1. above, 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 right of first refusal request in one business day as defined above, the contractor shall process the referral request as if the MTF declined to see the patient. Monthly, no later than the 10th calendar day in the following month, the contractor shall provide each MTF with a report of the number of referrals forwarded based on the Right of First Refusal provision, the number accepted by the MTF, the number individually rejected by the MTF, and the number rejected by the MTF as a result of the automatic rejection after 1 business day.

7.2.2.3. The contractor shall contact the MTF POC for the coordination of Same Day and Seventy-two 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.

7.2.2.4. The Right of First Refusal will be forwarded for only those beneficiaries residing within the Prime Service Area 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. Right of First Refusal 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.

7.2.2.5. In instances where the MTF elects to accept the patient, the MTF will advise the MCSC within one business day, as defined above in paragraph 7.2.2.1. The MCSC will notify the beneficiary of the MTF's acceptance and provide instructions for contacting the MTF to obtain an appointment.

7.2.3. Provision Of Reports

7.2.3.1. The contractor shall ensure that network specialty providers provide clearly legible specialty care consultation or referral reports, operative reports, and discharge summaries to the beneficiary's initiating provider within 10 working days of the initial referral visit, procedure(s), follow-up clinic visits (when a report to the referring provider is considered clinically warranted), and after the final authorized visit. The contractor will ensure a report from the initial specialty encounter is returned to the initiating provider within 10 working days 98% of the time. The preferred method of delivery to MTF providers

is electronic and will be addressed in the Memorandum Of Understanding (MOU). Each MTF will establish a single POC for the receipt of the required documents. (The MTF single POC may be an individual or a single office with more than one telephone number.) In urgent/emergent situations, a preliminary report of a specialty consultation shall be conveyed to the beneficiary's initiating provider within 24 hours (unless best medical practices dictate less time is required for a preliminary report) by telephone, fax or other means with a formal written report provided within the standard 98% of the time. All consultation or referral reports, operative reports, and discharge summaries shall be provided to the provider who initiated the referral within 30 calendar days. If the accreditation standards organization has a more stringent specialty referral-reporting requirement, the contractor shall adhere to that standard.

7.2.3.2. The requirements specified in paragraph 7.2.3.1. above, apply to all referrals for professional services provided by a health care provider (as defined in 32 CFR 199) to assist the initiating provider in the diagnosis and treatment of a patient, including, for example, imaging studies (reports by the interpreting radiologist), physical therapy, occupational therapy, and speech therapy. The performance requirement does not apply to referrals for non-professional services such as durable medical equipment or laboratory studies.