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TRICARE
MANAGEMENT ACTIVITY
MB&RB

CHANGE 175
6010.54-M
APRIL 3, 2013

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: **REIMBURSEMENT AND CODING UPDATES 13-001**

CONREQ: 16410

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See page 3.

EFFECTIVE DATE: As indicated, otherwise upon direction of the Contracting Officer.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Aug 2002 TRM, Change No. 159 and Aug 2002 TSM, Change No. 102.

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ATTACHMENT(S): **53 PAGE(S)**
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WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT.

CHANGE 175
6010.54-M
APRIL 3, 2013

REMOVE PAGE(S)	INSERT PAGE(S)
CHAPTER 1	
Section 9.1, pages 1 and 2	Section 9.1, pages 1 and 2
CHAPTER 7	
Section 2.1, pages 7 through 10	Section 2.1, pages 7 through 10
Section 2.2, pages 5 and 6	Section 2.2, pages 5 and 6
Section 3.10, pages 1 through 3	Section 3.10, pages 1 through 3
Section 3.13, pages 1 through 3	Section 3.13, pages 1 through 4
Section 22.1, pages 1 through 5	Section 22.1, pages 1 through 5
CHAPTER 12	
Section 4.2, pages 17 through 47	Section 4.2, pages 17 through 49

SUMMARY OF CHANGES

CHAPTER 1

1. Section 9.1. This change updates codes affected by the 2013 updated Current Procedural Terminology (CPT)[1]/Healthcare Common Procedure Coding System (HCPCS) mental health codes published by the AMA.

CHAPTER 7

2. Section 2.1. The temporary codes for Computed Tomographic Colonography (CTC), Level III procedure code 0066T or 0067T, have changed to new CPT 74263.

3. Section 2.2. The temporary codes for CTC, Level III procedure code 0066T or 0067T, have changed to new CPT 74263.

4. Section 3.10. This change updates codes affected by the 2013 updated CPT/HCPCS mental health codes published by the American Medical Association (AMA), and corrects an error in the code range for the first eight outpatient mental health visits.

5. Section 3.13. This change updates codes affected by the 2013 updated CPT/HCPCS mental health codes published by the AMA.

6. Section 22.1. This change updates codes affected by the 2013 updated CPT/HCPCS mental health codes published by the AMA.

CHAPTER 12

7. Section 4.2. This change updates codes affected by the 2013 updated CPT/HCPCS mental health codes published by the AMA.

CHAPTER 1
SECTION 9.1

PRIMARY CARE MANAGERS

ISSUE DATE: May 15, 1996
AUTHORITY: 32 CFR 199.17

I. POLICY

A. TRICARE prime enrollees shall select or have assigned to them primary care managers (PCMs) according to guidelines established by the Military Treatment Facility (MTF) Commander and Regional Director.

1. A PCM may be a network provider, or an MTF PCM by name/supported by a team. If a group practice is listed as a network provider, all members of the group practice must be TRICARE/CHAMPUS-authorized providers.

2. The following types of individual professional providers are considered primary care providers and may be designated PCMs, consistent with governing State rules and regulations: internists, family practitioners, pediatricians, general practitioners, obstetricians/gynecologists, physician assistants, nurse practitioners, and certified nurse midwives.

B. A TRICARE Prime enrollee must seek all his or her primary health care from the PCM with the exception of Clinical Preventive Services. If the PCM is unable to provide a primary care service, the PCM is responsible for referring the enrollee to another primary care provider. A TRICARE Prime enrollee must be referred by the PCM for specialty care or for inpatient care. Failure to obtain a PCM referral when one is required will result in the service being paid under Point of Service procedures with a deductible for outpatient services and cost-shares for in- and outpatient services.

C. The PCM is responsible for notifying the contractor that a referral is being made. The contractor will assist the Prime enrollee in locating an MTF or network provider to provide the specialty care and in scheduling an appointment. Additionally, the contractor will conduct a prospective review and authorize the service in accordance with the contractor's best practices.

II. EXCEPTIONS

PCM referral is not required for the following services:

A. Services provided directly by the PCM.

B. Emergency care.

C. Services provided as part of the comprehensive clinical prevention program offered to Prime enrollees.

D. The first eight outpatient mental health visits per beneficiary in a fiscal year do not require PCM or Health Care Finder (HCF) referral and do not require preauthorization. Mental health visits exceeding eight in a fiscal year require authorization, but do not require a referral. The authorization of outpatient mental health care after the first eight visits (visits nine forward) shall be in accordance with the MCSC's best practices. This does not apply to mental health care received by active duty personnel. Mental health care for active duty personnel requires preauthorization. See Chapter 7, Section 3.10.

NOTE: Active Duty Service Members (ADSMs) require preauthorization before receiving mental health services. The contractor shall comply with the provisions of the TRICARE Operations Manual (TOM), Chapters 17 and 18 when processing requests for service for active duty personnel.

- END -

(c) Individuals diagnosed with Inflammatory Bowel Disease (IBD), Chronic Ulcerative Colitis (CUC), or Crohn's disease. For these individuals, cancer risk begins to be significant eight years after the onset of pancolitis or 10 to 12 years after the onset of left-sided colitis. For individuals meeting these risk parameters, optical colonoscopy should be performed every one to two years with biopsies for dysplasia.

(4) The effective date for coverage of flexible sigmoidoscopy or optical colonoscopy for individuals at **increased** or **high risk** for colon cancer is October 6, 1997.

(5) Computed Tomographic Colonography (CTC).

(a) CTC (CPT[5] procedure code 74263) is covered as a colorectal cancer screening **ONLY** when an optical colonoscopy is medically contraindicated OR cannot be completed due to a known colonic lesion, structural abnormality, or other technical difficulty is encountered that prevents adequate visualization of the entire colon.

(b) The effective date for coverage of CTC as indicated above is March 15, 2006.

(c) CTC is **NOT** covered as a colorectal cancer screening for any other indication or reason.

d. Prostate Cancer.

(1) Rectal examination. Digital rectal examination will be offered annually for all men beginning at age 50 who have at least a 10 year life expectancy. It should also be offered to begin for men age 45 and over with a family history of prostate cancer in at least one other first-degree relative (father, brother, or son) diagnosed with prostate cancer at an early age (younger then age 65) and to all African American men aged 45 and over regardless of family history. Testing should be offered to start at age 40 for men with a family history of prostate cancer in two or more other family members.

(2) Prostate-Specific Antigen (PSA).

(a) Annual testing for the following categories of males:

1 All men aged 50 years and older.

2 Men aged 45 years and over with a family history of prostate cancer in at least one (1) other family member.

3 All African American men aged 45 and over regardless of family history.

4 Men aged 40 and over with a family history of prostate cancer in two or more other family members.

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(b) Screening will continue to be offered as long as the individual has a 10 year life expectancy.

(3) The effective date for prostate cancer screening is October 6, 1997.

2. Infectious Diseases.

a. Hepatitis B screening. The effective date for screening pregnant women for HBsAG during the prenatal period was March 1, 1992.

b. Human Immunodeficiency Virus (HIV) testing.

(1) Effective July 7, 1995, TRICARE may share the cost of routine HIV screening tests for pregnant women, and

(2) Extra and Standard plans may share the cost of HIV testing when medically necessary; i.e., when performed on individuals with verified exposure to HIV or who exhibit symptoms of HIV infection (persistent generalized lymphadenopathy). Claims for HIV testing must include documentation by the attending physician verifying medical necessity. Claims that meet the criteria for coverage are to be reimbursed following the reimbursement methodology applicable to the provider's geographic location.

(3) HIV testing is covered when done in conjunction with routine pre-operative services by an independent laboratory or clinic. If the HIV testing is done while the patient is in an inpatient setting, the testing should be included in the Diagnostic Related Group (DRG).

c. Prophylaxis. The following preventive therapy may be provided to those who are at risk for developing active disease:

(1) Tetanus immune globulin (human) and tetanus toxoid administered following an injury.

(2) Services provided following an animal bite:

(a) Extra and Standard plans may share the cost of the administration of anti-rabies serum or human rabies immune globulin and rabies vaccine.

(b) Extra and Standard plans may also cost-share the laboratory examination of the brain of an animal suspected of having rabies if performed by a laboratory which is an authorized provider and if the laboratory customarily charges for such examinations. In order for the examination charges to be paid, the animal must have bitten a beneficiary, the charges for the examination must be submitted under the beneficiary's name, and the beneficiary must be responsible for the cost-share on the claim.

NOTE: Charges by any source for boarding, observing, or destroying animals, or for the collection of brain specimens are not covered.

(3) Rh immune globulin when administered to an Rh negative woman during pregnancy and following the birth of an Rh positive child or following a spontaneous or induced abortion.

(4) For treatment provided to individuals with verified exposure to a potentially life-threatening medical condition (i.e., hepatitis A, hepatitis B, meningococcal meningitis, etc.), claims must include documentation by the attending physician verifying exposure.

(5) Isoniazid therapy for individuals at **high risk** for TB to include those:

(a) With a positive Mantoux test without active disease;

(b) Who have had close contact with an infectious case of TB in the past three months regardless of their skin test reaction; or

(c) Who are members of populations in which the prevalence of TB is greater than 10% regardless of their skin test reaction - including injection drug users, homeless individuals, migrant workers, and those born in Asia, Africa, or Latin America.

NOTE: In general, isoniazid prophylaxis should be continued for at least six months up to a maximum of 12 months.

(6) Immunizations.

(a) Coverage is extended for the age appropriate dose of vaccines that meet the following requirements:

1 The vaccine has been recommended and adopted by the Advisory Committee on Immunization Practices (ACIP) for use in the United States; and

2 The ACIP adopted recommendations have been accepted by the Director of the Centers for Disease Control and Prevention (CDC) and the Secretary of Health and Human Services (HHS) and published in a CDC *Morbidity and Mortality Weekly Report* (MMWR).

3 Refer to the CDC's web site (http://www.cdc.gov) for a current schedule of CDC recommended vaccines for use in the United States.

4 The effective date of coverage for CDC recommended vaccines is October 6, 1997, OR the date ACIP recommendation for the vaccine were published in a MMWR, whichever date is LATER.

(b) Immunizations recommended specifically for travel outside the United States are NOT covered, EXCEPT for immunizations required by dependents of active duty military personnel who are traveling outside the United States as a result of an active duty member's duty assignment, and such travel is being performed under orders issued by a Uniformed Service.

3. Genetic Testing.

a. Genetic testing and counseling is covered during pregnancy under any of the following circumstances:

(1) The pregnant woman is 35 years of age or older;

(2) One of the parents of the fetus has had a previous child born with a congenital abnormality;

(3) One of the parents of the fetus has a history (personal or family) of congenital abnormality; or

(4) The pregnant woman contracted rubella during the first trimester of the pregnancy.

(5) There is a history of three or more spontaneous abortions in the current marriage or in previous mating of either spouse; or

(6) The fetus is at an **increased risk** for a hereditary error of metabolism detectable in vitro; or

(7) The fetus is at an **increased risk** for neural tube defect (family history or elevated maternal serum alpha-fetoprotein level); or

(8) There is a history of sex-linked conditions (i.e., Duchenne muscular dystrophy, hemophilia, x-linked mental retardation, etc.).

NOTE: Extra and Standard plans may not cost-share routine or demand genetic testing or genetic tests performed to establish the paternity or sex of an unborn child.

4. School Physicals.

a. Physical examinations are covered for beneficiaries ages five through 11 that are required in connection with school enrollment. The effective date for coverage of school enrollment physicals is October 30, 2000.

b. Cost-sharing and deductibles are to be applied as prescribed under the beneficiary's respective coverage plan (i.e., in accordance with the cost-sharing and deductible guidelines and either TRICARE Standard or Extra coverage plans).

c. Standard office visit evaluation and management CPT codes (i.e., CPT[6] procedure code ranges 99201-99205 and 99211-99214) may be used in billing for school physicals; however, payment may not exceed what would have otherwise been reimbursed under the comprehensive Preventive Medicine Service codes for beneficiaries ages five through 11 (CPT[6] procedure codes 99383 and 99393).

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SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Colorectal Cancer (Continued):	**Proctosigmoidoscopy or Flexible Sigmoidoscopy for Individuals at Average Risk for Colon Cancer:** Once every three to five years beginning at age 50. **Proctosigmoidoscopy or Flexible Sigmoidoscopy for Individuals at Increased or High Risk for Colon Cancer:** **Increased Risk** (Individuals with a family history): Once every five years, beginning at age 40, for individuals with a first-degree relative diagnosed with a colorectal cancer or an adenomatous polyp at age 60 or older, or two second-degree relatives diagnosed with colorectal cancer. **High Risk:** Annual flexible sigmoidoscopy, beginning at age 10 through 12, for individuals with known or suspected Familial Adenomatous Polyposis (FAP). The effective date for coverage of proctosigmoidocopy or flexible sigmoidoscopy, regardless of risk, is October 6, 1997.	CPT[1] codes 45300-45321, 45327, and 45330-45339. HCPCS code G0104.
	Optical (Conventional) Colonoscopy for Individuals at Average, Increased, or High Risk for Colon Cancer: **Average Risk**: Once every 10 years for individuals age 50 or above. The effective date for coverage of optical colonoscopy for individuals at **average risk** is March 15, 2006. **Increased Risk (Individuals with a family history):** 1. Once every five years for individuals with a first-degree relative diagnosed with sporadic colorectal cancer or an adenomatous polyp before the age of 60, or in two or more first-degree relatives at any age. Optical colonoscopy should be performed beginning at age 40 or 10 years younger than the earliest affected relative, whichever is earlier. 2. Once every 10 years, beginning at age 40, for individuals with a first-degree relative diagnosed with sporadic colorectal cancer or an adenomatous polyp at age 60 or older, or colorectal cancer diagnosed in two second degree relatives.	

SERVICES	FREQUENCY OR AGE INTERVAL	RELEVANT PROCEDURE CODE
Colorectal Cancer (Continued):	**Optical (Conventional) Colonoscopy for Individuals at Average, Increased, or High Risk for Colon Cancer (Continued):** **High Risk:** 1. Once every one to two years for individuals with a genetic or clinical diagnosis of Hereditary Non-Polyposis Colorectal Cancer (HNPCC) or individuals at increased risk for HNPCC. Optical colonoscopy should be performed beginning at age 20 to 25 or 10 years younger than the earliest age of diagnosis, whichever is earlier. 2. For individuals diagnosed with Inflammatory Bowel Disease (IBD), Chronic Ulcerative Colitis (CUC), or Crohn's disease, cancer risk begins to be significant eight years after the onset of pancolitis or 10 to 12 years after the onset of left-sided colitis. For individuals meeting these risk parameters, optical colonoscopy should be performed every one to two years with biopsies for dysplasia. The effective date for coverage of optical colonoscopy for individuals at **increased** or **high risk**, is October 6, 1997.	CPT[1] codes 45355 and 45378-45385. HCPCS codes G0105 and G0121.
	Computed Tomographic Colonography (CTC) for Individuals in whom an Optical Colonoscopy is Medically Contraindicated or Incomplete: CTC is covered as a colorectal cancer screening **ONLY** when an optical colonoscopy is medically contraindicated OR cannot be completed due to a known colonic lesion, structural abnormality, or other technical difficulty is encountered that prevents adequate visualization of the entire colon. CTC is **NOT** covered as a colorectal cancer screening for any other indication or reason. The effective date for coverage of CTC for this indication is March 15, 2006.	CPT[1] code 74263.
Skin Cancer:	**Skin Examination:** Examination of the skin should be performed for individuals with a family or personal history of skin cancer, increased occupational or recreational exposure to sunlight, or clinical evidence of precursor lesions.	See appropriate level evaluation and management codes.

CHAPTER 7
SECTION 3.10

TREATMENT OF MENTAL DISORDERS

ISSUE DATE: December 5, 1984
AUTHORITY: 32 CFR 199.4(c)(3)(ix)

I. CPT[1] PROCEDURE CODE RANGES

90801 - 90899 for care provided through December 31, 2012.
90785 - 90899 for care provided on or after January 1, 2013.

II. POLICY

Benefits are payable for services and supplies that are medically or psychologically necessary for the treatment of mental disorders when: (1) the services are rendered by persons who meet the criteria of 32 CFR 199.6 for their respective disciplines (whether the person is an individual professional provider or is employed by another authorized provider), and (2) the mental disorder is one of those listed in DSM-IV and is of a severity not only to cause the patient distress but also to interfere with the patient's ability to carry out his or her usual activities.

III. POLICY CONSIDERATIONS

A. Professional and institutional providers of mental health services.

1. List of authorized providers. Only the types of providers listed below are considered qualified providers of mental health services. The person providing the care must meet the criteria of 32 CFR 199.6, whether that person is an individual professional provider or is employed by another authorized provider.

a. Psychiatrists and other physicians

b. Clinical psychologists

c. Certified psychiatric nurse specialists

d. Clinical social workers

e. Certified marriage and family therapists

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f. Pastoral counselors; and

g. Mental health counselors.

2. Professional staff of institutions providing mental health services. For those types of institutional providers that are certified by TMA, reviewers may assume that all professional staff meet regulatory criteria. Any evidence to the contrary is to be brought to the attention of the Special Contract Operations Office, TMA, immediately. Contractors shall notify institutional providers within their jurisdictions that payment is authorized only for professional services provided by employees meeting the program requirements. In any situation where the contractor obtains evidence that an institution is billing for professional services of unqualified staff, the case is to be submitted to the TMA Office of Program Integrity.

B. Review of Claims for Treatment of Mental Disorders. All claims for treatment of mental disorders are subject to review in accordance with claims processing procedures contained in the TRICARE Operations Manual (TOM).

1. Psychotropic drugs. All patients receiving psychotropic drugs must be under the care of a qualified mental health provider authorized by state licensure to prescribe drugs. That provider need not be the attending provider, but there must be evidence in the treatment plan of coordination between the various providers.

2. Electroconvulsive treatment (CPT[2] procedure codes 90870, 90871). Electroconvulsive treatment is covered when medically or psychologically appropriate and when rendered by qualified providers. However, the use of electric shock as negative reinforcement (aversion therapy) is excluded.

3. Ancillary therapies (no code, as separate reimbursement is not permitted). Includes art, music, dance, occupational, and other ancillary therapies, when included by the attending provider in an approved inpatient treatment plan and under the clinical supervision of a licensed doctoral level mental health professional. These ancillary therapies are not separately reimbursed professional services but are included within the institutional reimbursement.

4. Services by non-medical providers. With the exception of pastoral counselors, and mental health counselors, approved categories of non-medical providers may render covered services independent of physician referral and supervision. All providers, however, are expected to consult with, or refer patients to, a physician for evaluation and treatment of physical conditions that may co-exist with or contribute to a mental disorder. Failure to do so will result in denial of the non-physician provider's services on quality-of-care grounds. Questionable cases will be referred to peer review.

C. The first eight outpatient mental health visits per beneficiary in a fiscal year require no Primary Care Manager (PCM) or Health Care Finder (HCF) referral, nor is a preauthorization required (see Chapter 1, Section 9.1 and the TOM, Chapter 7, Section 2). This applies to outpatient mental health visits identified by CPT[2] codes 90801 - 90857 for

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services provided through December 31, 2012; and CPT[3] codes 90791 - 90853 for services provided on or after January 1, 2013.

IV. EXCLUSIONS

A. Sexual dysfunctions, paraphilias and gender identity disorders.

B. Drug maintenance programs when one addictive drug is substituted for another on a maintenance basis.

C. Specific developmental disorders.

D. Home visits for individual, family, or marriage counseling (CPT[3] procedure code 99510).

E. Microcurrent Electrical Therapy (MET), Cranial Electrotherapy Stimulation (CES), or any therapy that uses the non-invasive application of low levels of microcurrent stimulation to the head by means of external electrodes for the treatment of anxiety, depression or insomnia, and electrical stimulation devices used to apply this therapy.

F. Transcranial Magnetic Stimulation (TMS) (also referred to as repetitive TMS (rTMS)) for the treatment of major depressive disorder (CPT[3] procedure codes 90867 and 90868), is unproven.

V. EFFECTIVE DATE November 13, 1984.

- END -

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CHAPTER 7
SECTION 3.13

PSYCHOTHERAPY

ISSUE DATE: December 5, 1984
AUTHORITY: 32 CFR 199.4(c)(3)(ix)

I. CPT[1] PROCEDURE CODE RANGES

90804 - 90857 for care provided through December 31, 2012.
90832 - 90853 for care provided on or after January 1, 2013.

II. DESCRIPTION

Psychotherapy is the treatment for mental illness and behavioral disturbances in which the clinician establishes a professional contact with the patient and, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development.

III. POLICY

A. Benefits are available for inpatient and outpatient psychotherapy that is medically or psychologically necessary to treat a covered mental disorder.

B. Individual psychotherapy for patients with a mental disorder (DSM IV) that coexists with an alcohol and other drug abuse disorder is a covered benefit.

C. Charges for outpatient psychotherapy are not covered when the patient is an inpatient in an institution. Claims for outpatient psychotherapy must be denied for the entire period during which the beneficiary is an inpatient in the institution.

D. Employees of institutional providers are not authorized to bill for services rendered as part of that employment. Such services billed by the employee must be denied.

E. Eye Movement Desensitization and Reprocessing (EMDR) is covered for the treatment of Post-Traumatic Stress Disorder (PTSD) in adults.

F. Psychotherapy is not a Health and Behavior Assessment/Intervention. See Chapter 7, Section 16.2.

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IV. POLICY CONSIDERATIONS

A. Maximum duration of psychotherapy sessions for care provided through December 31, 2012:

1. Inpatient or outpatient individual psychotherapy (CPT[2] procedure codes 90806, 90807, 90818, 90819) approximately 45 to 50 minutes; or (CPT[2] procedure codes 90804, 90805, 90816, 90817) approximately 20 to 30 minutes.

2. Inpatient or outpatient group, conjoint or family psychotherapy: 90 minutes (CPT[2] procedure codes):

90846 - FAMILY PSYTX W/O PATIENT
90847 - FAMILY PSYTX W/ PATIENT
90849 - MULTIPLE FAMILY GROUP PSYTX
90853 - GROUP PSYCHOTHERAPY

3. Crisis intervention (CPT[2] procedure codes):

90808 - PSYTX, OFFICE, 75-80 MIN
90809 - PSYTX, OFF, 75-80, W/E&M
90821 - PSYTX, HOSP, 75-80 MIN
90822 - PSYTX, HOSP, 75-80 MIN W/E&M

B. Maximum duration of psychotherapy sessions for care provided on or after January 1, 2013:

1. Inpatient or outpatient individual psychotherapy: 30 minutes (CPT[2] procedure codes 90832 and 90833); 45 minutes (CPT[2] procedure codes 90834 and 90836); or 60 minutes (CPT[2] procedure codes 90837 and 90838).

2. Inpatient or outpatient group, conjoint or family psychotherapy (CPT[2] procedure codes):

90846 - FAMILY PSYTX W/O PATIENT
90847 - FAMILY PSYTX W/ PATIENT
90849 - MULTIPLE FAMILY GROUP PSYTX
90853 - GROUP PSYCHOTHERAPY

3. Crisis intervention (CPT[2] procedure codes):

90839 - PSYTX FOR CRISIS, FIRST 60 MIN
90840 - PSYTX FOR CRISIS, EACH ADDL 30 MIN

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C. Frequency of psychotherapy sessions.

NOTE: Beginning October 1, 1993, the mental health benefit year is changed from a calendar year to fiscal year. A patient is not automatically entitled to a designated number of sessions, and review can be more frequent when determined necessary.

1. The frequency limitations on outpatient psychotherapy apply to any psychotherapy performed on an outpatient basis, whether by an individual professional provider or by staff members of an institutional provider.

2. Treatment sessions may not be combined, i.e., 30 minutes on one day added to 20 minutes on another day and counted as one session, to allow reimbursement and circumvent the frequency limitation criteria.

3. Multiple sessions the same day: If the multiple sessions are of the same type--two individual psychotherapy sessions or two group therapy sessions--payment may be made only if the circumstances represent crisis intervention and only according to the restrictions applicable to crisis intervention. A collateral session not involving the identified patient on the same day the patient receives a therapy session does not require review.

4. Collateral visits (CPT[3] procedure code 90887). Collateral visits are payable when medically or psychologically necessary for treatment of the identified patient. A collateral visit is considered to be a psychotherapy session for purposes of reviewing the duration or frequency of psychotherapy.

5. Psychoanalysis (CPT[3] procedure code 90845). Psychoanalysis is covered when provided by a graduate or candidate of a psychoanalytic training institution recognized by the American Psychoanalytic Association and when preauthorized by the contractor.

6. Play therapy. Play therapy is a form of individual psychotherapy which is utilized in the diagnosis and treatment of children with psychiatric disorders. Play therapy is a benefit, subject to the regular points of review and frequency limitations applicable to individual psychotherapy.

7. Marathon therapy. Marathon therapy is a form of group therapy in which the therapy sessions last for an extended period of time, usually one or more days. Marathon therapy is not covered since it is not medically necessary or appropriate.

8. Inpatient psychotherapy and medical care. The allowable charge for inpatient psychotherapy includes medical management of the patient. A separate charge for hospital visits rendered by the provider on the same day as he/she is rendering psychotherapy is not covered. Payment is authorized only for medically necessary hospital visits billed on a day that psychotherapy was not rendered. If the provider who is primarily responsible for treatment of the mental disorder is not a physician, charges for medical management services by a physician are coverable, but only if the physician is rendering services that the non-physician provider is prohibited from providing. Concurrent inpatient care by providers of

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the same or different disciplines is covered only if second or third level review determines that the patient's condition requires the skills of multiple providers.

9. Physical examination. A physical examination is an essential component of the workup of the psychiatric patient, and for all admissions should be performed either by the attending psychiatrist or by another physician. The examination may lead to confirmation of a known psychiatric diagnosis or consideration of other unsuspected psychiatric or medical illness. When not performed by the attending psychiatrist, payment may be made to another physician for performance of the initial physical examination. Any additional concurrent care provided by a physician other than the attending psychiatrist may be covered only if it meets the criteria under inpatient concurrent care.

V. EFFECTIVE DATES

A. November 13, 1984.

B. April 16, 2007, for EMDR for the treatment of PTSD in adults.

- END -

CHAPTER 7
SECTION 22.1

TELEMENTAL HEALTH (TMH)/TELEMEDICINE

ISSUE DATE: April 17, 2003
AUTHORITY: 32 CFR 199.4 and 32 CFR 199.14

I. DESCRIPTION

A. Telemedicine and Telemental Health (TMH) utilize information and telecommunications technology to transfer medical information for diagnosis, therapy and education. The information may include medical images, live two-way audio and video (e.g., video-conferencing), electronic patient medical records, output data from medical devices and sound files. The telemedical interaction may involve two-way live audio and video visits between patients at the "originating site" and medical professionals at the "distant site." Telemental Health is not a substitute for face-to-face behavioral health care and should be considered as the service delivery mode of choice in those instances in which behavioral health care is difficult to access or where continuity of care is critical (for example, when face-to-face care is no longer possible and continuity with the provider is critical in ensuring health maintenance for the beneficiary).

B. Generally, two different kinds of technology are in use in telemedicine. One technology is a two-way interactive video. This technology is used, for example, when a consultation involving the patient and a specialist is necessary. The videoconferencing equipment or an interactive telecommunication system at two locations permits a "real-time" or "live" service or consultation to take place.

C. The other technology, called "store and forward," is used to transfer video images from one location to another. A camera or similar device records (stores) an image(s) that is then sent (forwarded) via telecommunications media to another location for later viewing. The sending of x-rays, computed tomography scans, or magnetic resonance images are common store-and forward applications. The original image may be recorded and/or forwarded in digital or analog format and may include video "clips" such as ultrasound examinations, where the series of images that are sent may show full motion when reviewed at the receiving location.

II. DEFINITIONS

A. Interactive Telecommunications System. Interactive telecommunications systems are defined as multimedia communications equipment that includes, at a minimum, audio-video equipment permitting two-way, real time service or consultation involving the patient and practitioner as appropriate to the medical needs of the patient. Telephone services excluded by 32 CFR 199.4(g)(52) do not meet the definition of interactive telecommunications systems.

B. Originating Site. The originating site is the site where the beneficiary is located and must be where an otherwise authorized TRICARE provider normally offers professional medical or psychological services, such as the office of a TRICARE authorized individual professional provider (e.g., physician's office), or a TRICARE authorized institutional provider. A patient's home is not an originating site.

C. Distant Site. The term "distant site" means the site where the physician or practitioner, providing the professional service, is located at the time the service is provided via a telecommunications system.

D. Telepresenter.

1. Telemedicine. An individual with a clinical background (e.g., Licensed Practical Nurse (LPN), Registered Nurse (RN), etc.) trained in the use of the equipment who is available at the originating site to "present" the patient, manage the cameras and perform any "hands-on" activities to successfully complete the exam. For example, a neurological diagnostic exam usually requires a nurse capable of testing a patient's reflexes and other manipulative activities.

2. Telemental Health (TMH). Most behavioral health encounters do not require a physical examination by a provider. Therefore, for the provision of TMH, an individual with or without a clinical background (e.g., TRICARE authorized medical or behavioral health provider) who is trained in the use of the equipment and who is available at the originating site to "present" the patient, manage the equipment and perform any "hands-on" activities to successfully complete the clinical encounter, may be utilized. The need for a telepresenter with a clinical background is determined by the provider referring the beneficiary to TMH (for an initial TMH encounter) or by the provider delivering TMH care. When TMH care is provided without prior referral or authorization, the TMH provider will determine during the initial encounter whether the individual is appropriate for TMH care and if a telepresenter with a clinical background is necessary.

III. POLICY

A. Telemental Health (TMH).

1. Scope of Coverage. The use of interactive audio/video technology may be used to provide clinical consultation, office visits, individual psychotherapy, psychiatric diagnostic interview examination, and pharmacologic management when appropriate and medically necessary. These services and corresponding Current Procedure Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes are listed below:

a. For care provided through December 31, 2012:

- Individual psychotherapy (CPT[1] procedure codes 90804 - 90809)
- Psychiatric diagnostic interview examination (CPT[1] procedure code 90801)
- Pharmacologic management (CPT[1] procedure code 90862)

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b. For care provided on or after January 1, 2013:

- Individual psychotherapy (CPT[2] procedure codes 90832 - 90838)
- Psychiatric diagnostic interview examination (CPT[2] procedure codes 90791 - 90792)
- Pharmacologic management (add-on CPT[2] procedure code 90863)

2. Technical Requirements. A provider of TMH services shall have video technology components meeting or exceeding American Telemedicine Association (ATA) Standards as outlined in their most current applicable consensus standards and guidelines for TMH, but at a minimum as follows:

a. A minimum bandwidth of 384 kbps (H.263), 256 kbps (H.264), or technical equivalent.

b. A monitor with a:

- Minimum net display of 16 inches diagonally; and
- Non-anamorphic video picture display.

c. A minimum video resolution of one Common Intermediate Format (CIF), or one Source Input Format (SIF).

d. Security. All internet protocol sessions shall be encrypted unless they are conducted entirely on a protected network, or using a virtual private network connection.

e. No later than July 1, 2010, originating sites with more than 50 visits per calendar year shall have cameras with pan, tilt, and zoom capabilities that can be remotely controlled from the distant site.

3. Current TRICARE rules regarding mental health (e.g., preauthorizations) shall apply to TMH services.

B. Telemedicine Procedures. The use of interactive audio/video technology may be used to provide clinical consultations and office visits when appropriate and medically necessary. These services and corresponding CPT or HCPCS codes are listed below:

- Consultations (CPT[2] procedure codes 99241 - 99255)
- Office or other outpatient visits (CPT[2] procedure codes 99201 - 99215)
- End Stage Renal Disease (ESRD) related services (HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318)

C. TMH and Telemedicine.

1. Requirements. Requirements, criteria, and limitations applicable to medical and psychological services shall also apply to services involving TMH/telemedicine health.

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2. Providers.

a. TRICARE authorized providers rendering TMH/telemedicine services are required to be practicing within the scope and jurisdiction of their license or certifications. Otherwise authorized TRICARE providers must be licensed under all applicable licensing requirements of the state(s) in which services are provided and or received.

b. The provider is responsible for ensuring correct TMH/telemedicine licensure. Violation of state licensure laws may have serious consequences for both the consulting health care providers, as well as the referring provider.

c. Providers shall ensure that appropriate staff are available to meet patient needs before, during, and after TMH encounters.

3. Conditions of Payment.

a. For TRICARE payment to occur, interactive audio and video telecommunications must be used, permitting real-time communication between the TRICARE authorized provider distant site and the TRICARE beneficiary.

b. As a condition of payment, the patient must be present and participating in the TMH/telemedicine visit.

NOTE: A TMH/telemedicine service originating from a patient's home is not covered.

4. "Store and Forward" Technology. TRICARE allows payment for those telemedicine applications (such as teleradiology or telepathology) in which, under conventional health care delivery, the medical service does not require face-to-face "hands-on" contact between patient and physician. For example, TRICARE permits coverage of teleradiology, which is the most widely used and reimbursed form of telemedicine, as well as physician interpretation of electrocardiogram and electroencephalogram readings that are transmitted electronically.

5. ATA guidelines. In addition to requirements in this Section, TMH shall be delivered according to the requirements as directed in documents representing the most current applicable consensus standards and guidelines for TMH published by the ATA. It is the provider's responsibility to ensure compliance with the ATA guidelines. The policy stated in this section of the TPM has priority over any standard stated in the ATA guidelines. In the event of conflict between the two, the TPM shall be followed.

6. Reimbursement for TMH/Telemedicine

a. Distant Site.

(1) The payment amount for the professional service provided via a telecommunication system by a TRICARE authorized provider at the distant site is the lower of the CHAMPUS Maximum Allowable Charge (CMAC), the billed charge, or the negotiated rate, for the service provided. Payment for an office visit, consultation, individual

psychotherapy or pharmacologic management via a telecommunications system should be made at the same amount as when these services are furnished without the use of a telecommunications system.

(2) For TRICARE payment to occur, the provider must be a TRICARE authorized provider and the service must be within a provider's scope of practice under all applicable state(s) law(s) in which services are provided and or received.

(3) The beneficiary is responsible for any applicable copay or cost-sharing. The copayment amount shall be the same as if the service was without the use of a telecommunications system.

b. Originating Site Facility.

(1) For covered TMH/telemedicine services delivered via a telecommunications system, the payment for the originating site facility fee (Q3014) will be the lesser of the originating site fee or the actual charge. The facility fee for the originating site for 2009 is $23.72. For past and future years, the facility fee for the originating site is included in the annual updates of the CMAC file. It will be updated annually by the Medicare Economic Index (MEI). Annual updates of the originating site facility fee (Q3014) will be included in the annual updates of the CMAC file and TRICARE contractors will implement these updates in accordance with the annual CMAC updates.

(2) Outpatient cost-share rules will apply to this fee.

(3) For reporting TMH/telemedicine services, contractors will use CPT or HCPCS codes with a **GT** modifier for distant site and Q3014 for originating site to distinguish telemedicine services. By coding and billing the **GT** modifier with a covered telemedicine procedure code, the distant site provider certifies that the beneficiary was present at an eligible originating site when the TMH/telemedicine service was furnished.

(4) Payment is made only when the originating site is an otherwise authorized TRICARE provider normally offers professional medical or psychological services. No payment shall be made when the originating site does not satisfy this requirement (e.g., no payment shall be made when the originating site is the beneficiary's home).

IV. EFFECTIVE DATE August 1, 2003.

- END -

ENCLOSURE 2

APPENDIX B

SAMPLE

CLAIMS SUBMISSION REQUIREMENTS

To facilitate the processing of Partnership Claims, the following guidelines must be followed.

1. Each claim must be identified by a large, bold "Partnership" stamp that does not obscure the claim information. If claims are not identified in this manner, they will be processed as TRICARE claims since it is impossible for the TMA claims processor to otherwise distinguish them.
2. All Partnership claims are to be submitted on either a CMS 1500 (08/05) or DD 2642 claims form. No beneficiary-submitted claims will be processed.
3. The claim form must clearly indicate that it is from a participating provider by checking the "Yes" block next to "participating" on the appropriate TRICARE-approved claim form.
4. Only TRICARE-approved procedure codes are to be used to bill for all services provided.
5. Only procedures/services that are within the scope of the approved Agreement are to be billed.
6. The procedures/services billed to TRICARE are only those provided to TRICARE-eligible beneficiaries.
7. All partnership procedures/services are to be performed within the Military Treatment Facility (MTF), and the appropriate block on the TRICARE claim form must indicate that the procedures/services were provided in the MTF.
8. If a beneficiary has other health insurance (OHI), the claims for Partnership procedures/services must first be filed with the other coverage before being submitted to TRICARE. Documentation of the action taken by the OHI plan must accompany the partnership claim submitted to TRICARE.
9. The beneficiary must not be billed for any deductibles or cost-shares.
10. Only the fees specified in the Partnership Agreement are to be billed to TRICARE.

ENCLOSURE 2

APPENDIX C

SAMPLE

NEGOTIATED RATES

LETTER OF AGREEMENT
BETWEEN
(MTF Name)
AND
(Health Care Provider Name)

SUBJECT: List of Providers, Locations, Specialties and Costs

1. The Health Care Provider agrees to provide pediatric, primary care, and family practice physician services for $XX.XX per visit, and Physician Assistant Services at $XX.XX per visit.
   a. XXXXX Clinic: Family Practice and Pediatrics.
   b. XXXXX Clinic: Pediatrics and Family Practice.
   c. XXXXX MTF: Primary Care Services and Physician Assistant Services.
   d. XXXXXX Clinic: Family Practice Service, to include obstetric care up to the 36th week of gestation, and Physician Assistant Services.
   e. XXXXXX Clinic: Primary Care and Pediatrics.
   f. Psychology Services, provided through December 31, 2012, at XXXXXX, XXXXXXXX, and XXXXXX Clinics as listed below:

CPT CODE[1]	PROCEDURE	RATE:
90801	Diagnostic Interview (90 min)	$XXX.XX
90804	Psychotherapy (30 min)	$ XX.XX
90806	Psychotherapy (50 min)	$ XX.XX
90808	Psychotherapy (80 min)	$XXX.XX
90846	Family Therapy (w/o patient)	$ XX.XX
90847	Family Therapy (with patient)	$ XX.XX
90853	Group Therapy	$ XX.XX
96100	Psychological Testing	$ XX.XX
96115	Neurobehavioral Exam	$ XX.XX
90901	Biofeedback Training	$ XX.XX
90887	Exam Interpretation	$ XX.XX

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g. Psychology Services, provided on or after January 1, 2013, at XXXXXX, XXXXXXXX, and XXXXXX Clinics as listed below:

CPT CODE[1]	PROCEDURE	RATE:
90791	Diagnostic Evaluation	$XXX.XX
90832	Psychotherapy (30 min)	$XXX.XX
90834	Psychotherapy (45 min)	$XXX.XX
90837	Psychotherapy (60 min)	$XXX.XX
90846	Family Therapy (w/o patient)	$XXX.XX
90847	Family Therapy (with patient)	$XXX.XX
90853	Group Therapy	$XXX.XX
96100	Psychological Testing	$XXX.XX
96115	Neurobehavioral Exam	$XXX.XX
90901	Biofeedback Training	$XXX.XX
90887	Exam Interpretation	$XXX.XX

h. Psychiatry Services, provided through December 31, 2012, at XXXXXX, XXXXXXX, and XXXXXXX.

CPT CODE[1]	PROCEDURE	RATE:
90801	Diagnostic Interview (90 min.)	$XXX.XX
90802	Diagnostic Interview, Interactive (90 min)	$XXX.XX
90804	Psychotherapy (30 min.)	$ XX.XX
90806	Psychotherapy (50 min.)	$ XX.XX
90808	Psychotherapy (80 min.)	$XXX.XX
90846	Family Therapy (w/o patient)	$ XX.XX
90847	Family Therapy (with patient)	$XXX.XX
90853	Group Therapy (Each)	$ XX.XX
90862	Pharmacologic Management	$ XX.XX
90887	Interpretation of Psychiatric Exams	$ XX.XX
90901	Biofeedback Training	$ XX.XX
96100	Psychological Testing	$ XX.XX
96115	Neurobehavioral Status Exam	$ XX.XX

i. Psychiatry Services, provided on or after January 1, 2013, at XXXXXX, XXXXXXX, and XXXXXXX.

CPT CODE[1]	PROCEDURE	RATE:
90791	Diagnostic Evaluation	$XXX.XX
90792	Diagnostic Evaluation (w/medical svc)	$XXX.XX
90832	Psychotherapy (30 min)	$XXX.XX
90834	Psychotherapy (45 min)	$XXX.XX
90837	Psychotherapy (60 min)	$XXX.XX
90846	Family Therapy (w/o patient)	$XXX.XX
90847	Family Therapy (with patient)	$XXX.XX
90853	Group Therapy (Each)	$XXX.XX
90863	Pharmacologic Management	$XXX.XX
90887	Interpretation of Psychiatric Exams	$XXX.XX
90901	Biofeedback Training	$XXX.XX
96100	Psychological Testing	$XXX.XX
96115	Neurobehavioral Status Exam	$XXX.XX

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2. The MTF will endeavor to provide a nursing assistant. receptionist, and billing agent for each MTF location at no extra cost.

ENCLOSURE 2

APPENDIX D

SAMPLE

APPROVAL OF THE PARTNERSHIP AGREEMENT BETWEEN (MTF Name) AND (Health Care Provider Name)

The undersigned, as evidenced by their signatures below, approve this Military-Civilian Health Services Partnership Program Letter of Agreement.

_____	_____
TAO Director **(Typed Name and Title)**	**Date**
_____	_____
Surgeon General of the (specify Service Branch) **(Typed Name and Title)**	**Date**
_____	_____
Executive Director, TRICARE Management Activity **(Typed Name and Title)**	**Date**

ENCLOSURE 3

SAMPLE

TEMPLATE INTERNAL PARTNERSHIP AGREEMENT FOR GROUP AGREEMENTS

MILITARY-CIVILIAN HEALTH SERVICES PARTNERSHIP PROGRAM LETTER OF AGREEMENT BETWEEN (MTF Name) AND (Contractor Name)

A. GENERAL

1. This Agreement is entered into by and between **(MTF Name)**, hereinafter referred to as the Military Treatment Facility or MTF, and **(Contractor Name)**, hereinafter referred to as the Health Care Provider. The term "Health Care Provider" includes individual practitioners under contract with **(Contractor Name)**, and credentialed by the MTF. A list of individual practitioners will be provided to the MTF at least 5 workdays prior to commencement of services under this Agreement. This Agreement is effective for two years upon written notification to the parties of approval by the TMA Executive Director or designee.
2. The purpose of this Agreement is to integrate specific MTF and TRICARE program resources to provide medical services for TRICARE beneficiaries at **(MTF Name)**.
3. Individual practitioners complete application for clinical privileges at the MTF for the purpose of practicing medicine in **(Enter Specialty)**. The Health Care Provider agrees to all the terms and conditions of the application for clinical privileges at the MTF, as well as the terms and conditions of this Agreement.
4. The MTF is a U. S. Government health care facility within the Department of Defense (DoD) operated by the **(Military Department)**. The MTF is accountable to the Surgeon General of the **(Military Department)** as the equivalent of the Board of Trustees. The MTF Commander is the local representative of the Board of Trustees and is responsible for the operation of the MTF.
5. This Agreement does not become binding on either party until signed by the Executive Director, TRICARE Management Activity (TMA) (or designee). Their signed approval will become an enclosure to this Agreement (see Appendix D).
6. During the term of this Agreement, the Health Care Provider and its practitioners will not advise, recommend, or suggest that persons authorized to receive medical care at DoD facilities, should receive medical care from the Health Care Provider, or any other contracted health care practitioner, or employee, except pursuant to this Agreement.

7. The Health Care Provider and its individual practitioners are not prohibited, by reason of this Agreement, from conducting a private practice, if the following conditions prevail:
   a. No conflict with the performance of duties under the Agreement exists.
   b. Practice is not conducted at any DoD Medical Treatment Facility or using any U.S. Government property.
   c. The Health Care Provider and its individual practitioners comply with paragraph 6 above.

B. ARTICLES OF AGREEMENT

1. The MTF Commander, or Designee, shall:
   a. Review past and current performance of, determine qualifications of, determine liability insurance coverage of, and select potential health care entities.
   b. Comply with Utilization Review and Quality Assurance directives and **(Military Department)** regulations, including, but not limited to:
      1) Ensuring that individual practitioners of the Health Care Provider are credentialed in accordance (IAW) with DoD and Military Department directives and regulations and MTF bylaws. The **(MTF Name)** Credential's Committee has reviewed the Health Care Provider's credentials and found them acceptable IAW applicable regulations.
      2) Ensuring that individual practitioners and support staff of the Health Care Provider adhere to MTF bylaws and DoD and Military Department directives and regulations to the same extent and in the same manner as **(Military Department)** health care providers and support staff.
   c. Provide facilities, ancillary support, diagnostic and therapeutic services, equipment, and supplies necessary for the proper care and management of patients under this Agreement, to the extent available and authorized for that facility.
   d. Provide administrative support to the Health Care Provider's individual practitioners, to the extent available and authorized for that facility, including:
      1) Maintenance of patient records, including transcription and copying services, as may be necessary to satisfy both **(Military Department)** and private practitioner recordkeeping requirements.
      2) Maintenance of individual practitioner case, workload, and credentials files in support of credentialing processes.
      3) TRICARE administration requirements, including certification and submission, but only to the extent that it is not prohibited by 18 U.S.C. 203, 205. However, the Health Care Provider will be responsible for its own billing support.
      4) Authorizing subsistence at MTF dining facilities at the rates prescribed for civilian guests.
      5) To the extent allowed by U.S. law and regulation and by the Status Of Forces Agreement and host nation supplementary agreements, Health Care Provider Practitioners and associated support personnel will be afforded logistic support.

e. Educate MTF staff, beneficiaries, other TRICARE Partnership providers, and other interested civilian providers about the Partnership Program.

f. Provide appropriate reimbursement for care rendered in the MTF to patients not eligible for TRICARE benefits.

g. Encourage beneficiaries to use Partnership Program services rather than other TRICARE services for medical care.

h. Notify the appropriate TRICARE Claims Processor and TMA of all additions to or deletions from the attached list of practitioners by the Health Care Provider.

i. Comply with all regulatory and other requirements for granting access to DoD Computer Systems, including, but not limited to:

1) Obtaining necessary documentation from the Health Care Provider to enable a National Agency Check (NAC) (or other necessary check in the case of non-U.S. citizens) to be performed.

2) Following procedures specified by the TMA Privacy Office (in the case of U.S. citizens) or equivalent local procedures (in the case of non-U.S. citizens).

2. The Health Care Provider/Contractor shall:

a. Meet the licensing and privileging requirements of the MTF, to include, but not limited to, 10 U.S.C. sec. 1094 and DoD Directives 6025.13, for all Health Care practitioners and support personnel.

b. Provide full professional liability insurance covering acts or omission of all Health Care Provider practitioners, support staff, and other resources supporting practitioners as part of this Agreement to the same extent as is usual and customary in the civilian practice community. The MTF Commander or designee shall, after consultation with and concurrence of the Staff Judge Advocate, have the sole authority to determine whether the terms, conditions, and limits of the professional liability insurance policy meet the requirements of this paragraph. The insurance will be for all claims filed within the statute of limitation period provided by law. Evidence of such insurance will be provided by the Health Care Provider to **(MTF Name)** upon execution of this Agreement and thereafter, whenever the current certification expires.

c. Furnish evidence of Occurrence-Type professional liability insurance or, at a minimum, Claims-Made coverage which contains tail coverage endorsement, or an equivalent clause, providing indemnification for the United States for all claims filed within the statute of limitation period provided by law. Liability coverage is applicable to clinical privileges granted. Failure to maintain adequate coverage is cause for immediate termination of the Agreement.

d. Provide full disclosure of all information, including, but not limited to, past performance, as required by the credentialing process.

e. Abide by MTF bylaws and DoD and Military Department directives and regulations with regard to Utilization Review and Quality Assurance Directives, including, but not limited to, in service training, maintenance of records, utilization review, performance evaluation, release of medical information, and credentialing. The Health Care Provider understands and agrees to the responsibilities of meeting and sustaining professional qualifications and requirements commensurate with credentialing and privileging standards of the MTF for its providers and support personnel. Failure to meet these standards serves as a basis to cancel this Agreement immediately.

f. Abide by unique **(Military Department)** requirements concerning the nature of limited privileged communication between the patient and the Health Care Provider as may be necessary for security and Personnel Reliability Programs (PRP).

g. In general, use all available **(Military Department)** resources to include, but not limited to, specialty consultations, ancillary services, equipment and supplies for the optimal care of patients under this Agreement. The Health Care Provider/Contractor or **(MTF name)** will provide support personnel as shown in Appendix A of this Agreement.

h. Adhere to this TRICARE Health Care Provider Agreement and claim submission requirements concerning allowable payment for services rendered as stated in Appendix B to this Agreement. Allowable payment will be based on medical services delivered to patients in **(MTF Name)** and will be made by TRICARE to the Health Care Provider in the amount specified in Appendix C to this Agreement.

i. Claims for patients having private health insurance must be submitted to the private insurance carrier prior to filing any claim with the U.S. Government. The Health Care Provider individual practitioners may charge their customary fee to private insurance. If private insurance pays equal to, or more than the fee established by this Agreement, no claim may be filed to TRICARE. If the insurance pays less than the agreed fee, then a claim for the difference may be filed to TRICARE.

j. Abide by regulatory and other requirements for being granted access to DoD Computer Systems. This includes, but is not limited to, filling out all necessary forms and granting any necessary releases to enable a National Agency Check (NAC) (or other necessary check in the case of non-U.S. citizens) to be performed.

C. OTHER CONSIDERATIONS

1. Neither party shall assign, transfer, convey, sublet, or otherwise dispose of this Agreement, or the right, title to, or interest therein, or the power to execute such Agreement, to any other person, company, or corporation, without the other party's previous written consent. Consent must be, as a minimum, between the Health Care Provider, the MTF Commander, the TAO Director or designee, and TMA Executive Director or designee.

2. In the event of illness or incapacity rendering the Health Care Provider incapable of delivering services, care for patients under this Agreement shall be transferred to other health care providers at the discretion of the MTF Commander.

3. The proposed term of this Agreement is two (2) years with an option to renew for a two-year period based upon mutual agreement. Exercise of the renewal option requires affirmative written action on the part of the MTF and the Health Care Provider/Contractor not less than ninety (90) days prior to the end of the Agreement. Termination of this Agreement shall be predicated upon satisfactory written notice to the other party not less than ninety (90) days before the proposed termination date. The ninety (90)-day-notice requirements may be waived by mutual consent of the parties to the Agreement or unilaterally for the convenience of the Government (including its mobilization requirements).
4. Regardless of any provision of host nation law to the contrary, Health Care Provider practitioners shall abide by the **(Military Department)** rules and regulations concerning the confidentiality of patient records, as embodied in the Privacy Act of 1974, DoD regulations and directives, and **(Military Department)** regulations.
5. Regardless of any provision of host nation law to the contrary' Health Care Provider providers will abide by **(Military Department)** rules and regulations concerning release of information to the public, as embodied in the Freedom of Information Act, DoD Health Information Privacy Regulation (DoD 6025.18-R), and current DoD directives. This provision specifically requires Health Care Provider practitioners to obtain advance approval from the **(Military Department)** before publication of technical papers in any professional or scientific journals, at any seminars or conferences, or in any other written or oral media.
6. The MTF Commander designates **(Insert Name and Title of MTF Representative)** as the point of contact for the MTF. The Health Care Provider/Contractor designates **(Insert Name and Title of Representative)**, as the point of contact for the Health Care Provider/Contractor.
7. It is understood that no care rendered pursuant to this Agreement will be a part of a study, research grant, or other protocol without the written consent of the Director, TMA, and the Assistant Secretary of Defense (Health Affairs).
8. The MTF's liability for actions of its employees is governed by 10 U.S.C.1089, 10 U.S.C. 2734, and 28 U.S.C. 1346(b), 2671-80. Health Care Provider/Contractor practitioners are not employees within the definition of these Federal statutes. Under the terms of this Agreement, Health Care Provider practitioners are solely responsible for any and all liability incurred as a result of their actions or omissions, and the Health Care Provider practitioners shall indemnify the United States Government from any and all liability.
9. Disputes between the parties to this Agreement:
    a. If any dispute concerning this Agreement cannot be resolved between the Health Care Provider and the MTF point of contact, the decision of the MTF Commander is final.
    b. Choice of Law. United States law will control in any dispute between the Health Care Provider/Contractor and the U.S. Government concerning this Agreement.

10. Non-exclusivity. The Health Care Provider understands that this Agreement does not constitute an exclusive right to perform medical services at the MTF. The MTF reserves the right to execute other Agreements with TRICARE partners for the performance of medical services and to perform medical services by hiring and using its own employees and officers.
11. Modifications. This Agreement may only be modified in writing, signed by the Health Care Provider and the MTF Commander or designee and Executive Director, TMA or designee.

RECOMMENDATION FOR APPROVAL:

MTF Name	Health Care Provider/Contractor
_____	_____
Name of MTF Authorized Signer	Name and Title of Health Care Provider/Contractor Authorized Signer
Date: _____	Date: _____

Appendix A: Health Care Provider/Associated Support Personnel Staffing
Appendix B: Claims Submission Requirements
Appendix C: Negotiated Fee Schedule
Appendix D: Approval of the Partnership Agreement

ENCLOSURE 3

APPENDIX A

SAMPLE

HEALTH CARE PROVIDER/ASSOCIATED SUPPORT PERSONNEL STAFFING
LETTER OF AGREEMENT
BETWEEN
(MTF Name)
AND
(Health Care Provider/Contractor)

SUBJECT: Items Negotiated between the Two Parties

1. The **(MTF Name)** or Health Care Provider will endeavor to provide adequate nursing assistants, receptionists, and billing support for care provided under this Agreement. Nursing support personnel will attend a one day Newcomer's Orientation class, a three-day Nursing Orientation class, and all other training which the MTF normally requires of its own nursing support personnel. Such training may consist of courses on direct patient care, safety, and systems & security, but will not include military-related courses. Additionally, new receptionists/nursing assistants will contact the MTF or clinic Health Benefits Advisor for a briefing on TRICARE requirements and TRICARE eligibility. The MTF will be responsible for providing appointment and ancillary support services.
2. The Health Care Provider agrees to receive all TRICARE eligible patients. Patients who are determined to be TRICARE ineligible will be referred back to the MTF for reappointment.
3. The **(MTF Name)** or Health Care Provider recognizes that continuity of patient care is of the utmost importance to the MTF, and will endeavor to furnish support staff who are available for the duration of the Agreement.

MTF COMMANDER _____

_____ _____
Commander Provider

Date: _____ Date: _____

ENCLOSURE 3

APPENDIX B

SAMPLE

CLAIMS SUBMISSION REQUIREMENTS

To facilitate the processing of Partnership Claims, the following guidelines must be followed.

1. Each claim must be identified by a large, bold "Partnership" stamp that does not obscure the claim information. If claims are not identified in this manner, they will be processed as TRICARE claims since it is impossible for the TMA claims processor to otherwise distinguish them.
2. All Partnership claims are to be submitted on either a CMS 1500 (08/05) or DD 2642 claims form. No beneficiary-submitted claims will be processed.
3. The claim form must clearly indicate that it is from a participating provider by checking the "Yes" block next to "participating" on the appropriate TRICARE-approved claim form.
4. Only TRICARE-approved procedure codes are to be used to bill for all services provided.
5. Only procedures/services that are within the scope of the approved Agreement are to be billed.
6. The procedures/services billed to TRICARE are only those provided to TRICARE-eligible beneficiaries.
7. All partnership procedures/services are to be performed within the Military Treatment Facility (MTF), and the appropriate block on the TRICARE claim form must indicate that the procedures/services were provided in the MTF.
8. If a beneficiary has other health insurance (OHI), the claims for Partnership procedures/services must first be filed with the other coverage before being submitted to TRICARE. Documentation of the action taken by the OHI plan must accompany the partnership claim submitted to TRICARE.
9. The beneficiary must not be billed for any deductibles or cost-shares.
10. Only the fees specified in the Partnership Agreement are to be billed to TRICARE.

ENCLOSURE 3

APPENDIX C

SAMPLE

NEGOTIATED RATES

LETTER OF AGREEMENT
BETWEEN
(MTF Name)
AND
(Health Care Provider Name)

SUBJECT: List of Providers, Locations, Specialties and Costs

1. The Health Care Provider agrees to provide pediatric, primary care, and family practice physician services for $XX.XX per visit, and Physician Assistant Services at $XX.XX per visit.
   a. XXXXX Clinic: Family Practice and Pediatrics.
   b. XXXXX Clinic: Pediatrics and Family Practice.
   c. XXXXX MTF: Primary Care Services and Physician Assistant Services.
   d. XXXXXX Clinic: Family Practice Service, to include obstetric care up to the 36th week of gestation, and Physician Assistant Services.
   e. XXXXXX Clinic: Primary Care and Pediatrics.
   f. Psychology Services, provided through December 31, 2012, at XXXXXX, XXXXXXXX, and XXXXXX Clinics as listed below:

CPT CODE[1]	PROCEDURE	RATE:
90801	Diagnostic Interview (90 min)	$XXX.XX
90804	Psychotherapy (30 min)	$XXX.XX
90806	Psychotherapy (50 min)	$XXX.XX
90808	Psychotherapy (80 min)	$XXX.XX
90846	Family Therapy (w/o patient)	$XXX.XX
90847	Family Therapy (with patient)	$XXX.XX
90853	Group Therapy	$XXX.XX
96100	Psychological Testing	$XXX.XX
96115	Neurobehavioral Exam	$XXX.XX
90901	Biofeedback Training	$XXX.XX
90887	Exam Interpretation	$XXX.XX

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g. Psychology Services, provided on or after January 1, 2013, at XXXXXX, XXXXXXXX, and XXXXXX Clinics as listed below:

CPT CODE[1]	PROCEDURE	RATE:
90791	Diagnostic Evaluation	$XXX.XX
90832	Psychotherapy (30 min)	$XXX.XX
90834	Psychotherapy (45 min)	$XXX.XX
90837	Psychotherapy (60 min)	$XXX.XX
90846	Family Therapy (w/o patient)	$XXX.XX
90847	Family Therapy (with patient)	$XXX.XX
90853	Group Therapy	$XXX.XX
96100	Psychological Testing	$XXX.XX
96115	Neurobehavioral Exam	$XXX.XX
90901	Biofeedback Training	$XXX.XX
90887	Exam Interpretation	$XXX.XX

h. Psychiatry Services, provided through December 31, 2012, at XXXXXX, XXXXXXX, and XXXXXXX:

CPT CODE[1]	PROCEDURE	RATE:
90801	Diagnostic Interview (90 min.)	$XXX.XX
90802	Diagnostic Interview, Interactive (90 min)	$XXX.XX
90804	Psychotherapy (30 min.)	$XXX.XX
90806	Psychotherapy (50 min.)	$XXX.XX
90808	Psychotherapy (80 min.)	$XXX.XX
90846	Family Therapy (w/o patient)	$XXX.XX
90847	Family Therapy (with patient)	$XXX.XX
90853	Group Therapy (Each)	$XXX.XX
90862	Pharmacologic Management	$XXX.XX
90887	Interpretation of Psychiatric Exams	$XXX.XX
90901	Biofeedback Training	$XXX.XX
96100	Psychological Testing	$XXX.XX
96115	Neurobehavioral Status Exam	$XXX.XX

i. Psychiatry Services, provided on or after January 1, 2013, at XXXXXX, XXXXXXX, and XXXXXXX:

CPT CODE[1]	PROCEDURE	RATE:
90791	Diagnostic Evaluation	$XXX.XX
90792	Diagnostic Evaluation (w/medical svc)	$XXX.XX
90832	Psychotherapy (30 min)	$XXX.XX
90834	Psychotherapy (45 min)	$XXX.XX
90837	Psychotherapy (60 min)	$XXX.XX
90846	Family Therapy (w/o patient)	$XXX.XX
90847	Family Therapy (with patient)	$XXX.XX
90853	Group Therapy (Each)	$XXX.XX
90863	Pharmacologic Management	$XXX.XX
90887	Interpretation of Psychiatric Exams	$XXX.XX
90901	Biofeedback Training	$XXX.XX
96100	Psychological Testing	$XXX.XX
96115	Neurobehavioral Status Exam	$XXX.XX

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2. The MTF will endeavor to provide a nursing assistant, receptionist, and billing agent for each MTF location at no extra cost.

ENCLOSURE 3

APPENDIX D

SAMPLE

APPROVAL OF THE PARTNERSHIP AGREEMENT
BETWEEN
(MTF Name)
AND
(Health Care Provider Name)

The undersigned, as evidenced by their signatures below, approve this Military-Civilian Health Services Partnership Program Letter of Agreement.

_____	_____
TAO Director **(Typed Name and Title)**	**Date**
_____	_____
Surgeon General of the (specify Service Branch) **(Typed Name and Title)**	**Date**
_____	_____
Deputy Director, TRICARE Management Activity **(Typed Name and Title)**	**Date**

ENCLOSURE 4

SAMPLE

MILITARY-CIVILIAN HEALTH SERVICES PARTNERSHIP PROGRAM
ANNUAL JUSTIFICATION
BETWEEN
(MTF Name)
AND
(Individual/Group Health Care Provider Name)

1. This document is an addendum to the Letter of Agreement (LOA) dated _____ between the above listed parties. That LOA was approved by the TRICARE Management Activity (TMA) Executive Director, for the period (enter "from-to" dates provided in WPS' or PGBA's authorization letter), pending annual certification of the continued need for this Partnership Agreement.
2. The terms and conditions of the original LOA will be complied with to the full extent for the second year.
3. This addendum does not become binding on either party until it is approved by the TRICARE Regional or Area Office Director, the Service Surgeon General, and the TMA Deputy Director.
4. As the MTF commander, I certify/approve that the data contained in the original Business Case Analysis (BCA) is still valid and that the provider's services are still required.

_____ _____

MTF Commander **Date**
(Typed Name and Title)

The undersigned, as evidenced by their signature below, approve continuation of the partnership Agreement.

_____ _____

Director, TAO or TRO **Date**
(Typed Name and Title)

_____ _____

Surgeon General of the (specify Service Branch) **Date**
(Typed Name and Title)

_____ _____

Deputy Director, TMA **Date**
(Typed Name and Title)

ENCLOSURE 5

BUSINESS CASE ANALYSIS

TABLE OF CONTENTS

NOTE: A complete BCA must include all worksheets.

OVERVIEW

This TRICARE Management Activity (TMA) Business Case Analysis (BCA) template has been developed in accordance with TRICARE policy implementing the Military-Civilian Health Services Partnership Program, hereafter referred to as the "Partnership Program." The guidance contained herein is intended for use by the TRICARE Overseas Area Offices which do not have at-risk TRICARE Managed Care Support Contracts. The TRICARE Policy Manual 6010.54-M, August 1, 2002, Chapter 12, Section 4.2 titled, TRICARE OVERSEAS PROGRAM (TOP) PARTNERSHIP PROGRAM provides information regarding the Partnership Program.

http://www.tricare.osd.mil/tp02/c12s4_2.pdf

A partnership analysis should be initiated within the requesting Medical Treatment Facility (MTF) and is intended to assist MTF leadership, the appropriate Service Surgeon General and the TRICARE Area Office Director, and the Director of TMA in determining the feasibility of establishing a Partnership Agreement to augment or implement clinical services not available within the overseas military healthcare system.

There are three major elements of the partnership proposal: Executive Summary, MTF Optimization, and Other Benefits. The routing process is extensive beginning with the MTF through the TRICARE Area Office Director and appropriate Service Surgeon General to TMA-West. TMA-West will coordinate their recommendations through the Director, TMA for approval. Upon approval/disapproval by the Director of TMA, TMA-West will make notification to the MTF. Recommendations for disapproval at any level will be returned. Therefore, the process should begin at least 90 days before a requested start date of a new agreement or before an existing agreement expires.

How to Use the BCA Model:

1. **Complete a separate BCA if there are any factors which affect workload and/or financial analysis, such as requests of multiple Primary Care specialties or Specialists. For example, if you need two Primary Care specialties, an Internist and a Pediatrician, complete two BCAs: one for the Internist and one for the Pediatrician.**
2. **Fill in the white cells in all required worksheets. The turquoise cells will automatically populate by formula or pull from other worksheets in the BCA.**
3. **Finish by completing the Executive Summary. Provide a brief narrative to further support your request.**
4. **Submit through designated individual offices for approval according to the policy referenced above.**

Worksheet 2

DEFINITIONS	
Requested Partnership Providers	Total FTEs of new and/or renewal Partnership Providers requested by this BCA
Authorized Providers	Earned personnel positions based on Service standards.
Assigned Providers	Actual personnel assigned to authorized positions.
MTF Provider Average Per Year	MTF Providers Total Visits/MTF Providers Assigned
Partnership Provider Average Per Year	Partnership Providers Total Visits/Partnership Providers Assigned
Average Per Provider	Total Visits (MTF + Partnership Providers)/Providers Assigned (MTF + Partnership Providers)
Delta	MTF Authorized - (MTF Assigned + Partnership Requested)
Marginal Cost	Cost required to produce one more unit of service. The marginal cost for a patient visit might include a single-use instrument tray, medication, disposable equipment, dressing supplies, etc., used during the visit. List any marginal costs on the Financial Analysis worksheet.
Claims (Healthcare Costs)	Total Projected Annual Workload for Partnership Provider Requested x Cost Per Visit
Negotiated Rate	Rate per procedure negotiated with the Partnership provider.
Network/Local Rate	Actual or estimated rate for network or local provider in the community.

Worksheet 3

EXECUTIVE SUMMARY

Although this section appears first in the BCA, it is suggested that it be completed last.

Most of the information in the Analysis Summary is brought forward from the subsequent worksheets. The Analysis Summary concludes with an MTF Commander certification. A check mark entered before each statement certifies that the listed criteria was met before entering into this Partnership Agreement.

Comments in the Narrative section should effectively and concisely outline your key goals and objectives. Emphasize the most important facts, such as potential savings, long-term benefits, strategic focus, or any other factors that justify your decision. As a general rule, your narrative should include the nature and purpose of your Partnership Agreement request and highlight the major points and implications of your request. Details of your analysis should be provided in the appropriate worksheets.

I. ANALYSIS SUMMARY

Application for: New ▼

Demographics:

Requesting MTF (Name/Address)	
Requesting POC (Name/Phone/E-mail)	
Partnership Provider Name	
Provider Specialty/Clinic	
Clinic Practice Location	
Date Submitted (dd/mm/yy)	

Total Population Served: 0

Historical Workload (Last 12 Months):

PRIMARY CARE		SPECIALTY CARE	
MTF Provider Average Per Year	0	MTF Provider Average Per Year	0
Partnership Provider Average Per Year	0	Partnership Provider Average Per Year	0
Average Per Provider	0	Average Per Provider	0

Projected Workload (12 Months):

Total Proj Annual Workload for Partnership Provider(s) Requested	0	Average Per Provider Including Partnership	0

PCM Enrollment Ratio:

Average Enrollees Per Assigned PCM	**1 to**	0	Average Projected Enrolled per PCM	**1 to** 0
			Service Standard Ratio Per PCM	**1 to** 0

EXECUTIVE SUMMARY (CONT'D)

Summary of Cost Options:	Partnership	Network/Local	TDY
Cost First Year (Start-Up & Recurring)	-	-	-
Cost Second Year (Recurring)	-	-	-
Savings (Partnership vs. Network/Local)	-		
Savings (Partnership vs. TDY)	-		

Providers Assigned:	
Primary Care Providers (including assigned Partnership)	0.0
Specialty/Allied/Nurse (including assigned Partnership)	0.0

Other Benefits:

MTF Commander Certification:

I certify that:

- ☐ Use of the Partnership Program will meet a need for health care services that is not adequately being met by, and cannot be met with, existing MTF resources.
- ☐ Use of the Partnership Program is consistent with the mission of the MTF.
- ☐ Use of the Partnership Program is consistent with the high standards of quality health care established for MTFs.

II. NARRATIVE:

Worksheet 4

ELIGIBLE POPULATION	
This section should identify your eligible population. The source for the eligible population data is M2, CHCS, or the TRICARE Europe website. http://www.europe.tricare.osd.mil	
Active Duty Service Members	
Active Duty Family Members 0-18	
Active Duty Family Members 19+	
Retirees under age 65	
Retirees Age 65 or over	
Data Source(s):	**Total:** 0

Worksheet 5

PRIMARY CARE SUPPORT ANALYSIS

Complete this section if you are requesting a Primary Care Partnership Provider. For the requested Primary Care Specialty, enter the number of *Authorized* and *Assigned* FTEs for MTF Providers and the FTEs of *Assigned* and/or *Requested* Partnership Providers. *Requested* Partnership Providers is the total of new and renewal Partnership Providers requested by this BCA. If you are requesting more than one Primary Care Specialty (i.e., an Internist and a Family Practitioner), complete a separate BCA for each specialty.

This section should detail the proposal's impact on your current staffing levels. The data source for the Army is the Table of Distribution and Allowances for Providers Authorized/Assigned. For the Air Force, the data source is the Unit Personnel Manning Roster. For the Navy, the data source is the Navy Personnel System.

For providers who worked full-time, part of the year (i.e., newly assigned), part time FTE, or part time due to other duties (such as deployment), enter the FTE value in the *Assigned* cell as a fraction to the nearest tenth. For example, if a provider has worked 10 months of the year, enter .8 for the value in the *Assigned* cell. Or if the provider worked in the clinic 20 hours per week due to other duties, enter .5 for the FTE value in the *Assigned* cell. For each fraction, explain in the *Additional Comments* section what the fraction represents (i.e., provider worked part time due to other duties or was only available 10 months of the year due to deployment).

I. PRIMARY CARE SPECIALTY (INCLUDING PARTNERSHIP PROVIDERS)

Primary Care Specialty Requested	MTF		Partnership		Delta
	Authorized	Assigned	Assigned	Requested	
Family Practitioner ▼					0.0
Total:	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

II. ELIGIBLE ENROLLED/PCM RATIO

Avg Enrollees per Assigned PCM (MTF Provider(s) of Requested Specialty): **1 to:**

Service Standard Ratio Per PCM: **1 to:**

(If ratio is below Service standard, please justify below):

III. ANCILLARY STAFFING

Is ancillary staffing sufficient to handle additional projected workload?	Comments:
Yes ▼	

PRIMARY CARE SUPPORT ANALYSIS (CONT'D)

IV. NEGOTIATED RATE

Negotiated Rate for Partnership Provider(s) Per Visit	0.00

V. ADDITIONAL COMMENTS

Data Source(s):	

Worksheet 6

SPECIALIST/ALLIED HEALTH/NURSE CARE SUPPORT ANALYSIS

Complete this section if you are requesting a Specialist, Allied Health, or Nurse Support Partnership provider. For the requested provider, enter the number of *Authorized* and *Assigned* FTEs for MTF Providers and the FTEs of *Assigned* and/or *Requested* Partnership Providers. *Requested* Partnership Providers is the total of new and renewal Partnership Providers requested by this BCA. For example, if you are requesting an Orthopedist, provide the number of authorized and assigned FTEs of MTF Orthopedists and the number of assigned and/or requested Partnership Orthopedists. If you are requesting more than one provider, complete a separate BCA for each different type of provider. Follow the same guidance for Allied Health and Nurse Support Providers.

This section should detail the proposal's impact on your current staffing levels. The data source for the Army is the Table of Distribution and Allowances for Providers Authorized/Assigned. For the Air Force, the data source is the Unit Personnel Manning Roster. For the Navy, the data source is the Navy Personnel System.

For providers who worked full-time, part of the year (i.e., newly assigned), part time FTE, or part time due to other duties (such as deployment), enter the value for *Assigned* as a fraction to the nearest tenth. For example, if a provider has worked 10 months of the year, enter .8 for the FTE value in the *Assigned* cell. Or if the provider worked in the clinic 20 hours per week due to other duties, enter .5 for the FTE value in the *Assigned* cell. For each fraction, explain below what the fraction represents (for example, provider worked part time due to other duties or was only available 10 months of the year due to deployment).

I. PRIMARY CARE SPECIALTY (INCLUDING PARTNERSHIP PROVIDERS)

Specialist/Allied Health/Nurse Support Provider Requested	MTF		Partnership		Delta
	Authorized	Assigned	Assigned	Requested	
General Surgeon ▼					0.0
Total:	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

II. ANCILLARY STAFFING

Is ancillary staffing sufficient to handle additional projected workload? Yes ▼

Comments:

IV. NEGOTIATED RATE

Negotiated Rate for Partnership Provider(s) Per Visit 0.00

V. ADDITIONAL COMMENTS

Data Source(s):

Worksheet 7

PATIENT APPOINTMENT WORKLOAD

Complete this section to document historical workload for the requested Primary Care Specialty, Specialist, or Allied Health Provider over the past 12 months and to project the annual Partnership Provider workload for the next 12 months.

Historical Workload:
If this is a continuation of a previous Partnership Provider Agreement, enter workload data for the past 12 months in the Partnership Providers sub-section. If you also have MTF providers assigned in the requested specialty, enter workload data for the past 12 months in the MTF Providers sub-section. If this is a new Partnership Provider Agreement, the Partnership Provider sub-section will be blank. If you do not have any MTF Providers assigned to the requested specialty, the MTF Providers sub-section will be blank. Historical workload data can be obtained from M2 or CHCS by appointment type. Non-countable provider workload should not be included (such as RN, Medical Tech, or any other visit that is not considered countable).

Projected Workload:
Always project the annual workload of your Partnership Provider(s) requested, whether it may be a continuation of a previous service or a new service, and enter the value in the *Total Projected Annual Workload for Partnership Provider(s) Requested* field. For example, if you are requesting an Orthopedist Partnership Provider, enter the projected workload for the next 12 months. Or if you are requesting two Orthopedist providers, enter the combined projected workload for both providers for the next 12 months. Explain your method for calculating the projected workload.

I. HISTORICAL WORKLOAD (LAST 12 MONTHS)

CLINIC: _____ **SPECIALTY:** Family Practitioner ▼

YEAR: _____

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	TOTAL
Partnership Providers:													
Routine													**0**
Acute													**0**
Wellness													**0**
Other Appt													**0**
Total Visits	0	0	0	0	0	0	0	0	0	0	0	0	**0**
MTF Providers:													
Routine													**0**
Acute													**0**
Wellness													**0**
Other Appt													**0**
Total Visits	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Total Visits	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

PRIMARY CARE			**SPECIALTY CARE**	
MTF Provider Average Per Year			MTF Provider Average Per Year	
Partnership Provider Average Per Year		**OR**	Partnership Provider Average Per Year	
Average Per Provider			Average Per Provider	

PATIENT APPOINTMENT WORKLOAD (CONT'D)		
II. PROJECTED WORKLOAD (12 MONTHS)		
Total Proj Annual Workload for Partnership Provider(s) Requested	0	0
(Identify below method of calculating projected workload for Partnership Provider(s)):		
Data Source(s):		

Worksheet 8

FINANCIAL ANALYSIS

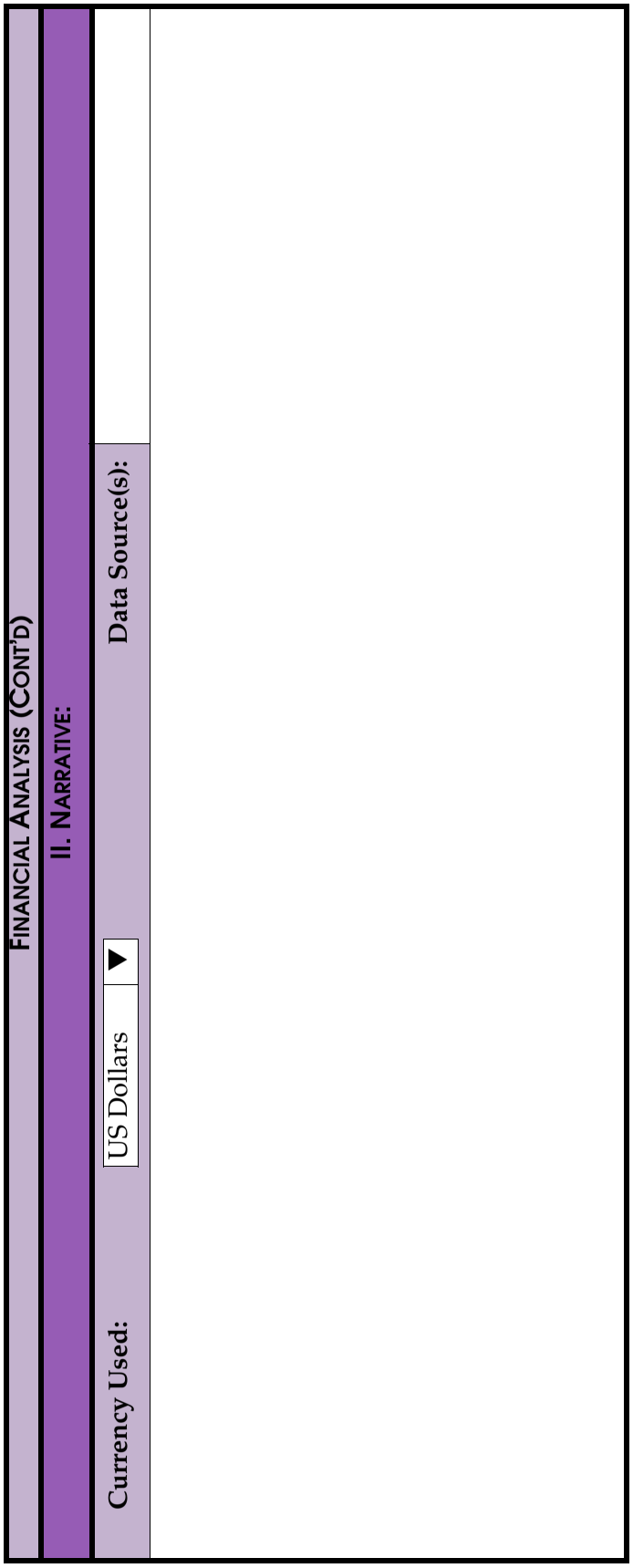
Complete this section using data from MCOAT, CDIS, EAS IV (or CRIS if your facility does not have access to EAS IV). The Navy source for financial data is the Navy Medicine Financial System. If you currently have a Partnership Provider, use actual cost data from the past 12 months. Second year costs should be projected based on actual costs from the previous year. New agreements should include start-up costs and annual recurring costs the first year and only include estimated recurring costs for the second year.

In the *Narrative* section, identify currency used throughout the Business Case Analysis, sources of data used, and discuss/identify any financial issues that are not apparent in the data.

I. SUMMARY OF COST OPTIONS

		Partnership	Network/Local	TDY
Start-Up Costs	**Equipment Purchase**		0.00	
	Remodel Costs		0.00	
	Furniture Costs		0.00	
	Other (Specify Below)		0.00	
	Total Start-Up Costs	**0.00**	**0.00**	**0.00**
Annual Recurring Costs	**Cost Per Visit**	0.00	0.00	0.00
	Equipment (Rental)		0.00	
	Facility Costs		0.00	
	Marginal Costs/Supplies		0.00	
	Per Diem/Lodging	0.00	0.00	
	Transportation	0.00	0.00	
	Claims (Healthcare Costs)	0.00	0.00	0.00
	Other (Specify Below)	0.00	0.00	0.00
	Total Recurring Costs	**0.00**	**0.00**	**0.00**
Cost First Year (Start-Up & Recurring)		**0.00**	**0.00**	**0.00**
Cost Second Year (Recurring)		**0.00**	**0.00**	**0.00**
Total Two Year Costs		**0.00**	**0.00**	**0.00**
Savings (Partnership vs. Network)		**0.00**		
Savings (Partnership vs. TDY)		**0.00**		

Worksheet 9


FINANCIAL ANALYSIS (CONT'D)
II. NARRATIVE:
Currency Used:
US Dollars
Data Source(s):

MULTIPLE RATES WORKSHEET

If you have multiple procedures and negotiated rates, use this worksheet to compute total annual healthcare costs. The total healthcare costs will automatically be entered into the Financial Analysis worksheet, *Claims (Healthcare Costs)*.

PROJECTED ANNUAL HEALTHCARE COSTS

PROCEDURE	ANNUAL WORKLOAD	PARTNERSHIP		NETWORK/LOCAL	
		NEGOTIATED RATE	TOTAL COST	RATE	TOTAL COST
			0.00		0.00
			0.00		0.00
			0.00		0.00
			0.00		0.00
			0.00		0.00
			0.00		0.00
			0.00		0.00
			0.00		0.00
			0.00		0.00
			0.00		0.00
			0.00		0.00
			0.00		0.00
			0.00		0.00
			0.00		0.00
			0.00		0.00
			0.00		0.00
			0.00		0.00
			0.00		0.00
			0.00		0.00
Total Projected Annual Healthcare Costs			**0.00**		**0.00**
Total Proj Annual Workload for Partnership Provider Requested	**0**				

Worksheet 10

OTHER BENEFITS		
Identify any readiness reasons that should be considered in evaluating this proposal. Examples of specific readiness issues could include deployments, training, etc., (greater than 180 days) that impacts your ability to provide care. Also consider any patient satisfaction benefits that will be derived from this proposal as well as any other reasons that should be considered in evaluating this proposal (for example, quality of life issues).		
	SYNOPSIS	**DETAIL**
1		
2		
3		

Worksheet 11

- END -