

Health Care Providers And Review Requirements

Revision: C-1, March 10, 2017

1.0 NETWORK DEVELOPMENT

The TRICARE Prime Remote (TPR) program has no network development requirements.

2.0 UNIFORMED SERVICES FAMILY HEALTH PLAN (USFHP)

2.1 In addition to receiving claims from civilian providers, the contractor may also receive TPR Program claims from certain USFHP designated providers (DPs). The provisions of TPR will not apply to services furnished by a USFHP DP if the services are included as covered services under the current negotiated agreement between the USFHP DP and Office of the Assistant Secretary of Defense, Health Affairs (OASD(HA)). However, the contractor shall process claims according to the requirements in this chapter for any services not included in the USFHP DP agreement.

2.2 The USFHP, administered by the DPs listed below currently have negotiated agreements that provide the Prime benefit (inpatient and outpatient care). Since these facilities have the capability for inpatient services, they can submit claims that the contractor will process according to applicable TRICARE and TPR reimbursement rules:

- CHRISTUS Health, Houston, TX (which includes):
 - St. Mary's Hospital, Port Arthur, TX
 - St. John Hospital, Nassau Bay, TX
 - St. Joseph Hospital, Houston, TX
- Martin's Point Health Care, Portland, ME.
- Johns Hopkins Health Care Corporation, Baltimore, MD.
- Brighton Marine Health Center, Boston, MA.
- St. Vincent's Catholic Medical Centers of New York, New York City, NY.
- Pacific Medical Clinics, Seattle, WA.

3.0 VETERAN'S AFFAIRS

The contractor shall reimburse for services under the current national Department of Defense/ Department of Veterans Affairs (DoD/DVA) Memorandum of Agreement (MOA) for "Referral of Active

Duty Military Personnel Who Sustain Spinal Cord Injury (SCI), Traumatic Brain Injury (TBI), or Blindness to Veterans Affairs Medical Facilities for Health Care and Rehabilitative Services.” (See [Section 4, paragraph 2.2](#) for additional information.) The contractor shall not reimburse for services provided to TPR enrollees under any local Memoranda of Understanding (MOU) between the DoD (including the Army, Air Force and Navy/Marine Corps facilities) and the Department of Veteran’s Affairs (DVA). Claims for these services will continue to be processed by the Military Services. However, the contractor shall process claims according to the requirements in this chapter for any services not included in the local MOU.

4.0 DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) [INDIAN HEALTH SERVICE (IHS), PUBLIC HEALTH SERVICE (PHS), ETC.]

Claims for services not included in the current MOU between the DoD (including the Army, Air Force and Navy/Marine Corps facilities) and the DHHS (including the IHS, PHS, etc.) shall be processed in accordance with the requirements in this chapter.

5.0 REVIEW REQUIREMENTS

5.1 Provision Of Documents

If the Specified Authorization Staff (SAS) requests copies of supporting documentation related to care reviews, appeals, claims, etc., the contractor shall send the requested copies to the SAS within four work days of receiving the request.

5.2 Primary Care

Service members enrolled in the TPR program can receive primary care services under TRICARE Prime without a referral, an authorization, or a fitness-for-duty review by the SAS (see [Addendum A](#)). Service members with assigned Primary Care Managers (PCMs) will receive primary care services from their PCMs. Service members without assigned PCMs will receive primary care services from TRICARE-authorized civilian providers, where available, or from other civilian providers where TRICARE-authorized civilian providers are not available.

5.3 Care Requiring SAS Review

The following care requires SAS review: all inpatient hospitalization, mental health care, invasive medical and surgical procedures (with the exception of laboratory/diagnostic services), and substance abuse.

5.3.1 Referred Care

5.3.1.1 The requesting provider shall follow the contractor’s referral procedures and shall contact the contractor for an authorization. Upon receipt of a civilian provider referral, the contractor shall perform a covered service review. If an authorization is required, the contractor shall enter the information in [Addendum B](#), required by the SAS for a fitness-for-duty review ([paragraph 5.3](#)). SAS will respond to the contractor within two business days. When a SAS referral directs evaluation or treatment of a condition, as opposed to directing a specific service(s), the contractor shall use its best business practices in determining the services encompassed within the Episode Of Care (EOC), indicated by the referral. A SAS authorization for health care includes authorization for any TRICARE

covered ancillary or diagnostic services related to the health care authorized (i.e., associated with the EOC). The contractor shall not communicate to the provider or patient that the care has been authorized until the SAS review process has been completed. The contractor shall use the same best business practices as used for other Prime enrollees in determining EOC when claims are received with lines of care that contain both referred and non-referred lines. Laboratory tests, radiology tests, echocardiogram, holter monitors, pulmonary function tests, and routine treadmill tests logically associated with the original EOC may be considered part of the originally requested services and do not need to come back to the PCM (if assigned) or Primary Care Provider (PCP) for approval.

5.3.1.2 If the SAS determines that the Service member may receive the care from a civilian source, the SAS will enter the appropriate code into the authorization/referral system. The contractor shall notify the Service member of approved referrals. The Service member may receive the specialty care from a Military Treatment Facility (MTF)/Enhanced Multi-Service Market (eMSM), a network provider, or a non-network provider according to TRICARE access standards, where possible. In areas where providers are not available within TRICARE access standards, community norms shall apply. (A Service member may always choose to receive care at an MTF/eMSM even when the SAS has authorized a civilian source of care and even if the care at the MTF/eMSM cannot be arranged within the Prime access standards subject to the member's unit commander [or supervisor] approval.) If the appointment is with a non-network provider, the contractor shall instruct the provider on payment requirements for Service members (e.g., no deductible or cost-share) and on other issues affecting claim payment (e.g., the balance billing prohibition). The contractor shall follow [Chapter 8, Section 5](#) when there are additional requests by an MTF/eMSM for Civilian Health Care (CHC) needs. The contractor shall adjudicate claims for additional MTF/eMSM requested civilian care in accordance with [Chapter 8, Sections 2 and 5](#).

5.3.1.3 If the contractor does not receive the SAS's response or request for an extension within two work days, the contractor shall, within one work day after the end of the two work day waiting period, enter the contractor's authorization code into the contractor's claims processing system. The contractor shall document in the contractor's system each step of the effort to obtain a review decision from the SAS. The first choice for civilian care is with a network provider; if a network provider is not available within Prime access standards, the contractor may authorize the care with a TRICARE-authorized provider. The contractor shall help the Service member locate an authorized provider.

5.3.1.4 If the SAS directs the care to a military source, the SAS will manage the EOC. If the Service member disagrees with a SAS determination that the care must be provided by a military source, the Service member may appeal only through the SAS who will coordinate the appeal as appropriate; the contractor shall refer all appeals and inquiries concerning the SAS's fitness-for-duty determination to the SAS.

5.3.1.5 If the Service member's PCM determines that a specialty referral or test is required on an urgent basis (less than 48 hours from the time of the PCM office visit) the PCM shall contact the contractor for a referral and send required information to the SAS for a fitness for duty review. The Service member shall receive the care as needed without waiting for the SAS determination, and the contractor shall adjudicate the claim according to TRICARE Prime provisions. If further specialty care is warranted, the PCM shall request a referral to specialty care. The contractor shall contact the SAS with a request for an additional SAS review for the specialty care.

5.3.2 Care Received With No Authorization or Referral

5.3.2.1 The contractor may receive claims for care that require referral, authorization, and SAS review, that have not been authorized or reviewed. If the claim involves care covered under TRICARE policy, the contractor shall pend the claim and supply the required information ([Addendum B](#)) to the SAS for review. If the SAS does not notify the contractor of the review determination or ask for an extension for further review within two workdays after submitting the request for coverage determination, the contractor shall then authorize the care. The contractor shall then release the claim for payment, and apply any overrides necessary to ensure that the claim is paid with no fees assessed to the Service member. However, the contractor shall not make claims payments to sanctioned or suspended providers (see [Chapter 13, Section 5](#)).

Note: Claims for care provided under the National DoD/DVA MOA for Payment for Processing Disability Compensation and Pension Examinations (DCPE) in the Integrated Disability Evaluation System (IDES) shall follow the routing requirements [specified in Chapter 17, Section 2, paragraph 3.2.5](#).

5.3.2.2 If the contractor determines that the requested service, supply, or equipment is not covered by TRICARE policy (including [Chapter 17, Section 3, paragraph 2.2.4](#)) and no Defense Health Agency (DHA) approved waiver is provided, the contractor shall decline to file an authorization and shall deny any received claims accordingly. The contractor shall notify the civilian provider and the remote Service member/non-enrolled Service member of the declined authorization with explanation of the reason. The notification to a civilian provider and the remote Service member/non-enrolled Service member shall explain the waiver process and provide contact information for the applicable Uniformed Services Headquarters Point of Contact (POC)/Service Project Officers as listed in [Chapter 16, Section 2, paragraph 2.0](#). No notification to the SAS is required.

Note: If the SAS retroactively determines that the payment should not have been made, the contractor shall initiate recoupment actions according to [Chapter 10, Section 4](#).

6.0 ADDITIONAL INSTRUCTIONS

6.1 Comprehensive Health Promotion and Disease Prevention Examinations

The contractor shall reimburse charges for comprehensive health promotion and disease prevention examinations covered under TRICARE Prime (see the TRICARE Policy Manual (TPM), [Chapter 7, Section 2.2](#)) without SAS review.

6.2 Vision And Hearing Examinations

The Service member may directly contact the contractor for assistance in arranging for vision and hearing examinations. The contractor shall refer Service members to SAS for information on how to obtain eyeglasses, hearing aids, and contact lenses as well as examinations for them.

6.3 No PCM Assigned

Service members who work and reside in areas where a PCM is not available may directly access the contractor for assistance in arranging for routine primary care and for urgent specialty or inpatient care with a TRICARE-authorized provider. Since a non-network provider is not required to know the fitness-for-duty review process, it is important that the Service member coordinate all

requests for specialty and inpatient care through the contractor. The contractor shall contact the SAS as required for reviews and other assistance as needed.

6.4 Emergency Care

For emergency care, refer to the TPM for guidelines.

6.5 Dental Care

Claims for active duty dental services will be processed and reimbursed by a single separate active duty dental program contractor. Claims for adjunctive dental care will be processed and reimbursed by the contractor or the TRICARE Overseas Program (TOP) contractor for overseas care.

6.6 Immunizations

The contractor shall reimburse immunizations as primary care under the guidelines in the TRICARE Reimbursement Manual (TRM).

6.7 Ancillary Services

A SAS authorization for health care includes authorization for any ancillary services related to the health care authorized.

7.0 SERVICE MEMBER MEDICAL RECORDS

7.1 For TPR-enrolled Service members with assigned PCMs, the contractor shall follow contract requirements for maintaining medical records.

7.2 Service members will be instructed by their commands to sign annual medical release forms with their PCMs to allow information to be forwarded as necessary to civilian and military providers. The contractor may use the current "signature on file" procedures to fulfill this requirement ([Chapter 8, Section 4, paragraph 6.0](#)). When a Service member leaves an assignment as a result of a Permanent Change of Station (PCS) or other service-related change of duty status, the PCM shall provide a complete copy of medical records, to include copies of specialty and ancillary care documentation, to the Service member within 30 calendar days of the Service member's request for the records. The Service member may also request copies of medical care documentation on an ongoing, EOC basis. The contractor shall be responsible for all administrative/copying costs. Network providers shall be reimbursed for medical records photocopying and postage costs incurred at the rates established in their network provider participation agreements. Participating and non-participating providers shall be reimbursed for medical records photocopying and postage costs on the basis of billed charges. Service members who have paid for copied records and applicable postage costs shall be reimbursed for the full amount paid to ensure they have no out of pocket expenses. All providers and/or patients must submit a claim form, with the charges clearly identified, to the contractor for reimbursement. Service member's claim forms should be accompanied by a receipt showing the amount paid.

Note: The purpose of the copying of medical records is to assist the Service member in maintaining accurate and current medical documentation. The contractor shall not make payment to the provider who photocopies medical records to support the adjudication of a claim.

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Note: Service members without assigned PCMs are responsible for maintaining their medical records when receiving care from civilian providers.

8.0 PROVIDER EDUCATION

The contractor shall familiarize network providers and, when appropriate, other providers with the TPR Program, special requirements for Service member health care, and billing procedures (e.g., no cost-share or deductible amounts, balance billing prohibition, etc.). On an ongoing basis, the contractor shall include information on Service member specialty care procedures and billing instructions in routine information and educational programs according to contractual requirements.

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