

Chapter 24

Section 6

Medical Management

Revision: C-91, June 25, 2021

1.0 GENERAL

All TRICARE requirements regarding Utilization Management (UM) and Quality Management (QM) shall apply to the TRICARE Overseas Program (TOP) unless specifically changed, waived, or superseded by the provisions of this section; the TRICARE Policy Manual (TPM), [Chapter 12](#); or the TRICARE contract for health care support services outside the 50 United States (U.S.) and the District of Columbia (hereinafter referred to as the “TOP contract”). See [Chapter 7](#) for additional instructions. Language in [Chapter 7](#) that has no direct application to the TOP contract does not apply (e.g., Diagnosis Related Group (DRG) validation reviews which are not applicable in any overseas location except Puerto Rico).

2.0 UTILIZATION MANAGEMENT

2.1 The contractor shall establish a Medical Management (MM)/UM Plan for care received by TRICARE beneficiaries.

2.1.1 The contractor’s MM/UM Plan shall recognize that the Military Treatment Facility (MTF) Primary Care Manager (PCM) retains clinical oversight for TOP Prime enrollees. As such, the enrolling MTF will determine medical and psychological necessity, and issue all referrals for TOP Prime enrollees, and provide UM and all case management services for the MTF-enrolled population. The contractor shall ensure that MTF-issued referrals and appropriate authorizations are entered into all applicable contractor systems to ensure accurate, timely customer service and claims adjudication. The contractor shall perform certain UM activities to assist the MTF with the medical management of TOP Prime inpatients as described in the TOP contract. The contractor shall provide notification to the MTF Commander or designee whenever an MTF enrollee is admitted to an inpatient facility (including mental health admissions), regardless of location.

Note: Newborns/adoptees who are deemed enrolled in TOP Prime (based on the sponsor’s MTF enrollment) shall receive clinical oversight from the MTF.

2.1.2 The contractor shall determine medical and psychological necessity, conduct covered benefit review, and issue authorizations for specialty care for TOP Prime Remote enrollees and all Service members who are on Temporary Duty/Temporary Additional Duty (TDY/TAD), in an authorized leave status, or deployed/deployed on liberty in a remote overseas location. The contractor shall provide notification of cases to the appropriate TRICARE Area Office (TAO) for reviews involving remote Service member requests for specialty care, and whenever hospital admissions have occurred for any beneficiary not enrolled to a TOP MTF (including mental health admissions), regardless of location.

Note: Newborns/adoptees who are deemed enrolled in TOP Prime Remote (based on the sponsor's TOP Prime Remote enrollment) shall receive clinical oversight from the TOP contractor.

2.1.3 The contractor shall review and authorize urgent care for beneficiaries enrolled to a stateside contractor who are traveling outside of the 50 U.S. and the District of Columbia.

2.2 The MM/UM Plan shall recognize that purchased care sector network providers are the responsibility of the TOP contractor and the contractor shall ensure that any adverse finding related to purchased care sector provider care is forwarded within five calendar days of identification to the appropriate TAO.

2.3 The MM/UM Plan shall include a process for identifying high utilization/high cost patients and locations.

2.3.1 At a minimum, this process shall include the identification of patients exceeding the frequency and/or cost thresholds established in the TOP contract. These thresholds apply to all TOP beneficiaries, including TOP Prime, TOP Prime Remote, TRICARE Select, and TOP TRICARE For Life (TFL).

2.3.2 The TOP contractor shall review these claims for appropriateness of care, and shall propose interventions to reduce overutilization or contain costs whenever possible. Proposed interventions to cost and/or overutilization shall be forwarded to the Government for review prior to contractor implementation.

2.4 The MM/UM Plan shall integrate efforts to identify potential fraud/abuse. Any cases identified as possible fraud/abuse shall be referred directly and exclusively to the Defense Health Agency (DHA) Program Integrity (PI) Office in accordance with [Section 14](#).

2.5 The TOP contractor shall provide case management services as outlined in the contract with DHA. Specific case management processes shall be addressed in the Statements Of Responsibilities (SORs) between the contractor, MTF Commanders, and the TAO Directors.

2.6 The TOP contractor shall closely monitor requests for inpatient care or medical evacuation services to ensure that services are medically or psychologically necessary and appropriate for the patient's condition. Beneficiaries will not be assigned to a particular facility or medically evacuated to a particular geographic location based solely on personal preference, but will be transported to the closest medical facility capable of providing appropriate stabilization and/or treatment.

2.7 Inpatient stays that exceed the standard Length-Of-Stay (LOS) for a local area in a purchased care sector country or U.S. commonwealth/territory shall be identified and reviewed for medical or psychological necessity. Unless a different standard has been identified by the government, the contractor shall use best business practices to determine the standard LOS for a particular overseas location. Upon Government request, the TOP contractor shall provide supporting documentation related to LOS determinations.

3.0 CONTRACTOR RELATIONSHIP WITH THE MILITARY HEALTH SYSTEM (MHS) TRICARE QUALITY MANAGEMENT CONTRACT (TQMC) CONTRACTOR

The provisions of [Chapter 7, Section 3](#) do **not** apply to the TOP.

4.0 CLINICAL QUALITY MANAGEMENT PROGRAM (CQMP)

The provisions of [Chapter 7, Section 4](#) are applicable to the TOP, except that the requirement for interface with the TQMC contractor is waived for the TOP. The TQMC contractor does not conduct regular, ongoing reviews to validate the appropriateness of the TOP contractor's quality of care and utilization review decisions; however, the TQMC contractor may provide such reviews on a limited basis upon Government request.

5.0 REFERRAL/AUTHORIZATION/HEALTH CARE FINDER (HCF) REQUIREMENTS

5.1 The TOP contractor shall develop procedures for processing referrals for TOP Prime and TOP Prime Remote enrollees in accordance with the TOP contract; [Chapter 8, Section 5](#); and this chapter. The TOP contractor shall conduct related authorization and HCF activities. The MTF will conduct medical and psychological necessity reviews for TOP MTF enrollees and determine that the requested care is not available in the MTF prior to forwarding the referral to the contractor.

5.2 The contractor shall conduct covered benefit reviews to determine whether the referred care is a covered TRICARE benefit. Medical or psychological necessity notification to beneficiaries regarding covered benefit findings shall follow the provisions of [Chapter 8, Section 5](#). The contractor shall locate an appropriate network or non-network purchased care sector provider for all authorized care and shall provide the provider information to the beneficiary. Upon beneficiary request, the contractor shall assist with scheduling an appointment for the beneficiary. The contractor shall also implement guarantee of payment or other business processes to ensure that TOP Prime and TOP Prime Remote beneficiaries have access to authorized care on a cashless, claimless basis.

5.3 The TOP contractor shall develop procedures for the identification and tracking of TOP enrollee claims submitted by a purchased care sector provider or a beneficiary without preauthorization/authorization.

5.4 The TOP contractor shall educate beneficiaries of the preauthorization/authorization requirements and of the procedures for requesting preauthorization/authorization. In MTF locations, these beneficiary education efforts may be conducted in conjunction with MTF staff. In remote locations, the contractor shall provide all beneficiary education. Although beneficiaries are required to obtain authorization for care prior to receiving payment for the care requiring TOP preauthorization/authorization, retroactive authorization may be requested following the care from the appropriate authority for issuing authorizations. Specifically, ADSMs enrolled in TOP Prime or TOP Prime Remote who seek urgent care from a purchased care sector without obtaining authorization will be required to contact their PCM within three business days so that a retroactive referral may be submitted. **Claims for ADSMs shall be processed in accordance with [Section 26](#).** Retroactive authorization requests shall not be accepted by the TOP contractor after this initial time frame without higher level approval (TAO or TOP Office). The contractor shall document preauthorization/authorizations according to current contract requirements.

5.5 If medical review is required to determine medical or psychological necessity of a service rendered, the TOP contractor shall follow the requirements outlined in [Chapter 7, Section 1](#) related to medical review staff qualifications and review processes.

5.6 The TOP preauthorization/authorization must be submitted with the claim or be available via internal contractor systems designated to interface with the claims processing system.

5.7 The TOP contractor shall maintain a preauthorization/authorization file.

5.8 When necessary, clarification of discrepancies between authorization data and data on the claims shall be made by the TOP contractor with the appropriate authorizing authority.

5.9 Except for obstetrical care or other long-term/chronic care authorizations, the TOP contractor shall consider authorizations valid for 180 days (i.e., date of service must be within 180 days of issue date). Authorizations may be granted for 365 days for obstetrical care, or for any other long-term/chronic conditions for which an extended care period is medically or psychologically necessary and appropriate. Only services that are applicable to the care authorization shall be covered under the authorization (i.e., a care authorization for obstetrical care cannot be extended to cover specialty care that is unrelated to the pregnancy).

5.10 Procedures for preauthorizations/authorizations for TOP beneficiaries for inpatient mental health care rendered in the 50 U.S. or the District of Columbia shall be developed by the TOP contractor. The TOP contractor shall authorize/review all stateside non-emergency inpatient mental health care (i.e., acute hospitalization psychiatric care, psychiatric Residential Treatment Center (RTC), Substance Use Disorder (SUD) inpatient/residential detoxification and rehabilitation for TOP Prime/TOP Prime Remote ADFMs, regardless of where the care is rendered. To perform this requirement, the contractor shall at a minimum provide:

- Three 24-hour telephone lines: one stateside toll free, one commercial and one fax for overseas inpatient mental health review requirement;
- Sample forms for use by the referring physician when requesting preauthorization/authorization for care; and
- A system for notification of the contractor when care has been authorized. Additionally, the TOP contractor shall:

5.10.1 Inform the beneficiary/provider if a desired facility is not a TRICARE authorized facility and offer the beneficiary/provider a choice of alternative facilities and assist with identifying stateside facilities for referring providers.

5.10.2 Upon request, either telephonically or by fax, from a referring provider, the contractor shall initiate preauthorization prior to admission for non-emergency inpatient care, including RTC, Substance Use Disorder Rehabilitation Facility (SUDRF), etc. (Essentially, all admissions defined by TPM, [Chapter 1, Section 6.1](#), as requiring preauthorization). The TOP contractor shall arrange ongoing utilization review, as indicated, for overseas beneficiaries admitted to any level of inpatient mental health care.

5.10.3 The review determination must conclude in either authorization or denial of care. Review results must be submitted via Health Insurance Portability and Accountability Act (HIPAA) compliant electronic means to the beneficiary/provider within 24 hours of the request. The review and denial process will follow, as applicable the processes outlined in [Section 7](#).

5.10.4 The TOP contractor shall provide an opportunity to discuss the proposed initial denial determination with the patient's attending physician AND referring physician (if different providers). The purpose of this discussion is to allow further explanation of the nature of the beneficiary's need for

health care support services, including all factors which preclude treatment of the patient as an outpatient or in an alternative level of inpatient care. This is important in those beneficiaries designated to return overseas, where supporting alternative level of care may be limited, as well as support for intensive outpatient treatment. If the referring provider does not agree with the denial determination, then the contractor shall contact the appropriate overseas TAO Medical Director to discuss the case. The TAO Director shall provide the schedule and contact information for all overseas TAO mental health advisors. The final decision on whether or not to issue a denial will be made by the TOP contractor.

5.10.5 The TOP contractor shall notify the referring provider if the patient is returning to ensure coordination of appropriate after-care arrangements, as well as facilitate discussion with the attending provider to ensure continuity of care is considered with the proposed after-care treatment plan.

5.10.6 The TOP contractor shall adhere to the appeals process outlined in [Section 12](#).

5.11 The required data elements for MTF referrals prescribed in [Chapter 8, Section 5, paragraph 6.1](#) may be altered to accommodate the delivery of health care overseas with the permission of the Government.

Note: Any alteration to the referral data elements prescribed in [Chapter 8, Section 5, paragraph 6.1](#) must be approved in writing by the DHA Contracting Officer (CO) prior to implementation.

6.0 MEDICAL TRAVEL

6.1 TOP Prime Enrollees and MTF-Referred Transient Beneficiaries

If the TOP contractor's HCF determines that appropriate medical or psychological care is not available in the beneficiary's local service area, the TOP contractor shall provide a Notification of Case (NOC) Report to the appropriate TAO per the medical travel requirements. Details for reporting are identified in DD Form 1423, Contract Data Requirements List (CDRL), located in Section J of the applicable contract. The NOC Report shall identify the nearest purchased care sector provider or facility that can provide adequate specialty care. The TOP contractor shall issue a care authorization upon MTF's request (as documented in the MTF's response to the NOC Report).

6.2 TOP Prime Remote and Self-Referred Transient Beneficiaries

If the TOP contractor's HCF determines that appropriate medical or psychological care is not available in the beneficiary's local service area, the TOP contractor shall provide a NOC Report to the appropriate TAO per the medical travel requirements. Details for reporting are identified in DD Form 1423, CDRL, located in Section J of the applicable contract. The NOC Report shall identify the nearest purchased care sector provider or facility that can provide adequate specialty care. The TOP contractor shall issue a care authorization upon TAO's request (as documented in the TAO's response to the NOC Report).

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