



DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
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IN REPLY REFER TO
BUMEDINST 6000.15
BUMED-M3
10 Oct 2013

BUMED INSTRUCTION 6000.15

From: Chief, Bureau of Medicine and Surgery

Subj: NAVY MEDICINE REFERRAL MANAGEMENT PROGRAM

Ref: (a) through (s), see enclosure (1)

Encl: (1) References
(2) Defer to Network Flow Chart
(3) Right of First Refusal Flow Chart
(4) Acronyms

1. Purpose. This instruction provides guidance for implementation by Navy medical treatment facilities (MTF). The overarching goal of referral management (RM) is to provide each patient with a seamless, well-coordinated continuum of care. MTF commanders, commanding officers (COs), and officers in charge (OICs) must build upon the framework established in this instruction to optimize the RM process and ensure the process is responsive to patient needs and the unique aspects of the local health care market. The goals of RM are to promote continuity of care and utilize resources efficiently. This instruction also supports the Surgeon General's Strategic Goals of Value in the management of enrollee network cost/recapture of care as well as the Strategic Enabling Objectives by optimizing technology and by standardizing business processes. References (a) through (r) provide additional information to clarify this directive. Enclosure (1) contains a list of references.

2. Cancellations. BUMED Memo 6000 Ser M3M12/04UM3M104019 of 25 June 2004 and BUMED Memo 6040 Ser M3/5/UM3/5855 of 16 Feb 2011 (NAVMED Policy 11-002) of 16 February 2011 are hereby canceled.

3. Scope. This instruction applies to all Navy Medicine activities, both in the continental United States and outside the continental United States. It applies to:

- a. Referrals initiated within a MTF (to include Branch Health Clinics);
- b. Referrals between MTFs;
- c. Right of first refusal (ROFR) requests coming into an MTF from civilian providers; and

d. Referrals originating from deployed or non-deployed Operational Medical Units. Operational Medical Units are defined as staff sick call and medical departments aboard surface or undersea vessels, aviation units, and group and battalion aid stations attached to Marine Corps units

4. Background

a. In May 2004, Deputy Director, TRICARE Management Activity (TMA) implemented policy and guidance supporting RM activities throughout the Military Health System (MHS) during the execution of the second generation of TRICARE contracts (TRICARE Next Generation of Contracts (TNEX)).

b. In June 2004, Navy Medicine provided interim guidance supporting MHS RM activities by establishing RM business rules and processes for healthcare delivery under TNEX.

c. The TRICARE Third Generation managed care support contract no longer requires the TRICARE Regional Contractor to ensure that clear and legible reports (CLRs) are received from providers on care referred to the purchased care system. This responsibility was transferred to the MTFs.

d. The Joint Healthcare Operations Council (JHOC) adopted the Air Force's Integrated Clinical Database (ICDB) Referral Management System Tracking Reports (RMSTR) as the MHS's RM tracking solution. Per reference (n), ICDB RMSTR is expected to improve the efficiency and effectiveness for network referral tracking and ROFR referrals from the network.

5. Discussion. A comprehensive standardized RM program will ensure that:

a. Patients receive timely access to specialty care. All specialty referrals are tracked for timely access to the physician or other authorized healthcare provider who originated the referral per reference (k).

(1) Quality control for information flow is maintained to protect patient confidentiality.

(2) Continuity of care is achieved.

b. All specialty referrals will be tracked, with the exception of referrals for Durable Medical Equipment (DME) and Hospice Care.

6. Responsibilities

a. Deputy Chief, Medical Operations (BUMED-M3) shall:

(1) Monitor effectiveness of the RM system in delivering care to patients.

(2) Identify/define/establish key performance metrics.

(3) Coordinate with Bureau of Medicine and Surgery (BUMED) Office of the Deputy Chiefs, Total Force (BUMED-M1), Installations and Logistics (BUMED-M4), and Resource Manager/Comptroller (BUMED-M8) to ensure staffing and funding occur to support policy implementation.

(4) Coordinate with BUMED Chief Information Office (BUMED-M6) to ensure required infrastructure and systems are in place to support the requirements of this instruction.

b. Navy Medicine Region Commanders shall:

(1) Incorporate RM activities and support, per reference (n), within overarching medical management activities, business rules, and goals.

(2) Provide resources to ensure adequate staffing exists to support RM programs.

(3) Ensure that MTFs within each region comply with establishing Referral Management Centers (RMC) and that they have appointed personnel to adequately support and ensure quality referrals.

c. Commanders, Commanding Officers/Officers in Charge of MTFs shall:

(1) Establish an RMC that is adequately resourced, based on historical and projected referral trends, focused on continuity of care, and the timely transfer of clinical consultations and referrals.

(2) Develop a Memorandum of Understanding in conjunction with the TRICARE Regional Office (TRO)/TRICARE Area Office, with the respective TRICARE contractor that incorporates a two-way process for transmitting referral information between the TRICARE contractor and the RMC.

(3) Assign a primary physician advisor and designate a secondary advisor, to cover leave and absences, responsible for the second level review process and advice on all referral issues.

(4) Adhere to the appropriate appeals and hearings policies for denials of care within the MTF per Chapter 12 of reference (g).

(5) Ensure Operational Forces Medical Liaison Services and RMCs coordinate timely access and health services referrals for the Operational Forces.

(6) Ensure that provider training and refresher training are conducted to address the standardized consult/referral process.

(7) Ensure that appropriate patient care is not delayed. MTF leadership shall monitor the RM process to ensure patients are seen within access to care (ATC) standards and have a seamless transition to care.

(8) Ensure that Composite Health Care System (CHCS) referral auto-closure will not be used within Navy MTFs. If it continues in the turned-on mode, referrals will auto-close prior to the accepted 120 days; therefore, the MTF will not be able to track referrals beyond 90 days.

d. Operational Forces Medical Liaison Service: Serves as the point of contact for medical department representatives (MDR) of the operational forces.

(1) Serve as an interface with the MTF and MDR on referrals generated by Operational Forces.

(2) Coordinate timely access and health services referrals for Operational Forces in consideration of deployment schedules and operational tempo.

e. RMC: Serves as the functional proponent for RM. The RMC facilitates continuity of care with the healthcare providers and support personnel. Duties include:

(1) Maintain standard operation procedures to direct and support RM activities.

(2) Ensure specialty care access through the use of the direct and purchased care systems.

(3) Track referrals using the MHS approved support tools to ensure continuity of care.

(4) Conduct provider training throughout the year to keep providers informed on process changes.

(5) Process incoming ROFR requests per Chapter 8, Section 5 of reference (g).

(6) Include/upload a copy of the consult report into Armed Forces Health Longitudinal Technology Application (AHLTA) for provider review per approved methods, such as the use of a scanned document.

7. Actions for the RMCs. Functions of RMCs include, but are not limited to the following:

a. Referral/Consult review

(1) For TRICARE covered services, the provider's referral will constitute a first level review. First level reviews are conducted per the MHS's current, approved Utilization Management (UM) guidelines per Section (a) (5) of reference (o).

(2) Second Level Reviews will be conducted for high cost, high utilization referrals and must use the approved MHS UM guidelines per reference (b).

(3) Retrospective reviews are conducted, as needed, to monitor referral trends to include high cost, high utilization referrals.

(4) First and second level reviews for MTF generated consults are conducted at the MTF level. Medical necessity for consult requests are the responsibility of the beneficiary's referring provider. To ensure that TRICARE policy is followed per references (b) and (k), and prior to sending these consult requests to appropriate contractors within the TRICARE program, providers are encouraged to coordinate medical necessity questions with RMC staff. Consult requests for non-covered services outside the MTF should not be forwarded to the managed care support contract (MCSC) for review. The waiver process to request to utilize Supplemental Health Care Program (SHCP) funds to obtain non-covered services for an Active Duty Service Member (ADSM) is outlined in reference (p).

(5) If the referral includes a non-covered service, the RMC (or the designee that determines non-covered services) notifies the referring provider in 2 business days. The referring provider is responsible for providing a referral status update to the patient within 3 business days.

(a) A non-covered service is a factual denial and is appealable in accordance with reference (g).

(b) If the MTF is unsure a service is a non-covered benefit, they shall contact their respective MCSC or TRO for further guidance.

(6) Prior to sending the referral to the MCSC, the RMC verifies eligibility (i.e., cases of special eligibility such as Secretarial Designees, Dependent Parents, etc.) and resolves eligibility discrepancies before further referral processing.

(7) For Reserve Component Line-of-Duty (LOD) care, the RMC shall verify that valid LOD documentation is on file in the MTF and the LOD condition is consistent with the reason for the referral prior to sending the referral to the contractor. The referral shall include a statement that the care is LOD related and shall be processed under the SHCP.

(8) All reviews are conducted in an efficient manner, according to consult priority, to avoid treatment delay. Referrals shall be forwarded to the MCSC within 1 business day upon receipt when care cannot be provided in the MTF per reference (g).

b. Active Duty Service Member Referral Management

(1) MTFs should collaborate with their MCSC to ensure ADSMs receive priority per reference (l) in their referral authorizations and appointments. Referring MTF providers need to

specify in the body of the referral when the ADSM should be seen (e.g., 72 hours, 7 days, 14 days, etc.) rather than using the default 28-day ATC standard for routine priority referrals. MTF leadership shall ensure policies are in place to address ADSM RM.

(2) ADSMs referred to the network may require prompt action with regard to referral processing to meet mission requirements. Assistant Secretary of Defense for Health Affairs (ASD(HA)), directs medical commanders to ensure specialty care services are uniformly available for ADSMs on medical hold within 1 week of identifying the need for an appointment per reference (l).

(3) Per reference (i), if an ADSM intends, while in terminal leave status, to reside outside of the Prime Service Area (PSA) of the MTF where the ADSM is enrolled, the MTF shall issue to the MCSC a single preauthorization for the ADSM to obtain from the Department of Veterans Affairs (VA) any necessary routine or urgent outpatient medical care. The period covered by this preauthorization shall be the entire anticipated span of the terminal leave period. Specific processes are outlined in Chapter 8, Claims Processing Procedures of reference (g).

(4) When an ADSM in a Temporary Additional Duty (TAD) status and seeks care at an MTF where they are not enrolled, the treating Primary Care Management team will determine the necessity and timeliness of any referrals. If the referral is urgent or the TAD prolonged, then the patient will be referred by the TAD MTF. If the nature of the referral is routine and can wait, then the ADSM's enrolled Primary Case Management team will be responsible for the care. In any case, the TAD MTF Primary Case Management team shall contact the ADSM's enrolled Primary Care Manager to ensure continuity of care. The TAD MTF shall ensure that CLR's for any care rendered while the ADSM is TAD are forwarded to the location where the ADSM's medical record is maintained.

(5) Per reference (q), in certain instances, non-covered services may be authorized by the Director, TMA. If an MTF determines a non-covered service is in the best interest of the ADSM and the Service, a SHCP waiver request, to include all documentation and justification, shall be submitted to the Navy Medicine region for initial review and consideration. If the Navy Medicine region concurs with the MTF's request, it shall forward the waiver with an endorsement to BUMED Healthcare Operations (BUMED-M3B1). Upon completion of review, BUMED shall forward the waiver recommendation to TMA. Waiver authority rests solely with the Director, TMA. If the waiver is approved, the requesting MTF will then be authorized to submit the consult referral to the TRICARE contractor with a statement that the Director, TMA has issued a SHCP waiver for the care.

(6) Non-ADSM beneficiaries are not covered under the SHCP waiver process. In the case of a denial for non-covered services the non-ADSM beneficiary can appeal the denial. This process will be outlined for them by the Managed Care Support Contractor in the denial letter. In such cases, request to appeal the denial of services should be submitted in accordance with the appeals process outlined in reference (g).

c. Specialty Referral Booking Guidance

(1) To support a patient centered referral process, it is highly encouraged that MTFs establish specialty care booking at the point of referral in the Primary Care Management team clinics. As an alternative to this method, all specialty care referrals are routed to the RMC or the multi-service market referral center for review and appointing to the MTF and when feasible to other MTFs.

(a) MTF specialty clinics will transfer referral review and appointment scheduling duties to the Primary Care Management team, Central Appointments Office (CAO), RMC, or the multi-service market referral center to the maximum extent possible.

(b) For highly complex subspecialty clinics and/or clinics that manage highly sensitive patient data, the central booking requirement is left to the discretion of the MTF commander, CO, or OIC.

(2) Specialty clinics will provide to the RMC, CAO, or multi-service market referral center standardized and current Specialty Clinic Booking Guidance for each clinic and each of their providers.

(a) The Specialty Clinic Booking guidance should be as unrestrictive as possible to retain or recapture the maximum number of specialty care referrals to sustain clinical currency and minimize purchased care costs.

(b) At a minimum, the Specialty Clinic Booking guidance should include:

1. Hours of operation;
2. Patient care priorities;
3. Specialty capability (including any limitations); and
4. Any other comments or information pertinent to specialty care, referral review, and appointing.

(3) Specialty Clinic Booking Guidance must be meticulously maintained by the specialty clinics with all changes communicated to the RMC per established MTF guidance.

(a) This guidance will be used by RMC, CAO, or multi-service market referral center personnel to review and book patients within clinic capability and capacity for their initial MTF specialty care referral appointments.

(b) Initial specialty care referral appointments should be booked prior to the patient's departure from the MTF on the same day the referral is written by the referring provider.

(c) If the RMC, CAO, or Primary Care Management team is unable to appoint the patient before leaving the MTF, the MTF shall establish written processes for how the MTF/RMC will notify patients of their scheduled specialty care appointments within 3 business days of the referral being written.

(d) MTFs are encouraged to develop processes that facilitate the referral process between the patient and the RMC. Whenever possible, patients should receive referral guidance and confirm contact information with the RMC prior to leaving the MTF.

(e) For multi-service market areas where it is not feasible for patients to receive their specialty care referral appointments prior to leaving the MTF, processes will be in place to ensure review and appointing occurs within 3 business days.

(4) Referrals to MTF specialty clinics must be booked in CHCS using the Appointment Order Processing function in order to link the appointment with the referral.

(5) MTF providers will complete their patient encounter documentation in AHLTA within 72 hours of the encounter.

(6) Specialty clinics will maintain an adequate number of appointments to meet demand. If the patient cannot be booked within Access to Care (ATC) standards (28 days), and the patient does not waive the ATC standard, the referral request will be deferred to the MCSC. Enclosure (2) is a flow chart of the defer to network process.

(7) If there is neither capability nor capacity for a given type of specialty care within the MTF, referral requests will be deferred to the MCSC for ADSMs and Prime beneficiaries. These referrals should be transmitted to the MCSC in a Health Insurance Portability and Accountability Act (HIPAA) compliant method within 1 business day from the date of the referral for routine referrals.

d. Clear and Legible Reports (CLR) Management

(1) All consult requests and results going out of, into, and within an MTF must adhere to the policy and business rules as outlined in reference (1) and tracked utilizing RMSTR, the MHS approved consult tracking tool.

(a) Obtain consult reports or CLRs for all network deferred consults, except for DME and hospice care, unless specifically requested by the referring provider. Upload CLRs into AHLTA using the approved MHS method and forward results to referring provider using, at a minimum, secure e-mail and hand delivery in addition to electronic submission.

(b) A copy of the consult report is to be placed in the medical record of all ADSMs at the time of receipt of the MTF and concurrently with the upload into AHLTA. In instances

where the ADSM's medical record is maintained at another location, (i.e., for Operational Forces), the MTF shall have processes in place to ensure that the CLR is sent to the location where the medical record is maintained to be included in the medical record.

(c) Electronically forward a list of consults not completed to the referring provider. To ensure continuity of care and per Joint Commission Guidelines, the referring provider shall document in AHLTA the action taken to either follow-up with the patient or cancel the referral.

e. Right of First Refusal Determinations and Management

(1) The RMC or multi-service market referral center will determine if the MTF has specialty care capability and capacity to accept ROFRs within ATC standards. [Note: If there is no appointment within the ATC standard, the patient may waive their ATC standard to be seen by the MTF.]

(2) ROFR determinations and processing must be made and the MCSC notified per TRICARE Operations Manual, Chapter 8, Section 5 of reference (g).

(a) Maintain an accurate MTF capability report and communicate updates and changes to the MCSC on a monthly basis or more frequently as needed.

(b) Respond to routine ROFR requests within 1 business day of receipt from the MCSC.

(c) Respond to urgent ROFR requests within 30 minutes of receipt of a telephone call from the MCSC.

(3) If the MTF does not respond to the MCSC with a decision regarding the ROFR within the required timeframe above, the MCSC will consider the ROFR to have been declined by the MTF and refer to the purchased care system. Enclosure (3) is a flow chart of the ROFR process. Enclosure (4) contains a list of acronyms.

(4) If the ROFR is accepted, the RMC will enter the ROFR into CHCS/AHLTA as a consult and type "ROFR" in the first space of the Reason for Referral field or in the Review Comment field.

(5) After the ROFR patient has been seen in the MTF, the RMC will obtain the consult report and any other clinical documentation from AHLTA and forward the results to referring provider within 10 business days of the appointment.

f. Trending Referral Patterns

(1) Provide MTF leadership with referral tracking trends on a monthly basis to track improvements in the RM system. Tracking trends should include:

(a) The number of referrals within the MTF that have been deferred to the network by specialty, and the reason it was not seen in the MTF (i.e., capacity, capability, continuity of care, out of the PSA, Overseas Contingency Operations (OCO) care, command directed, or point of service option).

(b) The number of referrals that have been referred to network for specialty care.

(c) The number of ROFRs coming into the MTF by specialty, response given to the MCSC and if declined, reason for declining, and appointment status (i.e., the average time to appointment in MTF, patient refusals, appointment kept, or no-show).

(2) Provide MTF leadership with information on status of referral system including the average time to obtain results on consult requests, and the percentage of outstanding CLRs, whether it is an MTF or ROFR request.

g. Additional Referral Visits or Specialty Care Authorization for MTF enrolled patients requests from network providers for patients to obtain additional referral care will be returned directly to the MTF for consideration and action. If the MCSC requests a referral from the MTF, then they shall provide the MTF, through the MTF's single point of contact [the RMC], a copy of the authorization and clinical information that served as the basis for the new authorization. The MTF will then decide whether the care is available within the MTF or should be performed in the network. The MTF must take into account continuity of care when deciding to render care within the MTF.

h. Management of Urgent and Routine Primary Care Referred to the Network

(1) The use of primary care services in the purchased care system should be minimized. MTF leadership is highly encouraged to develop written instructions and guidance governing the use of primary care services in the purchased care network.

(2) MTFs will develop processes to ensure referrals are generated for all patients sent to the purchased care system for urgent and routine primary care.

8. Records Management. Records created as a result of this instruction, regardless of media and format, shall be managed per reference (s).



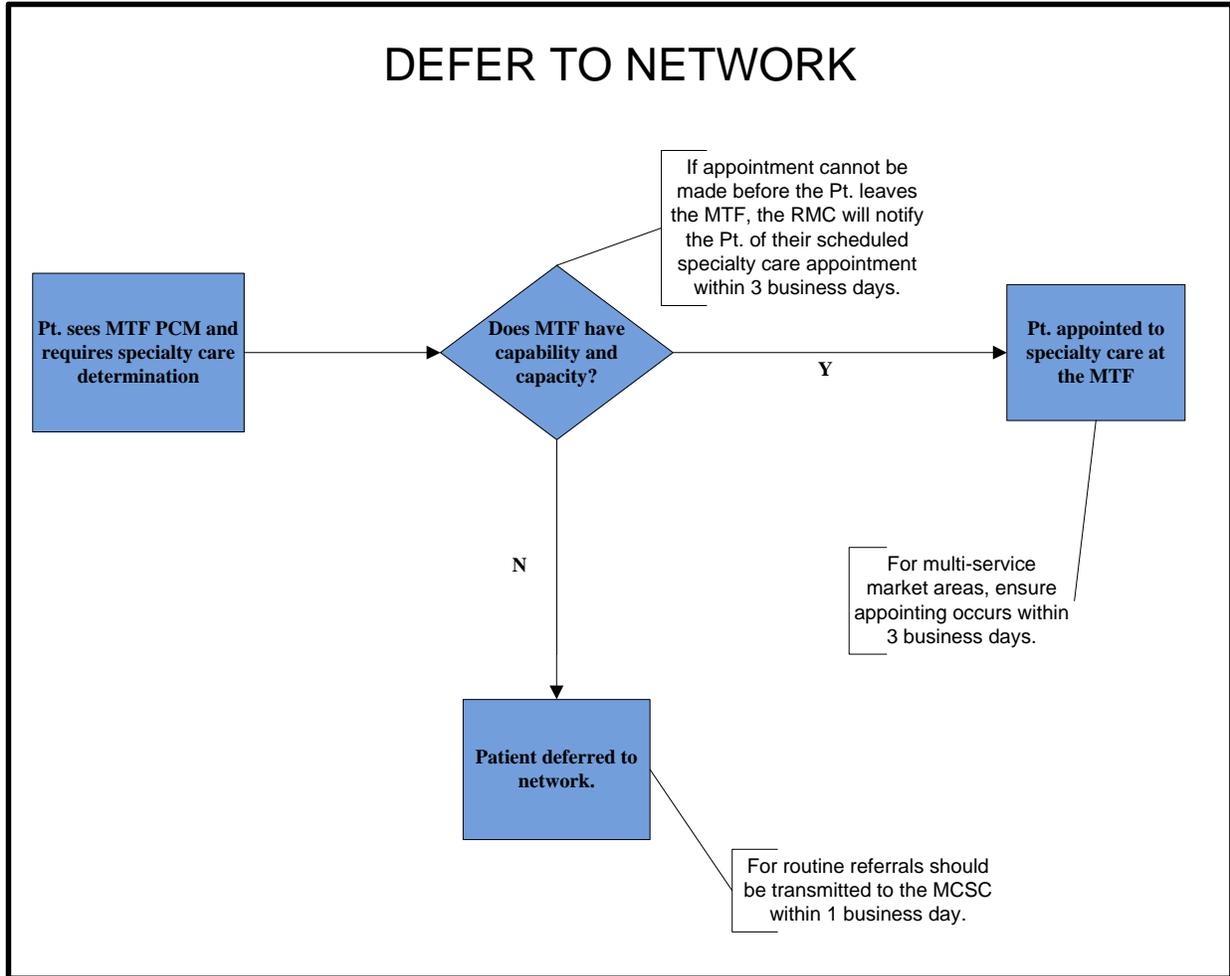
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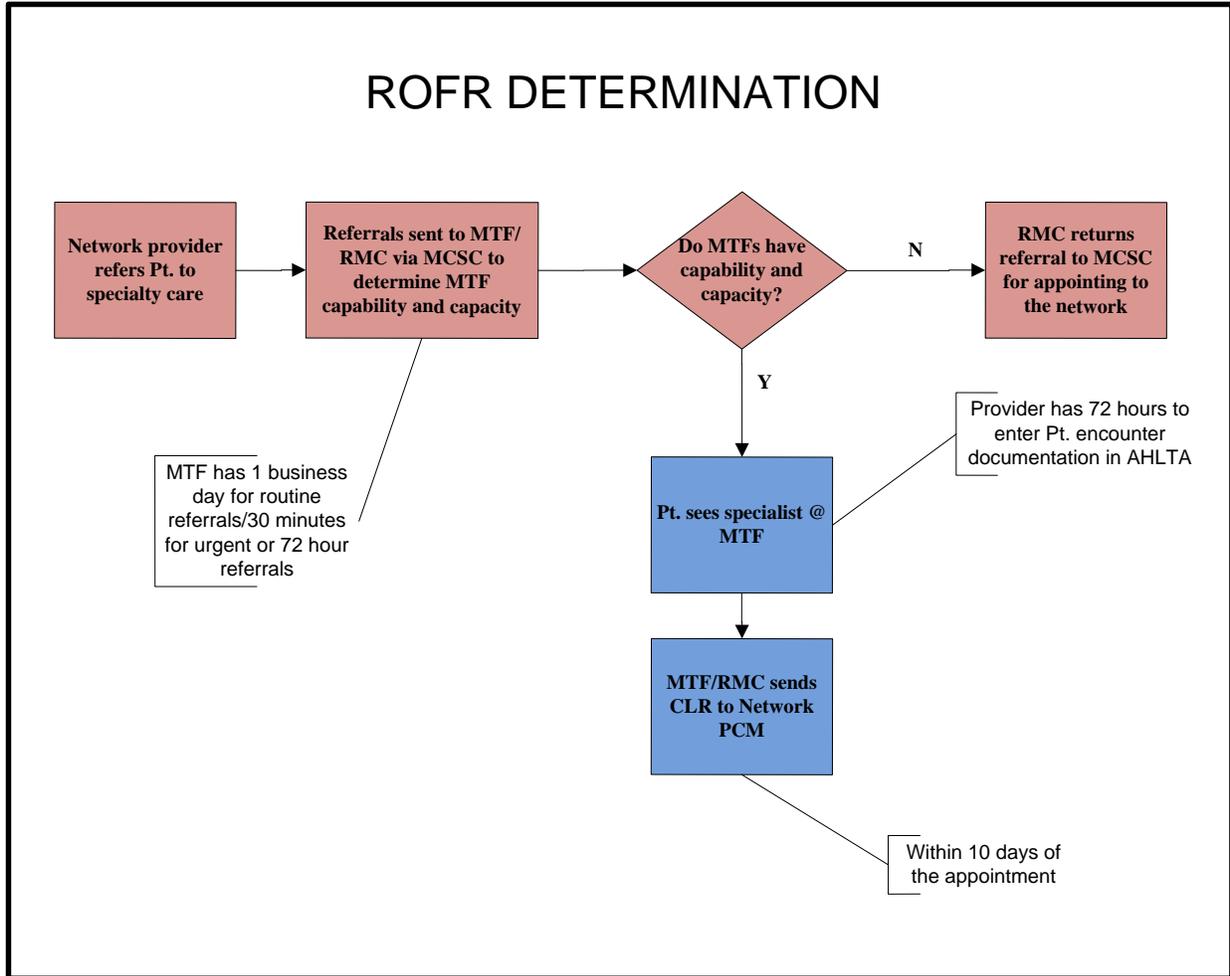
REFERENCES

- (a) DODI 1300.24 of December 1, 2009
- (b) DODI 6025.20 of January 5, 2006
- (c) DODI 6490.03 of August 11, 2006
- (d) Department of Defense Medical Management Guide, Version 3.0, 2009
- (e) TRICARE Management Activity (TMA) Policy Guidance for Referral Management of 5 May 2004
- (f) TRICARE Management Activity Policy Guidance for Referral Management of 29 Jul 2004
- (g) TRICARE Operations Manual 6010.56-M of 1 Feb 2008
- (h) Standards from The Joint Commission on Hospital Accreditation, current edition
- (i) Health Affairs Policy: 09-001 of Jan 16, 2009, Policy Memorandum for Preauthorization of Routine and Urgent Medical Care Provided by the Department of Veterans Affairs to Active Duty Service Members in Terminal Leave Status
- (j) Health Affairs Policy: 11-005 of Feb 23, 2011, TRICARE Policy for Access to Care
- (k) BUMEDINST 6440.8A
- (l) Health Affairs Policy: 03-026 of Oct 29, 2003, Policy for Personnel on Medical Hold
- (m) U.S. Air Force, Military Treatment Facilities (MTFs) Referral Management System (RMS) 2.5 Users' Guide
- (n) OASD(HA) Policy for the Clear and Legible Report of Feb 4, 2011
- (o) 32 CFR 199.15
- (p) 32 CFR 199.16
- (q) Health Affairs Policy 12-002 of Feb 12, 2012, Use of Supplemental Health Care Program Funds for Non-Covered TRICARE Health Care Services and the Waiver Process for Active Duty Service Members
- (r) SECNAVINST 5100.13E

DEFER TO NETWORK FLOW CHART



RIGHT OF FIRST REFUSAL FLOW CHART



ACRONYMS

ADSM	Active Duty Service Member
AHLTA	Armed Forces Health Longitudinal Technology Application
ATC	Access to Care
BUMED	Bureau of Medicine and Surgery
CAO	Central Appointments Office
CHCS	Composite Health Care System
CLR	Clear and Legible Reports
CM	Case Management
CO	Commanding Officer
DME	Durable Medical Equipment
ICDB	Integrated Clinical Database
LOD	Line of Duty
MCSC	Managed Care Support Contract
MDR	Medical Department Representative
MHS	Military Health System
MOU	Memorandum of Understanding
MTF	Medical Treatment Facility
OIC	Officer in Charge
PSA	Prime Service Area
RM	Referral Management
RMC	Referral Management Center
RMSTR	Referral Management System Tracking Report
ROFR	Right of First Refusal
SHCP	Supplemental Health Care Program
TAD	Temporary Additional Duty
TMA	TRICARE Management Activity
TNEX	TRICARE Next Generation of Contracts
TRO	TRICARE Regional Office
UM	Utilization Management