



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
WASHINGTON, DC 20301-1200

DHA-IPM 17-002
January 19, 2017

HEALTH AFFAIRS

MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (MANPOWER AND RESERVE AFFAIRS)
ASSISTANT SECRETARY OF THE NAVY (MANPOWER AND RESERVE AFFAIRS)
ASSISTANT SECRETARY OF THE AIR FORCE (MANPOWER AND RESERVE AFFAIRS)
DIRECTOR OF THE JOINT STAFF
DEPUTY ASSISTANT SECRETARY OF DEFENSE (HEALTH READINESS POLICY AND OVERSIGHT)
DEPUTY ASSISTANT SECRETARY OF DEFENSE (HEALTH SERVICES POLICY AND OVERSIGHT)
DEPUTY ASSISTANT SECRETARY OF DEFENSE (HEALTH RESOURCES MANAGEMENT AND POLICY)
ASSISTANT COMMANDANT FOR HUMAN RESOURCES, U.S. COAST GUARD

SUBJECT: Defense Health Agency Interim Procedures Memorandum 17-002, “Specialty Care Referral Accountability and Business Rules”

References: See Attachment 1

Purpose. This Defense Health Agency-Interim Procedures Memorandum (DHA-IPM), based on the authority of References (a) and (b), and in accordance with the guidance of References (c) through (l):

- Describes procedures for implementing uniform accountability and business rules for referral management and specialty care appointing. The DHA-IPM will provide clarifications to References (d) and (f).
- This DHA-IPM is effective immediately. It will be incorporated into a future DHA Procedural Instruction. This DHA-IPM will expire effective 12 months from the date of issue.

Applicability. This DHA-IPM applies to the Office of Secretary of Defense, the Military Departments, the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense (DoD), the Defense Agencies, the DoD Field Activities, and all other organizational entities within DoD.

Policy Implementation. This DHA-IPM provides clarifications to Reference (f). Uniform business rules minimize fragmentation, reduce unwarranted variation, and support the principles of a highly reliable organization. This guidance meets the referral accountability criteria listed in References (j), (k), and (l). The Accounting and Business Rules guidance establishes uniform accountability and business rules for referral management and specialty care appointing.

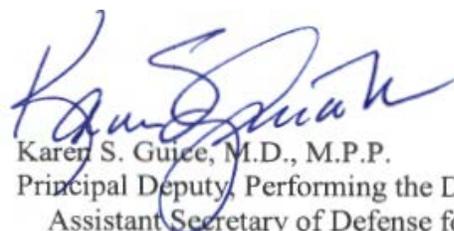
Responsibilities.

- The Director, Defense Health Agency (DHA), will facilitate the implementation of the DHA-IPM.
- The Director, Operations Directorate (J-3), will:
 - Oversee the development of Specialty Appointment and Referral Data collection, tracking, and analysis by the DHA's Operations Directorate (J-3); and
 - Recommend and track measures to assess referral management performance and compliance with the business rules outlined in this DHA-IPM.
- The Surgeons General of the Military Departments will:
 - Implement the specialty appointment and referral business rules outlined in this DHA-IPM; and
 - Monitor performance data on the specialty appointment and referral management process.

Procedures. See Attachment 2

Releasability.

- **Cleared for public release.** This DHA-IPM is available on the Internet from the DHA Website at <http://www.health.mil/dhapublications>.


Karen S. Guice, M.D., M.P.P.
Principal Deputy, Performing the Duties of the
Assistant Secretary of Defense for Health
Affairs

Attachments:
As stated

cc:
Surgeon General of the Army
Surgeon General of the Navy
Surgeon General of the Air Force
Medical Officer of the Marine Corps
Joint Staff Surgeon
Director of Health, Safety and Work-Life, U.S. Coast Guard
Surgeon General of the National Guard Bureau
Director, National Capital Region Medical Directorate

ATTACHMENT 1

REFERENCES

- (a) DoD Directive 5136.01, “Assistant Secretary of Defense for Health Affairs (ASD(HA)),” September 30, 2013
- (b) DoD Directive 5136.13, “Defense Health Agency (DHA),” September 30, 2013
- (c) DHA-Procedural Instruction 5025.01, “Publication System,” August 21, 2015
- (d) Health Affairs (HA) Policy Memorandum 11-005, “TRICARE Policy for Access to Care,” February 23, 2011
- (e) Title 32, Code of Federal Regulations, Part 199, Civilian Health and Medical Program of the Uniformed Services
- (f) HA Policy Memorandum 02-2011, “Policy for the Clear and Legible Report,” February 4, 2011
- (g) TRICARE Operations Manual 6010.56-M, February 2008, as amended
- (h) TRICARE Policy Manual 6010.57-M, February 2008, as amended
- (i) DoD Medical Management Guide, Version 3.0, 2009¹
- (j) Accreditation Handbook for Ambulatory Health Care¹, January 2015
- (k) The Joint Commission²
- (l) National Committee for Quality Assurance³

¹This Reference may be viewed at www.aaahc.org

²This Reference may be viewed at www.jointcommission.org/AHC

³This Reference may be viewed at www.ncqa.org

ATTACHMENT 2

PROCEDURES

1. OVERVIEW. This guidance supplements and provides clarifications to Reference (f) and establishes uniform accountability and business rules for referral management and specialty care appointing. Full compliance with this guidance is required within 12 months from signature for Medical Treatment Facilities (MTFs) in Multi- Service Markets (MSMs) and within 6 months from signature for all other MTFs.

The overarching objective of this guidance is to enhance the patient-centered focus for the referral management process by increasing uniformity, reducing wait times before appointment booking, improving central accountability for referral management performance, and synergizing the individual MTFs in MSMs to function as a unified healthcare system. To the extent practicable, this guidance applies to overseas locations with consideration that overseas/foreign locations often present unique circumstances.

2. SPECIALTY CARE REFERRAL ACCOUNTABILITY

a. MTFs will designate a single Referral Management Center or Office (RMC/O) that is accountable for managing and tracking all referrals generated by the MTFs, capturing all Clear and Legible Reports (CLRs), and managing Right of First Refusal (ROFR) referrals. In MSMs, the Senior Market Manager will centrally designate a single RMC/O that is similarly accountable for all referrals generated by MTFs within the market, capturing all CLRs, and managing ROFRs. Furthermore, MTFs within MSMs that retain referral management staffing onsite will accommodate standardized market-level processes and coordinate referral operations with the market's designated RMC/O to reduce fragmentation and enhance accountability.

b. Each designated RMC/O, including the market's centrally designated RMC/O, should be empowered to defer referrals to the network regardless of beneficiary category, specialty service line, or referring MTF in cases when the direct care system is unable to provide services within the standards set forth in this memorandum and Reference (d); however, MTF Commanders and/or Senior Market Managers will first make every effort to maximize use of the direct care system within access-to-care standards.

c. Each designated RMC/O is accountable for ensuring all initial specialty care referrals are either accepted for appointing to the direct care system or deferred to the network within 1 business day from the order date. One business day includes the order date plus the entire following day, excluding weekends and holidays. To facilitate meeting this standard, MTFs and MSMs should collaborate to minimize the number of specialty referral queues within the Composite Health Care System (CHCS) and collaborate to centrally manage the referral queues that are maintained.

d. The designated RMC/O should track, at the MTF specialty level, the number and percent of initial specialty referrals that were successfully dispositioned within 1 business day as: Appoint to MTF, Defer to Network, or No Appointment Required.

e. All initial specialty referrals should be entered into the Electronic Health Record (EHR) before the patient leaves the encounter. Furthermore, MTF Commanders and/or Senior Market Managers should provide a written referral workflow that minimizes the number of touchpoints (e.g., reviews) before a referral is accepted for appointing or deferred to the network.

f. The denial/cancellation of a referral, and the reason(s), should be communicated to the referring provider within 1 business day of the referral denial/cancellation. The referring provider/clinical team is then responsible for communicating to the patient within 1 business day that the referral was denied/cancelled, and whether or not a new referral will be ordered.

g. Patients should be notified when a referral is deferred to the network or accepted for appointing to an MTF. This communication can occur before the patient leaves the MTF, by live phone call or secure messaging after the patient leaves the MTF, or through automated methods (e.g., Audio-Communicator-Disease Management module, etc.). This contact attempt should occur within 1 business day from the time the review decision was entered into the EHR. The communication should inform the patient about how to make the direct care appointment, how to cancel the referral, and/or when to expect the network authorization letter or e-mail. For referrals accepted for MTF appointing, the communication should be repeated until the appointment is booked, the patient cancels the referral, or the message has been delivered three times on separate days. This process may be supplemented by letters to patients as needed. For referrals deferred to the network, a follow-up automated message should be sent 14 calendar days after the referral's order date to remind the patient to make an appointment with the civilian provider indicated in the authorization letter (if the patient has not done so already). The regional TRICARE contractor's phone number should also be provided in case the patient is having difficulty making an appointment.

h. The Carepoint Referral Management Suite (RMS) is the only interim electronic referral management application approved for MTF use to transmit and track all MTF-generated referrals until the DoD Healthcare Management System Modernization EHR is deployed at the MTF.

i. The auto-closure function in CHCS should be turned off.

3. DIRECT CARE REFERRAL BUSINESS RULES

a. The MTF Commander and/or Senior Market Manager will:

(1) To the greatest extent possible, establish processes that enable initial specialty care referrals to be appointed to the direct care system before the patient leaves the MTF. Appointed means the patient has been booked with a time and place for future care.

- (2) Track the average number of days from when the initial specialty referral was ordered until the referral is booked into CHCS.
- (3) Provide appointment booking keys in CHCS to trained front line support staff (e.g., in primary care, central appointing, etc.) in order to support patient-centered booking into specialty clinics before the patient leaves the MTF.
- (4) Ensure the Appointment Order Processing function is used to book initial MTF specialty appointments in CHCS in order to link the appointment to the referral and ensure correct tracking through CHCS and RMS.
- (5) Eliminate “clinic-book only” appointments for initial specialty care referrals, and only grant exceptions to guidance in writing when there are compelling medical or mission interests. When exceptions to guidance are granted in writing, the specialty clinic should proactively contact the patient to book the appointment within 1 business day after accepting the referral. The clinic should attempt contact no less than three times on three separate days, or until the appointment is booked, whichever effort concludes first. Each attempt to contact the patient should be documented in the EHR.
- (6) Eliminate referral requirements for preventative services at MTFs that may otherwise be obtained through the TRICARE network without a referral.
- (7) Provide “first call resolution” at all central appointment centers, RMC/Os and clinics that book initial specialty appointments. When a patient calls for a specialty care appointment, agents will be empowered to book the patient’s specialty appointment anytime the referral has an “Appoint to MTF” review. If the referral lacks a review disposition when the patient calls, then the appointment center agent will provide a “warm hand-off” to the RMC/O or specialty clinic to immediately review the referral and appoint or defer it. If “clinic-book only” appointments are authorized locally, and a patient calls the central appointment center for a “clinic-book only” appointment, then the appointment center will provide a “warm hand-off” directly to the specialty clinic to assist the patient.
- (8) Ensure specialty clinics and RMC/Os adequately staff phone lines to accept calls from the appointment center and return messages on the same business day messages are received.
- (9) Ensure patients are offered three different specialty appointment times within the 28 calendar day access to care standard. When the MTF or MSM cannot offer three different specialty appointment times within the access standard, then patients may be offered MTF appointments outside the standard, but only after being informed they are authorized network care.
- (10) Ensure patients are offered the first available MTF specialty care appointment that meets access to care standards within the market, regardless of referring MTF. Patient preference for MTF location should be considered and accommodated within access to care standards, when possible.

b. The designated RMC/O will:

(1) Use RMS to ensure all referrals are dispositioned as Appoint to MTF, Defer to Network, or No Appointment Required within 1 business day.

(2) Use RMS to identify consults generated in the EHR that are pending action (Appoint to MTF, Info Needed, Defer to Network, Refer to Subspecialty, Space Available) and, when appropriate, notify reviewing specialty clinics of pending consults requiring action.

(3) Administratively close all un-appointed referrals accepted by an MTF no later than 180 days beyond the order date. The RMC/O will notify the referring provider when the patient cancels a referral or when referrals are administratively closed.

(4) Maintain current TRICARE data showing network access to care performance by specialty care type, and inform patients when a deferral to the network may result in a longer wait-time for care than the direct care system.

4. PURCHASED CARE REFERRAL BUSINESS RULES

a. The designated RMC/O will:

(1) Ensure all defer to network referrals are transmitted and tracked in RMS.

(2) Verify that Reserve Component Line of Duty (LOD) documentation is on file in the MTF for any LOD conditions requiring care in the network. The referral must additionally include a statement relating the LOD to the referral so it can be processed under the Supplemental Health Care Program.

(3) Ensure that referral reviewers document a reason code in the CHCS Review Comment field for any referrals deferred to the network. The reason code should be encased in hard brackets [xx]. Use of at least one authorized reason code is required. Multiple codes may be used; however, each code must be in its own brackets. The following nine reason codes are authorized:

(a) [2nd] indicates a request for a second opinion.

(b) [CB] indicates lack of MTF capability for the specialty/services requested.

(c) [CP] indicates lack of MTF capacity (available appointments).

(d) [CC] indicates deferral for continuity of care operationally defined as follow on care from a specific specialist as part of a specific procedure or service that was performed within the previous 6 months.

(e) [DS] indicates deferral for travel distance exceeding access to care standards.

- (f) [NAR] indicates no pre-authorization required.
- (g) [OHI] indicates other health insurance or Medicare coverage.
- (h) [POS] indicates point of service or self-referred care.
- (i) [CMD] indicates a command-directed deferral by the Chief of Medical Staff.

(4) Track all MTF generated initial specialty care and urgent care referrals that were deferred to the network until closure. Closure occurs when the referring provider is notified that either a CLR is available for review, or notified the referral is closed in CHCS. The RMC/O is not required to track follow-ups, but should provide follow-up results to the referring provider if received. There is no requirement to track durable medical equipment and hospice referrals.

(5) Initiate efforts to capture the CLR as soon as a claim is discovered, upon request by the referring provider or no later than 60 days from the date the referral was ordered, whichever occurs first.

(a) When a CLR has not been documented in the EHR, check the applicable claims database for a claim.

(b) If a claim is found, request the CLR from the rendering network provider. If there is no response from the provider within 10 calendar days, repeat. If the provider still does not provide the CLR, then initiate TRICARE contractor procedures as per the TRICARE Operations Manual and/or the Memorandum of Understanding with the TRICARE regional contractor. Additionally, forward a report to the TRICARE Regional Office each month that lists all provider names, specialty care rendered, and referral Unique Identifier Numbers (referring MTF Defense Medical Information System (DMIS) number + date + CHCS Consult Order number) for which no CLR has been received after two attempts.

(c) After 180 days, if the CLR still has not been received, close the referral and annotate {CRNRR} in soft brackets in the CHCS Review Comment Field indicating a claim was reported but no results were received, and notify the referring provider.

(d) If no claim or evidence is found indicating the patient utilized the referral in the network after 180 days from the order date, then close the referral in CHCS and annotate {NU} in soft brackets in the CHCS Review Comment field indicating the patient did not use the referral, and notify the referring provider.

(e) If a patient cancels a referral, notify the referring provider.

(6) Upload all CLRs into the Healthcare Artifact and Image Management Solution (HAIMS) within 3 working days of receipt, close the referral in CHCS as "Deferred Results Received," and notify the referring provider.

(7) Upload both the original foreign language and the English translated CLR into HAIMS before closing it in CHCS. Both versions should be uploaded as one document with the English language version on top. The untranslated CLR does not have to be signed by the referring provider if the translated CLR was already signed.

(8) Use the following naming convention for CLRs loaded into HAIMS: “Network Results – Specialty MM/DD/YY” where the MM/DD/YY is the date the patient was seen, if available, or the date of the report. Use the same naming convention in the “Document Title” field in HAIMS for the associated CLR.

(9) The same naming convention as above applies for MTF clinics that receive and upload CLRs (i.e., time sensitive CLRs) into HAIMS. In these instances, providers may sign CLRs before entering them into HAIMS. Clinics will close the referrals in CHCS as “Deferred Results Received” per 4.a(6).

b. The referring provider will review the CLR within 3 business days of notification the CLR has been received.

5. ROFR REFERRAL BUSINESS RULES

a. The designated RMC/O will:

(1) Record and track all ROFRs accepted by an MTF. In addition, the RMC/O will notify the referring network provider when a beneficiary appointed under a ROFR fails to keep or book an MTF appointment.

(2) Print the encounter information from Armed Forces Health Longitudinal Technology Application, or other MTF sources, and send the consult report to the network physician within 10 days of the patient’s kept appointment.

(3) Track communications and results sent to a referring civilian provider in RMS.

b. Enter the accepted ROFRs from their CHCS ROFR clinic, which must have a clinic profile of Hospital Location: “MCP NON-MTF” to designate the referral as a ROFR in RMS.

c. Reconcile the tracking record for all accepted ROFRs no later than 60 days from receipt of the accepted ROFR. If any reports are outstanding, the RMC/O will attempt to locate the report. If the patient did not utilize the referral or keep the appointment, the RMC/O will close the referral in CHCS no later than 180 days from the date of acceptance and annotate {NU} in the CHCS Review Comment field to indicate the patient did not use the referral, and then notify the referring network provider.

d. Educate specialty clinics about the ROFR capability table and coordinate updates as often as needed, but no less than monthly.

GLOSSARY

ABBREVIATIONS AND ACRONYMS

CB	lack of MTF capability for specialty/services
CC	Deferral for Continuity of Care
CHCS	Composite Health Care System
CLR	Clear and Legible Report
CMD	Command-Directed Deferral by the Chief of Medical Staff
CP	lack of MTF capacity (available appointments)
CRNRR	Claim Received, No Results Received from Purchased Care Provider
DHA	Defense Health Agency
DHA-IPM	Defense Health Agency Interim Procedures Memorandum
EHR	Electronic Health Record
HAIMS	Healthcare Artifact and Image Management Solution
LOD	Line of Duty
MSM	Multi-Service Market
MTF	Medical Treatment Facility
NAR	no pre-authorization required
NU	Referral Not Used
OHI	other health insurance
POS	Point of Service or Self-Referred Care
RMC/O	Referral Management Center or Office
RMS	Referral Management Suite
ROFR	Right of First Refusal