

Referral Management



2008

Reference Guide

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Introduction

A goal of this handbook is to familiarize personnel with unique aspects of market referral management, educate on roles and responsibilities in referral processes, and provide a resource for referral processing.

Evans Army Community Hospital (EACH) is a member of Pikes Peak Multi-Service Market. As a member of a multi-service market, EACH works collaboratively with the 10th Medical Group, United States Air Force Academy (USAFA) and the 21st Medical Group, Peterson AFB in delivering healthcare to TRICARE beneficiaries. The Centralized Referral Center (CRC) and the centralized Medical Appointing System (MAS) are examples of that collaborative effort. Both functions are located in Building 1011 at 1681 Specker Avenue.

Beneficiary Population

Fort Carson is a projection platform for troop mobilizations and demobilizations. The Soldier Readiness Center (SRC) serves guard and reserve as well as soldiers who may be enrolled in other regions. A Warrior Transition (WTU) Program also located on the installation. In addition to a large retiree population, EACH services patients, 65 and older, enrolled under the TRICARE Plus program.

Roles and Responsibilities

Central Referral Center - (CRC) is composed of nurses who conduct utilization review for the market, and referral specialists who administratively process referrals to the Managed Care Support Contractor (MCSC), TriWest Healthcare Alliance, Inc., for authorization. CRC utilization review (UR) nurses determine if the patient will be seen in a market MTF or in the network based on capability and access.

Military Appointing System – Humana is contracted to provide centralized appointing for both primary care and specialty care for 10th Medical Group, 21st Medical Group, and EACH.

Provider Responsibility – Providers are required to coordinate urgent referrals with consulting providers. Providers are expected to write clear referrals; specifying the specialty requested; and provide concise medical documentation to support the reason for the referral.

Queue Review- may be accomplished by providers or designated clinic personnel. Clinic queues should be reviewed at least 2x daily to ensure processing of urgent referrals, TRICARE Plus referrals and/or to respond to referrals redirected for more information.

Referral Management Center - Referral Management Center (RMC) is a branch of Medical Management Division, located on the east end of the 2nd floor. EACH RMC conducts consult tracking, supplemental healthcare management, TRICARE Plus network referrals, provider referral education, and network appointing assistance.

Soldier Readiness Center - The SRC provides and coordinates accessible quality medical care and services to deploying/returning Guard, Reserve, and active duty service members. The SRC is the hub that provides the highest quality healthcare to Fort Carson's power projection platform. A goal of the SRC is to provide an integrated health care system to ensure a healthy and ready force.

TRICARE Service Center (TSC) is located in EACH, 2nd floor, next to the Medical Library. TSC personnel assist with enrollment, TRICARE benefits, claims, and processes urgent consults.

TriWest Healthcare Alliance, Inc (TriWest) is the contractor for the Western Region. TriWest develops provider networks; determines medical necessity for TRICARE Prime; and authorizes non-MTF care (except for ADSM which is authorized by the Deputy Commander, Clinical Services). TriWest is responsible for consult tracking (i.e., ensuring network providers return consult reports to referring providers).

Utilization Management (UM) is a branch in the Medical Management Division. UM is an organization-wide, interdisciplinary approach to balancing quality, risk, and cost concerns in the provision of patient care. UM is the process of evaluating the medical necessity, appropriateness, and efficiency of healthcare services.

Warrior Transition Unit (WTU) provides a continuum of integrated care and services from point of injury, illness, or disease to return to duty (RTD) or transition from active duty.

Department of Defense Mandated Referral Requirements

Per TRICARE Operations Manual 60105-M , Chapter 8, Section 5 Para 7.2.1

“Referral from the MTF shall include all of the following information, at a minimum, unless otherwise specified. (See reference for format requirements).

** “Use of the National Provider Identifier (NPI) is required in accordance with HHS NPI Final Rule

*** The contractor shall use the CHCS generated order number (DMIS-YYMMDD-XXXXX) as a unique identifier. The first four digits of the UIN is the DMIS of the referring facility only.

ALL REFERRAL MUST BE GENERATED IN CHCS TO MEET THIS DOD MANDATED REQUIREMENTS FOR REFERRAL PROCESSING.

Writing a Referral

EACH shares the Composite Health Care System (CHCS) platform with 10th Medical Group, 21st Medical group and Buckley Clinic . In addition, most network providers are loaded in CHCS to accommodate network specialty ap- pointing. An alphabet differentiates specialties assigned to medical facilities other than EACH. For example, 10th Med Group Allergy will be **A Allergy**; Peterson- **P Allergy**; Buckley—**B Allergy**. EACH does not require an identifier therefore it is just **Allergy**. **Select TRICARE Network Evans** to direct a consult to the network. Select **TRI- CARE 65 Plus** to direct a patient 65 or older to the net- work.

To direct consults to EACH do not select specialties with an alphabet prefix.

1. CHCS QUEUE NAMING CONVENTIONS FOR PURCHASED CARE

A. TRICARE NETWORK EVANS – For active duty service members and TRICARE Prime enrollees (dependents).

B. TRICARE EVANS – 65 PLUS – For patients age sixty-five or older who have Medicare Part B; are eligible for Medicare Part A; and are enrolled to an EACH PCM.

2. Warrior Transition Unit/Soldier Readiness Center/ Deployment Health

To ensure Army mandated expedited referral access is met for WTU and Global War on Terrorism (GWOT) Deploy- ing soldiers the following psuedo–specialties will be se- lected in CHCS.

GWOT-Mob/Demob - Access standard Routine =7 Working Days or ASAP = 3 Working Days

GWOT - WTU- Access standard Routine = 7 Days or ASAP = 3 Working Days

** Medical board patients may be included in the expedited access process in the future.

A good referral contains the following elements:

1. ACCURATE PATIENT CONTACT INFO
2. Specialty Requested - Referral to: i.e. Ortho, Rheumatology, etc
3. Diagnosis
4. If renewal of referral to same specialty provider, please note any new findings.
5. Symptoms
6. Clinical Findings
7. Recent Treatments
8. Treatment Results (if available)
9. Significant Medical History
10. Cut and paste labs, rads, or if ordered at this visit include notation of what was ordered.
- 11.. Indicate “Evaluate Only” or “Evaluate & Treat.”

(Refer to MEDDAC Reg 40-30 for authorized medical records abbreviations.)

Provider to Provider Coordination

Contact information for network providers can be located using the link to the TriWest Web Page. The link is located on the MEDDAC website on the right side. Or you may go directly to:

<http://www.triwest.com>; click on “Find a Provider”.

Provider to provider coordination is required for all (both internal to MTF and external to network) urgent, i.e. priority is STAT, ASAP, 24 Hr. 72 hrs, etc.

URGENT REFERRALS

Urgent referrals may be STAT- patient must be seen within 24 hours; or ASAP patient must be seen within 72 hours. A consult must be medically necessary to be urgent. All urgent consults, whether urgent to network, urgent to another MTF or urgent internally to EACH requires provider to provider coordination.

General requirements – the priority chosen in ALHTA should match the language regarding priority in the body of the consult. Coordination information, i.e. the consulting physician group, phone number, fax number and if available appointment date or the words “First Available Appointment” should be included in the consult.

PROCEDURE FOR INTERNAL URGENT CONSULTS:

A. The requesting provider will contact another provider in the specialty clinic within the MTF to establish provider to provider coordination and determine necessity/consideration for priority appointment scheduling. **This is required.** Clinic staff (other than the requesting provider) may arrange for the actual appointment.

B. The requesting provider enters the consult request in AHLTA (or use alternate protocol if AHLTA unavailable) with identification of clinic patient being referred to, clinical information and appointment date/time. For example: “ORTHOPEDECS. RT ANKLE FX WHILE PLAYING FOOTBALL. SPOKE WITH DR. X, TO BE SEEN IN ORTHO TOMORROW 07:30AM.” Designated personnel, in the receiving clinic, review the clinic queue twice a day. Clinic personnel assigned to booking patients will contact the patient and schedule the appointment utilizing Appointment Order Processing (AOP). The patient will not be scheduled as a “walk-in.”

C. Internal urgent consults that are not coordinated, will be reviewed by personnel at the EACH RMC. If the consult is determined to be STAT/ASAP, RMC personnel will direct the consult to the appropriate clinic queue, and telephonically inform the clinic of the consult.

If the receiving clinic refuses to accept the consult without provider coordination, RMC will return the consult to the referring clinic queue with telephonic notification, or using best judgment defer the consult which will be processed as routine.

PROCEDURES FOR EXTERNAL URGENT CONSULTS

A. The requesting provider will initiate contact with a specialty provider within the TRICARE network (whenever possible) to establish provider to provider coordination and determine necessity/consideration for priority appointment scheduling. **This is required.** Clinic staff (other than the requesting provider) may arrange for the actual appointment.

B. The requesting provider enters the consult in AHLTA (or use alternate protocol if AHLTA is unavailable) with identification of clinic/specialist patient being referred to, clinical information and appointment date/time. For example: "CARDIOLOGY. CHEST PAIN, SHORTNESS OF BREATH. PLEASE EVAL AND TREAT. APPT. TOMORROW WITH ACME CARDIOLOGY AT 07:30AM." Fax #, Phone #

C. The Central Referral Center (CRC) personnel will review the request. If the information or priority is unclear or incomplete, CRC staff will contact the requesting provider for clarification. Once the information is complete, the CRC staff will fax the information packet to the TSC Clinical Liaison Nurse (CLN).

D. Once the authorization is processed, the CLN will notify the CRC of the authorization number. TriWest will also notify the receiving provider via fax of same information.

** Appointments made for soldiers by case managers must be documented in the comments section on the referral. Documentation format is:

CMDR Approved/Facility/Dr. I. Last name/appt mm/dd/yy/00004233/DO NOT FAX

1. The last comment will allow RMC to capture appointment information for consult report tracking and consult closure.

** Appointments made for soldiers by case managers must be documented in the comments section on the referral . Documentation format is:

CMDR Approved/Facility/Dr. I. Last name/appt mm/dd/yy/00004233/DO NOT FAX

2.Once the consult is deferred - DO NOT PULL THE CONSULT BACK BY PATIENT NAME. NOTHING ELSE CAN BE DONE TO THE CONSULT AT THAT POINT.

Prior Authorizations

Some referrals require prior authorization and additional documentation. See TriWest Authorization List on pages 11 & 12. Contact the TSC with questions regarding prior authorization requirements. Additionally, information is available at TriWest.com regarding medications that require prior authorizations. These lists may change frequently.



Prior Authorization List

All services listed below, provided by TRICARE civilian providers, must be reviewed for medical necessity and require prior authorization for all TRICARE programs administered by TriWest.

[View a comprehensive list of codes requiring prior authorization.](#)

BEHAVIORAL HEALTH / OUTPATIENT

- All Psychological and Neuropsychological testing (Inpatient & Outpatient)
- Behavioral health sessions after self-referred initial evaluation & 8 sessions (Pastoral Counselors, Licensed Professional Counselors and Mental Health Counselors require a physician referral)
- Crisis intervention (CPT codes 90808 and 90809)
- Electroconvulsive therapy
- Interpretation or Explanation of Results (collateral visits)
- Psychoanalysis
- Medication management exceeding twice/month

DENTAL

- Adjunctive dental (including anesthesia); and/or
- All dental care provided by a dentist or oral surgeon

DRUGS AND BIOLOGICALS

- Certain Chemotherapy drugs
- Injectables/Home Infusion
- A complete list of these drugs is also available on the Prior Authorization Drug List at www.triwest.com/ provider.

NOTE: NDC code is required on all prior authorization requests

DURABLE MEDICAL EQUIPMENT (DME) / PROSTHETICS

- Air flotation mattress and/or electric hospital bed
- Augmentative communication device
- Bone growth stimulator
- Chest compression system
- Continuous Glucose Monitor
- Gait trainers/standers
- Lift devices
- Neurostimulators
- Obstructive Sleep Apnea Devices
- Orthotics
- Power wheelchair or scooters
- Prosthetics
- Pumps - Insulin and Implantable
- Wound vac
- Other

ENTERAL FEEDINGS

EXTENDED CARE HEALTH OPTION (ECHO) PROGRAM

All services covered under the program

GENETIC TESTING

HEARING AIDS

HOME HEALTH CARE

HOSPICE

HYPERBARIC OXYGEN

INPATIENT FACILITIES

- All behavioral health including emergencies
- All elective medical / surgical admissions
- Emergency admissions require notification within 24 hours

NON-EMERGENT TRANSPORTS AND NON-EMERGENT AMBULANCE

PAIN MANAGEMENT AND BIOFEEDBACK SERVICES

RADIOLOGY

- Brain MRI
- Breast MRI
- Pet Scan
- Spine MRI
- Other

SURGICAL PROCEDURES

- Abortion, elective
- Bariatric
- Cosmetic procedures
- Hysterectomies
- Implantation of pumps and neurostimulators
- In-utero fetal
- Obstructive Sleep Apnea
- Spine
- Transplants, except corneal
- Other

THERAPIES

- Occupational therapy greater than 20 visits per episode for beneficiary over age 21
- Physical therapy greater than 20 visits per episode for beneficiary over age 21
- Speech therapy

NOTE: Speech therapy for Prime and Standard requires an individual Education Plan (IEP) for beneficiaries ages 3-21.

UNLISTED CODES

In order for TriWest to make an appropriate benefit determination, all care billed with an unlisted code(s) must include a description of the item and pricing, if available, and be prior authorized with the exception of unlisted supplies with a cumulative amount of \$100.00 or less.

REFERRALS

Referrals are necessary when a Primary Care Manager (PCM) cannot provide the necessary services. Active Duty Members (ADSMs) must always have a referral for all care outside of a Military Treatment Facility (MTF), except for emergencies. Referrals are required for most services for Prime and TRICARE Prime Remote (TPR) beneficiaries. The service is not listed on the Prior Authorization List. Referrals are not the same as authorizations. Refer to the pr handbook for additional information.

AUTHORIZATIONS

Authorizations are required for all procedures listed on the Prior Authorization List for all TRICARE beneficiaries in programs administered by TriWest, including Prime, TPR, Standard, Extra, TRICARE Reserve Select, and ECHO.

AUTHORIZATIONS ARE **NOT** REQUIRED FOR SERVICES **NOT** LISTED ON THE PRIOR AUTHORIZATION LIST

Please note that all services must be covered benefits under TRICARE in order to be reimbursed. However, not all require a prior authorization from TriWest. The following is a partial list of services which do not require authorization

- Annual Pap smear
- Cardiac stress tests and myocardial imaging
- Colonoscopy — Screening and diagnostic
- CT Scans — Screening is not covered.
- Dexa Scans — Screening is not covered.
- Durable Medical Equipment (DME) not on the Prior Authorization List
- Eight routine outpatient Behavioral Health visits per beneficiary, per fiscal year
- Esophagogastroduodenoscopy (EGD)
- Eye exams — Refer to www.triwest.com/provider, for more information on the vision benefit.
- Intravenous Pyelogram (IVP)
- Labs (except for genetic testing, which requires authorization)
- Mammograms — Annually for those over age 39. If patient is at high risk for breast cancer, a baseline mam is appropriate at age 35, then annually thereafter.
- Pulmonary Function Test (PFT)
- Radiographs
- Services in the Emergency Room
- Ultrasounds — Only covered if medically necessary. Screening to determine the baby's sex is not covered.
- Upper gastrointestinal (UGI)

OTHER HEALTH INSURANCE (OHI)

TRICARE is always primary for ADSMs. For all other TRICARE beneficiaries with OHI, TRICARE is secondary. TR beneficiaries who have OHI are not required to obtain prior authorizations for covered services, except for the follo services:

- Adjunctive dental care
- All Behavioral Health services, except for the initial eight self-referred visits annually
- Extended Care Health Option (ECHO) services
- Solid organ and stem cell transplants

When ordering consults for OB/GYN, Neck/Spine or Continuity of Care, please provide the information listed under the specified consult.

OB/GYN CON-SULTS	NECK/SPINE Consults	CONTINUITY OF CARE
LMP	CT RESULTS	PHYSICIAN NAME
Gravida Para	MRI RESULTS	PHYSICIAN'S PHONE #
US RESULTS	XRAY RESULTS	NUMBER OF VISITS

ITEMS (usually) NOT COVERED

Abortions	Electrolysis	Sex Changes
Acupuncture	Genetic Test- ing**	Sexual Dysfunction
Artificial In- semination	Investigational Drugs	Smoking Cessation- Products
Chronic Fatigue	OTC Drugs	Sterilization Rever- sals
Cosmetic Sur- gery	Rest Cures	Vitamins
Custodial Care	Self Help Courses	Weight Control

****Some types are covered such as breast cancer. All must have documentation as to family history.**

RADIOLOGY ORDERS

- A. Network agencies accept the CHCS ancillary order form as a legally signed order. An ancillary order is more appropriate than a consult for most radiological studies. However, if an order is not written appropriately, an agency declines the radiology order.
- B. EACH Radiology department must be contacted by the patient or the ordering clinic before scheduling or network referral actions are taken on an ancillary order. **Without a scheduling request, the Radiology department is unaware an order is in the system.**
- C. An appropriately written ancillary order has:
1. Diagnosis
 2. Symptoms, duration
 3. Specified body part to be studied
 4. Request should be written as a question, if a specific reason for test, i.e. Is mass in left breast?
 5. Requesting provider's beeper number at end of Reason for Exam.

Note: Please do not use rule out (R/O); evaluate for; or assess for. Agencies will not honor these orders, because of coding difficulty as well as medical/legal issues. Please, use language that is specific.

- D. When EACH Radiology is contacted by the patient or clinic, but cannot schedule the requested study, Radiology clerks refer the ancillary order to the TRICARE network. The patient is contacted by TriWest via a letter to schedule an appointment with the agency named in the letter.

URGENT RADIOLOGY ORDERS

Process:

- A. Requesting provider/clinic personnel will call **EACH Radiology Department Floor Sergeant at 524-4297** to coordinate the STAT/ASAP radiology procedure while patient is in the clinic. **THIS IS REQUIRED.**
- B. If EACH Radiology Department cannot accommodate the STAT/ASAP patient request, the clinic will direct the patient to the RMC. Referral Management personnel will coordinate a network radiology appointment for the STAT/ASAP radiology procedure. (PET scans, MRI of Brain and Spine require 2nd level review by TriWest.)

PET Scans may require additional forms (particularly if referred to Memorial Hospital Radiology). PET scans require second level review. Information required when ordering a PET Scan should include diagnosis, initial staging, or restaging, was CT , MRI, PET , hx of diabetes, type of cancer treatment .

Durable Medical Equipment (DME) REFERRALS (ADSM and TRICARE Prime)

Purchased DME equipment equal to or over \$1000 require prior authorizations. All rentals of medical equipment, with a cumulative rental cost of \$1,000 or more require an authorization.

- A. Urgent DME referral in CHCS
 1. Provider generates CHCS referral (i.e. SSN, Pt Name, mailing address)
 2. Provider completes medical necessity certification if required.

3. Send Prime patient with copy CHCS Order (use On Demand Function in CHCS for correct format) to TRICARE Service Center (TSC) on 2nd floor. Send any required supporting documentation with patient.
 - a. AD should be sent to Medical Management for DCCS approval/disapproval.
 - b. AD will then take documentation to TRICARE Service Center.
4. TSC personnel will coordinate urgent DME care.
5. TSC personnel will forward DME referrals that require second level along with the medical necessity documentation sent with patient .

B. Routine CHCS DME Consults

1. Provider enters consult in CHCS
2. Provider completes medical necessity certification
3. Clinic Personnel faxes medical certificate to Central Referral Center separate line (Fax: 524-2646).
4. Give copy of medical certificate to patient.

C. DME TRICARE Plus

1. Provider gives the patient a written script and Medical Necessity Certificate.
2. Patient takes script and Medical Necessity Certificate to a Medicare provider.

Out of Area Referrals

Out of area care requires referral and authorization coordination except for emergency care. Patients should notify their Primary Care Manager within 24 hours after an emergency room visit to request a referral for follow up care. Routine care is usually not an authorized out of area benefit. Referrals for out of area care must include the out of area provider's office and fax phone numbers.

Behavioral Health

Currently, Psychiatry and Psychology Services at Evans US Army Hospital are limited to Active Duty Service Members. Active Duty Service members **MUST** have a MTF referral for network behavioral health services.

TRIWEST Behavioral Health services are provided for by a network of various behavioral health specialties. A non-active duty Prime patient has several options for obtaining a network behavioral health appointment. Options A & B do not require a referral.

OPTION A: Call TRIWEST at 1-888-TRIWEST

You will be provided with the names and phone numbers of 2 or 3 network providers. Call provider (s) directly to schedule an appointment.

OPTION B: Visit the TriWest website at: <http://triwest.com>

1. Click on the area titled **Behavioral Health**
2. Click on the option **Find a Provider**
3. Click on the option **Mental Health/Substance Abuse**
4. Search for a provider by specialty (psychiatrist, psychologist, social worker, marriage therapist) and location.
5. Call the provider directly to schedule an appointment.

OPTION C: Primary Care Manager writes a consult.

Within 5 to 10 days, the patient will receive an authorization letter, from TriWest, containing the Name, address and phone number of a Behavioral Health provider.

With a referral, the consulting provider should complete a PCM notification form which provides a limited behavioral health report to the referring provider. Patient usually has to sign a release of information form to permit this coordination.

Miscellaneous Referral Processes

Disease Management Referrals

Disease Management is responsible for asthma education, management, and asthma action plans. Patients must have a diagnosis of asthma prior to referral to our clinic. Please enter a PFT consult if the patient has not had one in the past six months, or has not had one at Evans. Patients should have this done prior to the appointment in DMC. Please make sure the patient has an aero-chamber (spacer) to use with their inhaler, if appropriate, as well as a peak flow meter. The patient should record the peak flow meter readings twice a day for two weeks prior to their DMC visit.

We do pre-diabetes classes and diabetes classes. We do not dispense glucometers for pre-diabetes patients. The 2-hour oral glucose tolerance test (performed after an overnight fast of at least ten hours, measuring the blood glucose before and 2 hours after drinking a 75-gram glucose solution) is the most sensitive test for diagnosis pre-diabetes, but is not always convenient. To order this test, you may type in 75 mg Glucola, 2hr PP, or PP 2hr glucose. You may decide to use the Fasting Glucose test (**best twice on nonconsecutive days**). If you choose to use the FPG test alone, however, it is important to note that some patients who have IGT or diabetes will be missed. You may want to consider how many other pre-diabetes risk factors are present in deciding which test is appropriate.

TEST	VALUE	DIAGNOSIS
FPG	100-125	Pre-diabetes
FPG	≥ 126	Diabetes
OGTT	2 hour value 140-199	Pre-diabetes
OGTT	2 hour value ≥ 200	Diabetes

For patients that are diagnosed with diabetes, please order a comprehensive metabolic profile, lipid panel (Evans), hemoglobin A1C, and Microalbumin random EACH. For diabetic patients who need a glucometer please order alcohol pads (200 per box), and Lancets medisense (200 per box), and either Precision Xtra test strips (50 per box) or Accucheck Comfort Curve test strips (50 per box). If the patient has type 1 DM please order the Precision test strips and Precision Ketone test strips also. (The Accucheck monitor does not have Ketone strips.) If the patient is on insulin please order a glucagon kit.

Pulmonary Function Referrals

General Guidelines:

Appointments are booked by consult only and scheduled by Humana. We do not schedule our own appointments. EACH test must have a separate consult (i.e. Full study and overnight pulse ox)

When submitting a consult, please clarify what type of study is needed with an accurate provisional diagnosis.

If you would like a patient seen ASAP, you must call or visit the clinic to coordinate this, as we may not have immediate openings.

Tests are read by Internal Medicine or Allergy Clinic and interpretation put into AHLTA. Time frame is usually 1 week.

Patient must be able to perform a reliable peak flow and understand complex instructions. Generally, the cutoff for children is 6 y/o.

The Pulmonary Clinic does not have a physician to evaluate patients or time allotted for Asthma education. They must be referred to the Disease Management Clinic.

Baseline Study:

Spirometry Only (SVC & FVC). Bronchodilator given if indicated by ATS guidelines unless requested by physician

Baseline study required prior to scheduling an Exercise test.

If no test is specified on consult, patients will get a baseline study only.

Full Study:

Spirometry, MVV, Diffusion study, Nitrogen washout. Bronchodilator given if indicated unless requested by physician

Patients will not be given the diffusion or N2 test if they have smoked within 8 hours.

Full study is indicated when screening for COPD & other Pulmonary Diseases, exposure to fumes, poor oxygenation, long time smoker, etc.

Sleep Study:

Please clarify if patient will be on any sleep aids, and if they should or should not use supplemental O2 while testing.

Exercise Test:

Test can be performed on either a treadmill or stationary bike. If not specified, pt will be tested on the treadmill.

SLEEP STUDY REFERRALS

Prior to requesting a sleep study, please conduct an assessment of the degree the patient's sleep symptoms by conducting the Epworth Sleepiness Scale.

The results of Epworth Sleepiness Scale should be included in the body of the consult, or attached to the consult order. (Epworth Sleepiness Scale, Page 21)

EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you.

Use the following scale to choose the most appropriate number for each situation.

- 0 = would never doze
- 1 = *slight* chance of dozing
- 2 = *moderate* chance of dozing
- 3 = *high* chance of dozing

SITUATION	Chance of Dozing
Sitting and reading	0 – 1 – 2 – 3
Watching TV	0 – 1 – 2 – 3
Sitting, inactive in a public place (theater or a meeting)	0 – 1 – 2 – 3
As a passenger in a car for an hour without a break	0 – 1 – 2 – 3
Lying down to rest in the afternoon when circumstances permit	0 – 1 – 2 – 3
Sitting and talking to someone	0 – 1 – 2 – 3
Sitting quietly after a lunch without alcohol	0 – 1 – 2 – 3
In a car, while stopped for a few minutes in traffic	0 – 1 – 2 – 3

TRIWEST COGNITIVE REHAB REQUESTS for ADSM

For all Cognitive Rehab requests from the MTF for ADSM- it will be loaded strictly with the profiles for PT, OT, and Speech.

If the referring provider also would like the ADSM to have CPT code 97532 (Cognitive skills development- development of cognitive skills to improve attention, memory, problem solving, direct contact with patient for 15 minutes- this is not a TRICARE covered benefit and can only be approved for ADSM)- they will need to request specific approval for this CPT code in addition to the Cognitive Rehab.

For example- “Requesting Cognitive Rehab and 97532 for up to 50 units” (One unit= 15 minutes)

If the referring provider is also requesting neuropsychiatry testing as part of the Cognitive Rehab, this needs to specifically be requested.

For example - “**Requesting Cognitive Rehab and neuropsychiatry testing**”

(This will create 2 separate authorizations – one medical /surgery auth for the PT/OT/ST and one BH auth for the neuropsychiatry testing. However- only 1 auth/referral is needed from the MTF).

Please contact your respective Clinical Liaison Nurse with any questions.

Consult Tracking

Consult tracking is the process by which the Referral Management Center works collaboratively with the Managed Care Support Contractor to retrieve reports from network providers within a specified period.

The success of consult tracking relies on MTF and contractor access to network appointment information. The contractor's tracking system does not start until the patient or MTF supplies the date and place of the network appointment.

The MTF assist in this process by:

1. Documenting appointment information in the comments section of the consult.
Appointment format is Facility Name/ First Initial, Last name of provider/mm/dd/yy (appt date)/auth number if available/
2. RMC personnel provide this information to the MCSC contractor.
3. MCSC contractor is accountable for obtaining the consult report from the network provider, once appointment information is loaded into the contractor's system.
4. RMC closes the consult in CHCS once an initial consult report is received.
5. RMC electronically and or manually deliver the consult report to Outpatient Medical Reports.

Electronic Processing for Network Reports

Policy Letter 52, Consult Report Retrieval, mandates RMC as the MTF entry point for all network reports.

PROCEDURES:

All network consult reports will be processed through the RMC. Reports received in clinics will be faxed to 1-866-867-7926, TriWest Consult Tracking. These reports will arrive at EACH via BrightFax, a HIPAA compliant fax server. Hard copy reports are shared with Contractor Liaison for tracking, then given to Medical Records for scanning into the electronic medical record. Please note: Radiological pictures may not scan. Medical Records will notate in electronic record, report is in medical record.

Requests for network reports should be directed to the TriWest Consult Tracking Analyst at 524-1647. TriWest can only request reports from their network providers. Please appreciate that in most cases the consulting provider is not contractually required to supply a report until 10 days after the date of the last appointment.

Reports for radiology, laboratory, ordered **by EACH Provider** performed by a network agency are scanned into AHLTA Telephone (T-Con) consults to the ordering provider.

The TCON can be found under current encounter until the provider signs it. Then the TCON with the rad/lab information can be found under past encounters.

Outpatient Medical Records is responsible for scanning or pasting network reports into the patients electronic medical record.

Reports are filed electronically under tabs in clinical notes. The search for a specific note can be narrowed by using the time filter function. For example: If the patient's appointment was in July 2007, apply the filter for 01 July 2007 thru 31 Sep 2007, then search for the correct tab using the information below.

AHLTA Clinical Notes Drop Down Box Types:

Advance Directive Report Living Will, Medical Durable Power of Attorney and a CPR Directive	
Ambulatory Blood Pressure	N/A
Attending Staff Notes	History and Physical
Discharge Summary Report 502) Record of In-patient Treatment	Narrative Summary (SF)
Operative Report Register Number: Inpatient	Operative Report/
Outpatient Consultation	BrightFax (initial)
Outpatient Report (Bright Fax almost 85%)	SF 558 ER Treatment
Outpatient Surgery Report	Same Day Surgery / No register number
Patient Notes	N/A
Physician Progress Notes Mental Health/DA 4700 , Cancer staging	Civilian Outpatient
Procedure Report Radiology Reports, Sleep Studies, Lab reports (excludes inpatient or emergency room) EKGs check previous encounters before scanning.	
Text Notes	All Other

Referral Specialists

Phyllis Morris-Samuels:

526-7674

Emergency Room
Behavioral Health
Family Practice
Pediatrics

Patricia Baca:

(719) 526-7274

Allergy
OB/Gyn
Disease Management
Audiology

TBD

526-7701

Warrior Family Clinic .
DeRaimondo Clinic
Ophthalmology
Otolaryngology

Joyce Luken:

526-3786

Gastroenterology
Internal Medicine
Pain Management
Podiatry
Surgery

Referral Specialists

Elisabeth Dokie:

524-5004

Soldier Readiness Center
Warrior Transition Unit
Traumatic Brain Injury

Mandy Moore

524-4224

Soldier Readiness Center
Warrior Transition Unit
Traumatic Brain Injury

Linda Webber

526-7271

Occupational Therapy
Orthopedics
Robinson Family
Urology

Gerri Quinones

(719) 524-5008
Office Automation

TRICARE Plus

REFERENCES

MEDDAC Regulation 40-5, Medical Management Plan

MEDDAC Regulation No. 40-30, Preparation and
Maintenance of Clinical Records

Policy Letter 50, Internal Consult Process

Policy Letter 52, Consult Report Retrieve

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