

**BY ORDER OF THE
SECRETARY OF THE AIR FORCE**

AIR FORCE INSTRUCTION 44-176

30 OCTOBER 2014

**59TH MEDICAL WING
Supplement**

16 MAY 2016

Medical

ACCESS TO CARE CONTINUUM



COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

ACCESSIBILITY: Publications and forms are available on the e-Publishing website at www.e-Publishing.af.mil for downloading or ordering.

RELEASABILITY: There are no releasability restrictions on this publication.

OPR: AFMSA/SG3SA

Certified by: AF/SG3
(Brig Gen Charles E. Potter)

Supersedes: AFI44-176, 12 September
2011

Pages: 57

(59MDW)

OPR: 59MDOG/SGA

Certified by: 59 MDOG/CC
(Colonel Rachel Lefebvre)

Supersedes: AFI 44-176_59MDW
Supplement, 18 April 2012

Pages: 5

This publication implements AFPD 44-1, Medical Operations. It provides guidance and procedures for Access to Care (ATC) operations within the Air Force Medical Service (AFMS). It establishes the roles, responsibilities, definitions and requirements for implementing, sustaining and managing ATC for AFMS Medical Treatment Facilities (MTFs). Organizational alignment of these functions may vary between MTFs. It applies to individuals at all levels including the Air Force Reserve and Air National Guard (ANG), contract personnel and volunteers who are working in military treatment facilities except where noted otherwise. This publication may be supplemented at any level, but all supplements must be routed to the Office of Primary Responsibility (OPR) listed above for coordination prior to certification and approval. Refer recommended changes and questions about this publication to the OPR listed above using the AF Form 847, *Recommendation for Change of Publication*; route AF Forms 847 from the field through the appropriate chain of command. The authorities to waive wing/unit level requirements in this publication are identified with a Tier (“T-0, T-1, T-2, and T-3”) number following the compliance statement. See AFI 33-360, *Publications and Forms Management*, Table 1.1 for a description of

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(59MDW) AFI 44-176, *Access to the Care Continuum*, 30 October 2014, is supplemented as follows: The purpose of this supplement is to establish policy and procedures unique to the 59th Medical Wing. This instruction applies to all personnel assigned, attached, or on contract to the 59th Medical Wing (59 MDW). This instruction does not apply to the Air National Guard or Air Force Reserve. Refer recommended changes and questions about this publication to the Office of Primary Responsibility using the AF Form 847, *Recommendation for Change of Publication*. The authority to waive requirements is the publication approval authority. Ensure that all records created as a result of processes prescribed in this publication are maintained IAW Air Force Manual 33-363, *Management of Records*, and disposed of IAW Air Force Records Information Management System (AFRIMS) Records Disposition Schedule (RDS).

SUMMARY OF CHANGES

This document has been substantially revised and must be completely reviewed. Major changes include identification of tiered waiver authorities for unit level compliance items. This document has been substantially shortened and focused on required compliance items for medical clinics. It is not directed toward dental clinics within the AFMS.

(59MDW) This publication has been revised. This rewrite of AFI 44-176_59 MDW SUP includes: updated compliance, simplified appointing and access guidance.

Chapter 1

PROGRAM OVERVIEW

1.1. Definition of Access To Care (ATC) Management. ATC Management encompasses myriad Military Treatment Facility (MTF) functions and is an integral part of healthcare delivery, regardless of the care delivery model or platform, inpatient or outpatient. ATC Management includes, but is not limited to: day-to-day management of templating, scheduling, and appointing functions, including those made by telephone, in person, electronic secure messaging, and the internet; information systems management, including provider network file and table building, and clinic and provider profile management; empanelment and demand management and analysis; referral management activities; appointing telephony management; and effective and efficient personnel management in support of this mission. ATC is not limited to a traditional appointment with a provider. It also includes the concept of Enhanced Access which provides multiple opportunities for the MTF to provide appropriate, high quality, and timely care in other venues by other team members. Enhanced Access will be incorporated into MTF ATC strategy.

1.2. Goals of ATC Management. Implement and sustain a systematic, proactive, programmatic, and responsive access program for all clinics and services. Appointment access must meet standards as stated in 32 Code of Federal Regulations 199.17, implemented by the Office of the Secretary of Defense (OSD) in Department of Defense Instruction (DoDI) 6025.20 (Medical Management (MM) Programs in the Direct Care System (DCS) and Remote Areas). The end result is the right patient is provided the right health care service, at the right time, in the right setting. The right setting may include over the phone, in the office, or via internet, and it may be with a provider other than a physician.

1.3. Objectives of ATC Management. A successful access management program is commander led, with a multidisciplinary oversight approach including employment and sustainment of a well-researched, efficient and effective plan that maintains access to services, meets mission requirements, and satisfies the wellness needs of beneficiaries and ensures a satisfactory experience with all health care services. Each MTF will place the following objectives among its top priorities:

- 1.3.1. Implementation of effective Enhanced Access strategies. (T-3)
- 1.3.2. Provide access to health care services/appointments within access standards. (T-3)
- 1.3.3. Maximize provider-patient continuity. (T-3)
- 1.3.4. Achieve patient and staff satisfaction through monitoring and proactive actions. (T-3)
- 1.3.5. Provide a patient-centered appointment system, by telephone, in person, via internet, or through secure messaging. (T-3)
- 1.3.6. Maximize first call resolution by resolving the patient's request for health care services during their first contact, in person, telephone call, internet request or secure message, and with as few steps as possible. (T-3)
- 1.3.7. Make needed capacity available and optimize internal appointment supply. (T-3)

1.4. HIPAA Compliance. ATC Management functions are subject to the Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules and national standards,

including compliance with DOD 6025.18-R, DOD Health Information Privacy Regulation, DOD 8580.02-R, DOD Health Information Security Regulation, and AFI 41-210, **Chapter 6**, TRICARE Operations and Patient Administration Functions, or as superseded by new or revised HIPAA privacy or security regulations or instructions. (T-0)

1.4.1. Ensure that appropriate administrative, technical, and physical safeguards are in place for the use and disclosure of protected health information (PHI). (T-0)

Chapter 2

ROLES AND RESPONSIBILITIES

2.1. MTF Commander.

2.1.1. Will continuously pursue and efficiently utilize available staff and resources to support the beneficiary population's health care and wellness needs. (T-0)

2.1.1.1. Ensures health care services are provided within ATC standards. (T-0)

2.1.2. Ensures the enrolled population receives care within ATC standards for all appointment types at least 90 percent of the time. (T-3)

2.1.3. Sets standards and procedures to maintain continuity so that patients are appointed with his or her Primary Care Manager (PCM) no less than 70 percent of the time and 90 percent of the time with the Patient Centered Medical Home (PCMH) team in Family Health, Pediatrics and Internal Medicine clinic, and to maximize continuity for routine care in Flight and Operational Medicine clinics. (T-3)

2.1.4. Ensures ATC performance measures, to include team and PCM continuity, are briefed monthly at the Executive Staff Meeting. (T-3)

2.1.5. Appoints an Access Manager. This will be the most senior Group Practice Manager (GPM) if one is assigned. (T-3)

2.2. Access Manager/Access Management Team.

2.2.1. The MTF will form an Access Management Team which will have a multidisciplinary membership that operates together to optimize delivery of timely, effective care to its beneficiary population. (T-3)

2.2.2. The Chair of the Access Management Team will be the Access Manager. The Chief of the Medical Staff (SGH) will be the alternate chair. (T-3)

2.2.3. The Access Manager is responsible for managing the Access Management Team, objectively reporting good and bad ATC measures/results and recommending corresponding access improvement strategies to executive leadership. (T-3)

2.2.4. This team will include at a minimum: the Access Manager, SGH, Chief Nurse (SGN); Administrator (SGA); Health Care Integrator (HCI); Health Service Management 4A Functional; Aerospace Medical Service 4N Functional; Flight Commanders and Non-Commissioned Officers in Charge (NCOICs) of all applicable clinics, to include Family Health, Internal Medicine, Pediatrics, Flight Medicine and specialty/surgical clinics as needed based on the product line mix of the MTF. The Medical Operations Squadron (MDOS), Medical Support Squadron (MDSS) and Aero Space Medicine Squadron (AMDS) Commanders are highly encouraged to participate and/or be members of the Access Management Team as well. (T-3)

2.2.5. The Access Management Team will meet at least monthly to review/coordinate all templating, scheduling, appointing, clinic/appointment staffing, provider coverage, supply shortfalls and surpluses and other timely clinical operational issues with the goal of optimizing

access to care at the MTF. (T-3) The ATC meeting involves a large number of clinicians, and therefore will not meet during patient care hours. (T-3)

Chapter 3

APPOINTING AND SCHEDULING

3.1. Overview of Appointing.

3.1.1. MTFs will construct templates and schedules using the nine Military Health System (MHS) Standard Appointment types (see chart below). Definitions can be found on the ATC AFMS Knowledge Exchange (Kx). (T-3)

3.1.2. Appointing personnel will select one of the five ATC categories (see chart below) in the Composite Health Care System (CHCS) appointing search function in order to book scheduled appointments. The appropriate ATC standard is chosen based on one or more of the following: 1) the timeline of the patient's request for care; 2) provider directive; 3) locally based protocols (T-3).

Table 3.1. Military Health System (MHS) Standard Appointment Types.

ATC Category/ CHCS Search Option	MHS Standard Appointment Type That Should Be Chosen/Booked (NOTE: See 3.2 for use of \$ sign appointments)	ATC Standard (Time In Which The Appointment Type Needs To Be Booked)
Acute	ACUT and ACUT\$	24 Continuous Hours/1440 minutes
	OPAC and OPAC\$	24 Continuous Hours/1440 minutes
Routine	ROUT and ROUT\$	7 Calendar Days/10,080 minutes
Wellness	WELL and WELL\$ PCM and PCM\$	28 Calendar Days/40,320 minutes
Specialty	SPEC and SPEC\$ PROC and PROC\$	28 Calendar Days/40,320 minutes, or per Provider Designation not to exceed 28 Calendar days
Future	EST or EST\$ GRP or GRP\$	No Standard or per Provider Designation

3.1.3. MTF leadership will establish appointing processes that will successfully match the patient's needs with the appropriate ATC category, while striving to maximize patient/PCM continuity. (T-0)

3.1.4. **(Added-59MDW)** In addition to the policies outlined in AFI 44-176 the 59 MDW will adhere to the protocols developed in collaboration with its San Antonio Military Health System (SAMHS) partners, and executed by the enhanced multi-service market's Consult and Appointment Management Office (CAMO). SAMHS protocols are consistent with the Simplified Appointing model outlined in AFI 44-176.

3.1.5. **(Added-59MDW)** Appointing protocols will be developed by clinic leaders and coordinated with the CAMO for standardization across SAMHS. These standard operating

procedures are reviewed and updated by clinic leaders, but no less than twice per year, and as needed.

3.1.6. **(Added-59MDW)** In order to achieve first-call resolution for all patients, the 59 MDW provides for a coordinated effort including warm hand-offs to team nurses, red t-cons to foster structured hand-off of the patients' information to the teams, and cross booking across teams as coordinated by the clinic staff. This effort is practiced across the entire SAMHS to limit transfers to the Nurse Advice Line (NAL) or unnecessary additional contacts by the patient.

3.2. Use of Dollar Sign (\$) Suffix on Appointment Types.

3.2.1. Use of the \$ suffix on appointment types is prohibited from use in all clinics that have PCMs assigned. (T-3)

3.2.2. The \$ may be used in specialty clinics, but will be limited to no more than 10% of initial specialty (SPEC) appointments. To the greatest extent feasible, the appointing function should be performed by the central appointing call center or Referral Management Center staff. (T-3)

3.3. Maintaining PCM Continuity/Patient Centered Medical Home Team (PCMH)/PCM Booking.

3.3.1. Continuity will remain the primary objective of MTF primary care access policy. Standard booking protocols will be developed and executed to achieve the following:

3.3.1.1. Patient - PCM (provider) continuity should be maintained at or greater than 70% in Family Health, Pediatrics and Internal Medicine clinics, and routine care continuity should be maximized in Flight and Operational Medicine clinics.

3.3.1.2. Patient - PCMH Team continuity should be maintained at or greater than 90%.

3.3.1.3. The AFMS cross booking goal is 0%. However, judicious use of cross booking within a clinic product line (Family Medicine, Pediatrics, Internal Medicine, Flight Medicine) may be used when necessary for acute access within the remaining 10% of available appointments to maintain patient-MTF continuity. Cross booking performance (percent total booked appointments) by provider, team and MTF aggregate will be incorporated in regular reviews by the ATC Team, and reported to the MTF Executive Committee monthly. (T-3)

3.3.1.4. Under specific conditions of extended provider absences (deployment, hiring gaps, etc.), patients may be administratively re-empanelled equitably among the remaining PCMH providers for continuity purposes, with the expected impact on apparent cross booking.

3.3.1.5. Active Duty Service Member (ADSMs) will not be sent to the network for primary care during the duty day unless no other option is available to provide care.

3.4. Booking Transactions.

3.4.1. **Not Meeting Access Standards.** MTFs will use the ATC category search that best represents the patient's need, even if an appointment was not found within ATC standards. (T-0)

3.4.2. Patients Refusing Care Within Access Standards. MTFs will allow patients to waive ATC standards and request appointments outside of ATC Standards for provider continuity/convenience/personal reasons, even though the MTF may have appointments available inside ATC Standards with their PCM or other providers in the team/clinic. (T-3)

3.4.2.1. Patients Refusing All Appointment Times Offered. Appointing personnel will document patient refusals IAW current information system processes listed on the AFMS ATC Kx website to ensure it reflects the reason a patient refused all appointment times offered as opposed to not accepting care within ATC standards. (T-3)

3.4.3. Un-booked Appointments. MTFs will use the Un-booked Appointment Request/Reporting functionality in CHCS to allow for the tracking and reporting of patients who requested an appointment, a search was performed by an appointing agent, but the appointment request did not result in a booked appointment. (T-3)

3.4.3.1. Choosing Un-booked Appointment Reasons. Appointing personnel will choose the most accurate Un-booked Appointment Request reason from the list below, using the definitions that are listed on the AFMS ATC Kx website, best matching why the search attempt did not result in a booked appointment. (T-3)

3.4.3.1.1. Added to Waitlist

3.4.3.1.2. All Appointments Refused

3.4.3.1.3. Appointed to Network

3.4.3.1.4. No Appointments Available

3.4.3.1.5. No Appointments Available to Contractor

3.4.3.1.6. Patient Requested To Call Back

3.4.3.1.7. Request Referred to MCSC (Managed Care Support Contractor)

3.4.3.1.8. Request Referred to MTF Clinic

3.4.3.1.9. Self-Care Recommended

3.4.3.1.10. Unsuccessful Telephone Transfer

3.4.3.1.11. Just Looking

3.4.3.1.11.1. Appointing personnel will not use 'Just Looking' as the default reason for searches that did not result in a booked appointment. (T-3)

3.4.3.1.12. Other (Free Text)

3.4.3.2. Appointing and MTF staff will not delete un-booked/unused appointment slots from the appointing system or remaining schedules. (T-3)

3.5. No-Shows.

3.5.1. An appointment is designated a No-Show when a patient does not keep a scheduled appointment or cancels within 2 business hours of the appointment, or within a specified time frame established by the MTF commander prior to the scheduled appointment. (T-3)

3.5.2. MTFs will strive to reduce no-show rates to no more than five percent (5%) of all booked appointments. (T-3)

3.5.3. MTF Commanders will publish and ensure that only one no-show policy is administered and applied throughout the MTF so as to not confuse staff and patients with differing policies between clinics/departments. (T-3) This no-show policy cannot violate other laws, regulations or policies. All MTFs will publish and market their locally established no-show policy to their beneficiaries. (T-3)

3.5.3.1. **(Added-59MDW)** 59 MDW No Show Policy.

3.5.3.1.1. **(Added-59MDW)** If a patient arrives after the scheduled appointment time, the clinic will make every effort to accommodate the patient the same day. If the patient does not arrive at all, the appointment will be documented as a no-show during end of day processing. This process will foster a patient-centered approach to care.

3.5.3.1.2. **(Added-59MDW)** The GPM will create/send no-show letters to the unit commanders for action for all active duty no-shows.

3.5.3.1.3. **(Added-59MDW)** The CAMO business rules indicate that, following a no-show, the CAMO staff will contact the patient to reschedule if the consult is still active. The patient will be given the option to reschedule the appointment (waiving ATC) and the previous no-show will be documented in review notes when rescheduling.

3.5.3.1.4. **(Added-59MDW)** At the discretion of the specialty service, on the second no-show of an initial specialty care appointment, the consult may be administratively closed and the referring provider notified. The patient will require a new referral if the patient still requires this specialty care.

3.5.4. Providers/staff will follow-up on and document all no-show and Left Without Being Seen (LWOBS) patients to ensure patient wellness/safety. (T-0)

3.5.4.1. **(Added-59MDW)** All clinics will contact patients within 72 hours of a no-show or left without being seen (LWOBS), as described below, to determine if the patient still requires care. All attempts to contact patients will be documented in the patient's electronic health record.

3.5.5. At least three attempts over a 72-hour period will be made and documented to make contact with No-Show/LWOBS patients. (T-3)

3.6. Late Patient Arrival for Scheduled Appointment (Late-Show).

3.6.1. MTF Commanders will publish one Late-Show policy and ensure that it is administered and applied consistently throughout the MTF so as not to confuse staff and patients with differing policies between clinics/departments. (T-3)

3.6.1.1. **(Added-59MDW)** The 59 MDW late patient policy provides guidance on the handling of patients arriving after their appointed time. This policy forms the basis for handling late arrivals, and is the driver for using end of day processing as the only mechanism for designating appointments as no-shows. Therefore clinic staff will use no method other than end of day processing to record no-shows.

3.6.1.2. **(Added-59MDW)** In the event a patient arrives past their scheduled appointment time the following steps will be taken.

3.6.1.2.1. **(Added-59MDW)** Screen the patient and work them into the patient flow as quickly as possible.

3.6.1.2.2. **(Added-59MDW)** If the patient will experience a delay being worked into the flow, screen patient to determine if any aspects of their situation can be handled by support staff such as a T-con or preventative health issue.

3.6.1.2.3. **(Added-59MDW)** If an urgent issue exists, the clinic will accommodate the patient as appropriate.

3.6.1.2.4. **(Added-59MDW)** If no urgent issue exists and the situation requires a provider visit, the patient is given their choice of two options; wait to be worked in between other scheduled patients, or be rescheduled at their convenience.

3.6.1.2.5. **(Added-59MDW)** If the patient chooses to reschedule, the clinic will book another appointment before the patient leaves the clinic. If the patient prefers not to be given an appointment on the spot, they are directed to call the CAMO to book another appointment.

3.7. Patient Cancellations.

3.7.1. MTFs will establish a separate cancellation telephone number/call tree option that is available/open 24 hours a day, seven days a week to capture patient's appointment cancellation requests. (T-3)

3.7.2. Appointment cancellation phone numbers and internet appointment cancellation processes via TRICARE Online (TOL) will be clearly found/understood on MTF websites, appointment line messages, phone books and other readily available means. (T-3)

3.7.3. MTFs will develop a process to ensure that appointment cancellation notifications received from phone answering machines, automated reports, secure messaging, email, text messages and/or other means are translated back into CHCS in a timely manner so that these patient cancelled appointments can be reopened for booking. (T-3)

3.7.3.1. **(Added-59MDW)** The CAMO agents will cancel appointments when requested by patients who leave a message as directed on the CAMO phone tree.

3.7.3.2. **(Added-59MDW)** Each clinic will appoint two members to receive Audio Communicator (ACS) daily email receipt. The Group Practice Managers (GPM) will validate the ACS recipient list quarterly.

3.7.3.2.1. **(Added-59MDW)** Requests to cancel appointment made through ACS will be canceled in CHCS by the clinic staff at earliest opportunity, but not later than 0800 the next duty day.

3.7.3.2.2. **(Added-59MDW)** GPMs will monitor clinic compliance.

3.8. Facility Cancellations.

3.8.1. MTFs will take necessary actions to minimize facility cancellations. (T-3)

3.8.2. MTFs will establish schedule management processes to govern the facility cancellation process to include who has authority, when this practice is authorized, and what feedback/reports are generated during facility cancellations. (T-3)

- 3.8.2.1. **(Added-59MDW)** Facility cancellations will be limited to unavoidable situations and must be approved by the flight commander prior to canceling appointments.
- 3.8.2.2. **(Added-59MDW)** The GPM will report facility cancellations at the Access Working Group as needed.
- 3.8.3. MTFs must notify affected patients of their facility cancelled appointment as soon as possible. (T-3)
- 3.9. **(Added-59MDW)** Freezing appointments can be used to temporarily block schedules when provider availability cannot be confirmed due to leave, TDY, training, etc. This practice should be limited and frozen appointments must be released or cancelled at a minimum of 7 days prior to appointment.

Chapter 4

DETAIL CODES

4.1. Use of Detail Codes.

4.1.1. MTFs may use detail codes to further define appointment type definitions on templates and schedules. (T-3)

4.1.2. MTFs will use the tri-service approved operational definitions.(T-3)

4.2. Use of Patient Access Type Detail Codes.

4.2.1. MTFs will use no more than one patient access type detail code per appointment slot. This ensures appointing personnel correctly identify the category of patient (i.e. Active Duty, Family Member, etc.) to be booked into a particular slot. (T-3)

4.3. Use of Web Enabled (WEA) Detail Codes.

4.3.1. MTFs will use the WEA detail code to identify all the appointment slots the MTF wants available for display and booking via the TOL appointing function. (T-3)

4.3.2. MTFs will web enable at least 80 percent of appointments in Family Health, Pediatrics, Internal Medicine, Flight Medicine Primary Care clinics and Optometry clinics to maximize the availability and use of TOL appointing. (T-3)

4.4. Use of Provider Book Only (PBO) Detail Codes.

4.4.1. The use of the PBO detail code restricts booking by other members of the clinic and the central appointing function either at the MTF or the multi-market office. MTFs will have specific procedures for the use of the PBO detail code approved by the Access Management Team. (T-3)

4.4.1.1. **(Added-59MDW)** The use of the provider book only (PBO) detail code will be approved by the 59 MDW Access Manager as delegated by the Access Working Group.

4.4.2. The use of the PBO detail code will be limited to those appointments in excess of required centrally bookable appointment levels for PCMH and specialty clinics. No more than 10% of each provider's available appointments, as measured weekly, will use the PBO detail code. (T-3)

Chapter 5

TEMPLATE/SCHEDULE MANAGEMENT AND ADMINISTRATION

5.1. Template Management.

5.1.1. GPMs/Access Managers/Health Care Integrators will develop and maintain an ongoing demand management forecast to be used to quantify the necessary supply of appointments required to meet access standards. (T-3)

5.1.2. GPMs/Access Managers will report these demand management forecasts to the access management team who in turn work with medical staff members to forecast the necessary supply of appointments, the schedule appointment type mix and projected setting required to meet beneficiary access.

5.1.3. Provider templates will be developed in support of current PCMH guidance and the demand management forecast. (T-3)

5.1.4. GPMs/Access Managers will develop processes to ensure that appointment templates are reviewed on a semi-annual basis by the affected provider and updated as needed. (T-3)

5.1.5. Access managers will ensure that providers, clinic chiefs, and the SGH document a review and approval of individual templates and clinic appointing protocols at least semi-annually to ensure provider accountability. (T-3)

5.1.5.1. **(Added-59MDW)** All provider templates will be reviewed by the individual provider no less than twice per year. The Flight Commander will approve all templates and report completion of semiannual review to the SGH.

5.2. Clinic Leader Schedule Release Responsibilities. Clinic leadership supported by the GPM will ensure that schedules are released to allow, at a minimum, a continuous/rolling 120-calendar day supply of available appointments for booking. (T-3)

5.3. Schedule Change Request. MTF/Clinic leadership will monitor appointment schedule change requests with the goal of minimizing: 1) continuous/repeated changes to opened schedules, 2) changes causing facility cancellations, and 3) the rescheduling of patients. (T-3)

5.4. Information System Usage.

5.4.1. All MTF medical clinics will use CHCS to schedule patient appointments. This will ensure that there is visibility of provider time and to allow data feeds to the Medical Expense and Performance Reporting System (MEPRS), Third Party Collection System, and other management reporting systems. (T-3)

5.4.2. AFMS MTF clinics are not permitted to use ledger books or meeting/personal scheduling software such as Outlook to maintain appointment schedules and/or to book medical appointments for beneficiaries. (T-3)

Chapter 6

VERIFYING AND UPDATING PATIENT INFORMATION AND ELIGIBILITY

6.1. Defense Enrollment Eligibility Reporting System (DEERS) Checks. A complete DEERS eligibility check will be accomplished at each patient interface, including booking via telephone or in person, telephone consultation requests, and check-in by a patient for scheduled, Walk-In, or Sick Call appointments. The only exception will be for telephone contacts made by/to providers. (T-0)

6.2. DEERS Updates. DEERS patient demographic information will be verified and updated at each patient interface, including booking via telephone or in person, telephone consultation requests, and check-in by a patient for scheduled, Walk-In, or Sick Call appointments. The only exception will be for telephone contacts made by/to providers. Demographic information includes the patient's current address and/or current telephone number in the local appointing information system registration data base. (T-3)

6.3. All staff booking appointments will follow National Patient Safety Guidelines and perform at least two patient identifier checks, including at a minimum full name and date of birth. (T-0)

6.4. Eligibility Questions. Any questions related to the patient's eligibility for care and enrollment status will be referred to the TRICARE Operations and Patient Administration (TOPA) Flight/Branch for review and determination. (T-3)

Chapter 7

APPOINTING PROCESSING

- 7.1. Clinic leadership will ensure that one staff member of the clinic/element is responsible for the timely and accurate completion of end of day (EOD) processing. (T-3)** This is to promote accountability. Clinic/element staff assigned to this task will perform EOD processing at the completion of each business day. (T-3)
- 7.2. Clinic/element staff will determine and then assign a patient appointment status for each appointment as accurately as possible by applying the definitions listed on the AFMS ATC Kx website. (T-3)**
- 7.3. Clinic/element staff will process and apply workload types (count/non-count) on appointment slots accurately as to match the actual care provided. (T-3)**
- 7.4. All providers registered on the final appointment status will match the providers who actually saw the patient. (T-3)**
- 7.5. Walk-in and Sick Call appointments will not have their appointment status changed to any other appointment status. (T-3)**
- 7.6. Open/unused appointment slots will not be deleted from the schedule. (T-3)**

Chapter 8

APPOINTING INFORMATION SYSTEM OPERATIONS

8.1. Division, Clinic, and Provider Profiles.

8.1.1. MTF leadership will clearly identify those responsible to establish and maintain division, clinic and provider profiles in the MTF appointing information system(s). (T-3)

8.1.1.1. **(Added-59MDW)** The 59 MDW Data Analysis Cell, Resource Management Element is responsible for the establishment and maintenance of all division, clinic, and provider profiles in CHCS.

8.1.2. MTF leadership will ensure the ATC Reporting Flag is set to "Yes" in each of their primary and specialty/surgical care clinic profiles that have active schedules in CHCS. (T-3)

8.1.3. The Self-Referral flag will be set to "Yes" in the clinic profile of clinics allowing self-referrals. (T-3)

8.2. Appointing Information System Booking Authority and Security Key Administration.

8.2.1. MTF leadership will establish who will have authority to book and cancel appointments in the appointing information system which will be reviewed annually with the goal of minimizing that number. (T-3)

8.2.1.1. **(Added-59MDW)** Only those requiring access to perform assigned duties will be assigned booking keys in each clinic. The Flight Commander will establish who will have authority, by position in each clinic to book, cancel, or change any appointment or appointment slot. The list of members holding booking keys will be reviewed and updated annually. Completion of annual review will be reported to the Access Working Group.

8.2.2. MTF leadership will identify positions and what appointment information systems security keys are needed to perform required duties (T-3). These appointment information system security keys include:

8.2.2.1. Changing appointment types.

8.2.2.2. Changing and/or adding detail codes.

8.2.2.3. Changing gender and age designations on appointment slots.

8.2.2.4. Booking appointments outside ATC standards.

8.2.2.5. Instantaneously creating and booking appointments while appointing the patient.

8.2.2.6. Deleting appointment slots.

8.2.2.7. Freezing and unfreezing appointment slots.

8.2.2.8. Facility canceling appointments.

8.3. Telephonic/Text/Email Appointment Reminder Systems.

8.3.1. MTF leadership will identify at least two MTF personnel who are responsible and trained to perform set up and maintenance of system settings and to receive and act upon output

such as cancellation/confirmation/change request responses from patients receiving telephone appointment reminders. (T-3)

8.3.2. MTF leadership will develop a robust telephonic/text/email reminder system registration program such as for TOL and MiCARE and to ensure that accurate telephone numbers are captured for patient communication. (T-3)

Chapter 9

TELEPHONE ADMINISTRATION AND SUPPORT TO APPOINTING

9.1. Appointing Telephony Functional Responsibilities.

9.1.1. The GPM will have primary functional control, and whenever possible have administrative control, of appointing personnel. (T-3)

9.1.1.1. **(Added-59MDW)** The CAMO will have primary functional and administrative control over the SAMHS central appointing function and is responsible for monitoring performance of appointing personnel.

9.1.2. The GPM will monitor each agent during four (4) calls per month and provide feedback on at least two (2) of those calls. Feedback forms are located on the AFMS ATC Kx website.

9.2. Telephonic Access Management Duties.

9.2.1. Key Performance Indicator (KPIs) targets include:

9.2.1.1. Percent of Abandoned Calls - Less than or Equal to 18%. (T-3)

9.2.1.2. Service Level – 90% of Calls Answered within 90 Seconds. (T-3)

9.2.1.3. Average Speed of Answer – Less than or Equal to 45 Seconds. (T-3)

9.2.1.4. Average Talk Time – Between 3 to 5 minutes. (T-3)

9.2.1.5. Utilization – Greater than or Equal to 70%. (T-3)

9.2.2. The GPM is responsible for reporting KPI measurement outcomes to the Executive Staff on a monthly basis and will recommend improvement strategies through the Access Management Multidisciplinary Team as needed. (T-3)

9.3. Automatic Call Distribution (ACD) Call Tree Considerations.

9.3.1. Call trees will not exceed five options in any given menu. Not included in the five options are cancelling an appointment, an option to return a caller to Option 1 on the menu, and an option to repeat a menu. (T-3)

9.3.2. Call menus will not exceed six layers. (T-3)

9.3.3. Option 1 from the opening or main menu will be to access the appointment desk/call center function to book appointments at the MTF only. The Nurse Advice Line (NAL) will not be made any part or sub-menus of Option 1. (T-3)

9.3.4. The Nurse Advice Line (NAL) will be placed on the call tree as an option other than Option #1 when the appointment line/call center is open for normal business hours (i.e. Option #2 or #3 behind primary care, specialty care and dental appointments for the MTF). (T-0) When the appointment line is closed during normal MTF business hours, the NAL can be moved to Option #1. (T-3)

9.3.5. Each system will ensure any on-hold music represents a professional atmosphere and is legally obtained for rebroadcast. (T-3)

9.3.6. To ensure consistent data collection across the AFMS, skill set naming conventions will start with the MEPRS code. (T-3)

9.3.7. All MTF PCM booked appointments will be routed through the Automatic Call Distribution (ACD) to capture workload. (T-3) While the use of skill sets is encouraged for high volume clinics, the calls may be routed by the ACD to a direct clinic line.

9.3.8. All changes to the Call Tree that impact the collection of ACD metrics must be approved by the Air Force Access to Care Program Office prior to implementation. (T-1)

Chapter 10

REFERRALS AND CONSULTS

10.1. Management of Referrals/Consults. All specialty/surgical care and Right of First Refusal (ROFR) referrals/consults will be managed IAW current AFMS Referral Management Business Rules and Assistant Secretary of Defense for Health Affairs (ASD (HA)) referral management (RM) guidance. (T-0)

10.1.1. **(Added-59MDW)** All referral requests from providers will be entered into CHCS/AHLTA in accordance with 59 MDWI 41-119, *Outpatient Referrals and Consultations*.

10.1.2. **(Added-59MDW)** Clinic leaders will, no less than monthly, review and update the capability report to reflect the services and beneficiary categories for which they can provide care. Updates to the capability report are approved by the SGH of each respective group (359MDG, 559MDG, 59MDOG, 59DG). The GPM will coordinate the clinic review and provide monthly updates to the CAMO.

10.1.3. **(Added-59MDW)** Clinics will ensure an adequate supply of bookable specialty appointments exist within the access standard to exceed the number of consults accepted.

10.2. Review and Booking of Referrals/Consults. The MTF's Capability and ROFR reports should be as unrestrictive as possible to retain/recapture the maximum number of specialty care referrals to sustain clinical currency and minimize purchased care costs. These reports should be updated as needed for accuracy. (T-3) The MTF Executive Staff or designee is the approval authority for the MTF's Capability and ROFR reports. (T-3) All referral requests will be routed to the RMC or multiservice market referral center for administrative review, appointing to the MTF, and processing to the Managed Care Support Contractor (MCSC). Exceptions to this process shall be approved by the Executive Staff or designee in writing. MTF specialty clinics exempted by the Executive Staff are responsible for referral review, booking, & tracking of those referrals. (T-3)

10.2.1. If the patient cannot be booked within the appropriate ATC standard as indicated by the referring provider's referral priority, and the patient does not waive the ATC standard, the patient will be referred to the purchased care system IAW current TRICARE and MCSC requirements. (T-0)

10.2.2. If there is neither capability nor capacity within the MTF, referral requests will be deferred to the MCSC for Prime and ADSM beneficiaries. (T-0)

10.2.3. Since the MCSCs do not process referral requests for Prime with Other Health Insurance, TRICARE-Plus, TRICARE for Life, and Standard beneficiaries, MTFs will have written processes in place to assist these beneficiaries with their referral requirements to the purchased care system providers. (T-3)

10.2.3.1. **(Added-59MDW)** The responsibility for managing referrals requests is shared between the 59MDW Referral Management Center and the CAMO. Written guidance for handling referrals is published in the 59 MDWI 41-119 and the San Antonio Military Health System Referral Management Center Business Rules. These

policies fully address the management of referrals for all beneficiary categories and require that Active Duty service members are given the highest priority.

10.3. Management of Unused Referrals.

10.3.1. The referring provider shall be notified by the RMC of all referrals not used or activated by their patients. (T-3)

10.3.2. The referring provider or team member will follow-up with the patient according to appropriate local protocols. (T-3)

10.3.2.1. **(Added-59MDW)** Specialty care clinics that manage their own consults will follow guidance published in the *SAMHS Referral Management Center Business Rules*.

10.3.2.2. **(Added-59MDW)** Consults may be closed at the patient's requests. The consult is closed in CHCS with a status of "no appointment required" and the comment code of "{NU}" for not utilized.

10.3.2.2.1. **(Added-59MDW)** All patient contact and attempts to contact will be documented as a referral review comment in CHCS.

10.3.2.2.2. **(Added-59MDW)** The referring provider must be notified when a consult is closed or placed in the SAMHS hold box.

10.3.2.3. **(Added-59MDW)** The referring provider or team will follow-up on all unused consults. The timeframe of this follow-up is at the discretions of the referring provider based on clinical determination and risk. All follow-ups will be documented in the patient's electronic health record.

10.4. ROFR Determinations and Management.

10.4.1. ROFR determinations must be made as outlined below and the MCSC must be notified of the determination. (T-0)

10.4.2. The MTF RMC or multiservice market referral center will determine if the MTF has specialty capability and capacity to accept ROFRs within ATC standards. (T-0)

10.4.3. If action is not taken on the ROFR per the TOM time requirements, it will be considered to be an implied denial of the ROFR and the MCSC will appoint to the purchased care system. (T-0)

10.5. Additional Referral Visits or Specialty Care Authorization.

10.5.1. For services beyond the initial authorization, the MCSC will use its best business practices in determining the extent of additional services to authorize. (T-0)

10.5.2. The MCSC shall not request a referral from the MTF, but shall provide the MTF's single POC [the RMC] a copy of the authorization and clinical information that served as the basis for the new authorization. (T-0)

10.6. Management of ADSM Referrals.

10.6.1. MTF leadership will ensure processes are in place and utilized to fully address the management of ADSM referrals. (T-0)

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

10.7.1. When patient demand for primary care services, including Enhanced Access opportunities, exceeds supply of an MTF to meet ATC standards, patients must be referred to the network/purchased care system. (T-0)

10.7.2. MTF leadership will develop written instructions governing when and how acute and/or routine primary care services in the purchased care system will be accessed and used. (T-3)

10.7.2.1. **(Added-59MDW)** Market protocols dictate maximum effort be applied to ensuring the patient is seen within the direct care system. When the availability of appointments in both the primary care and urgent care clinics is depleted, patients may be authorized to obtain care from network urgent care resources at the discretion of the PCMH team.

10.7.3. MTF leadership will work closely with their local MCSC management and nearby multi service market MTFs (if applicable) to ensure that the most effective and efficient utilization of MTF Direct Care/in-house resources are used. (T-3)

10.8. Referral Management Accountability and Tracking.

10.8.1. Referral results will be uploaded into the Healthcare Artifact and Image Management Solution (HAIMS)/electronic health record. (T-0).

10.8.2. Providers will be notified of new results via CHCS T-CON. The T-Con and the matching results will be titled: Network Results – Specialty MM/DD/YY, where the date is the encounter or results date. (T-3)

10.8.3. The MTF shall have a process in place ensuring referral results are reviewed and signed by the referring provider/PCM within three business days of receiving the results. The MTF will establish written processes to monitor referring provider review of results and notify the SGH/designee of deficiencies. (T-3)

10.8.4. For purchased care referral results, MTFs will have written processes in place for actively reconciling missing results to their conclusion on all initial specialty care referrals and urgent/primary care deferred to the network. (T-3)

10.8.4.1. **(Added-59MDW)** The CAMO receives Clear and Legible Reports from network providers for care rendered in the purchased care system. The results are populated in HAIMS and the availability of that information is conveyed to the requesting provider for appropriate follow-up, documentation, and disposition. The list of results received and processed by the CAMO is made available to 59 MDW Patient Safety staff for audits ensuring the appropriate measures have been completed.

10.8.5. MTFs must use Referral Management Suite (RMS) to process and track all referrals (T-0)

10.9. RM Performance Measurement and Reporting.

10.9.1. MTFs will implement established minimum performance measurement metrics as outlined in the AFMS Referral Management Business Rules. (T-3) These metrics report key indicators and outcomes of referral management functions.

10.9.2. Referral Management performance metrics will be reported to MTF leadership on a regularly recurring basis, but no less than quarterly. (T-3)

Chapter 11

AFTER HOURS CARE

11.1. MTF leadership will develop guidelines and procedures to ensure enrolled patients have access to their PCM or a designated PCM representative by telephone 24 hours per day, 7 days per week. (T-0)

11.1.1. **(Added-59MDW)** The single point of access for all SAMHS enrolled patients is the CAMO. During duty hours, if no appointments are available with the patient's PCMH team, the CAMO will transfer the patient to the clinic nurse under First Call Resolution criteria. The clinic nurse will triage patient to determine appropriate level of care.

11.2. The Nurse Advice Line (NAL) service will not be used as a substitute for enrolled patients having the ability to access their PCMs during normal MTF business hours using telephone or online appointment services. MTF leadership will develop phone tree options that will clearly state how each of these services can be accessed and for what needs. (T-3)

11.2.1. **(Added-59MDW)** NAL is available to our beneficiaries 24 hours per day, 7 days per week and is an option on the CAMO phone tree after duty hours. The NAL will not be used as a substitute for first call resolution during duty hours.

Chapter 12

HEALTH CARE ACCESS FOR TRICARE PRIME BENEFICIARIES NOT ENROLLED TO THE MTF OR IN A TRANSITION STATUS

12.1. Establish Guidelines. MTF leadership will establish guidelines to ensure appointment access to TRICARE Prime enrolled members who may be in a student status, travel status, transitioning enrollment between MTFs, transferring enrollment between Manage Care Support Contractors (MCSCs), or in a terminal/appellate leave status. (T-0)

12.1.1. (**Added-59MDW**) All beneficiaries, to include transitioning TRICARE Prime enrollees, may obtain access to all medical services through the Wilford Hall Urgent Care Center.

12.2. Coordination with Other DoD MTFs. Leaders of MTFs located in multi-market areas will develop guidelines to ensure that clear lines of responsibility are delineated in delivering care to TRICARE Prime beneficiaries enrolled to other multi-market MTFs in their area. (T-0) The goal is to maximize care provided by the PCM to which they are enrolled.

12.3. Same Level Enrollee Access. All TRICARE Prime enrollees will be given the same level of access to appointments within the MTF regardless of their Prime enrollment location. (T-0)

12.4. Enrolled Elsewhere Access. If the MTF cannot provide care for beneficiaries enrolled elsewhere within its direct care system, either because these beneficiaries cannot contact their own PCM for consultation or gain care from the MTF to which they are enrolled, the MTF will ensure that a referral is entered authorizing care to be provided by network/contract resources for these beneficiaries. (T-0)

Chapter 13

AIR RESERVE COMPONENT (ARC) ACCESS TO CARE

13.1. Introduction.

13.1.1. The following DoD and Air Force publications provide guidance for determining ARC eligibility: AFI 41-210, *Patient Administration Functions*; AFI 36-2910, *Line of Duty (Misconduct) Determination*; AFI 44-170 *Preventive Health Assessment*; Department of Defense Directive (DoDD) 1332.18 *Separation for Retirement for Physical Disability*; *Air Force Reserve Command (AFRC) PHA Guide*; and DoDI 1332.38 *Physical Disability Evaluation*. In addition, Title 10 USC Section 1074 and Title 37 USC Section 204 (g)(h) as well as AFRC/SG and Air National Guard (ANG)/SG can be used for references.

13.1.2. ARC members who incur or aggravate an injury or illness in the line of duty while performing active duty, active duty for training or inactive duty for training or while traveling directly to or from such duty, shall be provided the medical or dental care appropriate for the condition until the member is found returned to duty, or the injury, illness or disease cannot be materially improved by further hospitalization or treatment and the member has been separated as a result of a Disability Evaluation System determination. (T-0)

13.2. ARC Health Care Benefits for Air Force required evaluation.

13.2.1. ARC members assigned to ARC Units with sufficient medical assets will receive their required evaluations (e.g., Periodic Health Assessment (PHA), annual Dental exam, etc.) from their respective servicing Reserve Medical Unit or Guard Medical Unit or other approved source. (T-2)

13.2.2. AFRC members attached to Regular Air Force (RegAF) units or assigned to ARC Units without a servicing AFRC Medical Unit will receive their required AFRC PHA evaluations from a RegAF MTF or other approved source. (T-2)

13.2.3. Many ARC members travel considerable distances from their home to their unit of assignment or have limited time to complete these appointments on duty days. When an ARC member is seen in the MTF, clinic/ancillary services personnel must complete all physical and ancillary services on the same day. (T-3) This does not include the completion of the paperwork, only the actual testing and evaluation.

13.2.4. ARC members residing outside the MTF catchment area or more than 40 miles from their units' servicing MTF may also obtain these evaluations from any MTF close to their residence.

13.2.5. ARC members are not required to be in military status to schedule an appointment; however, they must be in military status at the time of the examination, and must provide approved documentation to clinic staff that they are in military status. ARC members with an approved LOD do not need to be in a military status for examination. (T-2)

13.2.6. ARC members will have the same level of access for these required evaluations as RegAF members. (T-0)

13.3. ARC Access to Care for Line of Duty (LOD) Determinations.

13.3.1. Access to care is allowed during the determination of the LOD, but only for the condition identified for LOD determination. (T-1) The ARC member must provide documentation of LOD(s) that are in process or have been determined LOD in order to receive follow-up care (e.g., AF Form 348). (T-3)

13.3.2. The line of duty findings will determine eligibility for continued medical/dental care. (T-0) According to AFI 41-210, entitlement exists only for the medical condition determined to be In the Line of Duty. An AF Form 348, AFRC Form 348, or DD Form 261, Report of Investigation Line of Duty and Misconduct Status, or Provisional LOD with all signature blocks complete, is required to establish eligibility. LOD is valid for care only until the service member is found fit and returned to duty or separated by the DES system for the documented medical condition.

13.3.2.1. ARC members will have the same level of access to care as RegAF members for treatment of those conditions identified as LOD or LOD/SA (Service Aggravated) in the LOD determination. (T-0)

13.3.2.2. ARC members not on orders will normally show as ineligible in DEERS (Defense Enrollment Eligibility Reporting System). This does not, however, preclude the booking of an appointment for the ARC member by appointing agents. Should further verification of eligibility be required, appointing agents can contact the ARC member's unit administrator/medical representative or by consulting the MTF access manager. (T-3)

13.3.3. ARC members are not eligible for care when the determination is NOT in the Line of Duty. (T-0) Care received at this point is at the member's expense.

13.4. ARC Referrals. ARC members who require follow-up care not in the area where the initial treatment was rendered are referred to the closest MTF near their home. Appropriate medical authority from the referring MTF will contact the appropriate medical authority at the receiving MTF to ensure care is delivered. The referring MTF will notify the member's supporting ARC medical unit of the referral action for tracking purposes. (T-1)

13.4.1. ARC members who are serving under Title 10 Contingency, Title 10, or Title 32 orders who are identified with potential duty-related illness or injury should be referred in an urgent manner (72 hour consult), to include maximum utilization of both RegAF and off-base referral sites. (T-1) This practice will ensure timely identification and access to entitled healthcare prior to the end of mobilization or contingency orders and without a break in service that can result in loss of medical benefits.

13.4.2. Any care referred outside the MTF will only be paid for if the LOD process has been initiated or completed. In addition, the referral must be coordinated with the Reserve and Service Member Support Office Great Lakes (R&SMSO-GL) (formerly MMSO) by MTF staff. (T-1) Coordination with the R&SMSO-GL will ensure services are rendered without a denial of claim.

Chapter 14

MANAGEMENT OF MENTAL HEALTH ACCESS TO CARE

14.1. Mental Health ATC Management.

14.1.1. **MTF Access Manager/GPM Responsibilities.** The GPM will provide at least a monthly consultation on the management of templates and schedules and the measurement of the Mental Health clinic's performance in meeting ATC standards to the leadership and templating/scheduling staff of the Mental Health Clinic. (T-3)

14.1.2. **Guiding Principles.** The overall management of mental health access will be IAW current ASD (HA) Policy. (T-0)

14.2. Emergent Mental Health Care. MTFs will establish processes to ensure that initial requests for emergent care will be provided on an immediate basis as dictated by the threat. (T-0)

14.2.1. **(Added-59MDW)** Patients may self-refer by telephone or by walking in. These patients are evaluated for signs of acute stress and provided a new patient evaluation visit in the clinic or other appropriate emergency services as determined by mental health team.

14.3. Urgent Mental Health Care. Urgent mental health care will be provided within 24 hours or less. Clinics can book these patients into ACUT appointments or walk them in. (T-0)

14.4. Routine Mental Health Care.

14.4.1. Routine mental health care will be provided within one week/7 calendar days of the patient's request. Beneficiaries will retain the option of deferring this routine mental health assessment past this 7 day standard. (T-0)

14.4.2. Patients may be appointed to their assigned PCM, Behavioral Health Optimization Program (BHOP) Provider, or to the Mental Health Clinic.

14.4.3. Mental Health Clinics will use ROUT appointment types in their templates and schedules and use the Routine ATC Category to book initial self-referral requests. (T-0)

14.5. Mental Health Clinic Appointment Types. Appointment types will be used IAW the definitions of AFI 44-176, Chapter 3. Only five standard appointment types are permitted to be used with or without \$ suffixes as per the following:

14.5.1. ACUT/ACUT\$ slots will be used to book urgent mental health care requests within 24 hours. (T-3)

14.5.2. ROUT/ROUT\$ slots will be used to book initial requests for a new mental health condition or exacerbation of a previously diagnosed condition for which intervention is required, but is not urgent, within 7 days, or when a patient self-refers. (T-3)

14.5.3. SPEC/SPEC\$ slots will be used to book any Routine priority referral/consult requests for initial mental health care evaluations within the time frame requested by the referring provider or not to exceed 28 days. SPEC will not be used when a patient self-refers. (T-3)

14.5.3.1. **(Added-59MDW)** A SPEC appointment is used for a one time evaluation such as Personnel Reliability Program (PRP) clearance, Military Training Instructor/Military Training Leader clearance, special duty evaluation and review, medical evaluation board evaluation, etc.

14.5.4. EST/EST\$ slots will be used to book appointments when providers direct the patient to come back (follow-up) for additional mental health care/course of therapy. These appointments will be booked within the time frame requested by the mental health provider. (T-3)

14.5.5. GRP/GRP\$ slots will be used for patients who require group therapies, counseling, or teaching sessions where a mental health provider will perform the service in a group setting. The detail code fields can be used to provide further information about the care to be provided in the group appointment, (e.g., STRESS for a Stress Management Class). A group appointment should be scheduled per self-referral of the patient, the clinic's or referring provider's policy or designation. (T-3)

14.5.5.1. **Automated Neuropsychological Assessment Metrics (ANAM).** GRP appointment slots can also be used for ANAM assessments for 1 to 50 personnel being scheduled during the same time slot. To clarify the care being provided in this group appointment, it is recommended that two additional detail codes be used in combination with the GRP standard appointment type. This will alert appointing agents to book the proper individuals into these slots. This coding will also provide a mechanism to monitor the number of ANAM assessments being performed. They are: (T-3)

14.5.5.1.1. **For Pre-deployment Assessments:** Use MH detail code (for Mental Health) combined with the RPRE detail code (for Readiness Pre-Deployment). (T-3)

14.5.5.1.2. **For Post-deployment Assessments:** Use the MH detail combined with the RPD (Readiness Post-deployment) detail code. (T-3)

14.6. Behavioral Health Optimization Program (BHOP) Appointing.

14.6.1. Appointment types for BHOP: Family Health Clinic embedded service BHOP clinics are permitted to use four standard appointment types with or without \$ suffixes as per the following: (T-3)

14.6.1.1. ACUT/ACUT\$ slots will be used to book urgent behavioral health care requests within 24 hours. (T-3)

14.6.1.2. ROUT/ROUT\$ slots will be used for self-referrals to book initial requests for a new behavioral health condition or exacerbation of a previously diagnosed condition for which intervention is required but is not urgent within 7 days. (T-3)

14.6.1.3. SPEC/SPEC\$ slots will be used to book any Routine priority referral/consult requests for initial mental health care evaluations within the time frame requested by the referring provider or not to exceed 28 days. SPEC will not be used when a patient self-refers. (T-3)

14.6.1.4. EST/EST\$ slots will be used to book appointments when providers direct the patient to come back (follow-up) for additional behavioral health care. These appointments will be booked within the time frame requested by the BHOP provider. (T-3)

14.6.1.5. GRP/GRP\$ (Group) appointment type will be used for patients who require therapy, counseling, or teaching sessions where a provider performs the service in a group setting. (T-3)

14.7. Unscheduled Visit Function of CHCS. WALK-IN visits are also allowed and will be used when a patient urgently needs to be seen and there is no appointment available, but the patient does not require care in the Mental Health Clinic. (T-3)

Chapter 15

MANAGEMENT OF DIAGNOSTIC AND ANCILLARY CARE ACCESS TO CARE

15.1. ATC Standards and Referral/Consult Priorities. AFMS Radiology, Laboratory and Pharmacy (Ancillary) departments/services will provide diagnostic services, procedures, or tests per the ATC time standard assigned if the test or service is requested by the provider's referral/consult priority or using the specific timeframe requested by the provider. (T-3)

15.2. Guidance if Referral Not Entered. If a consult/referral is not requested by the provider for radiology, laboratory care, (input through order entry in CHCS/AHLTA) then no specific ATC time standard is identified thus no time standard can be applied to when a test or service needs to be performed. Additionally, there are no ATC standards applied in the Radiology, Laboratory or Pharmacy scheduling functions of CHCS, therefore there are no ATC standards that can be tracked. In the absence of a provider's medical guidance, lab tests will be completed IAW the College of American Pathology standards and radiology tests IAW the American College of Radiology practice guidance. (T-0)

Chapter 16

MANAGEMENT OF PHYSICAL THERAPY (PT) CARE ACCESS

16.1. Management of PT Care and Referrals. Specialty care PT referrals will be managed IAW current AFMS referral management policies and guidance. (T-3)

16.2. Appointment Types Used in PT Templates and Schedules. Appointment types will be used IAW chapter 3 of this AFI. (T-3)

16.2.1. PT clinics are permitted to use five standard appointment types with or without \$ suffixes per this AFI when setting up their templates and schedules. They are:

16.2.1.1. ACUT and ACUT\$ slots will only be used to schedule direct access (i.e., no referral needed) neuromusculoskeletal evaluations and for acute musculoskeletal and neuromuscular conditions that should be seen within 24 hours. (T-3)

16.2.1.2. SPEC and SPEC\$ slots will be used to schedule/book any Routine priority referral/consult requests for initial physical therapy care evaluations by a physical therapist, (officer or civilian/contract equivalent) within the time frame requested by the referring provider or not to exceed 28 days. (T-3)

16.2.1.3. EST and EST\$ slots will be used to schedule/book appointments to the physical therapist for the purpose of reevaluation or treatment. These appointments will be booked within the time frame requested by the physical therapist. (T-3)

16.2.1.4. PROC and PROC\$ slots will be used to schedule PT care appointments to enlisted, civilian, or contract PT technicians or equivalent providers as approved/directed by the physical therapist. The majority of appointments scheduled for PT technicians will use the PROC/PROC\$ appointment type. If multiple patients are to be seen at the same time by the PT Technician in a group setting for PT care/courses of therapy to be provided, the PROC/PROC\$ appointment type with multiple appointment slots during the same time will be used. All PROC/PROC\$ appointments will be booked within 28 days to meet the Specialty Care ATC standard. (T-3)

16.2.1.5. GRP and GRP\$ slots will be used for patients who require group teaching/education classes/sessions by any physical therapist or PT technician. (T-3)

16.3. Guidance if Physical Therapist and PT Technician Treat Patient During Same Visit. If both the physical therapist and the PT technician see a patient during a visit, the appointment type used will default to the one that was originally chosen when booking the appointment. For example, if a PROC appointment is booked for the PT tech, but during the visit the physical therapist sees the patient, then the appointment type for the visit remains PROC(\$).

Chapter 17

MANAGEMENT OF AUDIOLOGY/HEARING CONSERVATION SCHEDULING

17.1. Audiology/Hearing Conservation scheduling must adhere to all of the operational definitions. (T-3)

17.2. Hearing Conservation (Audiology) encounters must be scheduled in the FBNA MEPRS clinic regardless of appointment type booked. (T-3)

17.3. Clinical Audiology encounters must be scheduled in the BHDA MEPRS clinic regardless of appointment type booked. (T-3)

Chapter 18

ACCESS TEAM TRAINING, MANAGEMENT AND TRAINING RESOURCES

18.1. Management and Training of GPMs.

18.1.1. To ensure that the GPM is optimally trained for the position, GPMs must attend the resident AFMS GPM Orientation Course conducted at the Medical Education and Training Campus (METC) or the mobile course, within two to four months of assuming the GPM position. (T-3)

18.1.2. The GPM will attend an Access Improvement Seminar once during the first year of each assignment as a GPM, and the Patient-Centered Medical Home Operations (PCMHO) Course either in-residence at METC or via the mobile course upon assignment as a GPM. (T-3)

18.1.3. It is also highly encouraged that GPMs attend an Appointing Information Systems Hands-on Training Course during their first assignment as a GPM.

18.1.3.1. GPMs will remain in the position no less than 2 years. (T-3)

18.2. Training of Appointing Agents.

18.2.1. MTFs will establish and require initial and annual refresher appointing training for all personnel who have CHCS booking keys. (T-3)

18.2.1.1. **(Added-59MDW)** Initial appointing training for all staff will be completed and documented by the CHCS training team prior to that individual being given the CHCS keys to perform appointing functions.

18.2.1.2. **(Added-59MDW)** The GPM will provide training material to the TRICARE Operations and Patient Administration (TOPA) Flight to be included in annual refresher training for clinic staff.

18.2.1.2.1. **(Added-59MDW)** The CAMO agents are trained by the CAMO supervisor and will not be required to complete the annual 59 MDW refresher training.

18.2.1.3. **(Added-59MDW)** The supervisor will ensure training completion is documented in the Air Force Training Record System and/or the AF Form 1098, *Special Task Certification and Recurring Training* by the appropriate training manager.

18.2.2. Evidence of required training will be documented and tracked within the MTF. (T-3)

THOMAS W. TRAVIS, Lieutenant General,
USAF, MC, CFS
Surgeon General

(59MDW)

NICOLA CHOATE, Colonel, USAF, MC

Chief of the Medical Staff

Attachment 1**GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION*****References***

10 USC Sections 1074, 1078

32 Code of Federal Regulations, 199.17, Parts I and II Title 10 USC Section 1074

(Added-59MDW) 59 MDWI 41-119, *Outpatient Referrals and Consultations*, 19 December 2013

Title 37 Section 204 (g)(h)

DoDI 1241.2, *Reserve Component Incapacitation System Management*, 30 May 2001

DoDI 1332.38 *Physical Disability Evaluation*, 10 April 2013

DoD 6025.18-R, *DoD Health Information Privacy Regulation*, 24 January 2003

DoD 8580.02-R, *DoD Health Information Security Regulation*, 12 July 2007

ASD (HA) 11-005, *TRICARE Policy for Access to Care and Prime Service Area Standards*, 23 February 2011

AFI 33-360, *Publications and Forms Management*, 25 September 2013

AFI 36-2910, *Line of Duty (Misconduct) Determination*, 4 October 2002

AFI 41-210, *Patient Administration Functions*, 6 June 2012

AFI 44-102, *Medical Care Management*, 20 January 2012

AFI 44-119, *Medical Quality Operations*, 16 August 2011

AFI 44-170, *Preventive Health Assessment*, 30 January 2014

AFI 44-171, *Patient Centered Medical Home and Family Health Operations*, 18 January 2011

AFI 44-172, *Mental Health*, 14 March 2011

AFI 46-101, *Nursing Services and Operations*, 28 October 2011

AFI 48-101, *Aerospace Medicine Enterprise*, 05 June 2013

AFI 48-123, *Medical Examinations and Standards*, 05 November 2013

AFMAN 33-363, *Management of Records*, 01 March 2008

College of American Pathologists, Laboratory Accreditation Program, Standards for Accreditation, 2013 Edition, March 2013

2013 Accreditation Handbook of the Accreditation Association of Ambulatory Health Care

2013 Practice Guidelines and Technical Standards, American College of Radiology, May 2013

Standards and Guidelines for NCQA's Patient-Centered Medical Home (PCMH) 2011, 21 November, 2011, as amended

The Joint Commission National Patient Safety Goals (NPSG) (CAMAC / Ambulatory Health Care) Goal 1 - 01.01.01, 9 December 2008

Prescribed Forms

None

Adopted Forms

AF Form 847, *Recommendation for a Change of Publication*

(Added-59MDW) Adopted Form

(Added-59MDW) AF Form 1098, *Special Task Certification and Recurring Training*

Abbreviations and Acronyms

AAAHC—Accreditation Association for Ambulatory Health Care

ACD—Automated Call Distribution

(Added-59MDW) ACS—Audio Communicator

ADSM—Active Duty Service Member

AF—Air Force

AFI—Air Force Instruction

AFMS—Air Force Medical Service

AFRC—Air Force Reserve Command

AFMSA—Air Force Medical Support Agency

AHLTA—Armed Forces Health Longitudinal Technological Application

AMDS—Aerospace Medical Squadron

ANG—Air National Guard

ARC—Air Reserve Component

ATC—Access to Care

BHOP—Behavioral Health Optimization Program

(Added-59MDW) CAMO—Consult and Appointment Management Office

CHCS—Composite Health Care System

DEERS—Defense Enrollment Eligibility Reporting Systems

DoDI—Department of Defense Instruction

DoDD—Department of Defense Directive

EOD—End-Of-Day Processing

GPM—Group Practice Manager

HA—Health Affairs

HCI—Health Care Integrator

IMA—Individual Mobilization Augmentee

JC—Joint Commission
Kx—Knowledge Exchange
LOD—Line of Duty
MDOS—Medical Operations Squadron
MDSS—Medical Support Squadron
(Added-59MDW) MDW—Medical Wing
MEPRS—Medical Expense Reporting and Performance System
MHS—Military Health System
MTF—Military Treatment Facility
NAL—Nurse Advice Line
NCQA—National Committee for Quality Assurance
OSD—Office of the Secretary of Defense
PCM—Primary Care Manager
PHA—Preventive Health Assessment
PT—Physical Therapy
RC—Reserve Component
RMC—Referral Management Center
ROFR—Right of First Refusal
(Added-59MDW) SAMHS—San Antonio Military Health System
SGA—Administrator
SGH—Chief, Medical Staff
SGN—Chief Nurse
TOL—TRICARE On-Line
TOM—TRICARE Operations Manual
TOPA—TRICARE Operations and Patient Administration
MCSC—TRICARE Regional Contractor

Attachment 2

AFMS REFERRAL MANAGEMENT BUSINESS RULES (T-2)

No	Step/ Decision Point	Referral Management Center (RMC) Business Rules (BRs). The terms referrals and consults are used interchangeably in document. Green Bold identifies an Efficiency Opportunity or Best Practice.
1.	RMC Staff Training	<p>At minimum, the RMC staff will:</p> <ol style="list-style-type: none"> 1. Read the AFMS RMC guidance AFI 44-176, and the Composite Health Care System (CHCS) Referral Management and Appointing System Instruction Manuals 2. Complete CarePoint Referral Management Suite (RMS) and AHLTA training. <p>Other job aids: Managed Care Support Contractor (MCSC) website/tools training; TRICARE Operations Manual (TOM) chapters related to referrals; TRICARE Policy Manual (TPM) on the TRICARE benefit; other MTF training.</p>
2.	Locate RMC w/Patient In Mind	<p>The RMC should be located within the MTF (exception: Multi-Service Markets (MSM)) and in close proximity to the primary care clinics to promote patient convenience and staff communication. The RMC location will be configured to accommodate queues and patient privacy. At a minimum, RMC equipment should include telephones, voice mail capability, dual monitor computers with internet, high speed scanners, fax machines with fax forward capability, and phone headsets. The RMC staff will have access to CHCS, AHLTA, RMS, Healthcare Artifact and Image Management Solution (HAIMS) and Secure Messaging (SM). The use of RMS is mandatory.</p>
3.	Educate MTF Providers & Clinical Staff	<p>The MTF will train providers/clinical staff during orientation/in-processing and on a recurring basis as needed on the following: roles and responsibilities for ordering referrals/consults, correct order entry via CHCS/AHLTA, specialty capability within the MTF/multi-service market (MSM), non-covered benefits to avoid writing referrals that will be denied, use of network specialists, and avoidance of directed referrals and use of non-network specialists unless clinically justified. Per the TRICARE Third Generation (T3) Contracts, “The contractor shall provide customer service support equal to 40 person-hours per month to be used at the discretion of and for the purpose specified by the MTF Commander.” Therefore, MTFs can request from the MCSC to train MTF providers on non-covered benefits, use of network and non-network providers, and appropriate use of directed referrals. Best Practice (Travis AFB): An RMC staff member regularly attends clinic huddles, clinic staff meetings, medical management meetings, and ProStaff in case providers and clinical staff have referral questions as well as briefs them on referral processes, issues, and trends as needed. UM should also train providers on medical necessity, providing copies of Milliman Care Guidelines (MCG) requirements as needed.</p>

No	Step/ Decision Point	Referral Management Center (RMC) Business Rules (BRs). The terms referrals and consults are used interchangeably in document. Green Bold identifies an Efficiency Opportunity or Best Practice.
4.	Consult and Referral Definitions and Priority Types	Definition of a consult: a request for an opinion on the best course of treatment for a patient; the referring provider continues care for patient based on the advice of the consulted provider. Definition of a referral: a request to evaluate and treat and assume care for the patient for the condition. The terms referrals and consults are used interchangeably in this document. Referrals generated for tracking purposes (labs, radiology, disease management, HEDIS, ancillary orders, etc.) do not meet the definition of a specialty care referral/consult and will not be processed or tracked by the RMC.
4.1	Routine Referrals	The DoD access to care (ATC) standard for routine referrals is 28 days from date the referral was written. See BR 11, "Appoint Referral to MTF Specialty Clinic", for waiving ATC standards.
4.2	Emergent and Urgent Referrals	For referrals with a priority other than "Routine," the provider/clinical team will contact the specialist directly and arrange an appointment. The RMC/MCSC can assist the PCM/team with locating a network provider. The accepting provider's name, appointment date, phone number (if available) and location/facility will be annotated within the referral.
4.3	Urgent Primary Care Referrals	The MTF will manage and track consults for urgent primary care. Per the TOM, Chapter 8, Section 5, the patient is required to contact the MTF during duty hours and his/her PCM after duty hours prior to seeking urgent primary care in the purchased care. Urgent primary care consults requested during or after duty hours will be entered into CHCS/AHLTA NLT the next duty day. With documented training and written algorithms, other staff members (e.g., appointing agents, etc.) may enter consults for urgent primary care into CHCS. The consult must be signed by a credentialed provider. The RMC will transmit the consult to the MCSC and obtain the urgent primary care consult results. Best Practice: Travis AFB Fast Track Urgent Primary Care Referrals
5.	Request Referral/ Consult	Credentialed providers will order consults in CHCS/AHLTA before the end of the patient encounter so the patient can go to the RMC for guidance/counseling. At a minimum, providers should include on the referral: a provisional diagnosis; reason for referral to include treatments attempted and outcome(s); care or service requested; and whether the specialist is to evaluate or evaluate and treat the patient. The RMC staff will not enter new or renewal referrals/consults.
6.	Route Referrals to RMC	All specialty care referrals will be routed through CHCS/AHLTA to the RMC or MSM RMC for administrative review, appointing to the MTF, and processing. Specialty care clinics that perform their own reviews will be approved by the Executive Staff or designee in writing. MTF specialty clinics exempted by the Executive Staff will be responsible for referral review, booking, and tracking of those referrals. See Kx for instructions on correct CHCS file/table, ancillary procedure, and clinic set up.

No	Step/ Decision Point	Referral Management Center (RMC) Business Rules (BRs). The terms referrals and consults are used interchangeably in document. Green Bold identifies an Efficiency Opportunity or Best Practice.
6.1		MTFs will configure the RMC as a “Clinic” location type in the CHCS Hospital Location file, use ELAA MEPRS code and populate the “Clinic Specialty” field with all clinic specialties available in the MTF and purchased care.
6.2		The MTF’s CHCS ancillary procedures will have the name of the specialty in the “Clinic Specialty” field and the RMC in the “Consulting Clinic” field. Applies only for specialty care referrals as defined in BR 4.
7.	Send Patients to the RMC	Referring provider/team should instruct patients with referrals to go to the RMC prior to leaving the MTF. (Exception: MSM RMCs located at a distance from the referring MTF). Patients who are unable to go to the RMC should be given an RMC brochure by the provider/clinic staff which explains the RM process, contact information of MCSC for authorization questions, and RMC’s contact information for questions. The RMC can save providers/clinical staff 5-10 minutes per patient by educating and answering patient questions on the referral process. Best Practice (Tinker): Providers/clinical staff use verbiage such as “stop by the RMC to activate your referral.” RMC brochures are available in all examination rooms and clinic areas.
8.	Assist Patients	RMC staff will confirm patient’s TRICARE eligibility and contact information (ensure preferred phone number is entered in the CHCS “home phone number” field); appoint the patient’s MTF specialty appointment prior to leaving the MTF or explain how they will be notified of their appointment and explain the purchased care referral process. Refer the patient to the MCSC or Beneficiary Counseling and Assistance Coordinator for TRICARE health plan coverage information as needed. Best Practice: Encourage all patients to utilize SM for referral questions and provide the RMC their purchased care referral results or appointment information. SM minimizes phone tag with patients.
9.	Perform Referral Review	All specialty care referrals (except self-referrals and “referrals” for administrative tracking) will be initially reviewed and booked (MTF specialty clinics only) by the RMC staff based on the specialty care clinics’ appointing guidelines. RMC staff should consult with MTF’s subspecialty clinics or send the referral to the specialist for review as needed. The review process ends when the referral is dispositioned with an Appoint to MTF or Defer to Network status. Each referral reviewer (e.g., RMC, specialty clinic, SGH, UM nurse, MSM RMC, etc.) will have one business day from the date the referral was received to make a determination on the referral to prevent delays in care.
9.1	Mandatory Referral Information	The RMC will review referrals for administrative completeness to minimize delays in referral processing and appointing. All RMC staff are expected to be able to perform CHCS referral reviews and RMS processing/tracking. The RMC may complete missing information or over-ride incorrect fields if permitted; otherwise, the RMC will return the

No	Step/ Decision Point	Referral Management Center (RMC) Business Rules (BRs). The terms referrals and consults are used interchangeably in document. Green Bold identifies an Efficiency Opportunity or Best Practice.
		referral to the originating provider for completion. The MTF should ensure that all referrals include sufficient clinical, administrative information to allow the consulted provider to appropriately evaluate the patient and contact the referring provider/MTF as needed. Referring providers should have approved and standardized references (for example, MCG, MCSC medical necessity guidelines, mental health, ASAM for chemical dependency, etc.) to assist them in writing complete referral requests which will mitigate rejection by the MCSC or specialty clinic for “more information needed” reasons. Best Practice: The RMC and MM staffs provide referring providers written examples/specific information from approved references on what information would make the referral complete. This can be done via AHLTA Tasking, email, or paper routing.
10.	Requests for Referrals or Referral Renewals	Patient requests for a referral or referral renewals will be directed to the PCM/team. The RMC will not enter requests for referrals or referral renewals (excludes ROFRs). For requests by network specialists for additional visits, per TOM Chapter 8, Section 5, 6.1.7, “For services beyond the initial authorization, the MCSC shall use its best practices in determining the extent of additional service to authorize. The MCSC shall not request a referral from the MTF...” This applies for non-ADSM patients. ADSM patients require MTF approval/referral renewal.
11.	Appoint Referral to MTF Specialty Clinic	The initial MTF specialty appointment will be booked in CHCS using the Appointment Order Processing (AOP) function in order to link the appointment with the referral and ensure correct tracking through CHCS/RMS. The initial specialty appointment will be booked IAW DoD ATC standards. If the MTF cannot meet the ATC standard, the appointing staff should ask patients if they would waive their ATC standard and opt for a later appointment. MTFs cannot mandate patients to waive their ATC standard. If the patient does not waive their ATC standard, then the patient will be deferred to the purchased care. Best Practice: patient leaves the MTF with initial appointment with the MTF specialty clinic (patient-focused service and prevents rework of phone-tag with the patient by RMC/clinic staff).
11.1	MTF Specialty Clinic Appointing Guidelines	Specialty clinics will provide the RMC and MSM RMC with current appointing guidelines. The appointing guidelines should be as unrestrictive as possible to retain/recapture the maximum number of specialty care referrals within the MTF.

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11.2	Appoint or Forward Referral to Another MTF	<p>If the referring MTF (e.g., Bolling AFB) is on the same CHCS host as the consulting MTF (e.g., Andrews AFB), the referring MTF (Bolling) will select the consulting clinic (e.g., Andrews RMC) and enter a review status of “Refer to Subspecialty” (code 14).</p> <p>If the referring MTF (e.g., Laughlin AFB) is not on the same CHCS host as the consulting MTF (e.g., SAMMC Consult & Appointing Office (CAMO)), the referring MTF (Laughlin) will enter a review status of “Defer to Network” (code #10) and in the first line of the “Review Comment” field will type “To MTF/” plus the DMIS of the consulting MTF, e.g. TO MTF/0066. Complete the Clinic specialty field, indicating the specialty requested. Transmit the referral to the consulting MTF. The consulting MTF’s RMC (e.g., CAMO) will enter the referral in CHCS/AHLTA as a consult and in the first line of the Review Comment field will type “From MTF/” plus the DMIS of the referring MTF, e.g., FROM MTF/0114.</p>
12.	Perform Right of First Refusal (ROFR)	<p>A ROFR is a referral from a beneficiary enrolled to a network civilian PCM sent to the MTF by the MCSC for appointing consideration. Beneficiaries enrolled to a civilian PCM have the following CHCS DMIS locations and numbers: USAFE (6913), PACAF (6914), Latin America (6915), (No location assigned to 6916), North (6917), South (6918), and West (6919). RMS recognizes a ROFR entered into CHCS if the clinic from which you are entering the referral displays in its CHCS clinic profile as “Hospital Location: Non-MTF”. MTFs should ensure the fullest extent of ROFR acceptance to sustain clinical currency.</p>
12.1	Timelines to Accept or Decline ROFRs	<p>The MTF will accept/decline urgent priority ROFRs received within 30 minutes of receipt or as updated in TOM 8.5. The MTF will accept/decline routine priority ROFRs received within one business day of receipt or as updated in TOM 8.5. Failure to respond to ROFR requests within the prescribed times is an implied MTF declination and the MCSC will send the patient to the network.</p> <p>If the ROFR is accepted, the RMC will enter the ROFR into CHCS/AHLTA as a consult. If the ROFR is entered in Referral Booking, convert the referral to a consult in CHCS in order to track results. In both cases, use the CHCS downtown provider or generic downtown provider as the referring provider. <u>Include ROFR or Right of First Refusal on the first line of the Reason for Referral or Review Comment fields.</u> The RMC or specialty clinic will notify the patient of their ROFR appointment. The RMC will forward the specialty care report via a HIPAA/Privacy Act compliant method to the referring civilian PCM within 10-business days of the patient’s kept appointment.</p>
13.	Recapture Referrals	<p>Definition of recaptured referral: When a MTF enrolled patient receives a secondary referral from the purchased care specialist and the MTF has the specialty capability requested in the secondary referral, the secondary</p>

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		referral becomes a recaptured referral. Documenting recaptured referrals shows the value of the RMC and the purchased care cost avoidance (savings) accomplished by the MTF. Examples: The purchased care orthopedic specialist refers the patient to radiology to get an MRI and to physical therapy. The MTF has a MRI and PT. The MCSC sends the referrals to the MTF which accepts them. The MTF has recaptured two referrals. Another example is when the RM staff redirects a referral for the purchased care back into the MTF. This occurs when the referring provider does not know that the specialty care requested is available within the MTF. The difference between a ROFR and Recapture referral is the patient's place of enrollment (civilian vs. MTF PCM).
13.1	Measuring Recaptured and Redirected Referrals	Measuring the number of referrals that the RMC/MTF recaptured or redirected back to the MTF provides data on the MTFs efforts to maximize MTF capabilities and decrease purchased care costs. Enter the following codes in the CHCS Review comment field in hard brackets, [xx]. Reports available in RMS.
	[RECAP]	MTF enrollee received secondary referral and MTF was able to recapture the specialty/service requested.
	[REDIRECT]	Referral redirected back to the MTF. Shows return on investment for RMC
13.2	ROFR vs. Recapture	Although the Services define ROFRs and recapture as above, the MCSC does not differentiate between the two. The MCSC sends recapture opportunities as ROFRs. Therefore, the MCSC ROFR metrics will include recapture opportunities. Use of RMS deferred reason codes assist MTFs with identifying ROFR versus recapture referrals.
14.	Defer Referral to Network Provider	When there is no specialty care available in the MTF, the RMC or MSM Referral Center will defer the referral to the network and transmit the referral to the MCSC. The RMC will assist patients with specialty care referrals not requiring MCSC authorization and advise them of their options based on their TRICARE health plan and eligibility (e.g., give provider options, book appointment). Best Practice: Book the appointment for the Non-Prime patient (e.g., TFL, Medicare, T-Plus) with the specialist of their choice while at the RMC. Service is patient-focused and helps the RMC when chasing results.
15.	Defer Referral to Non-Network Providers	The referring provider will provide the clinical justification for sending a patient to a non-network provider in the referral. The RMC should educate MTF providers to allow the MCSC to determine where to send the patient versus requesting by-name non-network providers. Non-network providers may not be TRICARE certified providers. Best Practice: non-network and out of area specialty care referrals require second level review/approval from the SGH to ensure all direct care and local specialty care options have been exhausted. Patient requests for specific non-network providers may exercise their Point of Service (POS)

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		option which incurs additional out of pocket costs. Non-Active Duty patients may also enroll in TRICARE Standard instead of TRICARE Prime. The POS option allows patients to receive non-emergency TRICARE-covered services from any TRICARE-authorized provider without requesting a referral from a PCM. The POS option does not apply to: <ol style="list-style-type: none"> 1. Active duty service members 2. Newborns and adopted children until they are enrolled in TRICARE Prime. 3. Beneficiaries with OHI, 4. Services that don't normally require a referral: Emergency care, preventative Care (from network provider) 5. First 8 outpatient mental health visits per fiscal year
16.	Document Reasons for Deferring a Referral to the Purchased Care	All Defer to Network referrals will have at least one of the below codes typed in the referral Review Comment field. Best Practice: Utilize the RMS “Deferred Reason Error Report to analyze reasons referrals are sent to the purchased care instead of kept in the MTF. Type the codes below in the CHCS Review Comment field of the referral encased in hard brackets [xx] . Use of at least one code is mandatory. Multiple codes may be used; however, each code must be in its own brackets. Reports available in RMS.
	[2nd]	Second opinion requested. Patient or provider requested a second opinion
	[CB]	Capability. MTF did not have specialty or services requested
	[CC]	Continuity of Care
	[CMD]	Command Directed. Referrals requiring approval from Chief of the Medical Staff or designee
	[CP]	Capacity. MTF did not have appointments available within the access to care standards
	[DS]	Distance. Exceeds TRICARE distance/travel requirements
	[NAR]	No Pre-authorization required
	[OHI]	Other Health Insurance. Patient has OHI or is Medicare eligible
	[POS]	Point of Service or Self-Referred care
17.	Laboratory and Radiology Studies, Durable Medical Equipment (DME) Which	The RMC will track (process and close) laboratory and radiologic study and DME referrals that require MCSC authorizations. DME invoices should be considered as a “result.” The RMC will check claims NLT 120 days from the date of the request to determine if patient obtained the DME and close the referral in CHCS as “Deferred Results Received.” If there is no claim or referral is cancelled by the patient, the RMC will notify the referring provider of the unused referral and close the referral in

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	Require MCSC Authorization	CHCS with the status of “No Appointment Required” (code #13) and in the very first spaces of the Review Comment field, type “{NU}” for “Not Utilized (see BR 30). Best Practice (USAFA and the Colorado MSM): When a patient presents to radiology for a procedure and it cannot be done at the MTF, the radiology clerk prints out the CHCS ancillary order. This order with the patient demographic is transmitted to the MCSC. This is care coordination that is done by the team and/or the ancillary service which cannot accommodate the patient requirement.
17.1	Laboratory and, Radiology Studies, DME Which Do Not Require MCSC Authorization	Laboratory and radiological orders that do not require MCSC authorization should not be entered as referrals. If the MTF enters referrals for ancillary services not requiring TRICARE authorizations, the “referral” will not be processed or tracked by the RMC staff. Tracking of DME that do not require authorization is optional. The RMC will close these DME referrals with “No Appointment Required.” Best Practice (USAFA, Travis): The UM or CM review and assist patients with obtaining their DME.
17.2	Disease Management, HEDIS Screening	Preventive care testing does not require TRICARE authorization; therefore, the RMC will not process, manage, or track PCM orders/referrals for screening exams. The RMC will not enter cancer screenings (breast, cervical and colorectal cancer screenings), HgbA1c results, and LDL HEDIS results in the TSWF MHSPHP AIM form. This function is out of the scope of RM functions and central RM contract.
18.	Send Clinical Information to Purchased Care Providers	The referring provider/team will obtain additional medical information (e.g. lab reports, x-rays, previous encounter notes, etc.) to provide to the purchased care specialist as requested/clinically required. The RMC can assist the PCM/team by faxing the documents to the specialist’s office. For STAT/ASAP referrals, the ordering provider/team is responsible for obtaining and sending the requested information to the specialist. Best Practice: Determine if purchased care providers are using the same SM vendor as the AFMS and transmit information via colleague to colleague communication. RMC brochures/education materials should specify how patients can obtain clinical records for the specialist. The MTF’s Release of Information department can provide requested patient records to the specialists’ office.
19.	Active Duty Service Members (ADSM)	MTFs will have processes to perform medical necessity reviews for ADSM referrals. By contract, the MCSCs does not perform medical necessity on ADSMs. Referrals for non-covered benefits require a waiver from DHA prior to sending referral to MCSC (see BR 20.1)
20.	Non-Covered Benefits	See TOM, Chapter 17, Section 3 for complete policy http://manuals.tricare.osd.mil/ : The MCSC will use the No Government Pay List (NGPL) and TRICARE Policy for included/excluded services to administer the TRICARE benefit for ADSMs. If the referral is a non-covered benefit, the MTF will provide the DHA Waiver approval with the

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		referral. If the waiver approval is not included when the referral is sent, the referral will be denied. IMPORTANT: TOM.17.2.2.4: TRICARE benefits may not be extended for complications resulting from non-covered surgeries and treatments performed outside the MTF for a Service member without an approved waiver. If the treatment is a non-covered TRICARE benefit, any follow-on care, including care for complications, will not be covered by TRICARE once the Service member separates from active duty or retires (32 CFR 199.4(e)(9); TPM, Chapter 4, Sections 1.1 and 1.2). The Services will provide appropriate counseling that such follow-on care is the member's personal financial responsibility upon separation or retirement.
20.1	Waiver for Non-Covered Benefit	The requesting provider and the MTF SGH will initiate the waiver process and complete required documents. All waiver packages for approval will be electronically sent to afmoa.sgat@us.af.mil with an email copy to the respective MAJCOM SGH per HIPAA/Privacy Act requirements. For questions, contact the AFMOA/SGAT region POC. Forms, DHA and AFMOA policy can be downloaded from the AFMS Knowledge Exchange. Once the waiver is approved, the RMC will fax the approved waiver with the referral to the MCSC.
21.	ADSM on Medical Hold	Health Affairs policy requires MTFs to ensure specialty care services are available for ADSMs on "medical hold" within two weeks of identifying the need for an appointment. MTFs should collaborate with their MCSCs to ensure that ADSMs receive their referral authorizations and appointments expeditiously. Referring MTF providers will 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.
22.	ADSMs on Terminal Leave: Pre-Authorization of Care at Department of Veterans Affairs	The MTF should assist RegAF personnel on terminal leave to obtain a pre-authorization for routine and urgent outpatient care at the Department of Veterans Affairs (DVA). If the RegAF member intends to reside outside of the Prime Service Area (PSA) of the CONUS MTF while on terminal leave, the RegAF member must coordinate with their PCM/clinical team for the pre-authorization referral. This does not apply to the OCONUS RegAF members on terminal leave that will take their terminal leave in CONUS. (Note: There is no requirement for the MTF to determine if the RegAF member on terminal leave is going to leave the area. There is no requirement for the MTF to determine if a DVA medical center/facility is in the area where the RegAF member will reside while on terminal leave. This information has been included in the Air Force Preparation Guide used for base separations briefings.
23.	Prime Patients with Other Health	OHI is insurance acquired through an employer, entitlement program or other source. The RMC will instruct Prime beneficiaries with OHI to submit referral requests to their primary health insurer and follow the

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	Insurance (OHI)	guidance provided by their primary health insurer for referral appointments. Under federal law, TRICARE is the secondary payer to all health benefits and insurance plans, except for Medicaid, TRICARE supplements, the Indian Health Service or other programs or plans as identified by the Defense Health Agency.
24.	OCONUS Pay Patients	"Pay Patients" are prioritized for care after ADSMs, Prime AD Family Members, Prime Retirees/Family members, RegAF Family Members not enrolled in TRICARE Prime, and T-Plus enrollees. "Pay Patients" are eligible to be seen within the MTF for primary and specialty care if capacity exists.
25.	TRICARE Plus, TRICARE For Life (TFL), Medicare Beneficiaries	If MTFs have specialty capability and capacity, MTFs are highly encouraged to accept self-referral specialty care requests from TFL/Medicare beneficiaries with or without a referral/request from their civilian PCMs. Often these requests are written on a provider's prescription form, requesting specialty care for the patient. These beneficiaries should be afforded the opportunity to be seen in the MTF based on the MTF's capability and capacity and currency case needs. Depending on where the patient presents, the specialty clinic or the RMC will enter a consult in CHCS. Be sure to obtain physician information from patient and notate on the referral so MTF results can be sent to the patient's PCM/referring provider. The RMC will provide the referring provider/PCM the results, and track the referral. Note: specialty access for TFL/T Plus patients cannot be at the expense of access for Prime patients seeking the same specialty care. In other words, Prime patients cannot be deferred to network due to lack of access used by TFL/T-Plus patients. Best Practice: Eglin, Keesler, Travis accepts self-referral patients and do not require the patient to have a referral before booking the specialty appointment.
26.	Patient Travel	For authorized care outside of the 100 mile MTF-radius, the TOPA travel section will assist patients with travel arrangements.
27.	Integrated Disability Evaluation System (IDES)	The Physical Evaluation Board Liaison Officer shall work with the RMC to process referrals for Compensation and Pension (C&P) examinations at the DVA. The RMC will ensure the administrative documentation required for C&P referrals per TOM, Chapter 8.5 are completed prior to transmitting to the MCSC.
28.	MTF Capability and ROFR /Recapture Reports	The MTF's Capability and ROFR reports should be as unrestrictive as possible to retain/recapture the maximum number of specialty care referrals to sustain clinical currency and minimize purchased care costs. The MTF will ensure these reports are updated as needed for accuracy. The MTF Executive Staff or designee will approve the MTF's Capability and ROFR reports. These reports will be provided to the MTF's RMC, MCSC, and the MSM RMC.

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29.	Referral Conditions and Decision Points	<p>The MTF will have processes for the below situations:</p> <ol style="list-style-type: none"> 1. Patient kept MTF initial specialty appointment—the MTF specialist will document referral report in AHLTA. PCM/referring provider will review the referral report (e.g. AHLTA Consult Log) 2. Received purchased care specialty results—RMC will import results into HAIMs (see BR 33) and will close referral in CHCS with “Deferred Results Received” (Code #23). RMC will notify the PCM/referring provider of purchased care results via T-Con (see BR 33.3). 3. Patient refuses or cancels the referral: RMC will close the referral in CHCS with the status of “No appointment required” (code #13) and will type ‘{NU}’ for “Not Utilized” in the “Review Comment” field (see BR 30). 4. Appointment not made after three MTF reminders (automated or other method): RMC will close the referral in CHCS with the status of “No appointment required” (code #13) and will type ‘{NU}’ for “Not Utilized” in the “Review Comment” field (see BR 30). 5. Patient “No Shows”: the RMC will follow the MTF’s No Show Policy. If referral is closed, follow 3 or 4 above. Define process when to close the referral (e.g., after 1, 2, or 3 ‘No Shows’ and who will close the referral in CHCS: the specialty clinic who documented the “No Show,” the RMC, or the referring provider/clinical team.)
30.	Reasons for Closing a Referral in CHCS	<p>The below referral Review Comment codes provide a means to track the reason the MTF is closing a referral. The use of the codes are optional except where indicated as mandatory. Use of codes enables leadership to view RMS reports on why the referral was closed. Only one code per referral. See RMS reports</p>
		Type the below in the CHCS Review Comment field of the referral encased in "{xx}" soft brackets.
	{ACPC}	Patient Cancelled via Audio Communicator Referral Reminder
	{CRNAR}	Closed Referral/No Appointment Required
	{CRNRR}	Claim Received but No Results Received
	{NRR}	Claim in system, but no results received despite efforts to obtain from provider MANDATORY
	{NU}	Referral Not Utilized MANDATORY
	{PCRMO}	Patient called the RMC/RMO to cancel the referral (not via AudioCommunicator Referral Reminder)
31.	Referral Tracking	<p>The RMC will be the MTF’s single POC to receive all purchased care specialty care referral results. The RMC will track all initial specialty care referral/consult results generated by the MTF from the time the referral is written until the results of the referral are provided to the referring provider/PCM and/or closure of the referral in CHCS. The</p>

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		RMC does not track follow-ups but will provide follow-up results to the referring provider/PCM. Referrals generated for tracking purposes (labs, radiology, disease management, HEDIS, ancillary orders, etc.) does not meet the definition of a specialty care referral/consult and will not be processed or tracked by the RMC (BR 4).
31.1	Automatic CHCS Closure of Referrals	MTFs will disable the automatic closure function in CHCS for referrals/consults. Exceptions to policy should be addressed to AFMSA/SG3SA.
31.2	Direct Care Referral Results	Referring providers will review the MTF specialty results available in AHLTA (e.g., AHLTA Consult Log).
31.3	ROFR and Recapture Results	The RMC will return completed ROFR/recapture specialty care referral results to the referring purchased care provider within 10 business days of the kept specialty encounter.
31.4	STAT / Urgent Referral Results	If immediate results for STAT and urgent priority specialty care referrals are clinically required, then the PCM/clinical team will request them from the purchased care specialist. The clinic will provide the purchased care provider the RMC fax number. If the PCM/clinical team needs referral results today or for a future scheduled patient appointment regarding the CLR results, and the CLR results are not in AHLTA, HAIMs or the medical records, then the PCM/clinical team should provide the RMC as much prior notice as possible for the RMC to obtain the needed CLR. Once received, the RMC will make the result(s) available to the requesting PCM/team.
32.	When to Start “Chasing” Purchased Care Clear and Legible Reports (CLRs)	The RMC will track the initial result of all specialty care referrals written by the MTF to closure (sent to the referring provider/PCM for review). If follow-up visit results are received from the specialist, the RMC will upload results in HAIMs and notify the referring provider/PCM for review. The RMC will request CLRs for specialty care referrals NLT 120 calendar days after the order entry date, unless otherwise requested by the referring provider or when scheduling appointments is known to require more than 120 calendar days from order entry date.
32.1		If a CLR has not been received in 120 calendar days after the order entry date, RMC personnel will: 1. Check the MCSC claims database to see if a claim has been paid. a. If claim was paid, the RMC will obtain purchased care provider’s name and contact information from the claim or the MCSC database and request the CLR from the provider. 1) If there is no response from the provider in 10 calendar days, repeat. 2) If the provider still does not provide the CLR, the RMC will close the referral in CHCS using the status of “Deferred results

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		<p>received” and type “{NRR}” for “No results received” in the “Review Comment” field. .</p> <p>b. Provide the MCSC Contract Liaison a list of purchased care providers that have refused to provide results. The liaison will submit list to the TROs.</p> <p>2. If there is no claim, and the MTF has reminded the patient three times to use their referral, the RMC will close the referral in CHCS with the status of “No appointment required” (code #13) and type “{NU}” for “Not Utilize” in the “Review Comment” field (see BR 30)..</p>
33.	Import CLRs into HAIMs	<p>The RMC will import the initial and follow up specialty care results, urgent primary care results, and laboratory results and radiology reports that require an authorization into HAIMs within three working days from receipt of results. The RMC will notify the referring provider/PCM of the results via T-Con. Note: Use of HAIMs for CLRs is mandatory per DoDI. If the MTF does not have HAIMs, follow AHLTA Scanning policy. If HAIMs is down, revert to AHLTA Scanning policy (see BR 40). Best Practice: SGH defines the priority of scanning results by general category. All referrals will be entered into the EHR, but it would help the RMC prioritize workload. The RMC contract staff will not import results for hospital discharge summaries, emergency room visits, labs/rads/exams for preventative health/HEDIS measures, and all loose documents not directly related to a referral.</p>
33.1	General Information	<p>1.A T-Con and HAIMs entry will be created for each CLR/result.</p> <p>a. The T-Con will be associated with the HAIMs entry so that the reviewing provider clearly understands which T-Con is for which HAIMs entry.</p> <p>b. For both parts, the following mandatory standard naming convention will be used: Network Results – Specialty MM/DD/YY where the MM/DD/YY is the date the patient was seen. For example, Network Results – Cardiology 2/10/14.</p> <p>2. Any existing shared folders used for the purpose of storing temporary results or other Protected Health Information may be maintained for 30 calendar days following the date of the original image upload. Thereafter, the electronic folder and documents must be deleted.</p> <p>3. Both the original foreign language and the English translated result/report will be uploaded into HAIMs. The untranslated result/report does not have to be signed by the referring provider if the translated result/report was already signed.</p> <p>4. Once loaded into HAIMs, the reviewing provider is <i>not</i> required to handwrite or “wet” sign the hard copy result/report. The paper copy of the result/report is <i>not</i> required to be filed into the paper outpatient medical record. However wet signatures and filing of paper copy may</p>

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		<p>be required for special programs (e.g. PRP) or payment issues. Before destroying the original hard copy or electronic result/report, ensure that the scanned document is legible by the provider. Ensure you have a quality check process in place to ensure right patient, right CLR and right record.</p> <p>5. Correcting errors: The MTF will have a quality check process to minimize PHI/PII errors.</p> <p>6. Contingency plan: When HAIMs is down for several hours, results may be entered into AHLTA Clinical Notes per the instructions in BR 40. If both AHLTA and HAIMs are down indefinitely, paper copy result/reports may be reviewed and signed by the provider. The signed reports will be sent back to the department scanning the reports/results to enter into HAIMs per the above instructions. A T-Con for the provider's notification and review is not needed since there is a wet signature on the result/report.</p>
33.2	Create HAIMs Encounter	See HAIMS RM Workflow Training slides_Nov 2013_Colorado MSMO found at AFMS Knowledge Exchange.
33.3	Create AHLTA T-Con	<ol style="list-style-type: none"> 1. Under the Folder List, select "Telephone Consults". 2. From the Toolbar/Action bar, click "New Telcon" icon; click "Yes" in the pop-up. 3. In the "Clinic" field, select the clinic location of the provider receiving the T-Con. AHLTA automatically defaults this field to the creator's location. You must change it. Once you click "OK," you cannot make changes. If you chose the wrong clinic and clicked "OK", you must cancel the T-Con and start over. 4. In the "Assigned Owner" field, select the provider receiving the T-Con. 5. In the "Reason for Telephone Consult" field, enter the following mandatory naming convention: "Network Results – Specialty MM/DD/YY". <ol style="list-style-type: none"> a. For example, "Network Results – Orthopedics 02/13/14" or "Network Results – Lab 02/13/14"; or "Network Results – Radiology 02/04/14". b. <u>The entry should match the name of the corresponding HAIMs entry</u> c. Click "OK" when done. Your T-Con will automatically display. d. If sending a courtesy copy notification of a result/report, use the following naming convention: "Network Results - Specialty MM/DD/YY—CC" (CC=courtesy copy). 6. In the "Note" field, reference the HAIMs entry in the T-Con. For example, "Please review the results in HAIMs titled Network Results – Orthopedics 02/13/14".

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		<p>7.For T-Con:</p> <ul style="list-style-type: none"> a.In the “Note” field, enter text. For example, “Please review the results in HAIMs titled Network Results – Orthopedics 2/13/14”. b.In the “Urgency” field, AHLTA defaults to “Medium.” Change as appropriate. c.In the “Diagnosis” box, select “V65.9 - Consultation Note”. d.In the “Admin” box: <ul style="list-style-type: none"> i.In the “Meets Outpt Visit Criteria (Workload)?” field, change the default “Yes” to “No”. ii.In the “E & M” field, ensure “99499” is selected. <p>8.From the Toolbar/Action bar, click “Save” and “Close” icons. Do not sign the T-Con. The receiving provider will sign the T-Con. The T-Con is automatically sent to the selected provider.</p>
33.4	Upload CLR in HAIMs and Associate T-CON	<ol style="list-style-type: none"> 1. From the Folder List, select Artifacts and Images. (Note: Telecon Tab is still open). 2.Select Import Asset icon 3.In the “Acquire Asset Import New” box, ensure “Browse and upload a file” and “Associate with Selected Encounter” boxes are checked. 4.Select “Browse” and locate CLR. Click “Upload” 5.Fill in Metadata fields as instructed in BR 33.5. 6.Select “Save and Close” 7.Close Artifacts and Images screen. Select “Close” button on toolbar. CLR is now available in HAIMs and is associated with the T-CON created, which makes it easier for the provider to find the HAIMs CLR.
33.5	Mandatory HAIMs Metadata Fields	<p>The RMC will fill out the below mandatory HAIMs metadata fields:</p> <ol style="list-style-type: none"> 1.Author Name: The author name is the purchased care provider or group that provided the CLR. 2.Date Document Created: The date that the patient visit occurred or the date of the CLR. 3.Document Type: Use the dropdown menu: for CLRs, select: Encounter Note—Consultation. Others, Radiologic report, Procedure Note, etc. 4.Document Title: Network Results – Specialty MM/DD/YY where the date is the date in #2 above. 5.Save and Close
33.6	Optional Metadata Fields	<ol style="list-style-type: none"> 1.Practice Setting: Outpatient 2.Specialty: Type a few characters and choose (e.g. orthopedics) 3.Procedure or Service: type a few characters and choose (e.g., MRI) 4.Save and Close
34.	Provider Review	<ol style="list-style-type: none"> 5.At a minimum, providers shall document their review of the HAIMs CLR in the corresponding T-Con. Ensure T-Con is non-count

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		<p>workload. Change T-Con medical coding as appropriate. Sign and close.</p> <p>6.Providers will review T-Cons notifying them of scanned results/reports within three business days from the receipt of the T-Con. Providers will have current surrogates in CHCS/AHLTA to review T-Cons in their absence.</p> <p>7.Completed T-Cons are assumed to mean that the provider has reviewed the result/report in HAIMs/AHLTA.</p> <p>Best practice: Quality Assurance/Data Quality Office monitors open provider encounters and/or pulls the ad hoc in BR 35 and provides to MTF leadership/providers.</p>
35.	CHCS Ad Hoc to Monitor Provider Review of Scanned CLRs	<p>When the T-Con naming convention is used per policy instructions, MTFs may use the CHCS Provider Review Ad Hoc that displays by provider by patient which CLRs scanned into HAIMs have been reviewed or not reviewed by noting if the T-Con associated with the scanned CLR has or has not been completed in AHLTA. On the printed ad hoc report, if the T-Con has been reviewed, a status of “Tel-Con status” will show next to the T-Con. If the T-Con has NOT been reviewed, a status of “Occ-Svc status” will show next to the T-Con.</p>
36.	Patient Hand-Off	<p>The MTF will have processes in place to assist with Medical In- and Out-processing:</p> <ol style="list-style-type: none"> 1.The losing MTF will provide pending/incomplete/un-resulted referrals to the patient. 2. The gaining MTF will follow-up on pending/incomplete/un-resulted referrals.
37.	Measures	<p>The MTF will report the below measures to MTF Executive leadership at least quarterly.</p>
37.1	Mandatory Measures	<p>Items 1-5 can be obtained from RMPMT.</p> <ol style="list-style-type: none"> 1.Number of specialty care referrals/consults 2.Number of urgent primary care referrals 3.Number of referrals seen in the MTF 4.Number of referrals deferred to other MTFs 5.Number of referrals deferred to the purchased care 6.Number and percentage of ROFRs accepted from the MCSC (Note: if the MTF has no ROFR capability, then items 6 and 7 are N/A) 7.Percent ROFR referral results sent to requesting civilian PCM within 10 days of the kept appointment 8.Reasons why urgent primary and specialty care referrals were deferred to network: Primary responsibility for this measure is with the GPM or UM nurse. Trends should be used to analyze access and recapture opportunities.

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37.2	Optional Recommended Measures	<ol style="list-style-type: none"> 1.Provider referral patterns (POC: UM): display by referring provider the total number of specialty care referrals written; further display the total number of specialty referrals by product line (aka clinic specialty). Rationale: identifies outliers against peers. 2.Display by PCM the percentage of total PCM appointments to total referrals written (POC: UM). For example, if the PCM had 100 kept appointments in a month and wrote 80 referrals from those 100 appointments, the percentage would be 80 divided by 100. Rationale: identifies outliers against peers who may need mentoring by the SGH. 3.Number of initial specialty care referrals reviewed by the MCSC that were denied/declined for lack of clinical information, lack of administrative information, not a covered benefit, or inappropriate referral. Rationale: returned referrals result in REWORK. 4.Number of initial specialty care referrals deferred to network and non-network for Prime dependents and non-Prime patients with OHI. 5.Number of specialty care referrals redirected or recaptured back into the MTF. Further breakdown total by product line. Rationale: cost avoidance efforts by the MTF; demonstrates value of RMC/UM processes. 6.Number of patients served by the RMC and customer satisfaction with service (survey). Rationale: provides RMC workload data and customer value. 7.Number of referral results for evaluation-only referrals not received within 60 days of the referral being written. Rational: ensures RMC is tracking eval only referrals and getting results to provider before the 120 day mark. 8.Number of referral results other than ROUTINE priority that were not received within 20 days from the date of the referral was written. Rational: ensures RMC is tracking urgent/emergent referrals and getting results to provider before the 120 day mark.
38.	Secure Messaging (SM), MiCare	The RMC will check their assigned SM box several times a day for new messages. The RMC should use SM to answer patient questions on referrals, obtain results from purchased care providers who are using the same SM vendor, and communicate with providers/clinical teams. Using SM to communicate with patients and purchased care providers about referrals saves the RMC time by decreasing unnecessary phone calls and eliminating telephone tag.
39.	Continuous Process Improvement	The MTF should review RM processes and workflows to decrease/eliminate re-work, expedite referral processing, and improve quality of referrals.
40.	When HAIMs is Down: Create	<ol style="list-style-type: none"> 1.Search and select patient in AHLTA: <ol style="list-style-type: none"> a.Select "Search" from Folder List. b.Input patient's name and click "Find".

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	AHLTA Clinical Note	<p>c.Select patient and click “OK”.</p> <p>d.From the Folder List, select “Clinical Notes”.</p> <p>2.From the Toolbar/Action bar, Click “New”:</p> <p>a.Enter a “POC” – your MTF. For RMC staff, this defaults to your RMC name.</p> <p>b.Select “Note Type”:</p> <p>i.For Referrals/Urgent Primary Care results: select “Consultation Note”.</p> <p>ii.For Laboratory results: select “Laboratory Report”.</p> <p>iii.For Radiology results: select “Radiology Report”.</p> <p>iv.Enter “Note Title:” Use only the following mandatory naming convention: Network Results – Specialty MM/DD/YY. For example, “Network Results – Orthopedics 03/01/14” or “Network Results – Lab 03/01/14”; or “Network Results – Radiology 02/28/14”, etc.</p> <p>3.In the Clinical Notes free text field, reference the T-Con you generated to notify the provider of this result/report. For example, “See T-Con dated 04/17/14 titled “Network Results – Orthopedics 04/1/14”.</p> <p>4.Import or copy and paste the information into the free text field. Do not include the fax cover that accompanied the result/report.</p> <p>a.If using PDF, there is a one-time set up to be able to copy images from a PDF. The next steps add the Snapshot (camera) icon to the PDF Toolbar:</p> <p>i.Select “Tools” and scroll all the way down the list of “More Tools.” Select “Snapshot Tool” and click “OK”.</p> <p>ii.Change view so image is legible (recommend 75%)</p> <p>iii.Click the “Camera” icon (Snapshot Tool). Drag the mouse to highlight the area you want to copy. When you lift your finger off the mouse, a pop-up window will appear. Click “OK”.</p> <p>iv.Go back to the AHLTA Clinical Note and right click in the free text field and “Paste” the selected graphic.</p> <p>b.If loading an image (e.g., BMP, JPEG, TIF, WMF), click the “Insert” icon from the Toolbar/Action bar. Select file and click “Open.” When you open the image, AHLTA inserts it into the Clinical Note. Click “Save” or “Close”</p> <p>c.If loading a document file (e.g., .TXT, .Doc, .RTF, .HTML), click the “Load” icon from the Toolbar/Action bar.</p>

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		<p>AHLTA will load the entire document into the Clinical Note.</p> <p>d.If the scanned document does not fit into one Clinical Note, create more Clinical Notes, naming each as “Network Results – Specialty MM/DD/YY Part X of X.” For example, “Network Results – Sleep Study 03/04/14 Part 1 of 4”.</p> <p>5.Sign Clinical Note:</p> <p>a.From the Toolbar/Action bar, click the “Sign” icon.</p> <p>b.In pop-up window, under “Primary Signature,” change default to “Provider.” (In CHCS/AHLTA, account users are all “providers”). Referral Management Centers should type “RMC”.</p> <p>c.In “Typed Name of Signer” field, type your full name. Tip: create name on Microsoft Word document and cut and paste into this field.</p> <p>d.Use mouse to sign. Signature does not have to be perfect as any mark in this field is sufficient to lock the note. To start over, click “Clear.” Click “OK” when done.</p>
40.1	AHLTA Clinical Notes Errors	Correcting errors: It is imperative that each MTF has a process in place for ensuring the correct patient with the right documents is double checked for accuracy prior to scanning or importing any document into AHLTA. MTFs that need to submit a request for an AHLTA expunction or legal correction should contact their local HIPAA POC for instructions.