

4A051, Module 3, Outpatient Administration



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- ≡ Lesson 2: Manage Secretarial Designee Program
- ≡ Lesson 3: Perform Line of Duty (LOD) Determinations Procedures
- ≡ Lesson 4: Referral Management

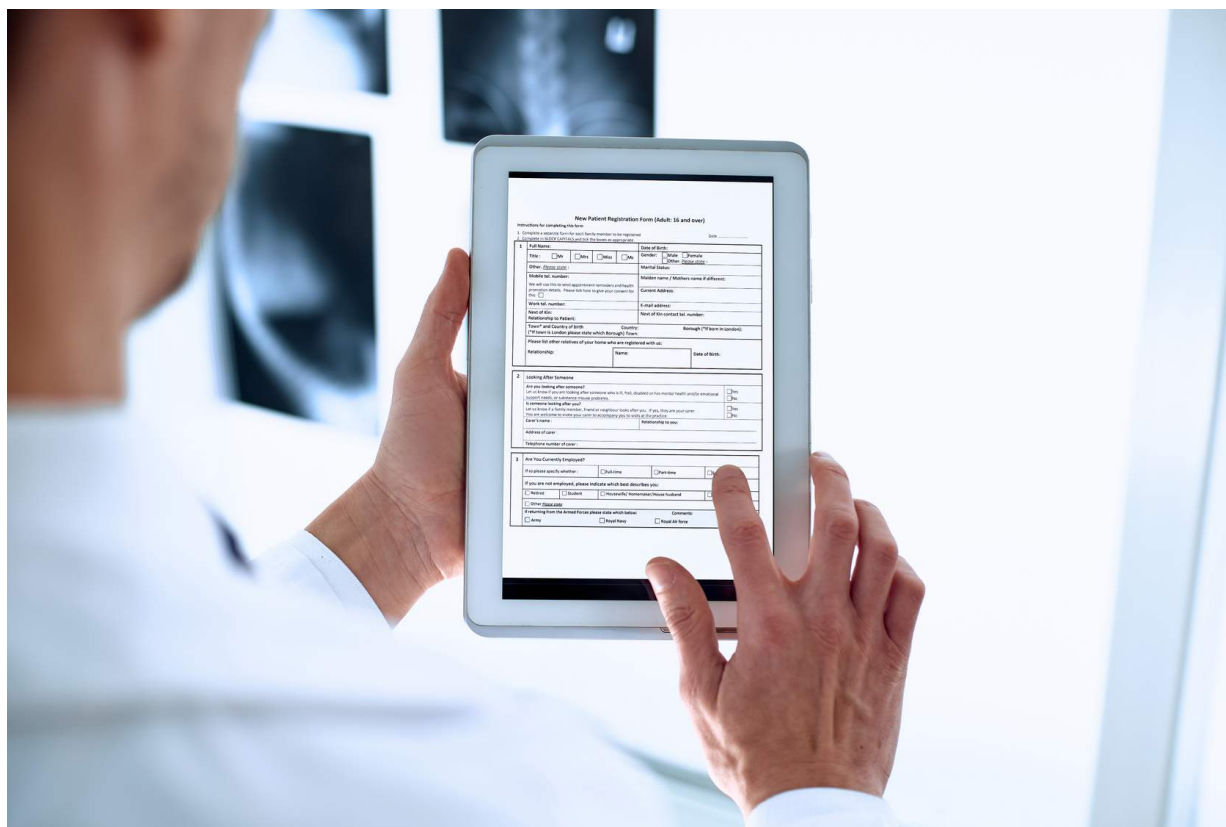
Lesson 1: Eligibility and Patient Registration

Click the video below to continue our journey!



After completing this lesson, the student will be able to verify eligibility and register patients, in accordance with

(IAW) prescribed guidance and publications.



Patient Registration

This is the process of enrolling a patient for care within the Military Health System (MHS). Information such as patient name, date of birth, beneficiary status, sponsor's social security number, etc., are input into MHS Genesis. This data is used to verify an individual's identity and to validate Defense Enrollment Eligibility Reporting System (DEERS) status which will determine eligibility to receive care. This information is also used to build/update the patient's comprehensive profile within the electronic health record.

Patient Eligibility

MTFs will perform DEERS checks for eligibility on all patients requesting care. MTFs will not provide routine care to patients whose eligibility cannot be verified unless a competent medical

authority determines a delay in care would create an unreasonable risk to the patient's health. In such cases, the MTF will require the patient to sign a statement of eligibility that indicates the patient's requirement to provide proof of eligibility within 30 days or be held responsible for the costs associated with the care provided. After the 30th day, if the individual has not produced evidence that satisfactorily verifies eligibility, the TRICARE Operations and Patient Administration Flight will forward the patient's information to the Resource Management Flight to initiate the billing process.





Emergency Services

For emergency services, MTFs will *provide care first* and verify eligibility after treatment.



If a patient fails a DEERS check, MTFs may still provide routine care within the direct care system in the following circumstances...

Reserve Component (RC) —

The patient is a member of the RC on active or inactive duty for less than 30 days and presents a copy of their orders or other administrative documentation.

Line of Duty(LOD) —

The patient is a member of the RC on active or inactive duty status, and is seeking healthcare related to a LOD medical or dental condition or a condition which is currently under LOD investigation in accordance with AFI 36-2910, Line of Duty (LOD) Determination, Medical Continuation (MEDCON) and Incapacitation (INCAP) Pay.

Contingency Operations —

If a RC service member is issued delayed-effective-date AD orders for more than 30 days in support of a contingency operation, the member and the member's family are eligible for early TRICARE medical and dental benefits beginning on the latter of either: (a) the date their orders were issued or (b) 90 days before the service member reports for duty or is activated to AD.

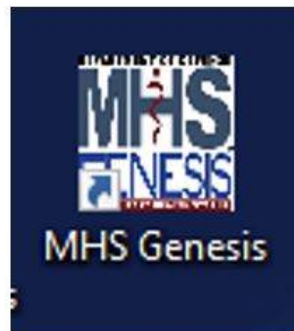
Secretarial Designee —

The patient has a Secretarial Designee letter that authorizes the care. Ensure the patient only receives care limited to the specific dates and diagnosis annotated in the approval letter.

***The steps below explain the patient
registration process.***

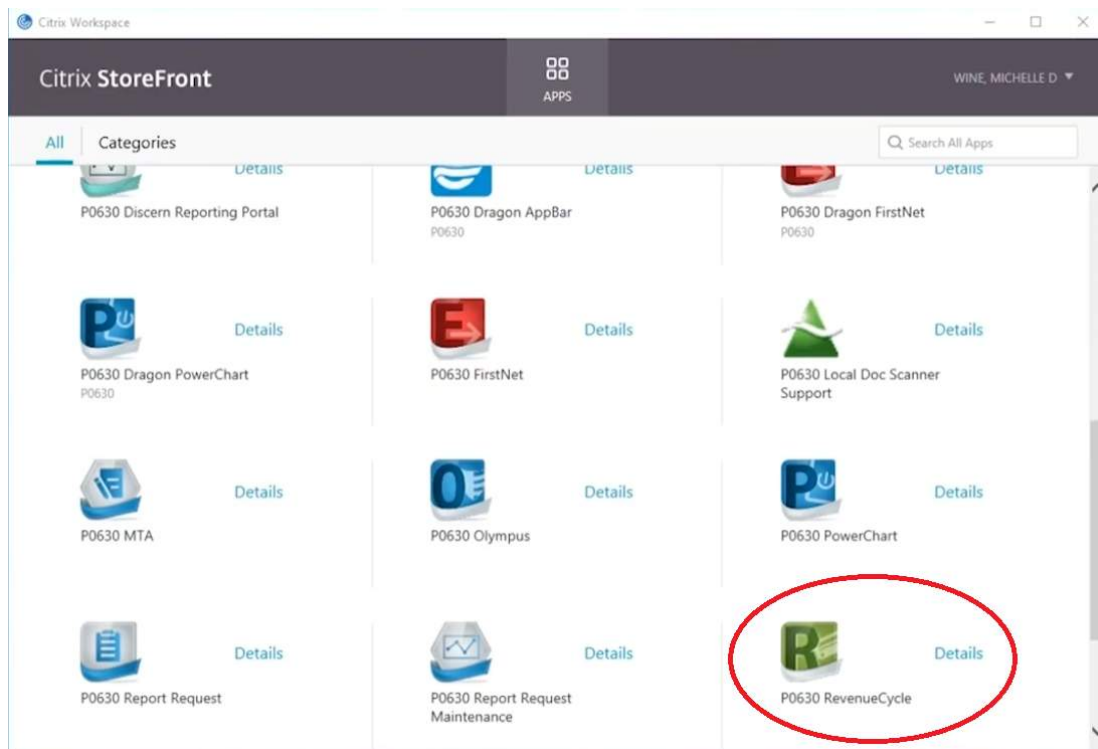
Step 1

Once DEERS status and eligibility is confirmed, *open MHS GENESIS (MHSG)* using the icon on your desktop. The MHSG homepage displays all applications within the electronic health record.



Step 2

Open Revenue Cycle, this is the application you will be using during the patient registration process.



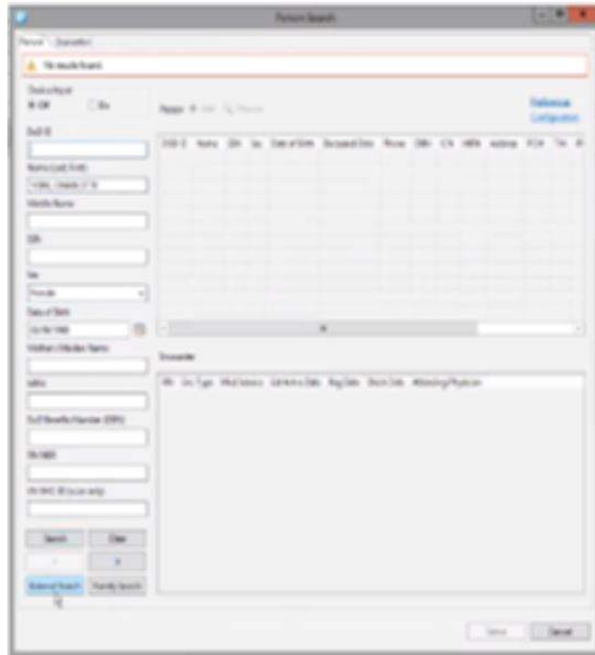
Step 3

Click the magnifying glass to open **Person Search**. Input the patient information that you have available such as the Department of Defense Identification (DoDID), name, sex, and birth date. Then select **Search**.



Step 4

If a **No Results Found** message appears, this means the patient is not in MHSG. *Select External Search* to determine if the patient exists in DEERS.



Step 5

The **Facility Search** window will open.

Input the facility name (DMIS) to align the patient to the facility and *select Search*. *Highlight* the facility and *click Select*. The External MPI (Master Patient Index) retrieve function runs, *wait* for the results to populate.

The screenshot shows a 'Patient Registration' form with the following sections:

- Header:** 'Patient Registration' title bar and a subtitle 'New Patient Registration - Patient Information'.
- Personal Information:**
 - Fields for 'First Name', 'Last Name', 'Date of Birth', 'Sex', 'Race', 'Ethnicity', 'Religion', 'Marital Status', 'SSN', and 'Mailing Address'.
 - A 'Phone Number' field with a dropdown for 'Area Code'.
- Emergency Contact:**
 - Fields for 'Emergency Contact Name', 'Relationship', 'Address', 'City', 'State', 'Zip', 'Phone Number', and 'Email Address'.
- Appointment Preferences:**
 - Fields for 'Preferred Contact Method', 'Preferred Appointment Time', 'Preferred Appointment Day', 'Preferred Appointment Location', and 'Preferred Appointment Time of Day'.
- Footer:** 'Save' and 'Cancel' buttons.

Step 9

Navigate to the **Patient Contact Info** tab. Add the mailing address and phone number; it is recommended to also add the home address at this time.

Add the personal email address and appointment reminder preferences if you have that information while registering the patient.

- Click + Add to open the **Add Appointment Reminder Preference** window. Select the person's **Preferred Contact Method**, enter their information, click **OK**.

The top screenshot shows a form titled 'Add Guarantor' with several sections. The first section has a 'Name' field and a 'Date of Birth' field. The second section has a 'Address' field. The third section has a 'Relationship' field. The bottom screenshot shows a confirmation dialog box with a 'Yes' button and a 'No' button.

Step 10

Navigate to the **Relationships** tab. Select **+ Add** to add a Guarantor to the person.

- The **Add Guarantor Person** window opens. Generally, the guarantor is *"Self"* if the patient has eligibility for care.
- Required fields *auto-populate* from the **Add Patient** conversation, *click OK*.

NOTE: If the patient is a dependent, the guarantor person will be the sponsor.

The top screenshot shows a software window titled 'Patient' with a yellow grid area for notes. The bottom screenshot shows a software window titled 'Insurance' with various input fields for patient information, including 'Patient Name', 'Date of Birth', 'Sex', 'Race', 'Ethnicity', 'Religion', 'Marital Status', 'Occupation', 'Education', 'Income', 'Insurance Type', 'Insurance Company', 'Insurance Policy Number', 'Insurance Start Date', 'Insurance End Date', 'Insurance Premium', 'Insurance Deductible', 'Insurance Co-pay', 'Insurance Out-of-Pocket', 'Insurance Maximal Payout', 'Insurance Renewal Date', 'Insurance Renewal Notice', 'Insurance Renewal Process', 'Insurance Renewal Status', 'Insurance Renewal Date', 'Insurance Renewal Notice', 'Insurance Renewal Process', 'Insurance Renewal Status'.

Step 11

Navigate to the **Insurance** tab.

NOTE: Once a new person is added to MHSG it will push their information to DEERS, so the next time an encounter is opened the insurance eligibility appears.

- There is no need to add insurance at this time, go back to **Patient Info** tab.
- Click **Save** to ensure the patient's information has been saved in MHSG.

The process is now complete and the patient is registered in MHSG!



CONTINUE

Knowledge Check. Select and submit the best option in response to the question below.

Airman McStuffy is working the front desk at the Family Health Clinic. Mrs. Patty and her husband just made a permanent change of station (PCS) to your base. Mrs.

Patty approaches the front desk asking Airman McStuffy to see a doctor. She explains that they are new in the area and have not stopped anywhere on base prior to coming to the MTF.

What critical step must Airman McStuffy accomplish first?

- ☐ Find a provider for Mrs. Patty, the walk-in patient
- ☐ Assess the patient yourself
- ☐ Book Mrs. Patty an appointment
- ☐ Accomplish a DEERS check to confirm eligibility

SUBMIT

Knowledge Check. Select and submit the best option in response to the question below.

Airman Dunkin is working the front desk in the Pediatric Clinic. Senior Airman (SrA) Smith comes up to the desk and asks to schedule an appointment for her son

who has never been seen at your MTF.

After validating her son's DEERS eligibility, what next step should Airman Dunkin take?

-
- ☐ Schedule the son's appointment
 - ☐ Tell SrA Smith to call the appointment line
 - ☐ Register the son in MHSG
 - ☐ Give SrA Smith the location of the nearest Urgent Care Clinic

SUBMIT

Knowledge Check. Select and submit the best option in response to the statement below.

When completing a patient registration, you only need *one* patient identifier.

☐

True

☐

False

SUBMIT

CONTINUE

Lesson 2: Manage Secretarial Designee Program

After completing this lesson, the student will be able to manage the Secretarial Designee (SECDES) program, IAW prescribed guidance and publications.

Program Purpose

The SECDES program allows for the Secretary of Defense and/or the Secretaries of the Army, Navy, and Air Force to designate individuals not otherwise entitled, for Department of Defense (DoD) healthcare (medical and dental) in MTFs. Under Section 8013 of 10 United States Code, the SAF has delegated authority and oversight responsibility for this program to the Secretary of the Air Force Administrative Assistant (SAF/AA).

The SECDES program only authorizes care within MTFs.



Program Guidelines

Secretarial designees from all uniformed services may receive treatment in Air Force MTFs. The secretarial designees normally receive space-available care at the specific MTF in which medical care is requested. Each individual designated by the SAF/AA must have a signed letter from that office establishing eligibility for care. The letter will include the:

- Effective date
- Coverage period
- Aeromedical evacuation/transport determination
- Specific treatment or care authorized in relation to the specific medical condition/incident

- Rate (charges) for care



NOTE: This does not permit the designee to utilize TRICARE benefits/entitlements or the aeromedical evacuation system.

The SAF/AA normally authorizes care for no more than two years. However, extensions for continuity of care can be granted but are limited in scope.

Air Force SECDES Criteria

Individuals who meet one or more of the following criteria may apply for SECDES status through the requesting MTF (*flip each card below to learn more*):

Teaching Case

When the case presents a unique teaching opportunity for the MTF staff or residency programs.

Best Interest of the Air Force

This category of designees includes those for whom it is in the best interest of the Air Force to provide continued care.

2 of 7

Continuity of Care

If continuity of care is a significant clinical issue in the individual's course of treatment and civilian medical care is not available or appropriate.

3 of 7

Abused Family Members and Dependents

Only applicable if all or some transitional benefits are denied by the Air Force personnel or finance

authorities, and/or the
Defense Finance and
Accounting Service.

4 of 7

Special Foreign Nationals

The SAF may authorize Air
Force healthcare benefits for
foreign nationals considered to
be critically important to the
interests of the United States.

5 of 7

Obstetrics, Maternal, and Pediatric Care

- Newborns of eligible family
member daughters
- Pregnant former AD
members and their
newborns
- Spouses of former AD and
their newborns

**SAF/AA Delegated Approval
Authority Programs**

- Civilian Trauma Program
- Extracorporeal Membrane Oxygenation Program
- Human Immunodeficiency Virus (HIV) Research Program

Applying for Air Force Designee Status

If adequate capabilities exist, then a designee request (*Attachment 2, shown below*) shall be completed no later than 30 days prior to expiration of medical benefits or requested designee start date. The request must be signed by the Military Treatment Facility Commander (MTF/CC) and forwarded to the Air Force Medical Operations Agency Health Benefits Division (AFMOA/SGAT). The request must contain a copy of the individual's discharge or separation papers and DD Form 214, *Certificate of Release or Discharge from Active Duty*, and the line of duty determination for reserve component service members, when applicable.

Attachment 2**SECRETARY OF THE AIR FORCE DESIGNEE EXAMPLE REQUEST**

Date

MEMORANDUM FOR (MAJOR COMMAND NAME AND ADDRESS)

FROM: (MILITARY TREATMENT FACILITY NAME AND ADDRESS)

SUBJECT: Secretary of the Air Force Designee Program Application

1. Request the following individual be granted Secretarial Designee status. The following information is provided in accordance with AFMAN 41-210, Chapter 4.
 - a. The patient's full name.
 - b. The patient's date of birth.
 - c. The patient's relationship to sponsor.
 - d. Sponsor's full name.
 - e. Sponsor's rank.
 - f. Sponsor's branch of service.
 - g. Last four numbers of the Sponsor's social security number.
 - h. Sponsor's military status (active duty retired, deceased) and reason for discharge or separation.
 - i. The exact date Designee status should begin.
 - j. The recommended length of Designation.
 - k. Transportation aboard an aeromedical evacuation aircraft is/is not requested. Identify whether the patient requesting Designee status might require transportation on aeromedical evacuation. If so, include patient's home address and estimated cost of military transport.
 - l. Reason for Designation: for example, age (specify date of birth), marriage status, sponsor leaving the service.
 - m. Justification: Identify both the primary program category/criteria best suited for the situation and a supporting narrative.
 - n. Diagnosis: The application should include diagnosis in both clinical and layman's terms.
 - o. Brief Case History: The application needs a brief (one or two paragraph) case history. For complex cases, attach a separate letter with additional details. Include a long-term prognosis, the patient's age when medical providers first diagnosed the problem, and when and where DoD sponsored care began. Histories must be understandable to non-medical personnel.
 - p. Name of attending physician.
 - q. Medical specialty required: Application should specify the type of medical specialist (orthopedics, pediatrics, etc.) who would provide care for the patient.
 - r. Name, rank, and duty phone (Defense Switched Network and commercial) of the Secretarial Designee caseworker.
 - s. Third Party Insurance Carrier: Identify if the sponsor, and or, applicant has Third Party Insurance.
 - t. Third Party Insurance Carrier Policy Number.
 - u. Space Availability: Indicate if the military treatment facility (MTF) has the capacity to treat the applicant.
 - v. Like-care TRICARE Prime patients are/are not being deferred to the network. Indicate if other TRICARE Prime beneficiaries with the same diagnosis are being deferred to the network.
 - w. Right of First Refusal status: Indicate if the MTF accepts/does not accept Right of First Refusals.
2. For additional information please call the caseworker at the above phone number.

//SIGNATURE BLOCK//

CONTINUE

Knowledge Check. Select and submit the best option in response to the question below.

As the manager of the Secretarial Designee Program, who do the request letters get sent to?

- ☐ DHA
- ☐ SAF/AA
- ☐ AFMOA/SGAT
- ☐ TRICARE

SUBMIT

Knowledge Check. Select and submit the best option in response to the statement below.

The SAF/AA normally authorizes care for more than two years.

☐ True

☐ False

SUBMIT

Knowledge Check. Select and submit the best option in response to the statement below.

Continuity of Care is a category that should be placed on the “SECRETARY OF THE AIR FORCE DESIGNEE REQUEST”.

☐ True

☐

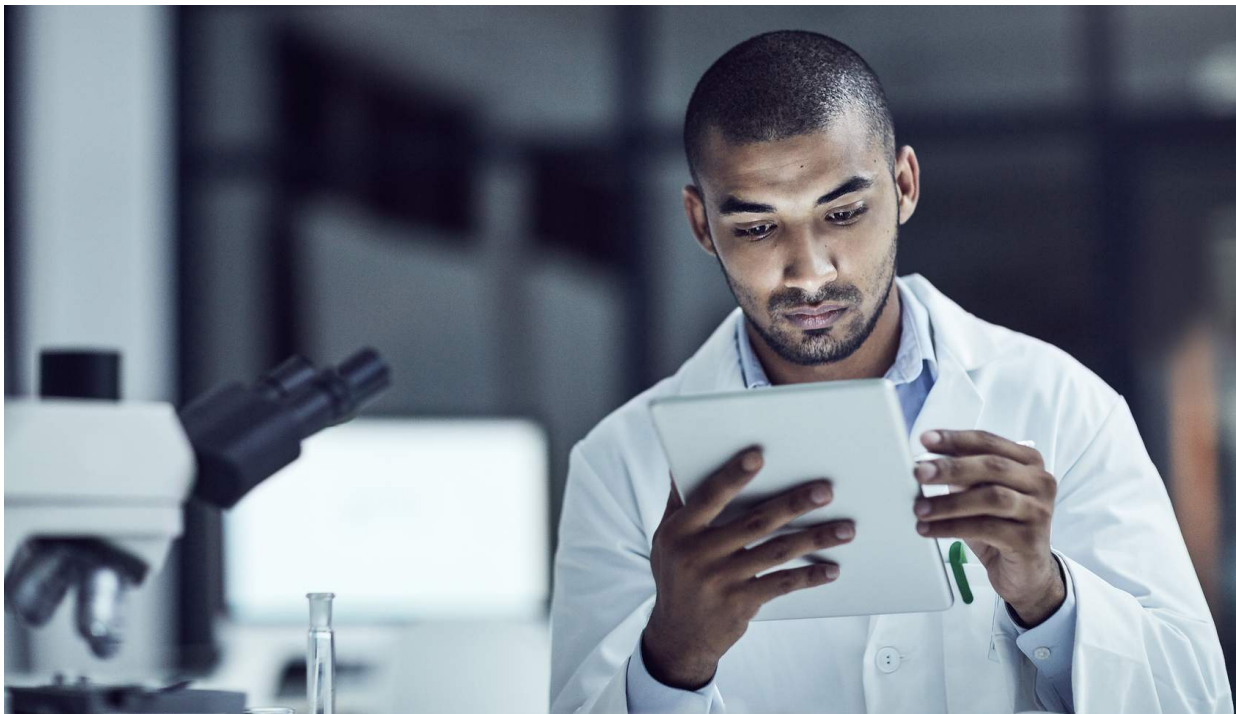
False

SUBMIT

CONTINUE

Lesson 3: Perform Line of Duty (LOD) Determinations Procedures

After completing this lesson, the student will be able to perform LOD determination procedures, IAW prescribed guidance and publications.



Line of Duty (LOD) Determination

An investigation into the circumstances of a member's illness, injury, disease or death is conducted to *determine* whether or not they were acting within the *line of duty* when the incident occurred. A service member who dies or sustains an illness, injury or disease prior to service, while absent without authority, or due to the member's own misconduct is not eligible for certain government benefits.



Select each step below to learn more about the LOD determination process.

Step #1 —

When a member incurs or aggravates an injury, illness or disease while serving in any duty status, the medical condition must be promptly reported within 72 hours to the member's supervisor or commander and servicing medical facility and unit. Failure to comply within the timeline will *NOT* impact the member's ability to have a Line of Duty determination, but will delay the approval/denial process.



Step #2 —

Full-time **military medical providers** shall review and sign an Air Force Form 348, *Line of Duty Determination*, within five working days. The provider will give a diagnosis, medical documentation, and provide an opinion whether the existing medical evidence supports the illness, injury, or disease, and determines if the condition existed prior to service or was service aggravated. Their job is to ADVISE the unit and wing commander.

Print Form Pages 1-3			LINE OF DUTY DETERMINATION		Print Instructions	
<p>PRIVACY ACT STATEMENT</p> <p>AUTHORITY: 10 U.S.C. 8013, Secretary of the Air Force and Executive Order 8987 (SSN), as amended.</p> <p>PURPOSE: To provide medical condition information and the circumstances surrounding the medical condition for a military duty status determination. The determination may be used in assignment, evaluation, compensation, separation and retirement processes.</p> <p>ROUTINE USES: The determination is kept permanently as part of your member personnel record. Disclosures generally permitted under 5 U.S.C. 552(a) of the Privacy Act. In addition, pursuant to 5 U.S.C. 552(a)(3), this record may be disclosed outside of DOD to the Department of Veterans Affairs and to dependents and survivors for benefit eligibility determinations.</p> <p>DISCLOSURE: Mandatory. Positive identification is required for accountability and compensatory benefits.</p> <p>SCORN: F036 AF PC C, Military Personnel Records System.</p>						
PART I. MEMBER INFORMATION						
1. TO: (Immediate Commander)		2. FROM: (Military Medical Provider Office Symbol)		3. REPORT DATE:		
		a. <input type="checkbox"/> MTF <input type="checkbox"/> PMU <input type="checkbox"/> GMLJ <input type="checkbox"/> Deployed Location				
4. NAME: (Last, First, Middle Initial)		5. SSN:		6. RANK:		7. ORGANIZATION/UNIT:
8. MEMBER'S STATUS: (X as applicable)						
<input type="checkbox"/> a. RegAF <input type="checkbox"/> b. AFR <input type="checkbox"/> c. ANG <input type="checkbox"/> d. USAFA Cadet <input type="checkbox"/> e. AFROTC Cadet						
f. DURATION OF ORDERS OR IDT DATE AND TIME: START (DATE/TIME) / END (DATE/TIME) /						
PART II. MILITARY MEDICAL PROVIDER						
9. INVESTIGATION OF (X one only) <input type="checkbox"/> DEATH <input type="checkbox"/> INJURY <input type="checkbox"/> ILLNESS <input type="checkbox"/> DISEASE						
10. NAME/LOCATION OF <input type="checkbox"/> a. MILITARY <input type="checkbox"/> b. CIVILIAN HOSPITAL OR TREATMENT FACILITY THAT FIRST PROVIDED TREATMENT						
c. TREATMENT PROVIDED ON: DATE: TIME:						
11. DESCRIPTION OF SYMPTOMS AND DIAGNOSIS						
12. DETAILS OF DEATH, INJURY, ILLNESS OR HISTORY OF DISEASE:						
13. MEDICAL OPINION OF MEMBER'S CONDITION WHEN FIRST TREATED:						
a. MEMBER <input type="checkbox"/> WAS <input type="checkbox"/> WAS NOT UNDER THE INFLUENCE OF ALCOHOL OR DRUGS. (See AFI 36-2910, Attachment 1)						
IF MEMBER WAS UNDER THE INFLUENCE, SPECIFY: <input type="checkbox"/> ALCOHOL <input type="checkbox"/> DRUGS						
b. TEST DONE: <input type="checkbox"/> ALCOHOL <input type="checkbox"/> IF YES, RESULTS:						
<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> DRUG						
c. MEMBER <input type="checkbox"/> WAS <input type="checkbox"/> WAS NOT MENTALLY RESPONSIBLE. (See AFI 36-2910, Attachment 1)						
d. PSYCHIATRIC EVALUATION (IF YES, DATE: RESULTS:						
COMPLETED: <input type="checkbox"/> NO <input type="checkbox"/> YES						
e. OTHER RELEVANT CONDITIONS:						
f. OTHER TEST(S): IF YES, DATE: RESULTS:						
<input type="checkbox"/> NO <input type="checkbox"/> YES						
14. ADDITIONAL INFORMATION REQUIRED FOR JSC MEMBERS TO BE COMPLETED BY ARC RNMJG/MJ						
a. MEMBER AT DEPLOYED LOCATION <input type="checkbox"/> NO <input type="checkbox"/> YES (IF YES, do not complete b-e) (See AFI 36-2910, para. 1.10.2)						
b. MEMBER'S CONDITION EPITS <input type="checkbox"/> NO <input type="checkbox"/> YES						
c. IF YES, WAS CONDITION SERVICE AGGRAVATED <input type="checkbox"/> NO <input type="checkbox"/> YES						
d. CONDITION POTENTIALLY UNFITTING (AW AF148-123 RETENTION AND/OR MOBILITY STANDARDS <input type="checkbox"/> NO <input type="checkbox"/> YES						
e. REQUIRES ARC LOD DETERMINATION BOARD FINALIZATION <input type="checkbox"/> NO <input type="checkbox"/> YES						

AF FORM 348, 20201016

PREVIOUS EDITIONS ARE OBSOLETE

PRIVACY ACT INFORMATION: The information in this form is FOR OFFICIAL USE ONLY. Protect IAW the Privacy Act of 1974.

Step #3

Line of Duty-Medical Focal Point (LOD-MFP) will place a copy of the LOD determination in the member's medical record and forward the Air Force Form 348 and associated documentation to the LOD program manager. They may brief the member of medical entitlements, if possible, and will expedite the process.



Step #4 —

The **LOD program manager** will ensure everything in the package is complete and provides the unit commander with all documentation. LOD program managers also:

- Audit and manage suspenses to ensure a timely process
- Work with the Medical Treatment Facility to ensure care is not delayed
- Ensure everything is in order so the LOD process can take place



Step #5 —

The **immediate commander** will make a determination that will be weighed by the wing commander. They may issue an interim LOD to establish care and treatment. The determination is then forwarded to the legal advisor.

The **legal advisor** reviews the package for legal sufficiency. Air Force Reserve wing commanders may choose to skip this step if the Line of Duty is informal.



Step #7 —

An appointing authority, usually the wing commander, reviews and annotates on the Air Force Form 348 to determine what actions should be taken. They can recommend a determination, or they must appoint an investigating officer to lead a formal investigation if the choice is a "formal Line of Duty." If they choose to make a determination, it is then forwarded to the LOD program manager for disposition. They may also request a reinvestigation.



Step #8 —

If a formal LOD is recommended, the investigating official will compile a detailed and legally reviewed report. The Air Force Form 348 will be reviewed by a reviewing authority and approved by an approving authority. The LOD program would continue with disposition.

Print Form Pages 1-3
Print Instructions

PART VI. ARC LOD DETERMINATION BOARD REVIEW		
28. MEDICAL REVIEW/RECOMMENDATION		
29. MEDICAL REVIEW REPRESENTATIVE		
a. NAME AND RANK	b. SIGNATURE	c. DATE
30. LEGAL REVIEW/RECOMMENDATION		
31. LEGAL REVIEW REPRESENTATIVE		
a. NAME AND RANK	b. SIGNATURE	c. DATE
32. ARC LOD BOARD ACTION/RECOMMENDATION		
<input type="checkbox"/> a. ILDO <input type="checkbox"/> b. NILOD-NOT DUE TO MEMBER'S MISCONDUCT (only if EPTS-NSA with no indication of misconduct) <input type="checkbox"/> c. FORMAL LOD DETERMINATION <input type="checkbox"/> d. REFER MEMBER TO DES FOR PROCESSING		
33. LOD BOARD ADMINISTRATOR		
a. NAME AND RANK	b. SIGNATURE	c. DATE
PART VII. APPROVING AUTHORITY (ARC ONLY)		
34. APPROVING AUTHORITY FINAL LOD DETERMINATION		
<input type="checkbox"/> a. ILDO <input type="checkbox"/> b. NILOD-NOT DUE TO MEMBER'S MISCONDUCT (only if EPTS-NSA with no indication of misconduct) <input type="checkbox"/> c. APPOINT AN INVESTIGATING OFFICER TO CONDUCT A FORMAL LOD INVESTIGATION <input type="checkbox"/> d. REFER MEMBER TO DES FOR PROCESSING (10 U.S.C. § 1207a)		
35. APPROVING AUTHORITY		
a. NAME AND RANK	b. SIGNATURE	c. DATE
PART VIII. REMARKS		

AF FORM 348, 20201016 PREVIOUS EDITIONS ARE OBSOLETE PRIVACY ACT INFORMATION: The information in this form is for OFFICIAL USE ONLY. Protect ANM the Privacy Act of 1974.

For reference, below is an example of a populated Air Force Form 348.



AF 348 Example Filled.pdf

88.3 KB



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



**DEPARTMENT OF THE AIR FORCE
INSTRUCTION 36-2910**

3 SEPTEMBER 2021

Incorporating Change 1, 28 September 2022

Certified Current 28 September 2022

Personnel

***LINE OF DUTY (LOD)
DETERMINATION, MEDICAL
CONTINUATION (MEDCON), AND
INCAPACITATION (INCAP) PAY***

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

Appeals

Appeals are straightforward, and are coordinate through the LOD program manager. A final LOD determination may be appealed by the member or next of kin (if member is deceased or incapacitated). The LOD program manager forwards the appeal to the officer who exercises general court-martial jurisdiction over the member, who then returns an approval or disapproval to the LOD. The program manager will notify the appellant in accordance with DAFI 36-2910.



NOTE: For reservists, the LOD program manager forwards the appeal to HQ AFRC/CD or ANGRC/CC who acts as the appellate authority.

CONTINUE

Knowledge Check. Select and submit the best option in response to the question below.

Who initially receives and coordinates LOD appeals?

- ☐ Line of Duty (LOD) program manager
- ☐ An officer who exercises court-martial jurisdiction over the member
- ☐ Air Force Personnel Center, Judge Advocate (AFPC/JA)
- ☐ Administrator (SGA)

SUBMIT

Knowledge Check. Select and submit the best option in response to the question below.

Once a determination is finalized, who oversees the case disposition?

- ☐ Line of Duty clerk
- ☐ Line of Duty program manager
- ☐ Investigating officer
- ☐ Appointing authority

SUBMIT

Knowledge Check. Select and submit the best option in response to the question below.

Once initiated by the military medical provider, who receives the Air Force Form 348?

- ☐ Line of Duty-Medical Focal Point (LOD-MFP)

- ☐ Line of Duty program manager
- ☐ Military medical provider
- ☐ Primary Care Manager (PCM)

SUBMIT

CONTINUE

Lesson 4: Referral Management

After completing this lesson, the student will be able to manage referrals IAW prescribed guidance and publications.



The MTF's **Referral Management Center (RMC)** is the hub for information regarding the referral management (RM) process, managed care support contractor (MCSC) authorizations, and patient referral questions.

A **referral** directs a patient to a specialist for a consult or evaluation.

The DHA **access to care (ATC) standard** for routine referrals is 28 days from date the referral was written.

The MTF's RMC is accountable for managing and tracking referrals generated by the MTF and civilian network providers (called Right of First Refusal (ROFR) referrals) until closure. The referral is considered closed when the:

- Referral is cancelled/denied
- Patient has cancelled/not used the referral
- Referring provider has received the Clear and Legible Report (CLR)

Guidance

The Air Force guidance for referral management is **Air Force Instruction (AFI) 44-176, Access to Care Continuum**, and **Air Force Manual (AFMAN) 41-210, Health Services**.

Military Health System (MHS) Genesis RM 2.0 has the steps to navigate through the program.



So, what does a breakdown of referral management look like?

Step 1

A referral is initiated by a credentialed provider by placing it into MHS Genesis. The MTF RMC will go into RM 2.0 to facilitate the referral.

MTFs will centralize specialty and behavioral health referral review and appointing for the first specialty care appointment.

If the MTF is in a market (e.g., San Antonio Military Health System), then referral review and appointing will be centralized at the market level. If this is the case, the MTF RMC will only be responsible for durable medical equipment (DME), home health (HH), or case management (CM) referrals.

Step 2

The MTF will book the initial MTF specialty appointment within the DHA ATC standards.

If the MTF cannot meet the ATC standard, the appointing staff should ask patients if they would like to waive their ATC standard and opt for a later appointment. In RM 2.0, the referral will be “Referred to” the specific MTF specialty clinic and the patient will be scheduled for an appointment.

If the patient does not waive their ATC standard, then the MTF will defer the patient to the network. In RM 2.0, the referral will be “Referred to” the MCSC for authorization. When authorized, a beneficiary letter with the authorization information to set up their appointment in the network. If the referral does not require authorization, the MTF RMC will assist the patients and advise them of their options based on their TRICARE health plan and eligibility.

Step 3

Right of First Refusal Referrals (ROFRs) are referrals from a beneficiary enrolled to a network civilian PCM sent to the MTF by the MCSC for appointing consideration.

The MTF RMC will accept the ROFRs, and patient would have to be seen at the MTF within 28 days or decline the ROFR and referral will be deferred to network. Accept/decline ROFR within 90 minutes of receipt for urgent, and 2 business days for routine priority.

Step 4

For any referral requesting out of area, out of network, or retroactive authorizations, the Chief of the Medical Staff (MTF/SGH) will have to review the referral.

If approved, the referral will be sent to MCSC for authorization.

Let's discuss tracking referrals.

Step 1

The RMC will track...

...all initial specialty care referral results generated by the MTF from the time the referral is written until the results are available to the referring provider (or cancelled/not used by the patient). In RM 2.0, the corresponding status will be selected:

- Completed
- Cancelled
- Not Utilized

Step 2

For ROFR referrals and referrals deferred to the network, a claim will be generated when the service has been rendered.

The MTF RMC should receive a clear and legible report (CLR) for the specialty appointment upon request by the referring provider or no later than 60 days from the date the referral was ordered, whichever occurs first. In RM 2.0, the corresponding status will be selected:

- Closed - Results Received
- Claim Received

If no claim and/or CLR is found and the patient has been reminded to use the referral, The MTF will close the referral NLT 180 days from the date the referral was ordered. In RM 2.0, the corresponding status will be selected:

- No Claim
- Not Utilized
- Claim Received
- No Results Received

Step 3

Create worklists.

RM 2.0 is equipped with features that allow the RMC staff to create certain worklists tailored to their need. This is beneficial for tracking specific types of referrals, status, medical service, etc.

MHS Genesis Reporting Portal-All Referral Report 2.0 is a report the RMC staff can pull to track all metrics such as the number of referrals for a specific specialty, number of referrals in a specific status, referrals deferred to network, etc.

For the last topic of this lesson, click each step below for attaching supplementary documents to a referral.

STEP #1

STEP #2

In RM 2.0, when you select a referral and go to the documents tab, all the records in the patient's file will be listed chronologically and you are able to attach relevant documents to the referral.

MICKEY, MOUSE

56 yrs Male DOB: MAY 15, 1967

Status: Closed Edit

Substatus: DOD - Administrative Edit Clear

Summary

Comments (1)

Documents

Insurance

Scheduling

Attached Documents

Create Letter

Action	Date	Subject	Author	Type	Source
No Documents Attached					

Available Documents

Begin10/08/2023End11/07/2023

Action	Date	Subject	Author	Type	Source
Add	11/03/2023	MH follow up not...	OREGEL, ARIAN...	Behavioral Healt...	Clinical
Add	10/31/2023	BEH Therapist O...	ROBINSON, BER...	Outpatient SUD...	Clinical
Add	10/31/2023	BEH SUD Form	ROBINSON, BER...	BEH SUD Form -...	Clinical
Add	10/31/2023	Immunization Sc...	RUTTO, ERICK K	Immunization Sc...	Clinical
Add	10/24/2023	Immunization Sc...	PLAZA, MIRCHO M	Immunization Sc...	Clinical
Add	10/22/2023	Immunization Sc...	DREW, NICHOLE...	Immunization Sc...	Clinical
Add	10/18/2023	Mass Vaccine Ass...	BERTHIAUME, C...	Immunization Sc...	Clinical
Add	10/18/2023	Mass Vaccine Ass...	BERTHIAUME, C...	Immunization Sc...	Clinical
Add	10/18/2023	Mass Vaccine Ass...	BERTHIAUME, C...	Immunization Sc...	Clinical

STEP #1

STEP #2

In the case that the network provider is requesting additional documentation such as labs, x-rays, clinical notes, etc., the MTF *Release of Healthcare Information (RHI)* will process that request.



CONTINUE

Knowledge Check. Select and submit the best option to complete the statement below.

The MTF RMC _____.

☐

initiates the referral

- ☐ facilitates the referral
- ☐ centralizes and appoints specialty care referrals
- ☐ initiates, facilitates, and centralizes the referral

SUBMIT

Knowledge Check. Select and submit the best option to complete the statement below.

If the MTF cannot meet the ATC standard,

- ☐ the MTF will automatically defer the patient to the network.
- ☐ the patient will have to wait until there is availability within the MTF.
- ☐ the appointing staff should ask patients if they would like to waive their ATC standard and opt for a later appointment.

☐

the patient's appointment will be squeezed in, in order to meet ATC.

SUBMIT

Knowledge Check. Select and submit the best option to complete the statement below.

MHS Genesis Reporting Portal-All Referral Report 2.0 is a report the RMC staff can pull to track

☐

the number of referrals for a specific specialty.

☐

the number of referrals in a specific status.

☐

referrals deferred to network.

☐

all of these answers are correct.

SUBMIT

Knowledge Check. Select and submit the best option in response to the question below.

If the patient's network provider is requesting additional documentation, who is responsible for complying with the request?

- ☐ The patient's PCM
- ☐ The MTF RMC
- ☐ The MTF RHI
- ☐ The patient

SUBMIT

CONTINUE