



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS

16401 EAST CENTRETECH PARKWAY
AURORA, COLORADO 80011-9066

TRICARE
MANAGEMENT ACTIVITY

PRD

CHANGE 47
6010.51-M
MARCH 27, 2007

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE OPERATIONS MANUAL (TOM)

The TRICARE Management Activity has authorized the following addition(s)/
revision(s) to 6010.51-M, reissued August 2002.

CHANGE TITLE: MEDICAL NECESSITY DOCUMENTATION

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): Pursuant to National Defense Authorization Act for
for Fiscal Year 2007 (NDAA FY 2007), Section 731(b)(2), where services are covered by
both Medicare and TRICARE, and medical necessity documentation is required for
claims processing, the contractor shall require only the documentation as specified by
the Medicare Indemnity Program. Appendix A is updated to define medical
necessity.

EFFECTIVE AND IMPLEMENTATION DATE: April 1, 2007.

Evie Lammle
Director, Program Requirements Division

ATTACHMENT(S): 13 PAGES
DISTRIBUTION: 6010.51-M

WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT

CHANGE 47
6010.51-M
March 27, 2007

REMOVE PAGE(S)

CHAPTER 8

Section 6, pages 1 through 5

APPENDIX A

pages 23 through 30

INSERT PAGE(S)

Section 6, pages 1 through 5

pages 23 through 30

CLAIM DEVELOPMENT

1.0. GENERAL

1.1. Pursuant to NDAA07, Sec 731(b)(2) where services are covered by both Medicare and TRICARE, and medical necessity documentation is required for claims processing, the contractor shall require only the documentation as specified by the Medicare Indemnity Program, for example, the CMS-Certificates of Medical Necessity. No additional documentation for medical necessity is generally required if the care has been preauthorized.

1.2. The contractor shall use available in-house methods, i.e., contractor files, telephone, DEERS, etc. to obtain missing, incomplete, or discrepant information. If this is unsuccessful, the contractor may return the claim to the sender with a letter stating that the claim is being returned, stating the reason and requesting the missing or required information. The letter shall request all known missing or required documentation. The contractor's system shall identify the claim as returned, not denied. The Government reserves the right to audit returned claims as required, therefore the contractor shall retain sufficient information on returned claims to permit such audits.

1.3. If a claim is to be returned to a beneficiary who is under 18 years of age and involves venereal disease, substance or alcohol abuse, or abortion, the contractor shall contact the beneficiary to determine how he or she wishes to complete it. See Chapter 8, Section 8, paragraph 6.0. regarding possible contact procedures and the need for both sensitivity and use of good judgment in the protection of patient privacy. **Mail development shall not be initiated on this type of claim without consent of the beneficiary irrespective of whether it is a network or non-network claim.**

2.0. AGREEMENT TO PARTICIPATE

2.1. If the provider has agreed to participate, payment to the full extent of program liability will be paid directly to the provider, but the payment to the provider from program and beneficiary sources must not exceed the contractor determined allowable charge except as provided in payments which include other health insurance which is primary. In such a case, the provisions of 32 CFR 199.8 and the TRICARE Reimbursement Manual, Chapter 4 will apply.

2.2. In all cases in which the contractor has documented knowledge of payment by the beneficiary or other party, the payment shall be appropriately disbursed, including, when necessary, splitting payment. (See the TRICARE Reimbursement Manual for cases where double coverage is also involved.) If it comes to the contractor's attention that the terms have been violated, the issue shall be resolved as outlined in Chapter 14, Section 6, paragraph 7.0., under procedures for handling violation of participation agreements. If the provider returns an adjustment check to the contractor indicating that payment had been made in full, an

adjustment check shall be reissued to the beneficiary/sponsor. If the non-network provider is clearly not participating or the intent cannot be determined, pay the beneficiary (parent/legal guardian).

3.0. CLAIMS FOR CERTAIN ANCILLARY SERVICES

If laboratory tests billed by a non-network provider were performed outside the office of the non-network provider, the place where the laboratory tests were performed must be provided. The contractor shall approve arrangements for laboratory work submitted by network physicians. To be covered, the services must have been ordered by an MD or DO and the laboratory must meet the requirements to provide the services as required under the 32 CFR 199, and TMA instructions.

4.0. V CODES

4.1. The ICD-9-CM codes listed in the Supplementary Classification of Factors Influencing Health Status and Contact with Health Services, otherwise known as V codes, deal with circumstances other than disease or injury classifiable to the ICD-9-CM categories 001-999. V codes are acceptable as primary diagnoses on outpatient claims (rarely on inpatient claims) to the extent that they describe the reason for a beneficiary's encountering the health care system. Claims with V codes as the primary diagnoses are to be processed as follows without development.

4.2. V codes which provide descriptive information of the reason for the encounter based on the single code, e.g., V03.X (Prophylactic vaccination and inoculation against bacterial diseases), V20.2 (Routine infant or child health check), V22.X (Supervision of normal pregnancy), V23.X (Supervision of high risk pregnancy) V25.2 (Contraceptive management), are acceptable as primary diagnoses. Claims with these codes may be processed according to TRICARE benefit policy without additional diagnostic information.

4.3. V codes for outpatient visits/encounters involving only ancillary diagnostic or therapeutic services are acceptable as the primary diagnosis to describe the reason for the visit/encounter only if the diagnosis or problem for which the ancillary service is being performed is also provided. For example, a V code for radiologic exam, V72.5, followed by the code for 786.50 (wheezing) or 786.50 (chest pain) is acceptable. If the diagnosis or problem is not submitted with a claim for the V-coded ancillary service and the diagnosis is not on file for the physician's office services, the claim is to be denied for insufficient diagnosis.

4.4. V codes for preventive services due to a personal history of a medical condition or a family history of a medical condition are acceptable as primary diagnoses when medically appropriate due to the personal or family history condition. Claims with these codes may be processed according to the TRICARE benefit policy without additional diagnostic information. Specifically, the treatment areas are as follows:

- Diagnostic and Screening Mammography, e.g., V725, V103, V1589 and V163.
- Pap Smears, e.g., V72.3, 76.2, and V15.89.
- Screening for Fecal Occult Blood, e.g., V10.00, V10.05 and V10.06.

4.5. Claims with the only diagnoses being V codes which do not fall into one of the above of categories, e.g., codes indicating personal or family histories of conditions, are to be returned for insufficient diagnosis. This includes those V codes corresponding to the V codes for "Conditions not Attributable to a Mental Disorder" in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

5.0. INDIVIDUAL PROVIDER SERVICES

Claims for individual providers (including claims for ambulatory surgery) usually require materially more detailed itemization than institutional claims. The claim must show the following detail:

- Identification of the provider of care;
- Dates of services;
- Place of service, if not evident from the service description or code, e.g., office, home, hospital, skilled nursing facility, etc.;
- Charge for each service;
- Description of each service and/or a clearly identifiable/acceptable procedure code; and
- The number/frequency of each service.

6.0. UNDELIVERABLE/RETURNED MAIL

When a provider's/beneficiary's EOB, EOB and check, or letter is returned as undeliverable, the check shall be voided.

7.0. TRICARE ENCOUNTER DATA DETAIL LINE ITEM - COMBINED CHARGES

Combining charges for the same procedures having the same billed charges under the contractor's "financially underwritten" operation, for TRICARE Encounter Data records, is optional with the contractor if the same action is taken with all. However, for example, if the claim itemizes services and charges for daily inpatient hospital visits from 03/25/2004 to 04/15/2004 and surgery was performed on 04/08/2004, some of the visits may be denied as included in the surgical fee (post-op follow-up). The denied charges, if combined, would have to be detailed into a separate line item from those being allowed for payment. Similarly, the identical services provided between 03/25 and 03/31, inclusive, would be separately coded from those rendered in April. The option to combine like services shall be applied to those services rendered the same calendar month.

8.0. CLAIMS SPLITTING

Under TEDs, a claim shall be split under the following conditions:

8.1. A claim covering services and supplies for more than one beneficiary (other than conjoint therapy, etc.) should be split into separate claims, each covering services and supplies for a specific beneficiary. This must be split under TEDs for different beneficiaries.

8.2. A claim for the lease/purchase of durable medical equipment that is paid by separately submitted monthly installments will be split into one claim for each monthly

installment. The monthly installment will exclude any approved accumulation of past installments (to be reimbursed as one claim) due on the initial claim. Must be split under TEDs.

8.3. A claim that contains services, supplies or equipment covering more than one contractor's jurisdiction shall be split. The claim and attached documentation shall be duplicated in full, and identification shall be provided on each document as "processed" by the contractor and then mailed to the other appropriate contractor having jurisdiction. The contractor splitting the claim, counts the remaining material as a single claim, and the contractor receiving the split material for its jurisdiction, counts it as a single claim, unless the split material meets one or more of the other criteria for an authorized split.

8.4. An inpatient maternity claim which is subject to the TRICARE/CHAMPUS DRG-based payment system and which contains charges for the mother and the newborn shall be split, only when there are no nursery/room charges for the newborn. See the TRICARE Reimbursement Manual, Chapter 1, Section 32.

8.5. Hospice claims that contain both institutional and physician services shall be split for reporting purposes. Institutional services (i.e., routine home care - 651, continuous home care - 652, inpatient respite care - 655, and general inpatient care - 656) shall be reported on an institutional claim format while hospice physician services (revenue code 657 and accompanying CPT codes) shall be reported on a non-institutional format. See the TRICARE Reimbursement Manual, Chapter 11, Section 4.

8.6. A claim for ambulatory surgery services submitted by an ambulatory surgery facility (either freestanding or hospital-based) may be split into separate claims for (1) charges for services which are included in the prospective group payment rate, (2) charges for services which are not included in the prospective group payment rate and are separately allowable, and (3) physician's fees which are allowable in addition to the facility charges. See the TRICARE Reimbursement Manual, Chapter 9, Section 1.

8.7. A claim submitted with both non-financially underwritten and financially underwritten charges shall be split. Non-financially underwritten charges shall be submitted as a voucher and financially underwritten charges shall be submitted as a batch.

8.8. A claim that contains both institutional and professional services may be split into separate claims for: (1) charges for services included in the Outpatient Prospective Payment System (OPPS), and (2) charges for professional services which are not included in the OPPS and are separately allowable.

9.0. PROVIDER NUMBERS

Claims received (electronic, paper, or other acceptable medium) with the provider's Medicare Provider Number (institutional and non-institutional) shall not be returned to the provider to obtain the TRICARE Provider Number. The contractor shall accept the claim for processing, develop the provider number internally, and report the TRICARE Provider Number as required by the TRICARE Systems Manual, Chapter 2, on the TED records.

10.0. TRANSGENDERED BENEFICIARIES

If a beneficiary or provider notifies the contractor of the beneficiary's transgendered status (either prospectively or through an appeal), the contractor shall flag that patient's file and defer claims for medical review only when there is a discrepancy between the patient's gender and the procedure, diagnosis or ICD-9 surgical procedure code. For care that the review determines to be medically necessary and appropriate, the contractor shall override any edit identifying a discrepancy between the procedure and the patient's gender. TED record data for transgendered claims must reflect the Person Sex as downloaded from DEERS (TRICARE Systems Manual, Chapter 2, Section 2.7) and the appropriate override code.

include “medical, psychological, surgical, and obstetrical,” unless it is specifically stated that a more restrictive meaning is intended.

MEDICAL CLAIMS HISTORY FILE: (Refer to Beneficiary History File.)

MEDICAL NECESSITY: *A collective term for determinations based on medical necessity, appropriate level of care, custodial care (as these terms are defined in 32 CFR 199.2) or other reason relative solely to reasonableness, necessity or appropriateness. Determinations relating to mental health benefits under 32 CFR 199.4 are considered medical necessity determinations.*

MEDICAL SUPPLIES AND DRESSINGS (CONSUMABLES): Necessary medical or surgical supplies (exclusive of durable medical equipment) that do not withstand prolonged, repeated use and that are needed for the proper medical management of a condition for which benefits are otherwise authorized under TRICARE, on either an inpatient or outpatient basis. Examples include disposable syringes for a diabetic, colostomy sets, irrigation sets, and ace bandages.

MEDICAL MANAGEMENT: Contemporary practices in areas such as network management, utilization management, case management, care coordination, disease management, and the various additional terms and models for managing the clinical and social needs of the beneficiary to achieve the short and long term cost-effectiveness of the MHS while achieving the highest level of satisfaction among MHS beneficiaries.

MEDICARE: Those medical benefits authorized under Title XVIII of the Social Security Act provided to persons 65 or older, certain disabled persons, or persons with chronic renal disease, through a national program administered by the DHHS, Center for Medicare and Medicaid Service, Medicare Bureau.

MEDICARE ECONOMIC INDEX (MEI): An index used in the Medicare program to update physician fee levels in relation to annual changes in the general economy for inflation, productivity, and changes in specific health sector practice expenses factors including malpractice, personnel costs, rent, and other expenses.

MENTAL HEALTH THERAPEUTIC ABSENCE: A therapeutically planned absence from the inpatient setting. The patient is not discharged from the facility and may be away for periods of several hours to several days. The purpose of the therapeutic absence is to give the patient an opportunity to test his or her ability to function outside the inpatient setting before the actual discharge.

MICROCOPY: A photographic reproduction so much smaller than the object photographed that optical aid is necessary to read or view the image. The usual range of reduction is from eight to 25 diameters. Also called microphotography.

MICROFICHE: Miniaturized images arranged in rows that form a grid pattern on card-size transparent sheet film.

MICROFILM: A negative or a positive microphotograph on film. The term is usually applied to a sheet of film or to a long strip or roll of film that is 16mm, 35mm, 70mm, or 105mm in width and on which there is a series of microphotographs.

MICROFORM: Any miniaturized form containing microimages, such as microcards, microfiche, microfilm, and aperture cards.

MILITARY HEALTH SYSTEM (MHS) BENEFICIARY: Any individual who is eligible to receive treatment in a Military Treatment Facility (MTF). The categories of Military Health System (MHS) beneficiaries shall be broadly interpreted unless otherwise specifically restricted. (For example: Authorized parents and parents-in-law are not eligible for TRICARE purchased care, but may receive treatment in an MTF (on a space available basis) and may access the TRICARE Health Care Information Line (HCIL)).

MILITARY MEDICAL SUPPORT OFFICE (MMSO): The joint services organization responsible for reviewing specialty and inpatient care requests and claims for impact on fitness-for-duty. MMSO is also responsible for approving certain medical services not covered under TRICARE that are necessary to maintain fitness for duty and/or retention on active duty. The Service Points of Contact (SPOCs) for Army, Navy, Marine Corps, and Air Force active duty service members (ADSMs) are assigned to the MMSO. See also Service Point of Contact definition.

MILITARY TREATMENT FACILITY (MTF): A military hospital or clinic.

MILITARY TREATMENT FACILITY (MTF) OPTIMIZATION: Filling every appointment and bed available within the MTF with the appropriate patient based on the capacity and capabilities of the MTF and the MTF's readiness/training requirements, as defined by the MTF Commander.

MILITARY TREATMENT FACILITY (MTF)-REFERRED CARE: When Military Treatment Facility (MTF) patients require medical care that is not available at the MTF, the MTF will refer the patient to civilian medical care, and the contractor shall process the claim ensuring that discounts, cost-shares, copayments and/or deductibles are applied when appropriate.

MISSING IN ACTION (MIA): A battle casualty whose whereabouts and status are unknown, provided the absence appears to be involuntary and the service member is not known to be in a status of unauthorized absence.

NOTE: Claims for eligible TRICARE beneficiaries whose sponsor is classified as MIA are processed as dependents of an active duty service member.

MOBILIZATION PLAN - TRICARE: A plan designed to ensure the government's ability to meet the medical care needs of the TRICARE-eligible beneficiaries in the event of a military mobilization that precludes use of all or parts of the military direct care system for provision of care to TRICARE-eligible beneficiaries.

MONTHLY PRO-RATING: The process for determining the amount of the enrollment fee to be credited to a new enrollment period. For example, if a beneficiary pays their annual enrollment fee, in total, on January 1, (the first day of their enrollment period) and a change in status occurs on February 15. The beneficiary will receive credit for ten months of the enrollment fee. The beneficiary will lose that portion of the enrollment fee that would have covered the period from February 15 through February 28.

MOST-FAVORED RATE: The lowest usual charge to any individual or third-party payer in effect on the date of the admission of a TRICARE beneficiary.

NATIONAL APPROPRIATE CHARGE LEVEL: The charge level established from a 1991 national appropriate charge file developed from July 1986 - June 1987 claims data, by applying appropriate Medicare Economic Index (MEI) updates through 1990, and prevailing charge cuts, freeze or MEI updates for 1991 as discussed in the September 6, 1991, final rule.

NATIONAL CONVERSION FACTOR (NCF): A mathematical representation of what is currently being paid for similar services nationally. The factor is based on the national allowable charges actually in use.

NATIONAL DISASTER MEDICAL SYSTEM (NDMS): A system designed to ensure that the United States is prepared to respond medically to all types of mass casualty emergency situations, whether from a natural or man-made disaster in the country or from United States military casualties being returned from an overseas conventional conflict. This system involves private sector hospitals located throughout the United States that will provide care for victims of any incident that exceeds the medical care capability of any affected state, region, or federal medical care system.

NATIONAL PREVAILING CHARGE LEVEL: The level that does not exceed the amount equivalent to the eightieth (80th) percentile of billed charges made for similar services during a twelve (12) month base period.

NATIONAL QUALITY MONITORING CONTRACT (NQMC): A national-level contractor responsible to DoD and TRICARE Management Activity (TMA) that performs second level reconsiderations for payment denials and focused retrospective quality of care reviews.

NEGOTIATED (DISCOUNTED) RATE: The negotiated or discounted rate, under a program approved by the Director, TMA, is the reimbursable amount that the provider agrees to accept in lieu of the usual TRICARE reimbursement, the DRG amount, the mental health per diem, or any other TRICARE payment determined through a TMA-approved reimbursement methodology.

NETWORK: The network of contractor-operated providers and facilities (owned, leased, arranged) that link the providers or facilities with the prime contractor as part of the total contracted delivery system. The agreements for health care delivery made by the contractor with the MTFs are also included in this definition.

NETWORK CARE: Care provided by the network of contractor-operated providers and facilities (owned, leased, arranged) that link the providers or facilities with the prime contractor as part of the total contracted delivery system. Thus a "network provider" is one who serves TRICARE beneficiaries by agreement with the prime contractor as a member of the TRICARE Prime network or of any other preferred provider network or by any other contractual agreement with the contractor. "Network care" includes any care provided by a "network provider" or any care provided to a TRICARE Prime enrollee under a referral from the contractor, whether by a "network provider" or not. A "network claim" is a claim submitted for "network care." (See the definition for "Non-Network Care.")

NETWORK INADEQUACY: Any occurrence of a prime beneficiary being referred to a network provider outside of the time and/or distance standards (except when the beneficiary waives access standards) or any beneficiary being referred to a non-network provider.

NETWORK PROVIDER: An individual or institutional provider that is a member of a contractor's provider network.

NONAPPEALABLE ISSUE: The issue or basis upon which a denial of benefits was made based on a fact or condition outside the scope of responsibility of TMA and the contractor. For example, the establishment of eligibility is a Uniformed Service responsibility and if the service has not established that eligibility, neither TMA nor a contractor may review the action. Similarly, the need for a Nonavailability Statement, late claim filing, late appeal filing, amount of allowable charge (the contractor must verify it was properly applied and calculated), and services or supplies specifically excluded by law or regulation, such as routine dental care, clothing, routine vision care, etc., are matters subject to legislative action or regulatory rule making not appealable under TRICARE. Contractors will not make a determination that an issue is not appealable except as specified in Chapter 13 and 32 CFR 199.10.

NONAVAILABILITY STATEMENT (NAS): A statement issued by a commander (or designee) of a Uniformed Services medical treatment facility that needed medical care being requested by a TRICARE beneficiary cannot be provided at the facility concerned because the necessary resources are not available. Requirement for a non-availability statement will be limited to inpatient mental health care, but may, at the direction of the Assistant Secretary of Defense (Health Affairs), be extended to other specific types of care. TRICARE Prime enrollees are exempt from NAS requirements, even under the Point-of-Service option.

NON-CLAIM HEALTH CARE DATA: That data captured by the contractor to complete the required TRICARE Encounter Data record for care rendered to TRICARE beneficiaries in those contractor owned, operated and/or subcontracted facilities where there is no claim submitted by the provider of care.

NONCURRENT RECORDS: Records that are no longer required in the conduct of current business and therefore can be retrieved by an archival repository or destroyed.

NON-DOD TRICARE BENEFICIARIES: These are TRICARE-eligible beneficiaries sponsored by non-Department of Defense uniformed services (the Commissioned Corps of the Public Health Service, the United States Coast Guard and the Commissioned Corps of the National Oceanic and Atmospheric Administration).

NON-NETWORK CARE: Any care not provided by "network providers" (see definition of "Network Care"), except care provided to a TRICARE Prime enrollee by a "non-network provider" upon referral from the contractor. A "non-network provider" is one who has no contractual relationship with the prime contractor to provide care to TRICARE beneficiaries. A "non-network claim" is one submitted for "non-network care."

NON-PARTICIPATING PROVIDER: A hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider that furnished medical services or supplies to a TRICARE beneficiary, but who did not agree on the TRICARE claim form to participate or to accept the TRICARE-determined allowable

cost or charge as the total charge for the services. A nonparticipating provider looks to the beneficiary or sponsor for payment of his or her charge, not TRICARE. In such cases, TRICARE pays the beneficiary or sponsor, not the provider.

NON-PRIME TRICARE BENEFICIARIES: These are TRICARE-eligible beneficiaries who are not enrolled in the TRICARE Prime program. These beneficiaries remain eligible for all services specified in 32 CFR 199 and are subject to deductible and cost-share provisions of the TRICARE Standard Program.

NORTH ATLANTIC TREATY ORGANIZATION (NATO) MEMBER: A military member of an armed force of a foreign NATO nation who is on active duty and who, in connection with official duties, is stationed in or passing through the United States. The foreign NATO nations are Belgium, Canada, Czech Republic, Denmark, France, Federal Republic of Germany, Greece, Hungary, Iceland, Italy, Luxembourg, the Netherlands, Norway, Poland, Portugal, Spain, Turkey, and the United Kingdom.

OFFICIAL FORMULARIES: A book of official standards for certain pharmaceuticals and preparations that are not included in the U.S. Pharmacopoeia.

OTHER SPECIAL INSTITUTIONAL PROVIDERS: Certain special institutional providers, either inpatient or outpatient, other than those specifically defined, that provide courses of treatment prescribed by a doctor of medicine or osteopathy; when the patient is under the supervision of a doctor of medicine or osteopathy during the entire course of the inpatient admission or the outpatient treatment; when the type and level of care and services rendered by the institution are otherwise authorized in 32 CFR 199; when the facility meets all licensing or other certification requirements that are extant in the jurisdiction in which the facility is located geographically; which is accredited by the Joint Commission on Accreditation if an appropriate accreditation program for the given type of facility is available; and which is not a nursing home, intermediate facility, halfway house, home for the aged, or other institution of similar purpose.

OUT-OF-AREA CARE: Urgent care received by Prime enrollees traveling outside the drive time access standard. These enrollees are not required to return to their PCM for urgent care.

OUT-OF-REGION BENEFICIARIES: TRICARE-eligible beneficiaries who reside outside of the region for which the contractor has responsibility, but who receive care within the region.

PARTICIPATING PROVIDER: A hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider who furnishes services or supplies to a TRICARE beneficiary and has agreed, by act of signing and submitting a TRICARE claim form and indicating participation in the appropriate space on the claim form, to accept the TRICARE-determined allowable cost or charge as the total charge (even though less than the actual billed amount), whether paid for fully by the TRICARE allowance or requiring cost-sharing by the beneficiary or sponsor. All network providers MUST be participating providers.

PENDING CLAIM, CORRESPONDENCE, OR APPEAL: The claim/correspondence/appeal case has been received but has not been processed to final disposition.

POINT-OF-SERVICE (POS) OPTION: Option under TRICARE Prime that allows enrollees to self-refer for non-emergent health care services to any TRICARE authorized civilian provider, in or out of the network. When Prime enrollees choose to use the POS option, i.e., to obtain non-emergent health care services from other than their PCMs or without a referral from their PCMs, all requirements applicable to TRICARE Standard apply except the requirement for an NAS. Point-of-Service claims are subject to deductibles and cost-shares (refer to definitions in this appendix) even after the enrollment/fiscal year catastrophic cap has been met.

PREAUTHORIZATION: A decision issued in writing by the Director, TMA, or a designee, that TRICARE benefits are payable for certain services that a beneficiary has not yet received.

PREFERRED PROVIDER ORGANIZATION (PPO): An organization of providers who, through contractual agreements with the contractor, have agreed to provide services to TRICARE beneficiaries at reduced rates and to file TRICARE claims on behalf of the beneficiaries and accept TRICARE assignment on all TRICARE claims. The preferred provider agreements may call for some other form of reimbursement to providers, but in no case will an eligible beneficiary receiving services from a preferred provider be required to file a TRICARE claim or pay more than the allowable charge cost-share for services received.

NOTE: The fact that the U.S. Food and Drug Administration has approved a drug for testing on humans would not qualify it within this definition.

PREVAILING CHARGE: The charges submitted by certain non-institutional providers which fall within the range of charges that are most frequently used in a state for a particular procedure or service. The top of the range establishes the maximum amount TRICARE will authorize for payments of a given procedure or service, except where unusual circumstances or medical complications warrant an additional charge. The calculation methodology and use is determined according to the instructions in the TRICARE Reimbursement Manual.

PREVENTIVE CARE: Diagnostic and other medical procedures not related directly to a specific illness, injury, or definitive set of symptoms, or obstetrical care, but rather performed as periodic health screening, health assessment, or health maintenance.

PRIMARY CARE: Those standard, usual and customary services rendered in the course of providing routine ambulatory health care required for TRICARE beneficiaries. Services are typically, although not exclusively, provided by internists, family practitioners, pediatricians, general practitioners and obstetricians/gynecologists. It may also include services of non-physician providers (under supervision of a physician to the extent required by state law). These services shall include appropriate care for acute illness, accidents, follow-up care for ongoing medical problems and preventive health care. These services shall include care for routine illness and injury, periodic physical examinations of newborns, infants, children and adults, immunizations, injections and allergy shots, and patient education and counseling (including family planning and contraceptive advice). Such services shall include medically necessary diagnostic laboratory and x-ray procedures and tests incident to such services.

PRIMARY CARE MANAGER (PCM): An MTF provider or team of providers or a network provider to whom a beneficiary is assigned for primary care services at the time of

enrollment in TRICARE Prime. Enrolled beneficiaries agree to initially seek all non-emergency, non-mental health care services from their PCMs.

PRIMARY CARE PHYSICIAN: A physician who provides primary care services to patients, but who is not a network physician performing Primary Care Manager functions under TRICARE Prime.

PRIMARY PAYER: The plan or program whose medical benefits are payable first in a double coverage situation.

PRIME CONTRACTOR: The single entity with which the Government will contract for the specified services.

PRIME ENROLLEE: An MHS beneficiary enrolled in TRICARE Prime.

PRIORITY CORRESPONDENCE: Correspondence received by the contractor from the Office of the Assistant Secretary of Defense (Health Affairs), TMA, and Members of Congress, or any other correspondence designated for priority status by the contractor's management.

PRIVACY ACT, TITLE 5, UNITED STATES CODE, SECTION 552A: A law intended to preserve the personal privacy of individuals and to permit an individual to know what records pertaining to him or her are collected, maintained, used, or disseminated, and to have access to and to have copied at the requestor's expense, all or any portion of such records, and to correct or amend such records. Concomitantly, it requires government activities which collect, maintain, use or disseminate any record of an identifiable personal nature in a manner that assures that such action is necessary and lawful; that any information collected is accurate, relevant, timely, and as complete as is reasonably possible and necessary to assure fairness to the individual, and that adequate safeguards are provided to prevent misuse or unauthorized release of such information.

PROCESSED TO COMPLETION (OR FINAL DISPOSITION):

1. **CLAIMS.** Claims are processed to completion, for workload reporting and payment record coding purposes, when all claims received in the current and prior months have been processed to the point where the following actions have resulted:
 - a. All services and supplies on the claim have been adjudicated, payment has been determined on the basis of covered services/supplies and allowable charges applied to deductible and/or denied, and
 - b. Payment, deductible application or denial action has been posted to ADP history.
2. **CORRESPONDENCE.** Correspondence is processed to completion when the final reply is mailed to the individual(s) submitting the written inquiry or when the inquiry is fully answered by telephone.
3. **TELEPHONIC INQUIRY.** A telephonic inquiry is processed to completion when the final reply is provided by either telephone or letter.

4. **APPEALS.** Final disposition of an appeal case occurs when the previous decision by the contractor is either reaffirmed, reversed, or partially reversed and the decision is mailed.

PROFILED AMOUNT: The profiled amount is the lower of the prevailing charge or the maximum allowable prevailing charge.

PROGRAM INTEGRITY SYSTEM: A system required of the contractor by the government for detecting overutilization or fraud and abuse.

PROSPECTIVE REVIEW: Evaluation of a provider's request for treatment of a patient before the treatment is delivered. This typically involves a provider requesting admission (non-emergent) or requesting selected procedures that require pretreatment certification and authorization for reimbursement.

PROVIDER: A hospital or other institutional provider of medical care or services, a physician or other individual professional provider, or other provider of services or supplies in accordance with the 32 CFR 199.

PROVIDER EXCLUSION AND SUSPENSION: The terms "exclusion" and "suspension", when referring to a provider under TRICARE, both mean the denial of status as an authorized provider, resulting in items, services, or supplies furnished by the provider not being reimbursed, directly or indirectly, under TRICARE. The terms may be used interchangeably to refer to a provider who has been denied status as an authorized TRICARE provider based on 1) a criminal conviction or civil judgment involving fraud, 2) an administrative finding of fraud or abuse under TRICARE, 3) an administrative finding that the provider has been excluded or suspended by another agency of the Federal Government, a state, or a local licensing authority, 4) an administrative finding that the provider has knowingly participated in a conflict of interest situation, or 5) an administrative finding that it is in the best interests of TRICARE or TRICARE beneficiaries to exclude or suspend the provider.

PROVIDER NETWORK: An organization of providers with which the contractor has made contractual or other arrangements. These providers must accept assignment of claims and submit claims on behalf of the beneficiary.

PROVIDER TERMINATION: When a provider's status as an authorized TRICARE provider is ended, other than through exclusion or suspension, based on a finding that the provider does not meet the qualifications, as set forth in 32 CFR 199.6 to be an authorized TRICARE provider.

QUALITY ASSURANCE PROGRAM: A system-wide program established and maintained by the contractor to monitor and evaluate the quality of patient care and clinical performance.

RECEIPT OF CLAIM, CORRESPONDENCE OR APPEAL: Delivery of a claim, correspondence, or appeal into the custody of the contractor by the post office or other party.

RECONSIDERATION: An appeal to a contractor of an initial determination issued by the contractor.