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TRICARE
MANAGEMENT ACTIVITY

PCPB

CHANGE 1
6010.56-M
MARCH 13, 2008

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE OPERATIONS MANUAL (TOM)**

The TRICARE Management Activity has authorized the following addition(s)/revision(s) to 6010.56-M, issued February 2008.

CHANGE TITLE: CONSOLIDATED UPDATE

PAGE CHANGE(S): See pages 2 through 5.

SUMMARY OF CHANGE(S): This change brings this Manual up-to-date with published changes in Aug 2002 TRICARE Operations Manual (TOM), 6010.51-M. The changes are the Cancer Trials benefit (Aug 2002 TOM, Change 59) and the Autism Demonstration Project (Aug 2002 TOM, Change 60). This change also includes several administrative changes to: correct errors and remove outdated material; remove reporting requirements which are now included in the contract(s) as deliverables; and to make minor clarifications to requirements.

EFFECTIVE AND IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Feb 2008 TPM, Change No. 1, Feb 2008 TRM, Change No. 1, and Feb 2008 TSM, Change No. 1.

Laura Sells
Chief, Purchased Care Procurement
Branch

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Chapter 1

Administration

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Contract Administration And Instructions

1.0 TRICARE MANUALS

These include the TRICARE Operations Manual (TOM), TRICARE Policy Manual (TPM), TRICARE Reimbursement Manual (TRM), and TRICARE Systems Manual (TSM). The TRICARE Manuals are the principal vehicles for general operating instructions to all health care delivery contractors and may be accessed at <http://manuals.tricare.osd.mil/>. The official archive copies of these documents are maintained at TRICARE Management Activity (TMA). The documents and all official changes to them will be maintained at TMA in an electronic medium using the PDF (Portable Document Format) format, and are available at the above web site. Distribution of paper copies will be on an exception basis. Regardless of publication medium, their printed and displayed appearance will be identical. The principal means of distribution will be via an electronic notification of publication and the contractor's subsequent download of the manual or change from the above web site. All proposed changes to these documents will be distributed for review and comment in an electronic medium, using PDF as the document format, and comments must be returned to TMA in an acceptable electronic format. Contractors shall furnish the TMA Procuring Contracting Officer (PCO) with designated point(s) of contact and e-mail address(es) for review and comment on proposed manual changes, and notification of final publication of manual changes.

2.0 IMPLEMENTATION OF MANUAL CHANGES

The contractor shall implement changes in requirements as specified by the PCO. If a contractor is unable to comply by the effective date, the PCO shall be notified in writing. The notification shall include the reasons for the noncompliance and a plan for reaching compliance. The proposal shall include milestones, if appropriate, and a firm date for completion.

3.0 COMMUNICATIONS WITH TMA

The contractor shall:

3.1 Provide complete replies to TMA requests for Rough Order Of Magnitude (ROM) estimates, comments, and/or cost estimates on proposed changes to the manuals. In addition, in the event of an urgent need imposed by law or a program requirement under which significant loss to the Government would result from delay, a period of less than 30 days will be imposed, whether it is a major or minor change.

3.2 Provide timely responses to all requests for information directed to them by TMA.

3.3 All cost estimates/proposals for changes shall be sent to TMA with a detailed substantiation of actual costs incurred and the basis of estimates.

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3.4 Use assigned Contracting Officer's Representative (COR) at TMA as the initial POC for program interpretation or other forms of guidance unless it is a situation which falls within the specific exceptions listed below.

4.0 TMA-REQUIRED MEETINGS

A 14 calendar day notice will be provided for all meetings hosted by TMA. The Managed Care Support Contractor (MCSC) shall provide representation at two regional MCSC/TRICARE Regional Office (TRO), and two regional provider conferences. The MCSC shall provide up to four contractor representatives at up to four additional meetings at the direction of the PCO per contract year. The cost of attendance at these meetings shall be included in the MCSC's per-member per-month price.

5.0 TMA DELEGATION OF RESPONSIBILITY

Responsibility has been delegated to TMA, Beneficiary and Provider Services (BPS) to perform the following:

- Grant exceptions to the claims filing deadline;
- Grant "good faith payments";
- Waive the signature requirements on TRICARE claims;
- Adjudicate and process unique claims requiring special handling, and claims for emergency care provided by a Department of Veterans Affairs (DVA) facility or a facility under the Bureau of Indian Affairs;
- Authorize benefits for which the authority has not otherwise been delegated to other TRICARE officials or MCSCs;
- Authorize an "override" of information contained on Defense Enrollment Eligibility Reporting System (DEERS), pending a system update, based on appropriate documentation regarding eligibility under the law, regulation and policy.

- END -

4.2 Nonexpedited Medical Necessity Reconsiderations

From the date of receipt by the contractor until processed to completion, the contractor shall meet the following processing standards for non-expedited medical necessity reconsiderations:

- Eighty-five percent (85%) within 30 calendar days;
- Ninety-five percent (95%) within 60 calendar days; and
- One hundred percent (100%) within 90 calendar days.

4.3 Nonexpedited Factual Reconsiderations

From the date of receipt by the contractor until processed to completion, the contractor shall meet the following standards for non expedited factual reconsiderations:

- Ninety-five percent (95%) within 60 calendar days of receipt; and
- One hundred percent (100%) within 90 calendar days from the date of receipt of the reconsideration request. The date of completion is considered to be the date the reconsideration determination is mailed to the appropriate parties.

4.4 Determinations Reversed by the Appeals Process

One hundred percent (100%) of contractor determinations reversed by the appeals process shall be processed to completion within 21 calendar days of receipt.

5.0 GRIEVANCES

All written grievances shall be stamped with the actual date of receipt within three workdays of receipt in the contractor's custody. The contractor shall provide interim written response by the 30th calendar day after receipt for all grievances not processed to completion by that date. The interim response shall include an explanation for the delay and an estimated date of completion. Ninety-five percent (95%) of all grievances shall be processed to completion within 60 calendar days from the date of receipt.

6.0 POTENTIAL DUPLICATE CLAIM RESOLUTION

6.1 The contractor shall utilize the automated TRICARE Duplicate Claims System (DCS) to resolve TMA identified potential duplicate claims payments.

6.2 The contractor shall move *Open* status potential duplicate claim sets to *Pending*, *Validate*, or *Closed* status on a first-in/first-out basis. To this end, contractor performance will be measured against the percentage of claim sets in *Open* status at the end of a month with load dates over 30 days old. No more than 10% of the potential duplicate claim sets remaining in *Open* status at the end of a month shall have load dates over 30 days old. Contractor compliance with this standard shall be determined from the Performance Standard Report generated by the DCS (see [Chapter 9](#), Summary/Management Report entitled "Performance Standards," for a description and example of the Performance Standard Report). The 10% standard becomes effective on the first day of the seventh month following the start of health care delivery or following system installation whichever is later.

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TRICARE Processing Standards

6.3 The contractor shall not be responsible for meeting the performance standard during any month in which access to the DCS is prevented for two working days due to failure of any system component for which the Government is responsible.

6.4 All overpayment recovery, refund, offset collection and adjustment requirements, including timeliness standards, are applicable to the operation of the DCS. Offsets shall be applied against any future payments to a debtor until the debt is satisfied.

- END -

beneficiary is required. A verbal statement from a Congressional staff member that written consent was obtained from the individual to whom the record pertains or from the parent in the case of a beneficiary under age 18, is sufficient for the contractor to release the requested information. The contractor shall not contact the beneficiary unless the Congressional office requests that it be done. Similarly, a record of an individual which would not be releasable directly to the individual (e.g., a medical record which would have an adverse effect on the individual) cannot be released directly to the Congressional office making the inquiry on behalf of the individual. Instead, the Congressional office shall be advised of the procedure for release of such record. Of course, in those cases where a contractor can respond to a Congressional request for assistance on behalf of an individual, without disclosing personal information which would fall under the Privacy Act, the contractor shall comply.

4.12.4 Replies to all Congressional inquiries and requests shall be completely responsive and handled as expeditiously as possible. Should it become evident that a response to a request cannot be made within 15 working days, an interim reply will be sent. The interim reply will indicate the anticipated date of completion and the steps being taken to obtain the information requested.

4.13 Disclosure Within The Agency

4.13.1 The Privacy Act prohibits the disclosure from TRICARE records of information concerning a beneficiary without the beneficiary's written consent except for "routine uses" as directed by the agency or disclosures made to officials and employees of the DoD (including TRICARE contractors) who have a need for the record in the performance of their duties, provided the use is compatible with the purpose for which the record is maintained.

4.13.2 Paragraph 4.3.4, defines "routine uses" with respect to disclosure of TRICARE records. TRICARE contractors should be aware that TRICARE Health Benefit Advisors (HBAs) and Uniformed Services claims officers are employees of the DoD authorized to receive information from TRICARE records if they have a need for the information in the performance of their duties. A TRICARE HBA who is assisting a beneficiary may receive TRICARE information pertaining to that beneficiary. If there is some reason to question release of the information, a request can be made for the beneficiary's written consent. The restriction on disclosure of only that information directly releasable to the beneficiary also applies to the HBA.

4.14 Appeals

Guidance for handling general correspondence also applies to appeal cases, except that a designated "representative" (as defined in [32 CFR 199.10](#)), may be communicated with on the same basis as the individual beneficiary. However, unless the representative is an attorney, a written statement from the beneficiary appointing the representative is required. (See [Chapter 12, Section 2](#), for requirements.)

5.0 TITLE VI OF THE CIVIL RIGHTS ACT OF 1964

5.1 Title VI of the Civil Rights Act of 1964 provides that no person shall, on the grounds of race, color or national origin, be excluded from participation under any program or activity receiving federal financial assistance. All federal departments and agencies extending such assistance are required to ensure that institutions or facilities participating in these federally-assisted programs do not discriminate against beneficiaries or employees on the grounds of race, color or national

origin. Hospitals, skilled nursing facilities, residential treatment centers and special treatment facilities determined to be authorized providers under TRICARE are subject to the provisions of Title VI.

5.2 Investigating complaints of noncompliance with Title VI is a function of the Office of Civil Rights of the DHHS. Any discrimination complaints involving Title VI that are received by contractors should be forwarded to the Office of Civil Rights, DHHS, North Building, 330 Independence Avenue, S.W., Washington, DC 20003. A copy of the material sent to the Office of Civil Rights must also be sent to TMA OGC, 16401 East Centretech Parkway, Aurora, Colorado 80011-9066.

6.0 SECTION 504 OF THE REHABILITATION ACT OF 1973

Section 504 as amended, states that no otherwise qualified handicapped individual shall, solely by reason of his or her handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. All federal agencies extending such assistance are required to ensure that both individual professional providers and institutions participating in these federally-assisted programs do not discriminate against beneficiaries or employees on grounds of a handicapping condition. Any discrimination complaints involving Section 504 that are received by contractors shall be forwarded to TMA within two working days of receipt.

7.0 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) AND DOD PRIVACY REGULATION

The contractor shall comply with the above Act and Regulation. TRICARE is a health plan and a covered entity. As business associates of the TRICARE Health Plan, the **contractor** and its subcontractors shall comply with the HHS Privacy Regulation. Network providers are not considered business associates, but must comply with the provisions of the HHS Privacy Regulation as covered entities.

7.1 HHS Privacy Regulation Relationship To Existing Federal And State Laws And Federal Regulations

The Privacy Act of 1974 and the DoD Privacy Regulation will be interpreted in a manner that will make them compatible with the HHS Privacy Regulation and the DoD HIPAA Privacy Regulation. If a regulation or law mandates a particular action, that regulation or law will take precedence over a regulation that makes a particular action discretionary. Further, the more specific regulation or law will take precedence over the more general regulation or law. Where a determination must be made as to the applicability of a privacy requirement, the general rule is that the more restrictive requirement will be applied.

The preamble of the HHS Privacy Regulation states:

“When a covered entity is faced with a question as to whether the privacy regulation would prohibit the disclosure of protected health information that it seeks to disclose pursuant to a federal law, the covered entity should determine if the disclosure is required by that law. In other words, it must determine if the disclosure is mandatory rather than merely permissible. If it is mandatory, a covered entity may disclose the

statutes. In the case of Residential Treatment Care (RTC) care, both the incoming and outgoing contractors are responsible for authorizing that part of the stay falling within their areas of responsibility; however, the incoming contractor may utilize the authorization issued by the outgoing contractor as the basis for continued stay.

2.10.5 Case Management and Disease Management

The incoming contractor shall receive case files and documentation regarding all beneficiaries under case management or disease management programs. The incoming contractor shall ensure seamless continuity of services to those beneficiaries.

2.10.6 Program Integrity

The incoming contractor shall receive case files and documentation regarding all open program integrity cases from the outgoing contractor NLT 30 days from the start of health care delivery. The incoming contractor shall work with the TMA Program Integrity Office (PI) to ensure seamless continuity of oversight of these cases.

2.10.7 Health Insurance Portability And Accountability Act of 1996 (HIPAA)

The incoming contractor, as a covered entity under HIPAA, may honor an authorization or other express legal document obtained from an individual permitting the use and disclosure of protected health information prior to the compliance date (HHS Privacy Regulation, §164.532).

2.10.8 Installation And Operation Of The Duplicate Claims System (DCS)

The incoming contractor shall have purchased, installed, configured, and connected the personal computers and printers required to operate the DCS NLT 60 days prior to the start of the health care delivery. See [Chapter 9](#), for hardware, software, printer, configuration and communications requirements and contractor installation responsibilities. Approximately 30-45 days prior to health care delivery, TMA will provide and install the DCS application software on the incoming contractor designated personal computers and provide on-site training for users of the DCS in accordance with [Chapter 9](#). Following the start of health care delivery, the DCS will begin displaying identified potential duplicate claim sets for which the incoming contractor has responsibility for resolving. The incoming contractor shall begin using the DCS to resolve potential duplicate claim sets in accordance with [Chapter 9](#) and the transition plan requirements.

2.10.9 Processing of Residual Claims

2.10.9.1 After 120 days following the start of health care delivery for all claims, the incoming contractor shall process claims received for care that occurred during the outgoing contractor's health care delivery period. (Prior to these dates, any claims received for care that occurred during the outgoing contractor's period, shall be transferred to the outgoing contractor for processing.) In the case of network claims, the incoming contractor shall attempt to obtain any negotiated rate or discount information for reimbursement purposes. If the incoming contractor is unable to obtain this information, the claim shall be reimbursed using standard TRICARE reimbursement methodologies as if no negotiated or discount rates were in effect.

2.10.9.2 Processing of Overseas Residual Claims

Residual claims for overseas care shall be processed by the TRICARE Overseas Program (TOP) contractor. One hundred twenty days following the end of any Managed Care Support Contractor's (MCSC's) health care delivery period, the TOP contractor shall process all claims, including adjustments, received for care in a foreign country that occurred during the outgoing MCSC's health care delivery period.

2.11 Contractor Weekly Status Reporting

The incoming contractor shall submit a weekly status report of phase-in and operational activities and inventories.

2.12 Public Notification Program-Provider And Congressional Mailing

The contractor shall prepare a mailing to all non-network TRICARE providers and Congressional offices within the region by the 45th calendar day prior to the start of health care delivery according to the specifications of the official transition schedule. The proposed mailing shall be submitted to the PCO and the COR, and the TMA Marketing and Education Committee (MEC) for approval NLT 90 calendar days prior to the start of each health care delivery period. The mailing shall discuss any unique processing requirements of the contractor and any other needed information dictated by the official transition schedule.

2.13 Web-Based Services And Applications

NLT 15 days prior to the start of health care delivery, the incoming contractor shall demonstrate to TMA successful implementation of all web-based capabilities as described in the contract.

2.14 TRICARE Handbook Mailing

NLT 30 days prior to the start of health care delivery, the MCSC shall mail one TRICARE Handbook to every residence in the region based on DEERS data.

3.0 INSTRUCTIONS FOR BENCHMARK TESTING

3.1 General

3.1.1 Prior to the start of health care delivery, the incoming contractor shall demonstrate the ability of its staff and its automated enrollment, authorization and referral, and claims processing systems to accurately process TRICARE claims in accordance with current requirements. This will be accomplished through a comprehensive Benchmark Test. The Benchmark Test is administered by the contractor under the oversight of TMA and must be completed NLT 60 days prior to the start of services delivery. In the event that an incumbent contractor succeeds itself, the extent of Benchmark testing may be reduced at the discretion of the TMA PCO.

3.1.2 A Benchmark Test shall consist of at least 300 but not more than 1,000 network and non-network claims, testing a multitude of claim conditions including, but not limited to, TRICARE covered/non-covered services, participating/non-participating providers, certified/non-certified

Enrollment Processing

The contractor shall record all enrollments on Defense Enrollment Eligibility Reporting System (DEERS), as specified in the TRICARE Systems Manual (TSM), [Chapter 3](#).

The contractor shall develop and implement an enrollment plan to support contractor enrollment of beneficiaries. The contractor shall consult with the Regional Director (RD) and all Military Treatment Facility (MTF) Commanders where Prime is offered in developing the enrollment plan.

1.0 ENROLLMENT PROCESSING

1.1 The contractor shall use the TRICARE Prime Enrollment Application and Primary Care Manager (PCM) Change Form (one combined form) Department of Defense (DD) Form 2876, and the TRICARE Prime Disenrollment Form DD Form 2877. The contractor shall ensure aforementioned forms are readily available to potential enrollees. The contractor shall implement enrollment processes (which do not duplicate Government systems) that ensure success and assistance to all beneficiaries.

1.1.1 The contractor shall collect TRICARE Prime enrollment applications at the TRICARE Service Centers (TSCs) or other sites mutually agreed to by the contractor, RD, and the MTF Commander, by mail, or by other methods proposed by the contractor and accepted by the Government.

1.1.2 Enrollment applications must be signed by the sponsor, spouse or other legal guardian of the beneficiary.

1.1.3 The contractor shall also accept and process TRICARE Prime enrollment applications via the Beneficiary Web Enrollment (BWE) process.

1.2 The contractor shall provide beneficiaries who enroll full and fair disclosure of any restrictions on freedom of choice that apply to enrollees, including the Point of Service (POS) option and the consequences of failing to make enrollment fee payments on time.

1.3 Enrollment shall be on an individual or family basis. For newborns and adoptees, see the TRICARE Policy Manual (TPM), [Chapter 10, Section 3.1](#).

1.4 The contractor shall follow the specifications of the Memorandum of Understanding (MOU) with the appropriate MTF Commander and RD and any other instructions from the RD in performing and coordinating enrollment processing with the MTF, the appropriate RD, and DEERS.

1.5 The contractor shall record all Prime enrollments from a centralized contractor data entry point on the DEERS using a Government-furnished systems application, the DEERS Online Enrollment System (DOES). The equipment needed to run the DEERS desktop enrollment

application shall be furnished by the Managed Care Support Contractor (MCSC) and shall meet technical specifications in the TRICARE Systems Manual (TSM), [Chapter 3](#).

1.5.1 MCSCs shall resend PCM Information Transfers (PITs) to MTFs when requested.

1.5.2 The MCSC shall submit required changes to the DEERS Support Office (DSO) as required.

1.6 At the time of enrollment processing, the contractor shall access DEERS to verify beneficiary eligibility and shall update the residential and mailing addresses and any other fields that they can update on DEERS.

1.6.1 If the enrollment form does not contain a mailing address, the enrollment form should be developed for a mailing address.

1.6.2 Enrollees may submit a temporary address (i.e., Post Office Box, Unit address, etc.), until a permanent address is established. Temporary addresses must be updated with the permanent address when provided to the contractor by the enrollee in accordance with the TSM, [Chapter 3, Section 1.4](#). Contractors shall not input temporary addresses not provided by the enrollee.

1.6.3 If the DEERS record does not contain an address, or if the application contains information different from that contained on DEERS in fields for which the contractor does not have update capability, the contractor shall contact the beneficiary by telephone within five calendar days, outlining the discrepant information and requesting that the beneficiary contact the military personnel information office.

1.7 Defense Manpower Data Center (DMDC)/DEERS shall print and mail the Universal TRICARE Beneficiary Cards directly to the enrollee at the residential mailing address specified on the enrollment application after receipt of the enrollment record. DMDC will also provide notification of PCM assignments for new enrollments, enrollment transfers, PCM changes, and the replacement of TRICARE Universal Beneficiary Cards. (See TSM, [Chapter 3, Section 1.4](#).) The return address on the envelope mailed by DMDC will be that of the appropriate MCSC. In the case of receiving returned mail, the MCSC shall develop a process to fulfill the delivery to the enrollee.

1.8 An enrollee must present both a TRICARE Prime identification card and a military identification card to a provider to demonstrate eligibility for TRICARE Prime program benefits.

2.0 ASSIGNMENT OF PCM

The contractor shall assign all enrollees a PCM by name (PCMBN) on DOES at the time of enrollment. This applies to beneficiaries assigned to Direct Care (DC) and civilian network PCMs.

2.1 All DC TRICARE Prime enrollees shall be enrolled to a Department of Defense (DoD) MTF Primary Care Location by the MCSCs. The contractor shall comply with the MTF Commander's specifications in the MTF MOU for which enrollees or categories of enrollees shall be assigned a DC PCM or offered a choice of civilian network PCMs.

2.1.1 The contractor shall enroll TRICARE Prime beneficiaries to the MTF until the capacity is optimized in accordance with the MTF Commander's determinations; TRICARE Prime beneficiaries who cannot be enrolled to the MTF will be enrolled to the contractor's network.

Enrollment Portability

1.0 The term “contractor” applies to Uniformed Services Family Health Plan (USFHP) Designated Providers (DPs) as well as to Managed Care Support Contractors (MCSCs) for purposes of enrollment portability.

1.1 TRICARE Prime enrollees retain Prime coverage whenever they move or travel. Enrollment portability provisions apply to TRICARE Prime enrollees’ travel or relocation to or from all areas, including the Continental United States (CONUS), Europe, Latin and South America, the Pacific, Alaska, and any others. The contractor for the region in which the beneficiary is enrolled on Defense Enrollment Eligibility Reporting System (DEERS) is responsible for providing continuing coverage and updating catastrophic cap accumulations for the enrollee while the enrollee is traveling or relocating, **except in the case of care provided overseas (i.e., care outside of the 50 United States and the District of Columbia). Civilian health care while traveling or visiting overseas shall be processed by the TOP contractor, regardless of where the beneficiary resides or is enrolled.**

1.2 A Prime enrollee may transfer enrollment after moving either temporarily or permanently to a new location. The enrolling contractor shall continue to provide health care coverage until the enrollee transfers enrollment to the contractor for the new location or until the beneficiary is no longer eligible for enrollment in Prime, the beneficiary disenrolls, or the beneficiary is disenrolled due to failure to pay required enrollment fees, whichever occurs first. Referral and authorization rules continue to apply. Primary Care Manager (PCM) referrals are required only for non-emergency specialty or inpatient care (see 32 CFR 199.17(n)(2)). Claims for non-emergency care without a referral shall be processed under the Point Of Service (POS) option. Under no circumstances will retroactive disenrollment be allowed in order to avoid POS cost-sharing provisions. Even though a Prime enrollee who is relocating must request a referral for nonemergency care from the PCM, the enrollee shall not be required to use a network provider, and the contractor shall ensure that the relocating TRICARE Prime enrollee’s copayment is applied correctly to claims for authorized care.

1.3 A Prime enrollee who is relocating to another contractor’s region or service area can transfer enrollment from the losing contractor to the gaining contractor by contacting the gaining contractor. During the initial contact, the gaining contractor shall provide region/site specific educational materials, key telephone numbers, the opportunity to select a new PCM, and the opportunity to disenroll completely from TRICARE Prime with no penalty for early disenrollment. If the enrollee chooses disenrollment, the gaining contractor shall send a disenrollment transaction to DEERS using the Government-furnished systems application and DEERS shall notify the losing contractor of the disenrollment.

1.4 The effective date of the transfer of enrollment from one region/site to another is the day the gaining contractor receives a TRICARE Prime beneficiary’s signed enrollment application agreeing to a transfer of enrollment. From that date, the beneficiary shall be considered enrolled at the new location and should contact the new PCM, the new region’s beneficiary services staff, or the designated provider for health care and health related assistance.

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Chapter 6, Section 2 Enrollment Portability

Note: The effective date for transfer of enrollment differs from the effective date for initial enrollment. See [Section 1](#) for information on initial enrollment in TRICARE Prime. For transfers, the original enrollment period on DEERS will remain in effect.

1.5 Within five working days of receipt of a beneficiary's signed enrollment application agreeing to a transfer of enrollment, the gaining contractor shall submit the transfer of enrollment to DEERS using the Government-furnished systems application DEERS Online Enrollment System (DOES). The effective date of the transfer shall be the day the gaining contractor received the signed enrollment application. Upon acceptance of the transfer of enrollment, DEERS will automatically notify the losing contractor of the change.

1.6 When TRICARE Prime enrollment changes from one contractor to another prior to the annual renewal for enrollees in beneficiary categories required to pay enrollment fees, future unpaid enrollment fees, such as those paid on an installment basis, will be due the gaining contractor. There will be no transfers of funds between contractors, and, if the enrollee relocates to an area where TRICARE Prime is not offered, there shall be no refund of the unused portion of the enrollment fee. **For beneficiaries who are relocating, there is no limit on the number of times an enrollment may be transferred.**

1.7 TRICARE Prime USFHP enrollees who are not TRICARE-eligible may only transfer enrollment from one USFHP designated provider to another USFHP designated provider; they may not transfer to an MCSC.

1.8 A TRICARE-eligible Prime enrollee who is not relocating may either transfer enrollment from an MCSC to a USFHP designated provider or from a USFHP designated provider to an MCSC under the rules of this section. However, such transfers are allowed only once during an enrollment period and no transfer back to the other plan during that enrollment period is permitted.

- END -

General

1.0 PURPOSE

The purpose of the TRICARE claims processing procedures is to help ensure that all claims for care received by TRICARE beneficiaries are processed in a timely and consistent manner and that Government-furnished funds are expended only for those services or supplies authorized by law and Regulation. The contractor shall review all claims submitted and accept Health Insurance Portability and Accountability Act (HIPAA) transaction and code sets. The review must ensure that sufficient information is submitted to determine:

- The patient is eligible.
- The provider of services or supplies is authorized under the TRICARE Program.
- The service or supply provided is a benefit.
- The service or supply provided is medically necessary and appropriate or is an approved TRICARE preventive care service.
- The beneficiary is legally obligated to pay for the service or supply (except in the case of free services).
- That the claim contains sufficient information to determine the allowable amount for each service or supply.

In this context, "beneficiary" includes authorized agents, see [Chapter 19](#).

2.0 WHO MAY FILE A CLAIM

2.1 Beneficiary/Provider

Any TRICARE eligible beneficiary or any individual who meets the requirements for eligibility under TRICARE, as determined by one of the Uniformed Services, may file a claim. Any institutional or individual professional provider certified under TRICARE may file a claim on a participating basis for services or supplies provided to a beneficiary and receive payment directly from TRICARE. The contractor shall deny any charge imposed by the provider relating to completing and submitting the applicable claim form (or any other related information). Such charges shall not be billed separately to the beneficiary by the provider nor shall the beneficiary pay the provider for such charges. These charges are to be reported as noncovered charges and denied as such.

2.2 State Agency

A state agency who administers the Medicaid Program may submit a claim, if there has been an agreement signed between the agency and TRICARE Management Activity (TMA). (Refer to the TRICARE Reimbursement Manual (TRM), [Chapter 1, Section 20](#).)

2.3 Participating Provider - Agency Agreement With A Third Party

Occasionally, a participating provider may enter into an agency agreement with a third party to act on its behalf in the submission and the monitoring of third party claims, including TRICARE claims. Such arrangements are permissible as long as the third party is not acting simply as a collection agency. There must be an agency relationship established in which the agent is reimbursed for the submission and monitoring of claims, but the claim remains that of the provider and the proceeds of any third party payments, including TRICARE payments, are paid to the provider. The contractor can deal with these agents in much the same manner as it deals with the provider's accounts receivable department. However, such an entity is not the provider of care and cannot act on behalf of the provider in the filing of an appeal unless specifically designated as the appealing party's representative in the individual case under appeal. Questions relating to the qualifications of any such business entity should be referred to the TMA Office of General Counsel (OGC), through the Contracting Officer (CO), for resolution.

3.0 TRICARE CLAIM FORMS

3.1 Acceptable Claim Forms

3.1.1 A properly completed acceptable claim form must be submitted to the contractor before payment may be considered. For paper claims, the contractor shall accept the following claim forms for TRICARE benefits: the DoD Document (DD) Form 2642, the Centers for Medicare and Medicaid Services (CMS) 1500 (08/2005), and the CMS 1450 UB-04. The American Dental Association (ADA) claim forms may be used in the processing and payment of adjunctive dental claims. Electronic claims shall be accepted in HIPPA compliant standardized electronic transactions (see [Chapter 19](#))

3.1.2 DD Form 2642, "Patient's Request For Medical Payment" ([Addendum A, Figure 8.A-1](#)). This form is for beneficiary use only and is for submitting a claim requesting payment for services or supplies provided by civilian sources of medical care. See [Appendix B](#) for a definition of "medical." Those include physicians, medical suppliers, medical equipment suppliers, ambulance companies, laboratories, Extended Care Health Option (ECHO) providers, or other authorized providers. If a DD Form 2642 is identified as being submitted by a provider for payment of services, the form shall be returned to the provider with an explanation that the DD Form 2642 is for beneficiary use only and that the services must be resubmitted using either the CMS 1500 (08/2005) or the CMS 1450 UB-04, whichever is appropriate. The form may be used for services provided in a foreign country but only when submitted by the beneficiary. Contact the TMA Administrative Office to order the DD Form 2642.

4.0 CLAIMS RECEIPT AND CONTROL

All claims shall be controlled and retrievable. The face of each hardcopy TRICARE claim shall be stamped with an individual Internal Control Number (ICN), which will be entered into the

Jurisdiction

The contractor shall determine that claims received are within its contractual jurisdiction using the criteria below.

1.0 PRIME ENROLLEES

When a beneficiary is enrolled in TRICARE Prime, contractor jurisdiction is determined by the beneficiary's regional enrollment. (Contractors shall use Defense Enrollment Eligibility Reporting System (DEERS) as the method to determine a beneficiary's enrollment status.) The contractor processes all claims for the enrollee no matter where the enrollee receives services (except for care received overseas, see below). For information on claims for relocating Prime enrollees, refer to [Chapter 6, Section 2](#). When a beneficiary's enrollment changes from one region to another during a hospital stay, the contractor with jurisdiction on the date of admission shall process and pay the entire Diagnostic Related Group (DRG) claim, including cost outliers. For inpatient claims paid on a per diem basis, to include DRG transfers and short stay outliers cases, and for professional claims that are date-driven, the contractor with the jurisdiction on the date of service shall process and pay the claim.

2.0 ALL OTHER TRICARE BENEFICIARIES

For a beneficiary who is not enrolled in TRICARE Prime, the contractor with jurisdiction for the beneficiary's claim address shall process the claim no matter where the beneficiary receives services (except for care received overseas, see below). This includes Continued Health Care Benefits Program (CHCBP) claims and claims from U.S. Government medical facilities other than those of the Uniformed Services (e.g., a claim for emergency care provided by a Department of Veterans Affairs (DVA) facility or a facility under the Indian Health Service (IHS), Public Health Services (PHS)). For inpatient claims paid under the DRG-based payment system, the contractor with jurisdiction for the beneficiary's claim address, on the date of admission, shall process and pay the entire DRG claim including cost outliers. For inpatient claims paid on a per diem basis, to include DRG transfers and short-stay outlier cases, and for professional claims that are date-driven, the contractor with jurisdiction for the beneficiary's claim address on the date of service, shall process and pay the claim.

3.0 CARE RECEIVED OVERSEAS

Claims for beneficiaries who reside overseas or who are enrolled in the TRICARE Overseas Program (TOP) shall be processed by the **TOP** contractor regardless of where the enrollee receives the services. Claims for CONUS-based beneficiaries who receive civilian health care while traveling or visiting abroad shall be processed by the **TOP** contractor, regardless of where the beneficiary resides or where they are enrolled. See [Chapter 24, Section 9](#), for additional information.

4.0 TRICARE/MEDICARE DUAL ELIGIBLES

Claims for services rendered to TRICARE/Medicare dual eligibles within the 50 United States, the District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands are the responsibility of the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) contractor.

5.0 PHARMACY CLAIMS

All claims for pharmaceuticals dispensed at a retail pharmacy or a mail order pharmacy are the responsibility of the TRICARE Pharmacy (TPharm) contractor. Claims for pharmaceuticals (e.g., injectibles) ordered by and administered in a physician's office or other place of practice such as a clinic, are the responsibility of the MCSCs for enrollees and residents of their Region. Claims for pharmaceuticals dispensed by a provider who does not have a National Council of Prescription Drug Plans (NCPDP) number are also the responsibility of the appropriate MCSC.

6.0 SUPPLYING OUT-OF-AREA PROVIDER INFORMATION

For out of area claims the regional contractor responsible for certifying providers and developing pricing data for the region where the services were provided shall supply provider and pricing information (both institutional and non-institutional) to the contractor responsible for processing the claims. The contractor shall respond within five workdays after receipt of such requests and shall designate a Point Of Contact (POC) for this purpose. The contractor shall follow the procedures below in requesting and providing information. Responses to such requests shall include only that information not available in the requester's own records or in TMA-provided records. The response shall verify whether or not the provider is a TRICARE-authorized provider and whether or not the provider is a network provider. The response shall also include the appropriate pricing of the services/supplies as well as specific data needed to complete contractor records and TRICARE Encounter Data (TED) submissions to the TMA.

6.1 Procedures For Contractor Coordination On Out-Of-Jurisdiction Providers

Contractors subject to the requirements of the TRICARE Systems Manual (TSM) who are responsible for processing claims for care provided outside of their provider certification jurisdiction shall first search available provider files, including the TMA-supplied copy of the TRICARE centralized provider file (to be provided at least weekly), to determine provider certification status, obtain related provider information, and determine if the certifying contractor has submitted a TRICARE Encounter Provider (TEPRV) record for the out-of-area provider.

6.2 File Search Unsuccessful

If the file search is unsuccessful, the following procedures apply:

6.2.1 The servicing (claims processing) contractor shall request provider information from the certifying contractor.

6.2.2 Each contractor shall designate a POC as specified in [paragraph 6.0](#) who shall be responsible for initiating actions related to such requests and ensuring these actions are timely and well documented.

6.2.3 The certifying contractor shall respond within five workdays of the request with either:

6.2.3.1 Complete provider information for the servicing contractor to process the claim and submit TED in situations when a TEPRV has already been accepted by TMA or,

6.2.3.2 The information that a TEPRV for the provider in question has not been submitted to or accepted by TMA and one of the following situations exist:

- The certifying contractor has sufficient documentation (including the provider's Taxpayer Identification Number (TIN)) to complete the certification process and determine the provider's TRICARE status; or
- The certifying contractor does not have sufficient documentation to determine the provider's status and complete the certification process; or
- The certifying contractor has sufficient information to determine that the provider does not meet TRICARE certification requirements without going through the certification process; or
- The situations above apply, but the certifying contractor is not subject to the requirements of the TSM.

6.3 TEPRV Record Submissions

6.3.1 Since the servicing contractor will be unable to complete TED processing until a TEPRV is accepted by TMA, a coordinated effort is required between the servicing contractor and the certifying contractor in the above situations. The certifying contractor is responsible for ensuring the TEPRV is accepted by TMA before supplying the provider information indicated. Contractors shall not delay submitting TEPRVs for providers who have requested certification and such certification has been granted or denied, solely because the provider has not yet submitted a TRICARE claim. When the TEPRV is accepted, the certifying contractor shall notify the servicing contractor of this within two workdays of its acceptance and supply the provider information. Following are procedures and time frames to facilitate this coordination.

6.3.2 If the certifying contractor has completed its provider certification process but has yet to submit the TEPRV (or the TEPRV has not passed TMA edits), the certifying contractor shall submit (or resubmit) the TEPRV within one workday of contact by the servicing contractor and notify the servicing contractor within two calendar weeks following the initial contact, of the TEPRV submission action taken and whether it was accepted.

6.3.3 If the certifying contractor does not have sufficient documentation to complete the certification process and submit a TEPRV, the certifying contractor shall initiate (or follow up on) the certification process within two workdays of the initial contact by the servicing contractor. If it is necessary to obtain documentation from the provider, the certifying contractor shall allow no longer than a two calendar week suspense from the date of its request.

6.3.4 Upon determination that the documentation is complete, the certifying contractor shall complete the certification process, submit the TEPRV, and notify the servicing contractor within one additional calendar week following completion of the certification process (i.e., within three

weeks of the initial contact by the servicing contractor). The certifying contractor shall also notify the provider of the certification determination and of procedures for contacting the certifying contractor in the future regarding provider-related (non-claim) matters (e.g., address changes).

6.3.5 If the certifying contractor is unable to complete the certification process within three calendar weeks following the initial contact, it shall submit the TEPRV and notify the servicing contractor within four calendar weeks following the initial contact.

6.3.6 If the certifying contractor has substantial evidence (e.g., state licensure listing) that the provider meets TRICARE certification requirements, it shall consider the provider certified and so inform the servicing contractor one work day after acceptance.

6.3.7 If the certifying contractor does not have substantial evidence that the provider meets TRICARE certification requirements, it shall not consider the provider to be certified. The servicing contractor shall deny the claim using an appropriate Explanation Of Benefits (EOB) message.

6.3.8 In either of the above cases, if the certifying contractor does not have the provider's TIN, it shall submit the TEPRV with a contractor Assigned Provider Number (APN) as described in the TSM, [Chapter 2, Section 2.10](#), Provider Taxpayer Number, and provide this number to the servicing contractor. The servicing contractor shall issue payment only to the beneficiary in this case if the claim is otherwise payable (even in the unlikely event that the provider is participating).

6.3.9 If, at the time of the servicing contractor's initial contact, the certifying contractor is able to determine that the provider does not meet the TRICARE certification requirements without going through the certification process, it shall submit the TEPRV and notify the servicing contractor within two calendar weeks of the initial contact. If the provider's TIN is not known, the certifying contractor shall assign an APN. The servicing contractor shall deny the claim using an appropriate EOB message.

6.3.10 If the certifying contractor is not subject to the requirements of the TSM, the servicing contractor will assign the provider sub-identifier (sub-ID) and create the TEPRV. The certifying contractor shall provide the servicing contractor with the minimum provider information listed below, within two workdays of the initial contact by the servicing contractor if the certification process has been completed or if a determination can be made that the provider does not meet the certification requirements without going through the process. If it has not been completed, the servicing contractor shall be so notified within two workdays of the initial contact and the procedures and time frames above shall be followed.

6.3.11 The servicing contractor shall notify the TMA Contracting Officer's Representative (COR) if the certifying contractor does not provide the required provider information and notification of the TEPRV's acceptance by TMA within 35 calendar days from the time of the initial contact.

6.4 Provider Data

The minimum provider data to be provided by the certifying contractor is the provider's certification status including the reason a provider is not certified if such is the case, any special prepayment review status, and the following data:

6.4.1 Provider Taxpayer Number or APN, or National Provider Identifier (NPI), as appropriate.

- 6.4.2** Provider Sub-ID (not required for NPI). Provider Sub-ID may need to be assigned by the servicing contractor if the certifying contractor is not subject to the requirements of the TSM.
- 6.4.3** Provider Contract Affiliation Code.
- 6.4.4** Provider Street Address.
- 6.4.5** Provider "pay to" address.
- 6.4.6** Provider State or Country.
- 6.4.7** Provider Zip Code.
- 6.4.8** Provider Specialty (non-institutional providers).
- 6.4.9** Type of Institution (institutional providers).
- 6.4.10** Type of reimbursement applicable (DRG, MHPD, etc.).
- 6.4.11** Per diem reimbursement amount, if applicable.
- 6.4.12** Indirect Medical Education (IDME) factor (where applicable), Area Wage Index (DRG).
- 6.4.13** Provider Acceptance Date.
- 6.4.14** Provider Termination Date.
- 6.4.15** Record Effective Date.
- 6.4.16** The certifying contractor shall provide additional data upon request of the servicing contractor or TMA to meet internal processing, prepayment review, or file requirements or, to create a TEPRV when the certifying contractor is not under the requirements of the TSM.

6.5 Maintenance Of TEPRV With An APN

In all cases when an APN is assigned, the certifying contractor shall attempt to obtain the provider's actual TIN. Within 10 workdays of receipt of the provider's TIN, the certifying contractor who is under the requirements of the TSM shall inactivate the APN TEPRV and add the TEPRV with the provider's TIN regardless of whether the provider meets TRICARE certification requirements.

All APNs must be associated with an NPI for providers who meet the Health and Human Services (HHS) definition of a covered entity and submit Health Insurance Portability and Accountability Act (HIPAA)-compliant electronic standard transactions or who otherwise obtain an NPI. Guidance for submitting the NPI on TEPRV records will be provided in a future order.

6.6 Provider Correspondence

Any provider correspondence which the servicing contractor forwards for the certifying contractor's action or information shall be sent directly to the certifying contractor's POC to avoid

misrouting. Within one week of receipt, the servicing contractor shall forward for the certifying contractor's action any correspondence or other documentation received which indicates the need to perform a provider file transaction. This includes, but is not limited to, such transactions as address changes, adding or deleting members of clinics or group practices, or changing a provider's TIN.

6.7 Provider Certification Appeals

6.7.1 Requests for reconsideration of an contractor's adverse determination of a provider's TRICARE certification status are processed by the certifying contractor. Any such requests received by the servicing contractor are to be forwarded to the certifying contractor within five workdays of receipt and the appealing party notified of this action and the reason for the transfer. The certifying contractor shall follow standard appeal procedures including aging the appeal from the date of receipt by the certifying contractor, except that, if the reconsideration decision is favorable, the provider shall be notified to resubmit any claims denied for lack of TRICARE certification to the servicing contractor with a copy of the reconsideration response. In this case, the certifying contractor shall ensure a TEPRV for this provider is accepted by TMA within one calendar week from the date of the appeal decision.

6.7.2 The servicing contractor shall forward to the certifying contractor within five workdays of receipt any provider requests for review of claims denied because the certifying contractor was unable to complete the certification process. The servicing contractor shall notify the provider of the transfer with an explanation of the requirement to complete the certification process with the certifying contractor. Upon receipt of the provider's request, the certifying contractor shall follow its regular TRICARE provider certification procedures. In this case, no basis for an appeal exists. If the provider is determined to meet the certification requirements, the special provider notification and TEPRV submittal requirements apply.

7.0 OUT-OF-JURISDICTION CLAIMS

Claims received as a paper claim shall be routed to the responsible contractor electronically as an 837 Electronic Data Interchange (EDI) claim and processed by the responsible contractor at the electronic claim rate. The contractor shall handle all claims involving billings outside its jurisdiction (including those to be processed by TMA, and dental claims to be processed by the SPOCs listed in [Chapter 17, Addendum B](#) under the TPR Program) as follows:

7.1 Totally Out-Of-Jurisdiction

When a contractor receives a claim with no services or supplies within its jurisdiction, it shall clearly indicate the original date of receipt on the claim. The contractor shall then forward the claim and supporting documentation to the appropriate contractor(s) within 72 hours of identifying it as being out-of-jurisdiction. This includes forwarding retail pharmacy claims to the TPharm contractor and claims for TRICARE/Medicare dual eligibles to the TDEFIC contractor. The transferring contractor shall also inform the claimant of the action taken and provide the address of the contractor to which the claim was forwarded.

7.2 Partially Out-Of-Jurisdiction

When a contractor receives a claim for services or supplies both within and outside its

jurisdiction before processing the services or supplies within its jurisdiction, and within 72 hours of identifying the out-of-jurisdiction items, the contractor shall:

- Draw lines through the in-jurisdiction items.
- Ensure the original date of receipt is clearly indicated on the claim.
- Send a copy of the claim and all supporting documents to the appropriate contractor(s).
- If more than one other contractor is involved, the transferring contractor shall provide each the name(s) of the other(s). The transferring contractor shall notify the claimant of the action taken and provide the address(es) of the contractor(s) to which the claim was forwarded.

8.0 NON-TRICARE CLAIMS

The contractor shall return claims submitted on other than approved TRICARE claim forms to the sender or transfer to other lines of business, if appropriate.

8.1 Civilian Health and Medical Program of the Department of Veteran Affairs (CHAMPVA) Claims

When a claim is identified as a CHAMPVA claim, the contractor shall return the claim to the sender with a letter advising them that the CHAMPVA Program's toll-free telephone number 1-800-733-8387, and instruct them to send the claim and all future CHAMPVA claims to:

Health Administration Center
CHAMPVA Program
P.O. Box 65024
Denver, Colorado 80206-9024

8.2 Veterans Claims

If a claim is received for care of a veteran not eligible for TRICARE and there is evidence the care was ordered by a DVA physician, the claim, with a letter of explanation, shall be sent to the DVA institution from which the order came. The claimant must also be sent a copy of the letter of explanation. If there is no clear indication that the DVA ordered the care, return the claim to the sender with an explanation that the veteran is not eligible under TRICARE and that the care ordered by the DVA should be billed to the DVA.

8.3 Claims For Parents, Parents-In-Law, Grandchildren, And Others

On occasion, a claim may be received for care of a parent or parent-in-law, a grandchild, or other ineligible relative of a TRICARE sponsor. Return the claim to the claimant with a brief explanation that such persons are not eligible for TRICARE benefits.

- END -

Referrals/Preauthorizations/Authorizations

1.0 REFERRALS

1.1 The contractor is responsible for reviewing all requests for referrals. The contractor shall not mandate an authorization, to include a medical necessity or utilization management determination, before referring a patient for an evaluation by a network Primary Care Manager (PCM) to obtain a referral prior to referring a beneficiary to a specialist. The contractor shall review the referral request, and if it is determined that the services being requested are not a TRICARE benefit, the beneficiary shall be informed that the services are excluded from coverage, and will not be paid by TRICARE, if obtained.

1.2 The TRICARE beneficiary must be “held harmless” in cases where the network provider fails to request a referral and the contractor either denies payment or applies the Point Of Service (POS) option. If the referral involves services rendered by a non-network provider, “hold harmless” cannot apply, as “hold harmless” only applies to network providers. Once the patient is evaluated by the specialist, the contractor may require an authorization before the services are provided or the procedure performed. In those instances where a contractor requires authorization of services in addition to those listed in [Chapter 7, Section 2](#), such authorization must be available to and appealable by all beneficiaries, whether enrolled or not. Within Prime Service Areas (PSAs), the Military Treatment Facilities (MTFs) have the Right of First Refusal (ROFR) for all referrals, as determined by the Memorandum of Understanding (MOU) between the contractor and each MTF.

2.0 PREAUTHORIZATIONS/AUTHORIZATIONS

2.1 The contractor is responsible for reviewing all requests for authorization. Issuance of authorizations shall not be used to restrict freedom of choice of the TRICARE Standard beneficiary who chooses to receive care from authorized non-network providers, except as required under [Chapter 7, Section 2](#).

2.2 The contractor is required to advise beneficiaries, sponsors, providers, and other responsible persons of those benefits requiring authorization before payment may be made and inform them of the procedures for requesting the authorization. Although beneficiaries are required to obtain authorization prior to receiving payment for the care listed at [Chapter 7, Section 2](#), authorization may be requested following the care. Whether the authorization is requested before or after care, all qualified care shall be authorized for payment. The contractor shall emphasize the need for concerned persons to contact a Beneficiary Counseling Assistance Coordinator (BCAC)/Health Benefits Advisor (HBA) or the contractor for assistance.

2.3 Because of the high risk that many services requiring special authorization may be denied, the contractor shall offer preauthorization for the care to all TRICARE beneficiaries who reside within its jurisdiction. The contractor shall process all requests for such authorization whether

submitted by the beneficiary, sponsor or provider requesting authorization on behalf of the beneficiary.

2.4 The contractor shall issue notification of preauthorization/authorization or waiver to the beneficiary or parent/guardian or a minor or incompetent adult, the provider, and to its claims processing staff. Notification may be made in writing by letter, or on a form developed by the contractor. These forms and letters are all referred to as TRICARE authorization forms. The contractor shall not issue an authorization for acute, inpatient mental health care for more than seven calendar days at a time.

2.5 The contractor shall document authorizations. The contractor must also maintain an automated authorization file or an automated system of flagging to ensure claims are processed consistent with authorizations. The contractor shall verify that the beneficiary, sponsor, provider, and service or supply information submitted on the claim are consistent with that authorized and that the care was accomplished within the authorized time period.

2.6 Prime enrollees receiving emergency care or authorized care from non-network, non-participating providers shall be responsible for only the Prime copayment. On such claims, contractors shall allow the amount the provider may collect under TRICARE rules; i.e., if the charges on a claim are subject to the balance billing limit (refer to the TRICARE Reimbursement Manual (TRM), [Chapter 3, Section 1](#) for information on balance billing limit), the contractor shall allow the lesser of the billed charges or the balance billing limit (115% of allowable charge). If the charges on a claim are exempt from the balance billing limit, the contractor shall allow the billed charges. Refer to the TRM, [Chapter 2, Section 1](#) for information on claims for certain ancillary services.

3.0 FAILURE TO COMPLY WITH PREAUTHORIZATION - PAYMENT REDUCTION

During claims processing, provider payments shall be reduced for failure to comply with the preauthorization requirements for certain types of care. See the TRM, [Chapter 1, Section 28](#), for more information.

4.0 PSYCHIATRIC RESIDENTIAL TREATMENT CENTERS

4.1 Before any claims for residential treatment center care may be paid, an authorization must be on file. The dates of service on the claim form and the name of the facility plus the Employer Identification Number (EIN) with suffix must correspond with the dates of the approval and the facility indicated on the authorization. If the beneficiary resides outside of the contractor's region, the contractor responsible for payment shall pay the claims at the rate determined by TRICARE Management Activity (TMA). When the contractor issues an Residential Treatment Center (RTC) authorization, it shall flag its files to preclude payment of any family or collateral therapy that is billed in the name of the residential treatment center patient. That cost is the responsibility of the residential treatment center, unless, as part of its negotiated agreement, the contractor agrees to a separate payment for such care. Under the TMA-determined rates, family therapists may bill separately from the residential treatment center (outside the all-inclusive rate) only if the therapy is provided to one or both of the parents residing a significant distance from the RTC. In the case of residents of a region, geographically distant family therapy must be certified by the contractor in order for cost-sharing to occur.

Chapter 9

TRICARE Duplicate Claims System - TRICARE Encounter Data (TED) Version

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Overview

Note: The TRICARE Management Activity (TMA) has developed a web-based version of the TRICARE Duplicate Claims System (DCS) that runs on the Internet/Nonsecure Internet Protocol Router Network (NIPRNET). The functionality of the web version mimics the functionality of the client/server (C/S) version as closely as possible. Differences will be in the telecommunications specifications and methods for requesting and accessing/displaying reports and data downloads. Please refer to the TRICARE Systems Manual (TSM), [Chapter 1](#) for information on connecting to the NIPRNET. The extract criteria used for identifying potential duplicate claim sets and the rules for operating the system and resolving duplicate claim sets are the same in the web version as they were in the C/S version. The web version will be accessed via a web browser (Microsoft® Internet Explorer (MSIE), Version 5.5, 6.0, or 7.0, or as directed by the Government). This differs from the C/S version which accesses the data via the Business-To-Business (B2B) Gateway. This manual explains the functions and shows examples of screens and reports in the web format.

All data in the Duplicate Claims System is protected by the Privacy Act of 1974 (PL 93-579); DoD HIPAA Privacy Regulation; and the HIPAA Privacy Regulation

The TRICARE DCS was developed by the TMA to automate the resolution of duplicate claim payments. The system facilitates the identification of actual duplicate claims payments, the initiation and tracking of recoupments, and the removal of duplicate records from the TRICARE Encounter Data (TED) database. The system also generates operational and management reports.

1.0 PREFACE

This document employs a number of conventions and application-specific terminology which may be unfamiliar to new users. Some of this terminology is directly related to concepts and activities pertaining to the system. Other terminology, although applied generally to the TRICARE community, takes on specific meaning in the system. In the interests of space and readability, this document uses the word contractor or the term "FI" (or contractors or FIs for the plural) to mean TRICARE Managed Care Support Contractor (MCSC)/TRICARE Dual Eligible Fiscal Intermediary Contractor (TDEFIC) organizations. Similarly, the term "claim" refers to claims or encounters or TEDs.

For highlighting certain features of the system, we have employed several stylistic conventions in this document. All references to "buttons" a user must click on with a mouse device are shown in capital letters and bold type (e.g., **RESOLVE THE SET** button). All field names are shown in upper and lower case letters and bold type (e.g., **Dupe?** field). All claim set status categories are represented in upper and lower case with italics (e.g., *Open* status). Menu Bar selections are shown with a letter underlined and in bold, just as they appear on the screen (e.g., **View** function). User selections to system prompts are generally shown within single quotes ('Y').

Users also should be aware that terminology used in this document is consistent with field names displayed on system screens. For example, the system uses three amount fields to resolve duplicate claims: total amount identified for recoupment in field **ID Recoup**; total amount actually recouped in field **Actual Recoup**; and total adjustment Government paid amount in field **Adjust Amount**.

In displaying these fields, the system captures the dollar amounts a user has entered for specific claims and computes totals for each of these fields. To ensure that the conventions and terms employed are fully understood by users, the Government will provide training and detailed instructions prior to initial system installation.

All processes associated with the use of the system and all outputs and results generated by or associated with the system, including claims, encounters, dispositions, recoupments, collections, adjustments, and TEDs, are subject to audit by the Government. The DCS is the property of the United States Government.

2.0 DEFINITION OF A DUPLICATE CLAIM PAYMENT

A duplicate claim or encounter is a payment made for services for which reimbursement has already been made on one or more previous claims or encounters. In other words, two or more payments were made for the same service for the same beneficiary.

For the purposes of the DCS, when two or more payments are issued for the same service for the same beneficiary, the additional payments are considered actual duplicate payments, regardless of whether the additional payments were justified or made in error, recoupment of the additional payments initiated, or refunds already received.

The criterion to use in determining if a claim represents an actual duplicate payment is an affirmative answer to the following question:

Have any or all of the services paid on this claim been paid on a previous claim/encounter?

It must be noted that "claims" displayed in the DCS are in fact TED records the contractors submitted. The Government assumes that the TED records submitted by contractors accurately reflect the adjudication of the claims and the dollars paid. When a user works in the DCS, they are seeing records that reside on the TED database. They are seeing what appears to the Government to be duplicate payments. Users might think of TED records as entries in the Government's checkbook. When a pair of TED records are displayed in the DCS, they are, in essence, representing two entries in the Government's checkbook. If these entries are not cancelled or adjusted, they represent actual dollars spent. For the purposes of the DCS, an unadjusted or non-cancelled TED record on the TED database represents a claims payment even if the claim appears on the contractor's claims processing system as having been adjusted or cancelled. All duplicate TED records displayed in the DCS must be flagged as actual duplicates, and must be corrected through adjustments and cancellations to remove the duplicate conditions from the TED database.

2.1 TED Dupes

The DCS identifies two kinds of duplicate TEDs:

- Those that represent actual overpayments (where two or more payments were actually made and recoupments must be initiated to recover the erroneous payments); and
- Those that were submitted but no actual payments were made (and therefore no recoupment actions need to be initiated).

It is this second kind of duplicate TED that we refer to as a "TED Dupe". TED Dupes most often occur when claims are processed but for some reason are pulled before the checks are actually sent and then re-processed under different claim numbers. If the original claims processed to the point that TEDS were created, submitted, and accepted by TMA, and not subsequently cancelled, the TEDS representing the reprocessed claims (with different claim numbers) will "dupe out" with the original, uncanceled, TEDs residing on the TED database. To the Government, all of those TEDs look like actual payments were made. There is no way for the Government to look at a TED and know that a check was not really issued and sent. They all look as though payments were made.

When a contractor, while researching potential duplicate claims in their system, discovers that a claim was not really paid but is appearing in the DCS as though it had been, the contractor may be tempted to flag the record in the DCS as not being an actual duplicate. This would be incorrect. Since the TEDs in the DCS look to the Government as if actual payment were made, the contractor must flag the TEDs as actual duplicates regardless of whether actual payments were made and recoupments initiated or not. Where a TED appearing in the DCS did not involve an actual payment, it still must be flagged as an actual duplicate and a cancellation submitted even though no recoupment was initiated and no refund received (remember, no check was actually sent) in order to correctly resolve this set. The cancellation will remove the duplicate condition on the TED database.

To resolve a set involving a TED Dupe, the contractor should flag the record as a 'Y' Dupe and populate the **ID Recoup Amount** with the Government paid amount. The contractor should then enter Government paid amount in the **Actual Recoup Amount** field and request that a cancellation TED be created and submitted to TMA. Once TMA receives the cancellation TED record and applies it to the TED database, the cancellation will appear in the set in the DCS as an adjustment. The contractor then needs to flag the cancellation with a 'Y' which will cause the DCS to populate the Adjust Amount field with the **Government Paid Amount**. Now the **Actual Recoup Amount** equals the **ID Recoup Amount** and the **Adjusted Amount** equals the **Actual Recoup Amount** and the set can be closed.

Where there are more than two TEDs in the set, resolution of the set may be more complicated but the important point to remember is that TED Dupes are Actual Dupes in the DCS and must be treated as if an actual duplicate payment had been made.

3.0 DEVELOPMENT OF THE SYSTEM

The DCS was developed to facilitate the identification and resolution of actual duplicate payments, increase accountability for recoupments, and verify the submission of TED adjustments to correct duplicate conditions in the TED database. The system was designed to optimize the

efforts of both TMA staff and contractor staff in meeting their respective responsibilities regarding duplicate claim payments.

3.1 TMA And Contractor Benefits

For the TMA, the system provides the tools to ensure that potential and actual duplicate payments are identified, recoupments are received, TED database corrections are made, and contractor standards of performance are met. For contractors, the system provides the tools to facilitate the research of potential duplicate payments and the identification of actual duplicate payments, document recoupment activities, and ensure that corrections to the TED database in the form of adjustments or cancellations are completed.

User defined, pre-formatted reports are included in the DCS to help analyze trends, contractor performance, and processing or procedural problems in contractor operations.

3.2 System Objectives

3.2.1 The system was designed to meet the following objectives:

- To create a user-friendly, cost-effective application using web-based technology;
- To preserve TED data integrity and display only those potential duplicate claims records applicable to each contractor;
- To provide as much data as possible to assist contractors in their efforts to identify actual duplicate payments;
- To improve the detection of actual duplicate claims payments through the use of match criteria that have been found to be successful in identifying duplicate claim payments;
- To automate methods for grouping and displaying institutional and non-institutional potential duplicate TEDs to contractors for research and resolution;
- To automate and simplify methods for contractors to report their determinations as to whether the identified potential duplicate TEDs represent actual duplicate payments and, if they do, to report the corresponding amounts expected to be recouped;
- To automate and simplify methods for contractors to report actual recoupment amounts and provide a mechanism for verifying that TED adjustments/cancellations were submitted and accepted, thereby correcting the duplicate condition in the TED database;
- To automate methods to facilitate TMA and contractor audits and performance monitoring and;
- To provide the capability to generate user defined reports and graphs.

3.2.2 In meeting these objectives, the system provides the tools to monitor timely contractor research and accurate identification of actual duplicate payments and aids in diagnosing processing problems that cause duplicate payments.

4.0 FUNCTIONAL CAPABILITIES OF THE DCS

The DCS is an on-line, real-time, user-friendly system. The DCS employs five different TED-based, duplicate detection match criteria to identify potential duplicate claims. It also accommodates contractor transitions, financially underwritten/non-financially underwritten claims, and duplicate claims payments caused by jurisdictional processing errors. The DCS improves TMA and contractor accountability of actual duplicate payments through the tracking of the amounts identified for recoupment, amounts actually received in refunds or offsets, and TED adjustments or cancellations submitted on receipt of the refunded or offset overpayments. The functional capabilities of the DCS supports the claims resolution process.

4.1 The Claims Resolution Process

The process by which duplicate claims are corrected in the DCS is referred to as the “claims resolution process”. To initiate the claims resolution process, the DCS identifies and groups potential duplicate claims into “sets”. This enables contractors to view matching claims and conduct the necessary research to determine if one or more claims in a set involve actual duplicate payments.

If one or more of the claims in a set represents an actual duplicate payment, the contractor will identify the duplicate payment by entering a ‘Y’ (for “Yes”) in the **Dupe?** field of that claim. If there are only two claims in the set, the other claim will have a ‘N’ (for “No”) in the **Dupe?** field to indicate it was the original or BASE claim. Only one claim in a set can be the BASE claim. The claims resolution process requires a contractor to enter a reason code to explain the cause of the duplicate payment and the dollar amount to be recouped. Upon receipt of the refund or offset, the contractor will enter the amount actually recouped.

After recording the amount actually recouped for the duplicate claim, the contractor must correct the duplicate condition in the TED database by submitting an adjustment/cancellation TED. When the TED adjustment has been processed and accepted, it will be transmitted to the DCS for processing. This processing, which generally occurs daily, adds adjustment transactions to appropriate sets. When the appropriate adjustment appears in a set, the contractor can verify removal of the duplicate condition from the TED database by flagging the adjustment transaction (i.e., by entering ‘Y’ in the **TED Adjust?** field of the claim). All claims identified as a duplicate payment must have a ‘Y’ in the **Dupe?** field, a valid reason code, and an amount identified for recoupment. Duplicate claims may also have an amount actually recouped and an adjustment amount.

The set can now be resolved by clicking the **RESOLVE THE SET** button which invokes the “rules of resolution”. (See [Section 4, Figure 9.4-1](#).) The rules state that a set can be resolved to a Closed status only if full recoupment has been received or if none of the claims in the set involve duplicate payments. If one of the claims is a duplicate payment but full recoupment was not received, the set can be resolved to a *Validate* status, providing an explanation has been entered to explain why full recoupment was not possible.

4.2 Extracting TED Data To Create And Maintain The Duplicate Claims Databases

Using the duplicate claims detection criteria, the DCS identifies potential duplicate claims from TEDs residing in the TED database. Copies of these claims are extracted from the TED database. At the same time, data elements and values required for system operation are added and the data is loaded to tables on a TMA DB2 Server. These tables comprise the Duplicate Claims Databases. TED data and DCS data residing in the Duplicate Claims Databases are accessible to users through the DCS application. See [Section 3, paragraph 1.0](#) for details on the building of the Duplicate Claims Databases.

5.0 SYSTEM DESIGN

In technical terms, the DCS is a “web-based” application. This term is used to describe an automated system that provides a user-friendly “web browser” environment on distributed personal computers (PCs) that interface with a transaction-based “server” environment that processes transactions, maintains databases, and optimizes the access and transfer of data between the two environments.

5.1 System Platforms

The DCS utilizes two platforms:

5.1.1 DB2 Server Platform

The DCS system resides on an IBM RS6000 Regatta P Series System. The operating system is Advanced IBM Unix (AIX). The database management system is IBM DB2, utilizing DB2 tables (i.e., the Duplicate Claims databases).

5.1.2 PC Platform

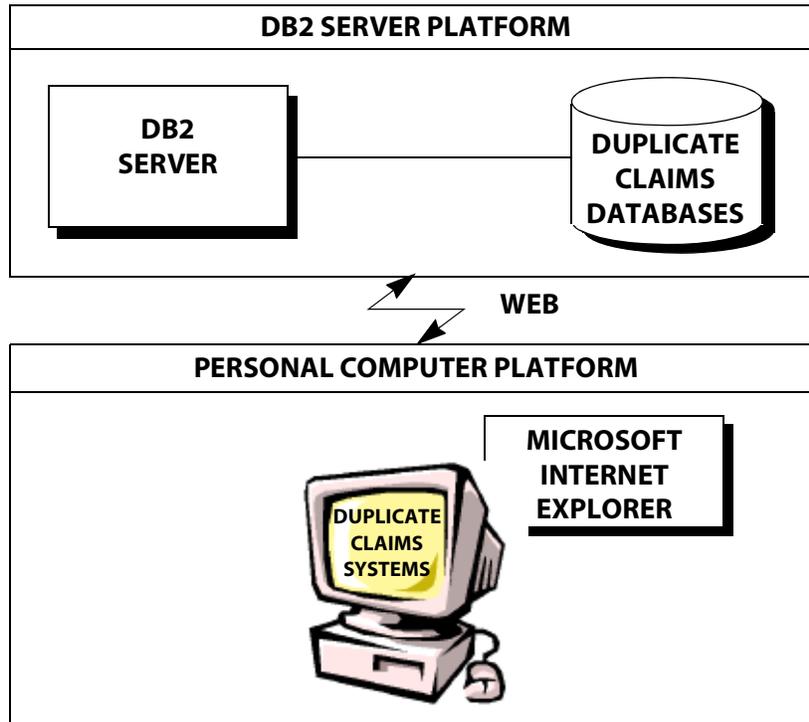
The PC platform is composed of PCs using MSIE, Version 5.5, 6.0, or 7.0, or as directed by the Government. These PCs may be stand-alone or networked computers. The PCs must have Internet access.

User screens include ease-of-use features such as tabs, buttons, scroll bars, shading, colors, **VCR** buttons, dialog boxes, user prompts, help messages, and error messages. These features enhance the display of claims data and facilitate movement from field to field, screen to screen, and claim set to claim set.

5.2 Communications

The two system platforms described above and shown in [Figure 9.1-1](#), operate independently. Data is transmitted from one platform to another through interfaces and a communications network. Users connect to this network and the DCS via contractor-supplied web communications. See the TSM, [Chapter 1](#) for the telecommunications requirements for accessing the TRICARE DCS.

FIGURE 9.1-1 SYSTEM PLATFORMS



5.3 Design Efficiencies

To optimize system resources, the DCS employs on-line and background processing. Users work only in the on-line mode of operations. The background mode is used for data handling, database maintenance, and system administration.

5.3.1 On-Line Processing Mode

The on-line processing mode contains system functionality for user activities, such as verifying that only authorized users gain access to system application software and duplicate claims data. Within this environment, the system provides menus for user functions, such as viewing potential duplicate claim sets through user-defined filters and criteria; locating specific claim sets by Claim Set Number, Patient ID, or **Internal Control Number (ICN)**; designating a claim as either an actual duplicate or a non-duplicate; entering identified and actual recoupment amounts; linking TED adjustments to identified actual duplicate claims; and resolving duplicate claim sets.

5.3.2 Background Mode

The background processing mode contains system functionality for system administration and maintenance, such as the interface with the TED data on the DB2 Server to identify and extract potential duplicate claims and associated TED adjustments and cancellations. Background processing also maintains the necessary controls to group matching claims into sets and ensures that each contractor accesses only their own data.

6.0 SYSTEM FUNCTIONS

The DCS provides a broad range of user functions to support contractor and TMA activities and to ensure system integrity.

6.1 Claim Set Resolution Functions

As specified in all Purchased Care contracts, contractors are responsible for both preventing and resolving duplicate claim payments. The DCS supports contractors in this responsibility by automating the resolution process. The automated process defines the rules under which the resolution of claim sets can be completed, provides users with screens to enter the results of duplicate payment research, and maintains the necessary interfaces with the TED database to ensure and verify correction of duplicate conditions.

To resolve claim sets with one or more claims determined to contain actual duplicate payments, users are required to perform five basic activities:

6.1.1 Enter a 'Y' or 'N' to indicate that a claim (or line item) does or does not represent an actual duplicate payment;

6.1.2 Select a reason code from a pre-defined list of reason codes for each claim, and enter a narrative description when prompted to explain why a claim does or does not represent an actual duplicate payment;

6.1.3 Enter the dollar amount identified for recoupment for each actual duplicate claim;

6.1.4 Enter the dollar amount actually received from the recoupment/offset action of each duplicate claim; and

6.1.5 Submit the TED adjustment and link this adjustment to the actual duplicate institutional claim or non-institutional line item after the adjustment has been processed by the TED system and loaded to the DCS.

6.2 Additional System Functions

A number of other tasks and data handling procedures facilitate duplicate claims resolution and maintenance of system integrity. These tasks and data handling procedures include:

6.2.1 Verifying user authorization through passwords and sign-on procedures;

6.2.2 Displaying to each contractor only those potential duplicate claim sets associated with that contractor;

6.2.3 Displaying TED adjustments associated with duplicate institutional claims or duplicate non-institutional line items;

6.2.4 Providing capabilities to track user activities;

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6.2.5 Providing system maintenance and data administration capabilities, e.g., automated support for reassigning claim sets upon contractor transitions;

6.2.6 Determining ownership of sets involving potential duplicate claims paid by two different contractors (i.e., multi-contractor sets).

Note: Although the owner designated by the system is the contractor who paid the latest claim, ownership can be switched to other contractors involved;

6.2.7 Highlighting claims that appear as potential duplicates in other sets;

6.2.8 Appending new TED claims to existing sets; and

6.2.9 Temporarily disabling sets involving provisionally accepted TEDs.

- END -

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2.5.1.6 The sum of the line item level allowed amounts on a non-financially underwritten non-institutional potential duplicate is less than \$30.00.

2.5.1.7 The sum of the line item level allowed amounts on an financially underwritten non-institutional potential duplicate is less than \$50.00.

2.5.1.8 The second byte of the claim's type of service code is 'B' (Retail Drugs & Supplies) or 'M' (Mail Order Pharmacy Drugs & Supplies).

2.5.2 Exclusion Of Certain Line Items

2.5.2.1 Prior to the implementation of the Outpatient Prospective Payment System (OPPS), the DCS excludes line items from the extract if the line item procedure code (HCPCS or CPT-4) is one of the following:

HCPCS	CPT-4 ¹	DESCRIPTION
A4000 - A4999	06888	Nutrition Equipment/Supplies - Purchase
A5000 - A6500	06942	Other Equipment/Supplies - Purchase
R_____	76499	Radiographic Procedure
P_____	84999	Clinical Chemistry Test
P_____	88305	Tissue Exam By Pathologist
	90593	Whole Blood Charges
	90594	Professional Components Charge
	90595	Outpatient Hospital - Physician's Charge
	90596	Outpatient Hospital - Recovery Room Charge
	90597	Outpatient Hospital - Operating Room Charge
	90599	Outpatient Hospital - Emergency Room Charge
J_____	90782	Injection (SC)/(IM)
J_____	90784	Injection (IV)
	94799	Unlisted Pulmonary Service Or Procedures
	99070	Special Supplies
	99088	Other Room, Ancillary and Drug Charges
	99592	Hospital Outpatient Birthing Room Charges

¹ CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

2.5.2.2 Anesthesia Assistants: When comparing two line items which have the same CPT-4 value (all five positions), if either of the CPT-4 Modifiers (CPT_4_1 or CPT_4_2) on one line item has a value of "QK" and either of the CPT-4 Modifiers on the other line item has a value of "QX" or a value of "QS".

2.5.2.3 Assistant Surgeon Modifiers: When comparing two line items which have the same CPT-4 value (all five positions), if either of the CPT-4 Modifiers on one of the line items has a value of "80", "81", "82", or "AS" and neither of the CPT-4 Modifiers on the other line item has any of these values.

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2.5.2.4 Left/Right: When comparing two line items which have the same CPT-4 value (all five positions), if either of the CPT-4 Modifiers on one of the line items has a value of "RT" and either of the CPT-4 Modifiers on the other line item has a value of "LT".

2.5.2.5 Professional/Technical Components: When comparing two line items which have the same CPT-4 value (all five positions), if either of the CPT-4 Modifiers on one of the line items has a value of "26" and either of the CPT-4 Modifiers on the other line item has a value of "TC".

2.5.2.6 Ambulance Services: When comparing two line items which have the same CPT-4 value (all five positions) and that CPT-4 value is in the range of "A0021" through "A0999", if the values of the first CPT-4 Modifier (CPT_4_1) on the two line items are not equal.

2.5.3 Other Exclusions

After potential duplicate claims have been identified and grouped into claim sets, a final test is applied to exclude certain types of claim sets least likely to contain actual duplicate claims. Claim sets are excluded if they meet any of the following conditions:

2.5.3.1 The claim set contains less than two claims after the elimination of claims in the set due to any of the previously listed exclusion criteria.

2.5.3.2 The set is a "Mother-Baby" claim set and contains no more than two claims, where one claim has a "6..." series principal diagnosis code (mother) and the other claim has a "V..." series principal diagnosis code (baby). (Applies only to institutional claims.)

2.5.3.3 The set is a "Multiple Birth" claim set and contains no more than two claims, where both claims have "V31..." through "V39..." series principal diagnosis codes. (Applies only to institutional claims.)

- END -

specifying a:

- Claim Set number
- Claim ICN
- Sponsor ID
- Patient ID

When the user selects **L**ocate Value from the **L**ocate menu bar, a pull-down menu appears from which the user can choose a claim set number, ICN, Sponsor ID, or Patient ID. Once one of the choices is selected, the user enters the desired number in a value box and clicks the **OK** button. After a few moments, the system will display the first set meeting the criteria selected.

If a user selects a specific claim set by set number on the pull-down menu (e.g., Claim Set 25), the system will display only the set with the number "25". If a user enters a specific Sponsor ID, Patient ID, or ICN, there may exist other sets in the system that contain claims with the same values. If multiple sets exist in the database that contain the same ICN, Sponsor ID or Patient ID, two options on the **L**ocate pull-down menu become active, i.e., "**L**ocate Next" or "**L**ocate Previous", allowing the user to go to the next or previous claim set containing that ICN or ID.

For example, if a user wants to see all of the sets with claims containing Sponsor ID "123456789", the user will select the "Sponsor ID" and enter "123456789" in the value box on the **L**ocate Value pull-down menu. The system will display the first set containing a claim with a Sponsor ID of "123456789". After viewing this set, the user can again select the **L**ocate function on the menu bar. If additional sets containing this ID exist in the database, the **L**ocate Next option on the pull-down menu is activated. If selected, the system will bring the second set containing Sponsor ID "123456789" into view. The user may continue to request the next claim set until no more are found in the system.

Likewise, if the **L**ocate Previous button is selected, a previous claim set containing the selection criteria will be displayed. The user may continue to request previous claims sets until no more are found in the system. The user can move between claims sets by using the **NEXT** and **PREVIOUS** options.

4.1.4 Modify

The **M**odify function enables a contractor to change the **Owner FI** field in a multi-contractor claim set or assign a contract/region to a multi-contractor claim set received from another contractor.

Each contractor will see two options in this function: Owner FI (only if it is multi-FI set) and Owner **R**egion (always). The Owner FI can select the Owner Region option to change the owner region assigned to the set. If the set is a multi-contractor set, the Owner FI also can select the Owner FI option to change the Owner FI to another contractor (Responsible FI). If a set is transferred to a new Owner FI, the new Owner FI must select the **Owner Region** option to change the Owner Region from "Region Unknown" to the applicable region associated with that set.

The **M**odify function also has a **G**overnment option for a select group of TMA staff. This option is not visible to contractor users. The **G**overnment option has a **S**tatus function that allows authorized TMA users to change the status of a set. The status of a set will not be changed by a TMA

user without first coordinating the change with the applicable contractor.

4.1.5 Report

The **R**eport function offers a selection of report and graph formats. See [Section 8](#) and [Addendum D](#), for descriptions of the available reports and detailed instructions on using the **R**eport function.

4.1.6 Utility

The **U**tility function enables a user to:

4.1.6.1 View **M**odify FI Explanation - View (but not edit) explanations given for changing the Owner FI field in multi-contractor sets.

4.1.6.2 Change or View **V**alidate Explanation - View explanations entered for validate claim sets and edit these explanations.

4.1.6.3 View **R**eason Code Explanation - View (but not edit) explanations associated with certain reason codes. The system requires that certain reason codes be supported by a narrative explanation. Users are prompted for the explanation when certain reason codes are selected.

4.1.6.4 Create, Change, or View **N**otepad - The **N**otepad function provides users with the capability to attach notes or comments to a set. **N**otepad entries are made at the set level. When ownership of a set changes, **N**otepad entries are carried with the set. **N**otepad entries may contain whatever the user wishes. To create or edit a Notepad entry, the user should select the **U**tility function. From the drop-down menu, the user should select "Create, Change, or View **N**otepad". In the screen that appears, the user can enter or edit text or delete the note altogether.

4.1.6.5 **D**ownload - Initiate a download of data to a local PC for ad hoc query and reporting purposes.

4.1.6.6 Modify **S**et User Defined Codes - Available to and used by a limited number of users selected by each contractor to create, modify, activate, de-activate or delete Set Level User Defined Codes for that region. (See [paragraph 3.2.2](#) for additional information.)

4.1.6.7 Modify **C**laim User Defined Codes - Available to and used by a limited number of users selected by each contractor to create, modify, active, de-activate or delete Claim Level User Defined Codes for that region. (See [paragraph 3.2.6](#) for additional information.)

4.1.6.8 **U**narchive Set - This option is only available when the user is in the History database. It may only be used by a limited number of users selected by each contractor. It allows the user to move the set from the History database to the Active database where changes to the set can be made.

Note: Sets that are unarchived will appear in the production database in *Closed* or *Validate* status. On a monthly basis, immediately following the monthly load process, the DCS will sweep the production database for sets that have been in *Closed* status for two years or *Validate* status for five years and will archive, i.e., move, these sets to the history database. If a user unarchives a set

Mass Change Function For Contract Transitions

1.0 CONTRACT TRANSITIONS

When a new contract is awarded, the Government establishes a transition plan for the outgoing and incoming contractors. This plan specifies the schedule for implementing transition activities, e.g., dates when certain types of claims and encounters become the responsibility of the new contractor.

A contractor has access to and can view only those potential duplicate claim sets for which the contractor has responsibility for resolving and is the designated **Owner FI**. When a contract transition occurs, access to the duplicate claim sets must be transferred to the incoming contractor for resolution, in accordance with the transition plan. The date the incoming contractor will assume responsibility for resolving the claim sets owned by the outgoing contractor will be determined during transition meetings. The type of claim sets (e.g., financially underwritten or non-financially underwritten), that will be transferred to the incoming contractor will be determined at transition meetings. The **Responsible FI** field may be changed to an inactive FI 99 for claims that will remain the responsibility of the outgoing contractor.

Under the terms of the transition plan, the incoming contractor will be responsible for resolving the claim sets transferred to them from the outgoing contractor, including all recoupments and submissions of adjustment and cancellation TRICARE Encounter Data (TED) records.

2.0 NEED FOR THE MASS CHANGE FUNCTION

When TEDs representing potential duplicate payments (along with their corresponding adjustment and cancellation TEDs) are extracted from the TED database and loaded into the Duplicate Claims Database, ownership (i.e., the **Owner FI** field) of each claim set is assigned. Additionally, a **Responsible FI** is assigned for each claim in the set. (See [Section 6, paragraph 1.2](#), for the definition of this field.) The contractor that is the **Owner FI** is responsible for resolving the set. When a contract transition occurs, responsibility for resolving a set may change. The Mass Change function manages this process by changing the **Responsible FI** field of all claims included in the transition plan. This field may be changed to the incoming contractor or to an inactive FI 99. It also may be left unchanged if the outgoing contractor remains an active contractor. The Mass Change function also changes the **Owner FI** field as appropriate.

For example, Contractor 1 has been using the Duplicate Claims System (DCS) for a year and the DCS has been extracting potential duplicates, creating claim sets and assigning ownership of these sets to this contractor. Effective, February 1, 2008, three states are carved out of this contractor's region and a new region is established. Contractor 2 is awarded the contract for this new region. The transition plan establishes that Contractor 2 will assume full responsibility for resolving potential duplicate claim sets, previously the responsibility of Contractor 1, for these

three states, on June 1, 2008. The DCS will identify the affected non-financially underwritten claims and change the **Responsible FI** field of the affected claims and the **Owner FI** field of the affected sets to Contractor 2 effective June 1, 2008.

3.0 DEFINING MASS CHANGES

The TRICARE Management Activity (TMA) is responsible for initiating the Mass Change function upon determination of the transition plan requirements pertaining to duplicate claims resolution. Mass Changes are initiated by the submission of Mass Change Specification Forms to the TMA Automated Data Processing (ADP) Facilities Management Services Contractor who is responsible for making the changes in the Duplicate Claims Database. A sample form is shown in [Figure 9.7-1](#).

The Mass Change Specification Form lists the data fields in the Duplicate Claims Database that may be used to identify claims and claim sets whose "ownership" must be changed to accommodate a contract transition. Once a Mass Change is performed, affected claims and claim sets will be accessible to the incoming contractor and removed from the view of the outgoing contractor.

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Chapter 9, Section 7

Mass Change Function For Contract Transitions

FIGURE 9.7-1 MASS CHANGE SPECIFICATION FORM

MASS CHANGE LEVEL: _____

MASS CHANGE SEQ: _____

DATA FIELD	FIELD LENGTH	VALUE
Mass Change Effective Date (DD MON YYYY format: 01 JUL 1995)	dd mmm yyyy	
Claim Set Status (Circle all affected by this change)	1	O, P, C, V, H
Claim Responsible FI (current value before Mass Change)	2	
Claim Responsible Contract (current value before Mass Change)	7	
Claim Processing FI	2	
Claim Processing Contract	7	
Beneficiary Region	2	
Provider Region	2	
Special Processing Codes	2	
Special Rate Code	2	
Financially Underwritten Indicator	1	
Provider Network Status Indicator	1	
Enrollment Code	2	
Beneficiary Zip Code Range	9	FROM: TO:
Provider Zip Code Range	9	FROM: TO:
Beneficiary Catchment Area Indicator	1	
Provider Catchment Area Indicator	1	
Processed To Completion Date Range	dd mmm yyyy	FROM: TO:
Care Begin Date Range	dd mmm yyyy	FROM: TO:
Care End Date Range	dd mmm yyyy	FROM: TO:
New Responsible FI	2	
New Responsible Contract	7	

Submitted by: _____
Approved by: _____

Date: _____
Date: _____

4.0 PERFORMING MASS CHANGES

The steps for performing a Mass Change are as follows:

- 4.1 The types of claims and claim sets to be transferred to a new contractor as well as the effective dates are defined in the transition plan.
- 4.2 These requirements are entered on the Mass Change Specification Form by TMA.
- 4.3 The Mass Change Specification Form is submitted to the TMA ADP Facilities Management Services Contractor at least two weeks prior to the date the change is to be effective.
- 4.4 The TMA ADP Facilities Management Services Contractor incorporates the mass change conditions after completion of the monthly load immediately preceding the mass change effective date.
- 4.5 The TMA ADP Facilities Management Services Contractor creates a report of the claims affected by the change.
- 4.6 TMA reviews and approves the list of claims.
- 4.7 Unless otherwise directed, the mass changes are thereafter applied to affected claims.

5.0 ADMINISTRATION OF MASS CHANGES

Mass changes will be strictly controlled by TMA in accordance with each contract's transition plan. See [Addendum C](#), for a description of the activities and time tables that can be incorporated in a contractor to contractor transition plan.

The Mass Change function ensures that claims affected by a transition are identified and appropriately assigned. This means that the **Responsible FI** field will be changed for all claims included in the transition plan.

5.1 Changes To The Owner FI

The Mass Change function also determines if the **Owner FI** should be changed. The system uses the following logic to determine the Owner FI.

5.1.1 If the Responsible FI being changed is not the owner of the set, then the Owner FI will not change.

5.1.2 If the Responsible FI being changed is the owner of the set and the Responsible FI is being changed to an FI other than 99, and there are no other claims in the set with the same Responsible FI as the one being changed, then the Owner FI will be changed to the new Responsible FI.

5.1.3 If the Responsible FI being changed is the owner of the set and the Responsible FI is being changed to an FI other than 99, and there is another claim in the set with the same Responsible FI as the one being changed, and the claim with the Responsible FI being changed has

an Identified Recoup amount greater than \$0.00, then the Owner FI will be changed to the new Responsible FI.

5.1.4 If the Responsible FI being changed is the owner of the set and the Responsible FI is being changed to an FI other than 99, and there is another claim in the set with the same Responsible FI as the one being changed, and the claim with the Responsible FI being changed has an Identified Recoup amount equal to \$0.00, then the Owner FI will not be changed.

5.1.5 If the Responsible FI being changed is the owner of the set and the Responsible FI is being changed to 99, and there are no other claims in the set with an FI other than 99, then the Owner FI will be changed to 99.

5.1.6 If the Responsible FI being changed is the owner of the set and the Responsible FI is being changed to 99, and there are other claims in the set with the same Responsible FI as the one being changed, then the Owner FI will not be changed.

5.1.7 If the Responsible FI being changed is the owner of the set and the Responsible FI is being changed to 99, and there are other claims in the set with an FI other than 99, and there are no other claims in the set with the same Responsible FI as the one being changed, and there are no non-FI 99 claims with an Identified Recoup Amount greater than \$0.00, then the Owner FI will be changed to the non-FI 99 claim with the latest processed-to-completion date.

5.1.8 If the Responsible FI being changed is the owner of the set and the Responsible FI is being changed to 99, and there are other claims in the set with an FI other than 99, and there are no other claims in the set with the same Responsible FI as the one being changed, and there are non-FI 99 claims with an Identified Recoup Amount greater than \$0.00, then the Owner FI will be changed to the non-FI 99 claim with an Identified Recoup Amount greater than \$0.00 that has the latest processed-to-completion date.

6.0 RESOLUTION ISSUE INVOLVING TRANSITIONED SETS FOLLOWING A MASS CHANGE

During a transition, when the outgoing contractor has ceased entering refund and adjustment data on the DCS, refunds may be received and/or TED adjustments may still be submitted for claims in Open and Pending sets. In this case, the incoming contractor may be required to resolve the set without knowing the amount of the refund received by the outgoing contractor.

If the actual recoupment amount was zero when the set was transferred from the outgoing contractor, the incoming contractor may apply the adjustment to the set while leaving the actual recoupment amount as zero dollars. Resolution would result in a Validate status, requiring an explanation by the incoming contractor that the outgoing contractor did not enter the actual recoupment amount.

- END -

Chapter 9

Section 8

Reports

The Duplicate Claims System (DCS) includes an integrated reporting system that generates standard and custom reports. These reports facilitate resolution activities and support contractor and the TRICARE Management Activity (TMA) auditing and management functions. In addition to the range of user-defined reports and graphs provided by the **R**eport function on the menu bar, the system provides the capability to download data to local tables. This capability, which is accessed through the **U**tility function on the menu bar, enables users to load DCS data into other database management or reporting software and subsequently generate a variety of ad hoc queries and reports. See [Addendum D](#), for report descriptions and sample reports.

There are predefined and semi ad hoc reports and graphs available to DCS users. Each report/graph has one or two parameter screens which allow the user to refine the report by choosing specific criteria to report on. The following is a list of “standard” parameters/criteria available for each report.

The “standard” parameters (available on most reports) are:

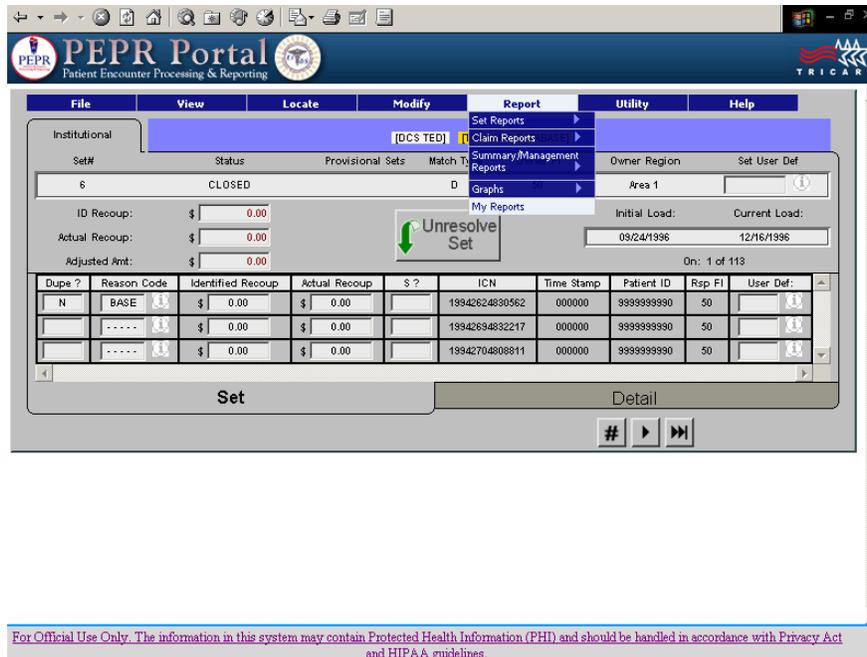
Claim Set Status	(All, C, O, P, V)
Adjustments	(All, Non-adjusted Sets, Adjusted Sets)
Set Owner Type	(All, Multi FI, Single FI)
Claim Type	(All, Institutional, Non-Institutional)
Match Type	(All, C, D, E, N, O)
Date Type	(Initial Load Date, Current Load Date, Last (Update) Date)
Set Range	(Beginning and Ending Set Numbers)
FI	(Select one from the list of available)
Region	(If FI selected, select one or more of available)

Some reports have other “special” parameters/criteria that may be selected depending on the report. (See [Addendum D](#), for report descriptions and available parameters.)

When a user selects a report, a Report Parameter Screen will appear. Every REPORT PARAMETER SCREEN will contain a **Most Common** tab on which the available “standard” parameters applicable for the selected report will be displayed. If the report has associated “special” parameters available, a second **Special** tab will be visible. Users may further refine their report criteria from the additional parameters on the **Special** tab.

1.0 USING THE REPORT FUNCTION

FIGURE 9.8-1 REPORT CATEGORIES MENU

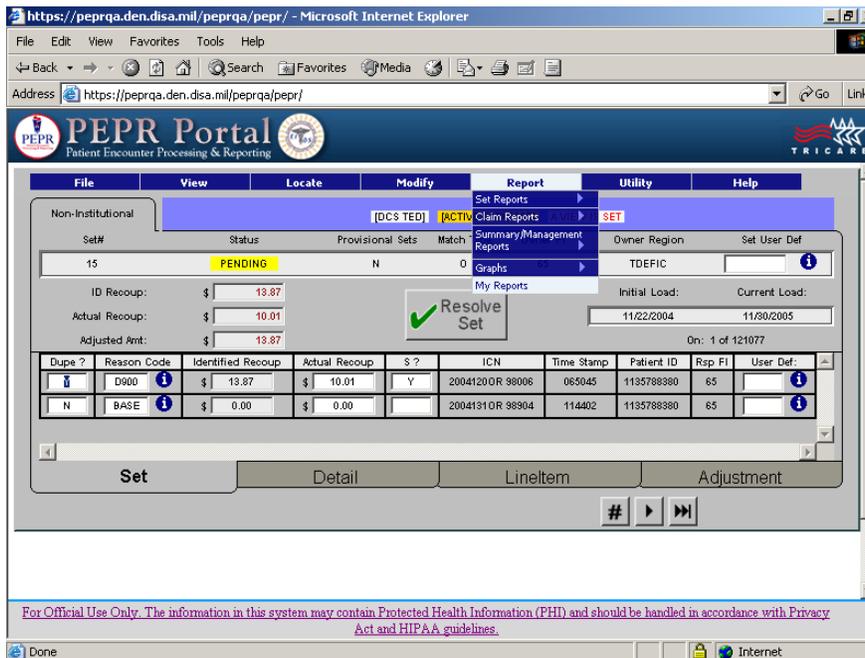


The menu bar on the top of every screen in the DCS includes a **R**eport function with a pull-down menu. When a user selects **R**eport from the menu bar, a report categories menu appears (shown in Figure 9.8-1) to display the four selections available to the user:

- Set Reports
- Claim Reports
- Summary/Management Reports
- Graphs
- My Reports

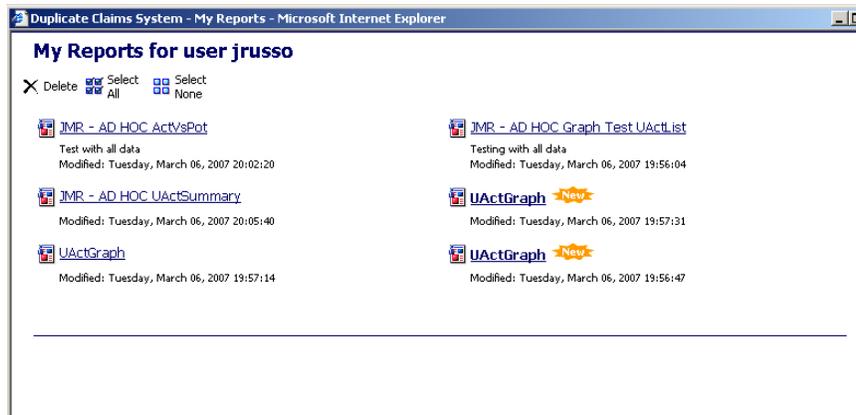
When a user selects one of the report categories, a list of the available report formats for that category appears. When a report format is selected, a parameter screen appears and presents the user with available options for limiting the sets and claims to be included in the report. The report parameter screen resembles the **V**iew screen. A number of options are presented from which the user can define the data to be included in the report. Figure 9.8-2, shows an example of options available for selecting data to be included in a report.

FIGURE 9.8-4 MY REPORTS SCREEN



An optional way of getting previously submitted or completed reports is to select the **Reports** function and then select the **MY REPORTS** option from the pull-down menu (Figure 9.8-4). The following screen (Figure 9.8-5) will be displayed.

FIGURE 9.8-5 REPORTS LISTING



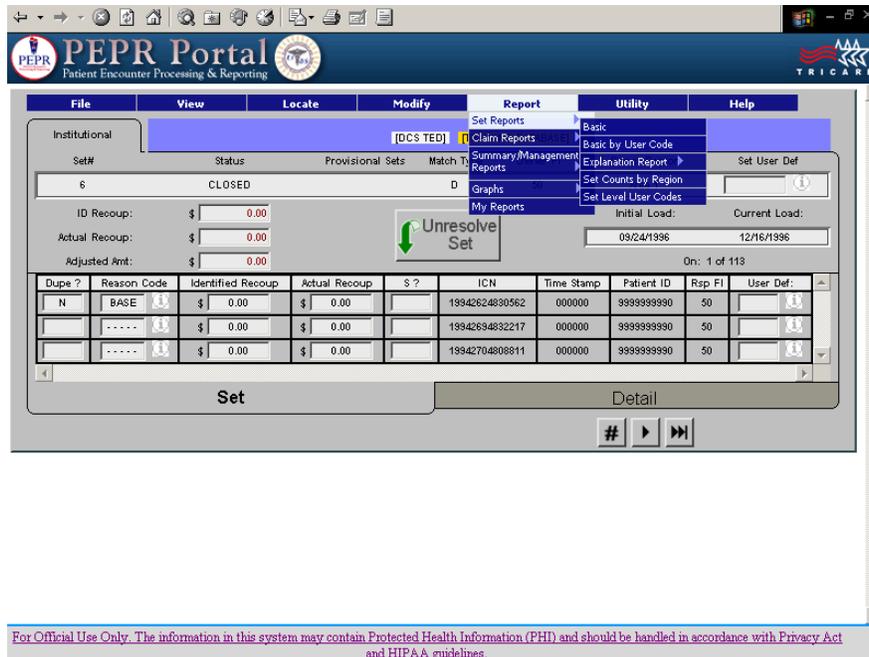
2.0 DESCRIPTION OF REPORTS

Addendum D contains a description and a sample of all available reports. The system groups reports into four categories, which are described briefly below. The first two categories of reports are based on set characteristics and claim characteristics. The other two categories of reports provide a range of summary and management analyses as well as graphical presentations of data. Each of the four categories of reports are further defined by menus to specify report formats and screens on which report parameters can be specified.

2.1 Set Reports

Set reports contain set information based on selection criteria established by the user. In other words, if a set has met the selection criteria for a report, all claims in the set will be included. Set reports are defined through menu(s) of set report formats and report parameter screens. A sample of set report menus are shown in [Figure 9.8-6](#).

FIGURE 9.8-6 SET REPORT MENU



2.2 Claim Reports

As the name suggests, claim reports contain listings of individual claims that meet specific criteria based on the report format selected and the filters applied by the user on the report parameter screen(s). Sample claim report menus are shown in [Figure 9.8-7](#). Examples of claim reports are:

2.2.1 All institutional claims in sets assigned to a particular region grouped by set status.

2.2.2 All claims in multi-contractor sets for a particular region by set status and within a specified initial load date time frame.

2.2.3 All claims identified as an actual duplicate in a set with *Pending* status and with a last update date between a specified date range.

2.2.4 All non-duplicates for a specified region which are not BASE claims.

2.2.5 Special report formats for Claim Reports have been developed for use by a contractor during the various stages of the claim set life cycle. For example, there is a report format that lists the claims identified as actual duplicates for which recoupment should be initiated. This report could be generated by a person researching potential duplicates and sent to the recoupment unit

Graphs menu are shown in [Figure 9.8-9](#).

The categories of report formats, in concert with report parameter screen options, provide users with flexible reporting tools to generate a wide range of reports. If a desired report cannot be devised through the use of the available report formats and the parameter screen options, users have the ability to download their data to their local hard drives, perform their own queries, and generate customized reports using their own database management spreadsheet, or report generation software.

See [Addendum D](#) for available report formats.

3.0 USING THE UTILITY FUNCTION TO DOWNLOAD DATA FOR ADDITIONAL ANALYSIS

Users have the capability to download duplicate claims data to their local system for additional analyses and reporting. This feature permits downloading of a contractor's data to a local PC, where it can be accessed from a PC-based database management program (e.g., Paradox®, Microsoft Access®, dBase®, etc.) or a spreadsheet program or query/report generator. This feature permits the user to perform analyses and develop reports not available in the DCS. Depending on the volume of data associated with a particular contractor, the process of downloading data could take some time.

3.1 How To Download Data

To initiate a download, a user should first set a view for the data to be downloaded then select **Utility** from the menu bar at the top of the screen, select **DOWNLOAD FROM UTILITY SCREEN** then a pop-up menu appears explaining that the user can download the current "**View**" to local ASCII fixed length tables and save them to a directory of the user's choice by clicking the 'Yes' box. A 'No' box is also provided to cancel or change the request. If the user clicks 'Yes', a matrix is displayed showing the names and brief descriptions of tables that can be downloaded. The user should follow the directions provided and click on the table(s) to be downloaded. A checkmark will appear to indicate the table(s) that have been selected. The user also can change the default directory to specify another directory to which the download should be saved. Tables available for downloading are:

dcset	set level data
dcclm	claim level data
dcutlzt	line item data
dcutladj	adjustment data
dcsetcmt	set level comments
dccmnt	claim level comments
dcsetlog	set log
dcsetusr	set level user defined codes
dcclmusr	claim level user defined codes
dccount	set counts
dccontract	region table
dcfi	FI/Contractor table
dcreas	reason codes
dccenroll	enrollment codes

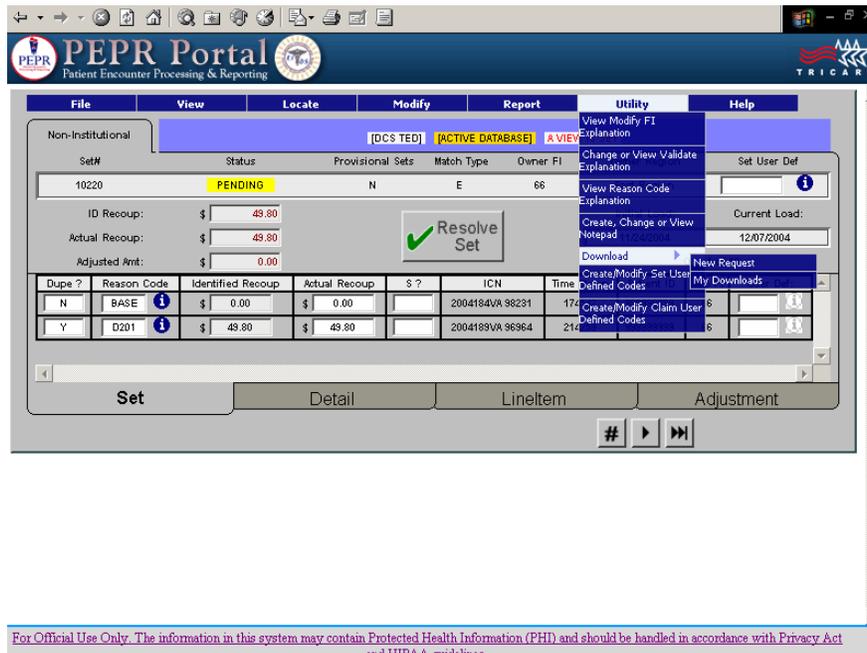
While the download is being processed, the system will display the message: **“Accessing Database.... Working.... Please Wait”**. This process can take several minutes or hours, depending on the number of claims/sets to be downloaded. The download will create ASCII fixed-length text files (files with extension of “txt”).

If a user uses the ASCII fixed-length files to generate reports, tables have to be defined in the database management software selected (dBase®, Microsoft Access®, etc.) and the ASCII files imported. [Addendum E](#), contains all of the information necessary to create the files, including the key or index fields.

It should be noted that downloaded files cannot be uploaded to TMA systems. This is a security feature to prevent corruption of the Duplicate Claims Database.

From the **Utility** menu, the **Download** pull-down menu allows the user to request a new download or preview previously requested downloads ([Figure 9.8-10](#)).

FIGURE 9.8-10 DOWNLOAD MENU



3.2 Specifying Data To Be Downloaded

Data to be downloaded may be specified in two ways. First, users should set a view through the **V**iew function of the menu bar to select specific claim types, set statuses, FIs/regions, match criteria, load dates, PTC dates, owner types, etc. Then, through the **D**ownload feature of the **U**tility function users may specify the data tables to include in the download.

3.0 CONNECTIVITY

Connectivity will through the internet to the PEPR Portal via MSIE, Version 5.5, 6.0, or 7.0, or as directed by the Government.

4.0 SYSTEM SUPPORT

4.1 For DCS support, contractors should call the **MHS Help Desk** at **1-800-600-9332**, then follow the prompts to the DCS. This will take the user to the San Antonio Help Desk.

4.2 System upgrades will occur automatically when users sign on to the system.

5.0 SYSTEM INSTALLATION AND TRAINING

5.1 Contractor Installation Responsibilities

Contractors are responsible for installing the MSIE, Version 5.5, 6.0, or 7.0, or as directed by the Government, and Adobe Reader, on their hardware, and establishing connectivity to the PEPR Portal. In addition to the communications software required to establish connectivity to the web-based DCS, contractors are responsible for installing their preferred operating system on their hardware.

5.2 Training

TMA will provide training to prospective users of the DCS. The training may be on-line or in person at a central location. TMA will coordinate with each contractor once the approach is defined.

6.0 CONTRACTOR POINTS OF CONTACT (POC)

To resolve multi-contractor duplicate claim sets, contractors are required to communicate and coordinate with each other (see [Section 6](#)). For each regional contract for which a contractor is responsible, the contractor is required to identify at least one individual to serve as the DCS POC. Contractor POCs must be individuals who are, or will be, trained in the use of the DCS, and are able to perform the required research and determine whether a particular claim is within their processing jurisdiction. For each regional contract for which they are responsible, contractors shall provide the name(s), title(s), business address(es), and business telephone number(s) of their POCs to the Procuring Contracting Officer (PCO), with courtesy copies to the Contracting Officer Representatives (CORs) and to the TMA DCS Program Representative. The POCs shall be provided to the PCO no later than (NLT) two weeks prior to implementation of the DCS.

Prior to system implementation, TMA will provide each contractor with the list of all DCS POCs. Whenever a new contract is awarded, TMA will notify all contractors of the new contractor's POC. Once the initial listing is provided to the contractors, it is the responsibility of each contractor to maintain the listing and keep TMA and the other contractors informed of any changes.

7.0 OPERATING PROCEDURES

For each regional contract for which a contractor is responsible, or for the TRICARE Dual

Eligible FI Contract (TDEFIC), the contractor shall develop internal operating procedures for the DCS. These internal operating procedures shall designate the responsible areas for the various duplicate claims resolution functions and establish time lines. For example, one contractor may decide that the adjustment unit shall be responsible for scanning the DCS on a weekly basis for the appearance of adjustments submitted and for closing sets. Another contractor may decide that the unit responsible for researching potential duplicate claims should also be responsible for scanning for adjustments and closing the sets on a daily basis.

Contractor contract requirements for overpayment recovery, refunds and offsets, adjustments, etc., including timeliness requirements, apply to the operation of the DCS. As a result, operating procedures must be developed which are consistent with all applicable contract requirements. Procedures must be established to ensure that recoupments are initiated in a timely manner following the research determination that a duplicate payment had been made. In other words, procedures must specify that after a decision has been made by the person responsible for determining that a duplicate payment was made, recoupment must be initiated in a timely manner and must be consistent with all overpayment recovery timeliness standards.

Contractors shall develop these procedures within 60 days of the date of system implementation and have them available for TMA review.

8.0 CONTRACTOR PERFORMANCE REQUIREMENTS

8.1 Contractors shall use the TRICARE DCS to resolve TMA identified potential duplicate claims payments.

8.2 Contractors shall move *Open* status potential duplicate claim sets to *Pending*, *Validate*, or *Closed* status on a first-in/first-out basis. To this end, contractor performance will be measured against the percentage of claim sets in *Open* status at the end of a month with Current Load Dates over 30 days old. No more than 10% of the potential duplicate claim sets remaining in *Open* status at the end of a month shall have Current Load Dates over 30 days old. Contractor compliance with this standard shall be determined from the Performance Standard Report generated by the DCS (see [Addendum D](#), Summary Management Report titled "Performance Standards", for a description and example of the Performance Standard Report). The 10% standard becomes effective on the first day of the seventh month following the start of services or following system installation whichever is later.

8.3 Contractors shall not be responsible for meeting the performance standard during any month in which availability of the DCS is prevented for two working days due to failure of any system component for which the Government is responsible. The Government is responsible for: TMA servers on which the DCS data resides; Government-supplied communications lines, if any; Government-supplied routers, if any; Government-supplied Channel Sending Unit (CSU)/Data Sending Unit (DSU) equipment that connect the routers to the communication lines, if any; and the DCS application software.

8.4 Contractors are responsible for their own PCs, printers, PC operating system software, and in-house communications software and equipment, including in-house Wide Area Network (WAN)/Local Area Network (LAN) equipment, circuits, and routers. Contractors are responsible for any contractor-supplied communication lines, contractor-supplied routers, and contractor-supplied CSU/DSU equipment that connect the routers to the communication lines. Contractors are

responsible for contractor-supplied internal and external networks, network connections to the routers, firewalls, and all software (including operating system, application, and network software) other than the DCS application-related software. Contractors are required to install and maintain hardware with MSIE, Version 5.5, 6.0, or 7.0, or as directed by the Government, and Adobe Reader. Contractors are responsible for maintaining their own networks, including hardware and software (other than the DCS software). TMA will fully support the DCS application software.

8.5 All overpayment recovery, refund, offset collection and adjustment requirements, including timeliness standards, are applicable to the operation of the DCS.

9.0 TRANSITIONS

The date when an incoming contractor will assume full responsibility for resolving all existing potential duplicate claim sets from the outgoing contractor (including completing existing recoupments), and for all new potential duplicate claim sets, shall be determined during transition meetings and be established in the transition plan/schedule.

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Chapter 9, Section 9

System Implementation And Operational Requirements

FIGURE 9.9-1 TRICARE DCS ACCOUNT ACTIVATION REQUEST FORM



TRICARE DUPLICATE CLAIMS SYSTEM ACCOUNT ACTIVATION REQUEST FORM

See Pages 5-6 for Form Instructions and Guidance

Upon Completion of this Form Including Block 9 & Attachment A, Fax to 303.676.3979

1. System Access (Please check the system for which you have mission/contract related access requirement)			
<input type="checkbox"/>	DCS - Web Version DCS		
<input type="checkbox"/>	Client/Server (C/S) Version		
2. Employment Category (Please check the category that applies)			
<input type="checkbox"/>	Government Employee, Uniformed Service Member, Military, or Civil Service working within/for DoD MHS		
<input type="checkbox"/>	Contractor working within the DoD Military Health System		
<input type="checkbox"/>	Government Employee, Uniformed Service Member, Military, or Civil Service working for other agency or directorate not a part of the DoD Military Health System		
<input type="checkbox"/>	Contractor working for Government Agency, not a part of the DoD Military Health System		
<input type="checkbox"/>	Other (Please describe) _____		
3. Applicant/Requestor Information			
Rank/GS Level/Title:			
Name (Last, First, MI):			
Complete Office Mailing Address:			
Sponsoring Organization Name: (Not Project Name)			
If Contractor, Employer Name			
Commercial Telephone Number:			
DSN:			
Email:			
IP Address of Workstation (Client Svr only):			
Network Translated IP Address (Client Svr):			
Account Validation PIN:			
Enter a 4 digit numeric PIN that you will use to validate your identity for account administration purposes. This must be the same number as entered when registering in the EIDS WebPortal.			
4. Password Action/Access Authorization Requested			
Check action requested: <input type="checkbox"/> NEW <input type="checkbox"/> CHANGE <input type="checkbox"/> DELETE <input type="checkbox"/> OTHER _____			
If you have a User ID, please enter it here: _____ (If your account has expired, enter your last user ID)			
Requested Access: <input type="checkbox"/> READ ONLY <input type="checkbox"/> READ/WRITE (supervisor must complete 4.A., below)			
Requesting Access to following contractor region number(s)*: _____			
* If access to multiple contractor regions is required, all region contractor numbers must be specified.			
4.A. Special Permissions Data for READ/WRITE Users (To be completed by requester's supervisor)			
Permission to create User Defined Codes? (Requires Prime Contractor approval):		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Permission to unarchive sets? (Requires Prime Contractor approval):		<input type="checkbox"/> YES	<input type="checkbox"/> NO
Supervisor Signature: _____		Phone#: _____	
Prime Contractor Signature: _____		Phone#: _____	

Version 12/6/06 - All previous versions are OBSOLETE

Contractor To Contractor Transition Guide

DATES	OUTGOING CONTRACTOR	TMA	INCOMING CONTRACTOR
Contract Award Through Start of Services	Continues to use the DCS to resolve potential duplicate claim sets.	Loads identifying and other information regarding the incoming contractor, the contract and region into the DCS. 30 - 45 days prior to the start of Services, TMA installs DCS software and trains the incoming contractor staff on the use of the DCS.	Purchases, configures and tests computer hardware, software and communications links required to operate the DCS No Later Than (NLT) 60 days prior to the start of Services.
Start of Services Through The Last Day of The Fourth Month Following The Start of Services (four months)	Continues to use the DCS to resolve potential duplicate claim sets.	TMA begins the ongoing process of identifying and loading potential duplicate claim sets associated with the incoming contractor. Within 60 days following Services, TMA prepares a "mass change" specification form which is to be executed on the first day of the fifth month after Services, for a "mass change" to transfer all potential duplicate claim sets from the outgoing contractor's DCS to the incoming contractor's DCS.	Incoming contractor begins using the DCS to resolve identified potential duplicate claim sets "owned" by the incoming contractor.
Last Day of The Fourth Month Following The Start of Services	At the close of business, the outgoing contractor shall cease researching <i>Open</i> claim sets and initiating new recoupments associated with duplicate claim payments. The outgoing contractor shall also cease entering refund data and linking adjustment data in the DCS for <i>Pending</i> and <i>Validate</i> claim sets.		Continues researching and resolving potential duplicate claim sets.

Note: This schedule shall be incorporated into the transition plans for the outgoing contractor and the incoming contractor. Actual dates shall be established in the transition plans.

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Chapter 9, Addendum C

Contractor To Contractor Transition Guide

DATES	OUTGOING CONTRACTOR	TMA	INCOMING CONTRACTOR
First Day of The Fifth Month Following Services	Beginning on the first day of the fourth month following Services, refund checks received and offsets taken for recoupments associated with duplicate claims payments and recoupment files associated with in progress duplicate claim recoupments shall be processed and forwarded to the incoming contractor in accordance with the Financial Procedures in the Transition Plan, the contract, and the TRICARE Operations Manual (TOM).	A "mass change" is initiated transferring all of the outgoing contractor's DCS data to the incoming contractor's DCS.	Outgoing contractor's DCS data appears on the incoming contractor's DCS. Incoming contractor begins performing DCS research, recoupment, and resolution functions on potential duplicate claim sets transferred from the outgoing contractor as well as continuing to resolve their own duplicate claim sets.
First Day of The Fifth Month Through The Last Day of TED Submissions For The Outgoing Contractor (as defined by the transition schedule)	The outgoing contractor shall have moved 100% of all <i>Open</i> DCS claim sets to a <i>Pending</i> , <i>Validate</i> , or <i>Closed</i> status by the last day of TED submissions (as defined by the transition plan).	TMA prepares to have the outgoing contractor's passwords deleted from the DCS effective on the first day following the last day of TED submissions for the outgoing contractor (as defined by the transition schedule). TMA shall generate monthly reports showing the status of the outgoing contractor's network claim sets.	Continues to research and resolve potential duplicate claim sets appearing on the DCS. By the last day of the sixth month following Services , the incoming contractor shall have completed the required research and have moved a sufficient number of <i>Open</i> sets to a <i>Pending</i> , <i>Validate</i> , or <i>Closed</i> status to ensure compliance with DCS performance standards which become effective for the incoming contractor on first day of the seventh month following Services.
First Day of The Seventh Month Following Services		Generates DCS reports to verify that the incoming contractor is in compliance with performance standards.	The DCS performance standards shall be in effect (see Chapter 1, Section 3, paragraph 6.0 for the DCS performance standards).
Last Day of TED Submissions For The Outgoing Contractor (as defined by the transition schedule)	By the close of business, the outgoing contractor shall generate any DCS reports it wishes for its records.		Continues to research and resolve potential duplicate claim sets appearing on the DCS.

Note: This schedule shall be incorporated into the transition plans for the outgoing contractor and the incoming contractor. Actual dates shall be established in the transition plans.

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Chapter 9, Addendum C

Contractor To Contractor Transition Guide

DATES	OUTGOING CONTRACTOR	TMA	INCOMING CONTRACTOR
First Day Following The Last Day of TED Submissions For The Outgoing Contractor (as defined by the transition schedule)	Outgoing contractor can no longer access the DCS.	Outgoing contractor's DCS passwords are deleted. TMA generates DCS management reports showing the status of all DCS sets owned by the outgoing contractor. TMA will change the Responsible FI of all claims from the outgoing contractor to FI 99. <i>Open</i> claim sets owned by FI 99 are moved to a closed status. <i>Pending</i> claim sets owned by FI 99 are moved to a <i>Validate</i> status.	Continues to research and resolve potential duplicate claim sets appearing on the DCS.

Note: This schedule shall be incorporated into the transition plans for the outgoing contractor and the incoming contractor. Actual dates shall be established in the transition plans.

- END -

Report Descriptions And Examples

REPORT CATEGORY:	Set Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SET REPORTS ⇒ BASIC
PRINTED REPORT TITLE:	Duplicate Claim System Sets Grouped by Set Number
REPORT DESCRIPTION:	This report provides set-level information regarding all of the sets loaded in the Duplicate Claim System. The fields displayed on the report are: Institutional/Non-Institutional Indicator; Set Number; Status; Set Match Type; Multi-Contractor Set? (Y/N); Owner FI; Region; Initial Load Date; Current Load Date; Last Update Date; Adjustments? (Y/N); Total Amount Identified For Recoupment; Total Amount Actually Recouped; Total TED Adjustment Amount; and Set Level User Defined Code.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters (Claim Set Status, Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus Set Level User Defined Codes.
REPORT NOTES:	The data used by this report format is set level data.

**DUPLICATE CLAIM SYSTEM SETS
GROUPED BY SET NUMBER**

Status Code = All
Set Number = All
Set User Codes = All
Adjust Type = All
Owner Type = All
Claim Type = All
Match Type = All
Owner FI = All
Owner Region = All

**50 - Acme Claims Processing
Undetermined Region**

INSTITUTIONAL

SET #	STAT	MATCH TYPE	MULTI FI?	OWNER FI	REGION	INITIAL LOAD DATE	CURRENT LOAD DATE	LAST UPDATE DATE	ADJ?	ID RECOUP	ACTUAL RECOUP	ADJUSTMENT AMOUNT	USER CODE
6	C	D	N	50	MDA90504C0050	09/24/1996	12/16/1996	12/31/1996	N	\$0.00	\$0.00	\$0.00	
15	O	N	N	50	MDA90504C0050	09/24/1996	09/24/1996	10/01/1996	Y	\$0.00	\$0.00	\$0.00	
22	V	D	N	50	MDA90504C0050	09/24/1996	09/24/1996	10/02/1996	Y	\$1,000.00	\$1,000.00	\$1,115.44	
INSTITUTIONAL TOTAL													
												\$1,115.44	

NON-INSTITUTIONAL

SET #	STAT	MATCH TYPE	MULTI FI?	OWNER FI	REGION	INITIAL LOAD DATE	CURRENT LOAD DATE	LAST UPDATE DATE	ADJ?	ID RECOUP	ACTUAL RECOUP	ADJUSTMENT AMOUNT	USER CODE
121	O	E	N	50	MDA90504C00050	09/24/1996	01/24/1997	01/24/1997	Y	\$0.00	\$0.00	\$0.00	
122	V	E	N	50	MDA90504C00050	09/24/1996	01/24/1997	01/24/1997	Y	\$0.00	\$0.00	\$0.00	A4
123	O	E	N	50	MDA90504C00050	09/24/1996	01/24/1997	01/24/1997	Y	\$0.00	\$0.00	\$0.00	
NON-INSTITUTIONAL TOTAL													
												\$0.00	
Undetermined Region TOTAL												\$1,115.44	
50 - Acme Claims Processing TOTAL												\$1,115.44	
												\$1,000.00	

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TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Set Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SET REPORTS ⇒ BASIC BY USER CODE
PRINTED REPORT TITLE:	Duplicate Claim System Sets Grouped by User Code
REPORT DESCRIPTION:	This report provides set-level information regarding all of the sets loaded in the Duplicate Claim System grouped by Set Level User Defined Codes. The fields displayed on the report are: Institutional/ Non-Institutional Indicator; Set Number; Status; Set Match Type; Multi-Contractor Set? (Y/N); Owner FI; Region; Initial Load Date; Current Load Date; Last Update Date; Adjustments? (Y/N); Total Amount Identified For Recoupment; Total Amount Actually Recouped; Total TED Adjustment Amount; and Set Level User Defined Code.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters (Claim Set Status, Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus Set Level User Defined Codes.
REPORT NOTES:	The data used by this report format is set level data.

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**DUPLICATE CLAIM SYSTEM SETS
GROUPED BY USER CODE**

Status Code = All
Set User Codes = All
Adjust Type = All
Owner Type = All
Claim Type = All
Match Type = All
Owner FI = All
Owner Region = All
Set Number = All

**50 - Acme Claims Processing
Undetermined Region**

A4 Test code a 4 am

NON-INSTITUTIONAL

SET #	STAT	MATCH TYPE	MULTI FI?	OWNER FI	REGION	INITIAL LOAD DATE	CURRENT LOAD DATE	LAST UPDATE DATE	ADJ?	ID RECOUP	ACTUAL RECOUP	ADJUSTMENT AMOUNT	USER CODE
122	V	E	N	50	MDA90504C0050	09/24/1996	01/24/1997	01/24/1997	Y	\$0.00	\$0.00	\$0.00	A4
NON-INSTITUTIONAL Totals													
										\$0.00	\$0.00	\$0.00	
A4 Test code a 4 am Totals													
										\$0.00	\$0.00	\$0.00	

Blank User Code

INSTITUTIONAL

SET #	STAT	MATCH TYPE	MULTI FI?	OWNER FI	REGION	INITIAL LOAD DATE	CURRENT LOAD DATE	LAST UPDATE DATE	ADJ?	ID RECOUP	ACTUAL RECOUP	ADJUSTMENT AMOUNT	USER CODE
6	C	D	N	50	MDA90504C0050	09/24/1996	12/16/1996	12/31/1996	N	\$0.00	\$0.00	\$0.00	
15	O	N	N	50	MDA90504C0050	09/24/1996	09/24/1996	10/01/1996	Y	\$0.00	\$0.00	\$0.00	
22	V	D	N	50	MDA90504C0050	09/24/1996	09/24/1996	10/02/1996	Y	\$1,000.00	\$1,000.00	\$1,115.44	
35	O	N	N	50	MDA90504C0050	09/24/1996	12/16/1996	12/16/1996	Y	\$0.00	\$0.00	\$0.00	
36	O	D	N	50	MDA90504C0050	09/24/1996	12/16/1996	12/16/1996	Y	\$0.00	\$0.00	\$0.00	
39	O	O	N	50	MDA90504C0050	09/24/1996	09/24/199	10/01/1996	Y	\$0.00	\$0.00	\$0.00	
NON-INSTITUTIONAL Totals													
										\$1,000.00	\$1,000.00	\$1,115.44	

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**DUPLICATE CLAIM SYSTEM SETS
GROUPED BY USER CODE**

Status Code = All
Set User Codes = All
Adjust Type = All
Owner Type = All
Claim Type = All
Match Type = All
Owner FI = All
Owner Region = All
Set Number = All

**50 - Acme Claims Processing
Undetermined Region**

Blank User Code

NON-INSTITUTIONAL

SET #	STAT	MATCH TYPE	MULTI FI?	OWNER FI	REGION	INITIAL LOAD DATE	CURRENT LOAD DATE	LAST UPDATE DATE	ADJ?	ID RECOUP	ACTUAL RECOUP	ADJUSTMENT AMOUNT	USER CODE	
121	O	E	N	50	MDA90504C0050	09/24/1996	01/24/1997	01/24/1997	Y	\$0.00	\$0.00	\$0.00		
123	O	E	N	50	MDA90504C0050	09/24/1996	01/24/1997	01/24/1997	Y	\$0.00	\$0.00	\$0.00		
144	O	N	N	50	MDA90504C0050	09/24/1996	09/24/1996	09/24/1996	N	\$0.00	\$0.00	\$0.00		
184	O	N	N	50	MDA90504C0050	09/24/1996	09/24/1996	09/24/1996	N	\$0.00	\$0.00	\$0.00		
185	O	N	N	50	MDA90504C0050	09/24/1996	09/24/1996	09/24/1996	N	\$0.00	\$0.00	\$0.00		
226	O	C	N	50	MDA90504C0050	09/24/1996	09/24/1996	10/01/1996	Y	\$0.00	\$0.00	\$0.00		
NON-INSTITUTIONAL Totals											\$0.00	\$0.00	\$0.00	
Blank User Code Totals											\$1,000.00	\$1,000.00	\$1,115.44	
Undetermined Region Totals											\$1,000.00	\$1,000.00	\$1,115.44	
50 - Acme Claims Processing Totals											\$1,000.00	\$1,000.00	\$1,115.44	

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TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Set Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SET REPORTS ⇒ USER LOG REPORT
PRINTED REPORT TITLE:	User Log Grouped By Set Number (Transaction History)
REPORT DESCRIPTION:	<p>This report identifies the users who made changes to a set and the dates on which the changes occurred. The fields displayed on the report are: Set Number; Status; Owner FI; Region; Initial Load Date; Current Load Date; Transaction Date; User ID; Total Amount Identified For Recoupment; Total Amount Actually Recouped; and Total TED Adjustment Amount. The report will identify all of the sets meeting the criteria selected on the report parameter screen and list all of the changes made to those sets along with the associated User Ids. The system detects changes to: the status of a set; the Owner FI; the Region; and the three total dollar amount fields. Whenever a change to one or more of these fields occurs, a "log" record is created and will appear on this report along with the User ID associated with the change(s). The report will not show log entries generated as a result of: sets to which claims have been added during the monthly load process; or sets that have been archived out of the active database to history. Users may see entries with an "System" or "CLAIMADD" as the User ID. These two User IDs are used by the DCS for set management purposes. These User Ids may appear when the system makes a change to a set. The report groups the data by Set Number in ascending order.</p>
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters (Claim Set Status, Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus User IDs.
REPORT NOTES:	The data used by this report format is set level data.

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

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**USER LOG GROUPED BY SET NUMBER
(TRANSACTION HISTORY)**

Status Code = All
Adjust Type = All
Owner Type = All
Claim Type = All
Match Type = All
Set Number = All
Owner FI = All
Owner Region = All
User ID = All

Set Number	Stat	Owner FI	Region	Initial Load Date	Current Load Date	Transaction Date	User Id	Total Amount Ident Recoup	Total Amount Actual Recoup	Total Paid TED Adjustment
26809	C	##	AAAAAA	12/07/2004	12/07/2004	02/08/2005	jdoe	\$65.38	\$65.38	\$0.00
26809	P	##	AAAAAA	12/07/2004	12/07/2004	02/08/2005	jdoe	\$65.38	\$65.38	\$0.00
26809	O	##	AAAAAA	12/07/2004	12/07/2004	02/09/2005	jsmith	\$0.00	\$0.00	\$0.00
26963	O	##	BBBBBB	02/07/2005	02/07/2005	02/08/2005	CLAIMADD	\$0.00	\$0.00	\$0.00
26963	O	##	BBBBBB	02/07/2005	02/07/2005	02/17/2005	jdoe	\$240.00	\$0.00	\$0.00
26963	O	###	AAAAAA	02/07/2005	02/07/2005	02/18/2005	SYSTEM	\$240.00	\$0.00	\$0.00
32085	O	##	CCCCCC	02/07/2005	02/07/2005	02/08/2005	CLAIMADD	\$0.00	\$0.00	\$0.00
32085	O	##	DDDDDD	02/07/2005	02/08/2005	02/08/2005	SYSTEM	\$0.00	\$0.00	\$0.00
32085	O	##	AAAAAA	02/07/2005	02/18/2005	02/18/2005	SYSTEM	\$0.00	\$0.00	\$0.00
32085	O	###	AAAAAA	02/07/2005	02/18/2005	04/01/2005	SYSTEM	\$0.00	\$0.00	\$0.00
32981	O	##	CCCCCC	02/07/2005	02/07/2005	02/08/2005	CLAIMADD	\$0.00	\$0.00	\$0.00
32981	O	##	CCCCCC	02/07/2005	02/07/2005	02/16/2005	jdoe	\$36.85	\$0.00	\$0.00
32981	O	##	CCCCCC	02/07/2005	02/07/2005	02/17/2005	jdoe	\$36.85	\$15.00	\$0.00
32981	O	##	CCCCCC	02/07/2005	02/07/2005	02/17/2005	jdoe	\$36.85	\$0.00	\$0.00
32981	O	###	AAAAAA	02/07/2005	02/18/2005	02/18/2005	SYSTEM	\$36.85	\$0.00	\$0.00
32981	p	###	AAAAAA	02/07/2005	02/18/2005	02/18/2005	jdoe	\$36.85	\$0.00	\$0.00

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TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Set Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SET REPORTS ⇒EXPLANATION REPORT ⇒ NOTEPAD
PRINTED REPORT TITLE:	Explanations Notepad
REPORT DESCRIPTION:	This report provides a listing of the notepad entries made on selected sets. The fields displayed on this report are: Set Number; Status; Match Type; Owner FI; Region; Initial Load Date; Current Load Date; and Notepad Entries.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters (Claim Set Status, Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, Set Range, FI, Region).
REPORT NOTES:	The data used by this report format is set level data.

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

Status Code = All
Adjust Type = All
Owner Type = All
Claim Type = All
Match Type = All
Owner FI = All
Owner Region = All
5 >= Set Number < = 8

Date: 4/28/05
Page 1

EXPLANATIONS NOTEPAD

50 - Acme Claims Processing

Set Number Status Match Type Initial Load Date Current Load Date

6	C	D	09/24/1996	12/16/1996
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Testing the Notepad

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TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Set Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SET REPORTS ⇒EXPLANATION REPORT ⇒VALIDATE
PRINTED REPORT TITLE:	Validate Status Explanations
REPORT DESCRIPTION:	This report provides a listing of the explanations entered when sets are resolved to a VALIDATE status. The Duplicate Claims System requires that an explanation be entered when a set is resolved to a VALIDATE status. One of the required Validate explanations describes why the amount actually recouped and the paid amount of the TED adjustments submitted do not equal the amount identified for recoupment. The other required Validate explanation describes why all of the identified line-items of a non-institutional actual duplicate claim have not been adjusted. The fields displayed on this report are: Set Number; Status; Match Type; Owner FI; Region; Initial Load Date; Current Load Date; and Validate Explanations.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Claim Set Status (Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, Set Range, FI, Region).
REPORT NOTES:	The data used by this report format is set level data.

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

Adjust Type = All
Owner Type = All
Claim Type = All
Match Type = All
Set Number = All
Owner FI = All
Owner Region = All

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VALIDATE STATUS EXPLANATIONS



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TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Set Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SET REPORTS ⇒EXPLANATION REPORT ⇒ MODIFY
PRINTED REPORT TITLE:	Modify FI Explanations
REPORT DESCRIPTION:	This report provides a listing of the explanations entered when the Owner FI is changed on multi-contractor sets. The Duplicate Claims System requires that an explanation be entered when ownership of a multi-contractor set is changed from one contractor to another. The explanation entered should indicate who changed set ownership, who the change was discussed with at the receiving contractor, the date the discussions and the change took place, and why ownership was changed. The fields displayed on the report are: Set Number; Status; Match Type; Owner FI; Region; Initial Load Date; Current Load Date; and the Modify FI Explanations.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Owner Type (Claim Set Status; Adjustments, Claim Type, Match Type, Date Type, Set Range, FI, Region).
REPORT NOTES:	The data used by this report format is set level data.

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

Status Code = All
Adjust Type = All
Claim Type = All
Match Type = All
Set Number = All
Owner FI = All
Owner Region = All

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Page 1

MODIFY FI EXPLANATIONS

50 - Acme Claims Processing

Undetermined

Set Number	Status	Match Type	Initial Load Date	Current Load Date
------------	--------	------------	-------------------	-------------------

63	O	N	09/24/1996	12/16/1996
----	---	---	------------	------------

Transferred iaw telcon 6/5/97

371	O	E	09/24/1996	12/16/1996
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Jurisdictional error, transfer coordinated

578	O	N	09/24/1996	01/28/1997
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transfer coordinated 7/11/97

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Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Set Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SET REPORTS ⇒ REGION UNASSIGNED
PRINTED REPORT TITLE:	Multi-Contractor Sets Region Missing
REPORT DESCRIPTION:	This report provides a listing of the multi-contractor sets in the Duplicate Claims System for which a region has not been assigned. All sets are assigned a region when they are loaded into the system and when mass changes occur. When ownership of a multi-contractor set is changed from one contractor to another, the receiving contractor must assign the applicable region to the set. If the receiving contractor does not assign a region, the set cannot be associated with a particular contract. This report will provide receiving contractors with a listing of the sets which have not had regions assigned. The fields displayed on the report are: Set Number; Status; Initial Load Date; Current Load Date; and Owner FI.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Owner Type and Set Range (Claim Set Status; Adjustments, Claim Type, Match Type, Date Type, FI, Region).
REPORT NOTES:	The data used by this report format is set level data.

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Chapter 9, Addendum D
Report Descriptions And Examples

Status Code = All
Adjust Type = All
Claim Type = All
Match Type = All
Owner FI = All
Owner Region = All

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**MULTI CONTRACTOR SETS
REGION MISSING**

Set Number	Owner FI	Status	Initial Load Date	Current Load Date
------------	----------	--------	-------------------	-------------------

21 - Grand Army Health Care

33676	21	O	02/07/2005	03/25/2005
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22 - Excel Health Care

33290	22	O	02/07/2005	03/25/2005
33504	22	O	02/07/2005	03/25/2005

23 - Seven Health Care

162	23	V	11/22/2004	11/22/2004
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Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Set Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SET REPORTS ⇒ SET COUNTS BY REGION
PRINTED REPORT TITLE:	Set Counts By Region
REPORT DESCRIPTION:	This report provides the numbers of sets of each match type by contract region. The report shows the number of sets of each match type, the percentage each match type represents of the total number of sets for the region, the number of sets for each match type which have associated adjustments, and the percentage of each match type which have been adjusted. This report will show the distribution of sets for a region across match types. It will also show the user how many sets in a given match type category have associated adjustments and the percentage of that match type category which have adjustments. This report can serve as a tool for contractors to help diagnose causes for duplicate payments and to help determine workload and needed resources.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Match Type and Set Range (Claim Set Status; Adjustments, Claim Type, Date Type, FI, Region) plus Set Level User Defined Codes.
REPORT NOTES:	The data used by this report format is set level data.

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

Status Code = All
Adjust Type = All
Claim Type = All
Match Type = All
Set Number = All
Owner FI = All
Owner Region = All

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Page 1

SET COUNTS BY REGION

50 - Acme Claims Processing

Undetermined

Match Type	# of Sets	% of Total	# of Adjusted Sets	% Adjusted
CPT-4 Code	4	3.74%	4	100.00%
Date Overlap	23	21.50%	17	73.91%
Exact	35	32.71%	32	91.43%
Near	29	27.10%	19	65.52%
Other	16	14.95%	9	56.25%
Region Totals	107	100.00%	81	75.70%
FI Totals	107	100.00%	81	75.70%

55 - East West Claims

Area 55

Match Type	# of Sets	% of Total	# of Adjusted Sets	% Adjusted
Exact	1	100.00%	1	100.00%
Region Totals	1	100.00%	1	100.00%
FI Totals	1	100.00%	1	100.00%

73 - HAL Systems Inc

Area 73A

Match Type	# of Sets	% of Total	# of Adjusted Sets	% Adjusted
Date Overlap	1	100.00%	1	100.00%
Region Totals	1	100.00%	1	100.00%
FI Totals	1	100.00%	1	100.00%

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Chapter 9, Addendum D
Report Descriptions And Examples

Status Code = All
Adjust Type = All
Claim Type = All
Match Type = All
Set Number = All
Owner FI = All
Owner Region = All

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SET COUNTS BY REGION

99 - Inactive Contractor

Inactive-Area 20

Match Type	# of Sets	% of Total	# of Adjusted Sets	% Adjusted
Near	1	100.00%	1	100.00%
Region Totals	1	100.00%	1	100.00%
FI Totals	1	100.00%	1	100.00%

Inactive -Area 30

Match Type	# of Sets	% of Total	# of Adjusted Sets	% Adjusted
Near	1	100.00%	1	100.00%
Region Totals	1	100.00%	1	100.00%
FI Totals	1	100.00%	1	100.00%

Grand Totals	111	100.00%	84	75.68%
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Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Set Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SET REPORTS ⇒ SET LEVEL USER CODES
PRINTED REPORT TITLE:	Set Level User Defined Field Definitions
REPORT DESCRIPTION:	This report displays the Owner FI, the Set Level User Defined Codes, their definitions, and whether they are active or inactive.
REPORT PARAMETER OPTIONS:	Users may not customize this report.
REPORT NOTES:	The data used by this report format is set level data.

TRICARE Operations Manual 6010.56-M, February 1, 2008Chapter 9, Addendum D
Report Descriptions And Examples

4/28/05

Page 1

**SET LEVEL USER DEFINED
FIELD DEFINITIONS**

Owner FI	Contract #	Code	Description	Active ?
50	MDA90504C0050	A4	Test code a 4 am	Y

51	MDA90504C0051	A4	testing	Y
51	MDA90504C0051	1A	Testy - 1A	Y
51	MDA90504C0051	2B	TEST - 2B	Y

52	58	2L	Test 232	Y
52	93D0004	86	testing	N
52	MDA90504C0052	86	testing	Y
52	94D0004	44	testing	Y
52	88D0006	45	TEST	Y
52	89D0002	2A	TEST	Y

54	88D0004	2E	Test	Y
54	89D0004	55	tesyting	Y

55	MDA90504C0055	B3	Test Code B 31	Y
----	---------------	----	----------------	---

56	88D0004	56	testing	Y
56	93D0004	2C	TEST	Y

73	89D0002	2F	Tst	Y
73	89D0002	2G	TEST	Y

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TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒ BASIC
PRINTED REPORT TITLE:	Basic Duplicate Claim Report Institutional and Non-Institutional Claim and Line Item Level Data
REPORT DESCRIPTION:	This report lists all of the claims loaded in the system grouped by claim number. The report will show institutional and non-institutional claims. This report format will allow the user to select by Duplicate Flag values. The fields displayed on the report are: Owner FI; ICN; Claim Level User Defined Code; Solicited Indicator; Set Number; Duplicate Flag Value; Reason Code; Processed-To-Completion Date; Responsible FI Number; Sponsor ID; Patient ID; Patient Name; Amount Billed; Amount Paid; Amount Identified For Recoupment; Amount Actually Recouped. For Non-Institutional claims, line item data will also be displayed. The line item fields displayed include: Line Item Number; Line Item Match Type; Procedure Code; Provider Tax ID; Provider Sub-ID; Place of Service; Type of Service; Care Begin Date; Care End Date; Line Item Amount Billed for the Procedure; and Amount Paid for the Procedure. The report identifies and prints all of the claims occurring in sets meeting the criteria selected on the report parameter screen.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters (Claim Set Status, Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus Dupe Flag Indicator; Solicited Indicator; Exclude Base; PTC Date; Set Level User Defined Codes; Claim Level User Defined Codes; Responsible FI; Region; and Enrollment Codes.
REPORT NOTES:	The data used by this report format is claim level and line item level data. If a non-institutional claim exists in more than one set, it will print for each set in which it exists. Each instance of these non-institutional claims existing in multiple sets will contain a different set number on the report.

**BASIC DUPLICATE CLAIM REPORT
INSTITUTIONAL AND NON-INSTITUTIONAL
CLAIM & LINE ITEM LEVEL DATA**

Status Code = All
Adjust Type = All
Owner Type = All
Claim Type = All
Match Type = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Dupe Flag = All
Set Number = All
Set User Codes = All
Exclude Base Claims = No
Solicited = All
Claim User Codes = All
Enroll Codes = All

50 - Acme Claims Processing

ICN	USR CD	S ?	SET#	DUP FLG	RSN CODE	PTC DATE	RESP FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER TAX ID	PROV SUB-ID	AMT BILLED	AMT GOVT PAID	AMT ID RECOUP	AMT ACTUAL RECOUP
19940462508505			251	N	BASE	3/10/1994	50	999999999	9999999990	SMITH,LESUEX	555555555	0000	\$2,175.00	\$933.37	\$0.00	\$0.00
	M Type	CPT-4	Provider Tax ID		Prov Sub ID		POS	TOS	Care Begin Date	Care End	Amt. Billed CPT-4	Govt PD Amt CPT-4				
4	C	99221					21	11	7/20/1992	7/20/1992	\$150.00		\$90.70			
19940462508505			252	N	BASE	3/10/1994	50	999999999	9999999990	SMITH,LESUEX	555555555	0000	\$2,175.00	\$933.37	\$0.00	\$0.00
	M Type	CPT-4	Provider Tax ID		Prov Sub ID		POS	TOS	Care Begin Date	Care End	Amt. Billed CPT-4	Govt PD Amt CPT-4				
3	E	99232					21	11	7/21/1992	7/24/1992	\$450.00		\$385.20			
19940462508505			253	N	BASE	3/10/1994	50	999999999	9999999990	SMITH,LESUEX	555555555	0000	\$2,175.00	\$933.37	\$0.00	\$0.00
	M Type	CPT-4	Provider Tax ID		Prov Sub ID		POS	TOS	Care Begin Date	Care End	Amt. Billed CPT-4	Govt PD Amt CPT-4				
1	N	43235					21	12	7/22/1992	7/22/1992	\$575.00		\$327.00			
19940462508505			254	N	BASE	3/10/1994	50	999999999	9999999990	SMITH,LESUEX	555555555	0000	\$2,175.00	\$933.37	\$0.00	\$0.00
	M Type	CPT-4	Provider Tax ID		Prov Sub ID		POS	TOS	Care Begin Date	Care End	Amt. Billed CPT-4	Govt PD Amt CPT-4				
2	N	45378					21	12	7/27/1992	7/27/1992	\$1,000.00		\$441.60			

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TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒ BASIC BY SET
PRINTED REPORT TITLE:	Basic Duplicate Claim Report By Set Institutional and Non-Institutional Claim and Line Item Level Data
REPORT DESCRIPTION:	This report lists all of the claims loaded in the system grouped by set number. The report will show institutional and non-institutional claims. This report format will allow the user to select by Duplicate Flag values. The fields displayed on the report are: Owner FI; ICN; Claim Level User Defined Code; Solicited Indicator; Set Number; Duplicate Flag Value; Reason Code; Processed-To-Completion Date; Responsible FI Number; Sponsor ID; Patient ID; Patient Name; Amount Billed; Amount Paid; Amount Identified For Recoupment; Amount Actually Recouped. For Non-Institutional claims, line item data will also be displayed. The line item fields displayed include: Line Item Number; Line Item Match Type; Procedure Code; Provider Tax ID; Provider Sub-ID; Place of Service; Type of Service; Care Begin Date; Care End Date; Line Item Amount Billed for the Procedure; and Amount Paid for the Procedure. The report identifies and prints all of the claims occurring in sets meeting the criteria selected on the report parameter screen.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters (Claim Set Status, Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus Dupe Flag Indicator; Solicited Indicator; Exclude Base; PTC Date; Set Level User Defined Codes; Claim Level User Defined Codes; Responsible FI; and Region.
REPORT NOTES:	The data used by this report format is claim level and line item level data. If a non-institutional claim exists in more than one set, it will print for each set in which it exists. Each instance of these non-institutional claims existing in multiple sets will contain a different set number on the report.

**BASIC DUPLICATE CLAIM REPORT BY SET
INSTITUTIONAL AND NON-INSTITUTIONAL
CLAIM & LINE ITEM LEVEL DATA**

Status Code = All
Adjust Type = All
Owner Type = All
Claim Type = All
Match Type = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Dupe Flag = All
Set Number = All
Set User Codes = All
Exclude Base Claims = No
Solicited = All
Claim User Codes = All
Enroll Codes = All

50 - Acme Claims Processing

SET#	ICN	USR CD	S ?	DUP FLG	RSN CODE	PTC DATE	RESP FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER TAX ID	PROV SUB-ID	AMT BILLED	AMT GOVT PAID	AMT ID RECOUP	AMT ACTUAL RECOUP
79862	19962044104011			Y	8/14/1996	8/14/1996	50	999999999	999999990	SMITH,LESLIE,X	555555555	0000	\$625.00	\$69.28	\$0.00	\$0.00
Li#	M Type	CPT-4	Provider Tax ID		Prov Sub ID	Care Begin Date	POS	TOS	Care Begin Date	Care End	Amt. Billed CPT-4	Govt PD Amt CPT-4				
1	O	42100				6/19/1996	11	O2	6/19/1996	6/19/1996	\$510.00		\$81.28			
79862	19962494100571			N	11/05/1996	11/05/1996	50	999999999	999999990	SMITH,LESLIE,X	555555555	0000	\$625.00	\$335.19	\$0.00	\$0.00
Li#	M Type	CPT-4	Provider Tax ID		Prov Sub ID	Care Begin Date	POS	TOS	Care Begin Date	Care End	Amt. Billed CPT-4	Govt PD Amt CPT-4				
1	O	42100				6/19/1996	11	O7	6/19/1996	6/19/1996	\$300.00		\$254.03			
2	O	42100				6/19/1996	11	O2	6/19/1996	6/19/1996	\$210.00		\$81.28			

99 - Inactive Contractor

SET#	ICN	USR CD	S ?	DUP FLG	RSN CODE	PTC DATE	RESP FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER TAX ID	PROV SUB-ID	AMT BILLED	AMT GOVT PAID	AMT ID RECOUP	AMT ACTUAL RECOUP
22221	19951000627827			N	BASE	4/24/1995	99	999999999	999999990	SMITH,LESLIE,X	555555555	0000	\$1,860.00	\$1,075.28	\$0.00	\$0.00
Li#	M Type	CPT-4	Provider Tax ID		Prov Sub ID	Care Begin Date	POS	TOS	Care Begin Date	Care End	Amt. Billed CPT-4	Govt PD Amt CPT-4				
1	N	99214				2/28/1995	11	O1	2/28/1995	2/28/1995	\$70.00		\$53.45			
2	N	93000				2/28/1995	11	O1	2/28/1995	2/28/1995	\$75.00		\$31.32			
3	N	93307				2/28/1995	11	O1	2/28/1995	2/28/1995	\$400.00		\$255.77			

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TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒ INSTITUTIONAL
PRINTED REPORT TITLE:	Institutional Claims
REPORT DESCRIPTION:	This report lists institutional claims grouped by current set status. This report lists institutional claims within their respective sets. The fields displayed on the report are: Owner FI; Institutional Indicator; Status Code; Set Number; ICN; Claim Level User Defined Code; Solicited Indicator; Dupe Flag Indicator; Processed to Completion Date; Responsible FI Number; Sponsor ID; Patient ID; Patient Name; Date of Birth; Provider Nbr; Provider Sub-ID; Amount Billed; Amount Allowed; and Government Paid Amount. The report identifies and prints all of the sets meeting the criteria selected on the report parameter screen. The report groups the claims in ascending set number order.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Claim Type (Claim Set Status, Adjustments, Set Owner Type, Match Type, Date Type, Set Range, FI, Region) plus Dupe Flag Indicator; Solicited Indicator; Exclude Base; PTC Date; Care Dates; Set Level User Defined Codes; Claim Level User Defined Codes; Responsible FI; Region; and Enrollment Codes.
REPORT NOTES:	The data used by this report format is claim level data. The billed and net Government paid amounts are claim level dollar amounts.

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INSTITUTIONAL CLAIMS

Status Code = All
Adjust Type = All
Owner Type = All
Match Type = All
Dupe Flag = All
Set Number = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Exclude Base Claims = No
Enroll Codes = All
Solicited = All
Set User Codes = All
Claim User Codes = All

50 - Acme Claims Processing

INSTITUTIONAL

Status Code : C

SET #	ICN	USR CD	S ?	DUP FLG	PTC DATE	RS FI	SPON ID	PATIENT ID	PATIENT NAME	DOB	PROVIDER NUMBER	PROV SUB-ID	AMT BILLED	AMT ALLOWED	AMT GOVT PAID
6	19942624830562			N	9/22/1994	50	999999999	9999999990	SMITH,LESLIE,X	11/16/1982	555555555	0000	\$6,080.00	\$1,739.29	\$1,739.29
6	19942694832217				9/28/1994	50	999999999	9999999990	SMITH,LESLIE,X	11/16/1982	555555555	0000	\$4,425.00	\$1,304.46	\$1,304.46
23747	19941170620950			N	6/30/1994	50	999999999	9999999990	SMITH,LESLIE,X	7/22/1980	555555555	0001	\$19,236.00	\$19,236.00	\$18,458.00
23747	19942000640016				7/21/1994	99	999999999	9999999990	SMITH,LESLIE,X	7/22/1980	555555555	0001	\$12,868.30	\$8,148.00	\$7,259.90
Status Totals													\$42,609.30	\$30,427.75	\$28,761.65

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INSTITUTIONAL CLAIMS

Status Code = All
Adjust Type = All
Owner Type = All
Match Type = All
Dupe Flag = All
Set Number = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Exclude Base Claims = No
Enroll Codes = All
Solicited = All
Set User Codes = All
Claim User Codes = All

50 - Acme Claims Processing

INSTITUTIONAL

Status Code :V

SET #	ICN	USR CD	S ?	DUP FLG	PTC DATE	RS FI	SPON ID	PATIENT ID	PATIENT NAME	DOB	PROVIDER NUMBER	PROV SUB-ID	AMT BILLED	AMT ALLOWED	AMT GOVT PAID
15	19941882424012			N	7/15/1994	50	999999999	9999999990	SMITH,LESLIE,X	1/06/1932	55555555	0000	\$8,353.93	\$431.50	\$431.50
15	19941882424013				7/25/1994	50	999999999	9999999990	SMITH,LESLIE,X	1/06/1932	55555555	0000	\$7,000.00	\$350.00	\$350.00
22	19933335170207			Y	7/15/1994	50	999999999	9999999990	SMITH,LESLIE,X	5/31/1972	55555555	0000	\$2,763.05	\$1,115.44	\$1,090.44
22	19942575143500			N	7/25/1994	50	999999999	9999999990	SMITH,LESLIE,X	5/31/1972	55555555	0000	\$2,936.87	\$1,115.44	\$1,087.54
Status Totals													\$21,053.85	\$3,012.38	\$2,959.48
Contractor Totals													\$63,663.15	\$3,440.13	\$31,721.13

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Date: 4/29/05
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INSTITUTIONAL CLAIMS

Status Code = All
Adjust Type = All
Owner Type = All
Match Type = All
Dupe Flag = All
Set Number = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Exclude Base Claims = No
Enroll Codes = All
Solicited = All
Set User Codes = All
Claim User Codes = All

73 - HAL Systems Inc

INSTITUTIONAL

Status Code :O

SET #	ICN	USR CD	S ?	DUP FLG	PTC DATE	RS FI	SPON ID	PATIENT ID	PATIENT NAME	DOB	PROVIDER NUMBER	PROV SUB-ID	AMT BILLED	AMT ALLOWED	AMT GOVT PAID
3461	19940474270059			N	3/04/1994	73	999999999	9999999990	SMITH,LESLIE,X	2/04/1994	555555555	0000	\$28,859.00	\$28,859.00	\$28,803.20
3461	19940474270059			N	3/04/1994	73	999999999	9999999990	SMITH,LESLIE,X	2/04/1994	555555555	0000	\$28,859.00	\$28,859.00	\$28,803.20
3461	19940474270059			N	3/04/1994	73	999999999	9999999990	SMITH,LESLIE,X	2/04/1994	555555555	0000	\$28,859.00	\$28,859.00	\$28,803.20
Status Totals													\$89,539.40	\$53,450.92	\$53,395.12
Contractor Totals													\$89,539.40	\$53,450.92	\$53,395.12
Report Totals													\$153,202.55	\$85,116.25	\$86,891.05

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TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒NON-INSTITUTIONAL ⇒ BY CLAIM
PRINTED REPORT TITLE:	Non-Institutional Claims
REPORT DESCRIPTION:	This report lists non-institutional claims grouped by current set status. This report lists non- institutional claims within their respective sets. The fields displayed on the report are: Owner FI; Region; Set Status Code; ICN; Claim Level User Defined Code; Solicited Indicator; Set Number; Dupe Flag Indicator; Processed to Completion Date; Responsible FI; Sponsor ID; Patient ID; Patient Name; Date of Birth; Amount Billed; Amount Allowed; and Government Paid Amount. The report identifies and prints all of the sets meeting the criteria selected on the report parameter screen. The report groups the claims in ascending set number order.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Claim Type (Claim Set Status, Adjustments, Set Owner Type, Match Type, Date Type, Set Range, FI, Region) plus Dupe Flag Indicator, Solicited Indicator, Exclude Base, Processed To Completion date, Care dates, Set Level User Defined Codes, Claim Level User Defined Codes, Responsible FI, Region, and Enrollment Codes.
REPORT NOTES:	The data used by this report format is claim level data. The billed, paid and net Government paid amounts are claim level not line-item level dollar amounts.

Date: 4/29/05
Page 1

NON-INSTITUTIONAL CLAIMS

Status Code = All
Adjust Type = All
Owner Type = All
Match Type = All
Dupe Flag = All
Set Number = All
Solicited = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Set User Codes = All
Claim User Codes = All
Exclude Base Claims = No
Enroll Codes = All

50 - Acme Claims Processing

Undetermined Region

Status Code: O

ICN	USR CD	S ?	SET #	DUP FLG	PTC DATE	RS FI	SPON ID	PATIENT ID	PATIENT NAME	DOB	AMT BILLED	AMT ALLOWED	AMT GOVT PAID
19963123242029			76070		11/15/1996	50	999999999	9999999990	SMITH,LESLIE,X	11/01/1932	\$2,700.00	\$1,005.60	\$754.20
19960814823188			76527	N	8/02/1996	50	999999999	9999999990	SMITH,LESLIE,X	9/23/1937	\$681.00	\$177.34	\$165.34
19963024810904			76527		11/04/1996	50	999999999	9999999990	SMITH,LESLIE,X	9/23/1937	\$681.00	\$177.34	\$165.34

Status Totals
\$4,062.00
\$1,360.28
\$1,084.88

Status Code: V

ICN	USR CD	S ?	SET #	DUP FLG	PTC DATE	RS FI	SPON ID	PATIENT ID	PATIENT NAME	DOB	AMT BILLED	AMT ALLOWED	AMT GOVT PAID
19941925400374	B4		122	N	7/25/1994	50	999999999	9999999990	SMITH,LESLIE,X	9/28/1899	\$455.00	\$307.10	\$230.32

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NON-INSTITUTIONAL CLAIMS

Status Code = All
Adjust Type = All
Owner Type = All
Match Type = All
Dupe Flag = All
Set Number = All
Solicited = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Set User Codes = All
Claim User Codes = All
Exclude Base Claims = No
Enroll Codes = All

50 - Acme Claims Processing

Undetermined Region

Status Code: V

ICN	USR CD	S ?	SET #	DUP FLG	PTC DATE	RS FI	SPON ID	PATIENT ID	PATIENT NAME	DOB	AMT BILLED	AMT ALLOWED	AMT GOVT PAID
19942065400200	B4		122		8/10/1994	50	999999999	9999999990	SMITH,LESLIE,X	9/28/1899	\$455.00	\$307.10	\$230.32
Status Totals											\$910.00	\$614.20	\$460.64
Region Totals											\$4,972.00	\$1,974.48	\$1,545.52
Contractor Totals											\$4,972.00	\$1,974.48	\$1,545.52

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TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

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NON-INSTITUTIONAL CLAIMS

Status Code = All
Adjust Type = All
Owner Type = All
Match Type = All
Dupe Flag = All
Set Number = All
Solicited = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Set User Codes = All
Claim User Codes = All
Exclude Base Claims = No
Enroll Codes = All

99 - Inactive Contractor

Inactive-Area 20

Status Code: 0

ICN	USR CD	S ?	SET #	DUP FLG	PTC DATE	RS FI	SPON ID	PATIENT ID	PATIENT NAME	DOB	AMT BILLED	AMT ALLOWED	AMT GOVT PAID
19951000627827			22221	N	4/24/1995	99	9999999999	9999999990	SMITH,LESLIE,X	9/20/1948	\$1,860.00	\$1,090.56	\$1,075.56
19951240640035			22221		05/11/1995	99	9999999999	9999999990	SMITH,LESLIE,X	9/20/1948	\$400.00	\$229.63	\$229.63
19951240640036			22221		05/11/1995	99	9999999999	9999999990	SMITH,LESLIE,X	9/20/1948	\$1,245.00	\$721.78	\$721.78
Status Totals											\$3,505.00	\$2,041.97	\$2,026.97
Region Totals											\$3,505.00	\$2,041.97	\$2,026.97
Contractor Totals											\$3,505.00	\$2,041.97	\$2,026.97
Grand Totals											\$8,477.00	\$4,016.45	\$3,572.49

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TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒NON-INSTITUTIONAL ⇒ BY LINE ITEM
PRINTED REPORT TITLE:	Non-Institutional Claims By Line Item
REPORT DESCRIPTION:	This report lists non-institutional claims grouped by current set status. This report displays line-item data. The fields displayed on the report are: Owner FI; Region; Set Status Code; ICN; Claim Level User Defined Code; Solicited Indicator; Set Number; Responsible FI; Sponsor ID; Patient ID; Patient Name; Provider Number; Provider Sub-ID; Line Item Number; CPT-4 Code; Care Begin Date; Care End Date; and Amount Paid CPT-4 Code. The report identifies and prints all of the sets meeting the criteria selected on the report parameter screen. The report groups the claims in ascending set number order.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Claim Type (Claim Set Status, Adjustments, Set Owner Type, Match Type, Date Type, Set Range, FI, Region) plus Dupe Flag Indicator, Solicited Indicator, Exclude Base, PTC Date; Care Dates; Set Level User Defined Codes; Claim Level User Defined Codes; Responsible FI; Region; and Enrollment Codes.
REPORT NOTES:	The data used by this report format is line item level data. The paid amounts are line item level dollar amounts.

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Report Descriptions And Examples

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NON-INSTITUTIONAL CLAIMS BY LINE ITEM

Status Code = All
Owner Type = All
Adjust Type = All
Match Type = All
Dupe Flag = All
Solicited = All
Set Number = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Exclude Base Claims = No
Set User Codes = All
Claim User Codes = All
Enroll Codes = All

50 - Acme Claims Processing

Undetermined Region

Status Code: O

ICN	USR CD	S?	SET #	RESP FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER NUMBER	PROV SUB-ID	LI	CPT-4 CODE	CARE BEGIN	CARE END	AMT GOVT PD CPT-4 CODE
19962044104011			79862	50	999999999	999999999	SMITH,LESLIE,X			1	42100	06/19/1996	06/19/1996	\$81.28
19962494100571			79862	50	999999999	999999999	SMITH,LESLIE,X			1	42100	06/19/1996	06/19/1996	\$254.03
19962494100571			79862	50	999999999	999999999	SMITH,LESLIE,X			2	42100	06/19/1996	06/19/1996	\$81.28
Status Total														\$416.59

Status Code: V

ICN	USR CD	S?	SET #	RESP FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER NUMBER	PROV SUB-ID	LI	CPT-4 CODE	CARE BEGIN	CARE END	AMT GOVT PD CPT-4 CODE
19941925400374	B4		122	50	999999999	999999999	SMITH,LESLIE,X			2	99231	04/22/1994	04/22/1994	\$125.08
19942065400200	B4		122	50	999999999	999999999	SMITH,LESLIE,X			3	99231	04/22/1994	04/22/1994	\$254.03
Status Total														\$250.16
Region Total														\$666.75
Contractor Total														\$666.75

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TRICARE Operations Manual 6010.56-M, February 1, 2008

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NON-INSTITUTIONAL CLAIMS BY LINE ITEM

Status Code = All
Owner Type = All
Adjust Type = All
Match Type = All
Dupe Flag = All
Solicited = All
Set Number = All
Owner Fl = All
Owner Region = All
Resp Fl = All
Resp Region = All
Exclude-Base Claims = No
Set User Codes = All
Claim User Codes = All
Enroll Codes = All

99 - Inactive Contractor

Inactive-Area 20

Status Code: O

ICN	USR CD	S?	SET #	RESP FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER NUMBER	PROV SUB-ID	LI	CPT-4 CODE	CARE BEGIN	CARE END	AMT GOVTPD CPT-4 CODE
19951000627827			22221	99	9999999999	9999999990	SMITH,LESLIE,X			1	99214	02/28/1995	02/28/1995	\$53.45
19951000627827			22221	99	9999999999	9999999990	SMITH,LESLIE,X			2	93000	02/28/1995	02/28/1995	\$31.32
19951000627827			22221	99	9999999999	9999999990	SMITH,LESLIE,X			3	93307	02/28/1995	02/28/1995	\$255.77
19951000627827			22221	99	9999999999	9999999990	SMITH,LESLIE,X			4	93320	02/28/1995	02/28/1995	\$134.97
Status Total													\$475.51	
Region Total													\$475.51	
Contractor Total													\$475.51	
Grand Total													\$1,142.26	

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TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒RISK ⇒ RISK BASIC
PRINTED REPORT TITLE:	Risk Report By ICN
REPORT DESCRIPTION:	This report provides a listing of claims based on the Risk Indicator values selected by the user. The Risk Indicator identifies the claim as either financially underwritten or non-financially underwritten. The claims are grouped by claim number. The report can show both institutional and non- institutional claims. The fields displayed on the report are: Owner FI; Region; ICN; Claim Level User Defined Code; Solicited Indicator; Set Number; Duplicate Flag Value; Risk Indicator; Responsible FI; Sponsor ID; Patient ID; Patient Name; Provider Number; Provider Sub-ID; Amount Billed; Amount Paid; Government Paid Amount; Amount Identified For Recoupment; Amount Actually Recouped; Adjustment Amount.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters (Claim Set Status, Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus Dupe Flag Indicator, Solicited Indicator, Exclude Base, PTC Dates, Care Dates, Set Level User Defined Codes, Claim Level User Defined Codes, Responsible FI, Region, Risk Indicator, and Enrollment Codes.
REPORT NOTES:	The data used by this report format is claim level data. For non-institutional claims, the billed, paid and net Government paid amounts are claim level not line-item level dollar amounts.

RISK REPORT BY ICN

Status Code = All
 Owner Type = All
 Claim Type = All
 Adjust Type = All
 Match Type = All
 Exclude Base Claims = No
 Owner Fl = All
 Owner Region = All
 Resp Fl = All
 Resp Region = All
 Enroll Codes = All
 Set Number = All
 Dupe Flag = All
 Solicited = All
 Claim User Codes = All
 Set User Codes = All
 Risk Ind = All

**50 - Acme Claims Processing
Undetermined Region**

ICN	USR CD	S ?	SET #	DUP FLG	RSK IND	RS FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER NUMBER	PROV SUB-ID	AMT BILLED	AMT ALLOWED	GOV PAID	ID RECOUP	ACTUAL RECOUP	ADJ AMOUNT
19933335170207			22	Y	N	50	999999999	999999999	SMITH,LESLIE,X	555555555	0000	\$2,763.05	\$1,115.44	\$1,090.44	\$1,000.00	\$1,000.00	\$1,115.44
19963024810904			76527		A	50	999999999	999999999	SMITH,LESLIE,X	555555555	A004	\$681.00	\$177.34	\$165.34	\$0.00	\$0.00	\$0.00
19963123242029			76070		N	50	999999999	999999999	SMITH,LESLIE,X	555555555	A001	\$2,700.00	\$1,005.60	\$734.20	\$0.00	\$0.00	\$0.00
19963240508876			77347		A	50	999999999	999999999	SMITH,LESLIE,X	555555555	0000	\$8,617.99	\$3,478.39	\$3,442.12	\$0.00	\$0.00	\$0.00
Region Totals													\$5,776.77	\$1,000.00	\$1,000.00	\$1,115.44	
Contractor Totals													\$5,776.77	\$1,000.00	\$1,000.00	\$1,115.44	

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 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRIVACY RULE IN REGARD TO THAT ACT, AND THE DOD 6025.18-R, DOD HEALTH INFORMATION PRIVACY REGULATION.

RISK REPORT BY ICN

Status Code = All
 Owner Type = All
 Claim Type = All
 Adjust Type = All
 Match Type = All
 Exclude-Base Claims = No
 Owner Fl = All
 Owner Region = All
 Resp Fl = All
 Resp Region = All
 Enroll Codes = All
 Set Number = All
 Dupe Flag = All
 Solicited = All
 Claim User Codes = All
 Set User Codes = All
 Risk Ind = All

**73 - HAL Systems Inc
Area 73A**

ICN	USR CD	S ?	SET #	DUP FLG	RSK IND	RS FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER NUMBER	PROV SUB-ID	AMT BILLED	AMT ALLOWED	GOV PAID	ID RECOUP	ACTUAL RECOUP	ADJ AMOUNT	
19940474270059			3461	N	N	73	999999999	999999999	SMITH,LESLIE,X	555555555	0000	\$28,859.00	\$28,859.00	\$28,803.20	\$0.00	\$0.00	\$0.00	
19942844200023			3461	N	N	50	999999999	999999999	SMITH,LESLIE,X	555555555	0000	\$30,340.20	\$12,295.96	\$12,295.96	\$0.00	\$0.00	\$0.00	
19950334208001			3461	N	N	50	999999999	999999999	SMITH,LESLIE,X	555555555	0000	\$30,340.20	\$12,295.96	\$12,295.96	\$0.00	\$0.00	\$0.00	
Region Totals												\$53,450.92	\$53,450.92	\$53,395.12	\$0.00	\$0.00	\$0.00	
Contractor Totals												\$89,539.40	\$53,450.92	\$53,395.12	\$0.00	\$0.00	\$0.00	\$0.00
Report Totals												\$104,301.44	\$59,227.69	\$58,847.22	\$1,000.00	\$1,000.00	\$1,115.44	\$1,115.44

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Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒RISK ⇒ RISK BY SET
PRINTED REPORT TITLE:	Risk Report By Set Number
REPORT DESCRIPTION:	This report provides a listing of claims based on the Risk Indicator values selected by the user. The Risk Indicator identifies the claim as either financially underwritten or non-financially underwritten. The claims are grouped by set number. The report can show both institutional and non-institutional claims. The fields displayed on the report are: Owner FI; Region; Set Number; ICN; Claim Level User Defined Code; Solicited Indicator; Duplicate Flag Value; Risk Indicator; Responsible FI; Sponsor ID; Patient ID; Patient Name; Provider Number; Provider Sub-ID; Amount Billed; Amount Allowed; Government Paid Amount; Amount Identified For Recoupment; Amount Actually Recouped; Adjustment Amount.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters (Claim Set Status, Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus Dupe Flag Indicator, Solicited Indicator, Exclude Base, PTC Dates, Care Dates, Set Level User Defined Codes, Claim Level User Defined Codes, Responsible FI, Region, Risk Indicator, and Enrollment Codes.
REPORT NOTES:	The data used by this report format is claim level data. For non-institutional claims, the billed, paid and net Government paid amounts are claim level not line-item level dollar amounts.

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RISK REPORT BY SET NUMBER

Status Code = All
 Adjust Type = All
 Owner Type = All
 Exclude Base Claims = No
 Claim Type = All
 Match Type = All
 Dupe Flag = All
 Set Number = All
 Owner Fl = All
 Resp Region = All
 Owner Region = All
 Resp Fl = All
 Solicited = All
 Set User Codes = All
 Claim User Codes = All
 Risk Ind = All
 Enroll Codes = All

50 - Acme Claims Processing

Undetermined Region

SET #	ICN	USR CD	S ?	DUP FLG	RSK IND	RS FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER NUMBER	PROV SUB-ID	AMT BILLED	AMT ALLOWED	GOV PAID	ID RECOUP	ACTUAL RECOUP	ADJ AMOUNT
22	19933335170207			Y	N	50	999999999	9999999990	SMITH,LESLIE,X	555555555	0000	\$2,763.05	\$1,115.44	\$1,090.44	\$1,000.00	\$1,000.00	\$1,115.44
39	19942715160390				N	50	999999999	9999999990	SMITH,LESLIE,X	555555555	0001	\$825.86	\$226.30	\$226.30	\$0.00	\$0.00	\$0.00
Region Totals													\$1,341.74	\$1,316.74	\$1,000.00	\$1,115.44	
Contractor Totals													\$1,341.74	\$1,316.74	\$1,000.00	\$1,115.44	

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RISK REPORT BY SET NUMBER

Status Code = All
 Adjust Type = All
 Owner Type = All
 Exclude Base Claims = No
 Claim Type = All
 Match Type = All
 Dupe Flag = All
 Set Number = All
 Owner FI = All
 Resp Region = All
 Owner Region = All
 Resp FI = All
 Solicited = All
 Set User Codes = All
 Claim User Codes = All
 Risk Ind = All
 Enroll Codes = All

99 - Inactive Contractor

Inactive-Area 20

SET #	ICN	USR CD	S ?	DUP FLG	RSK IND	RS FI	SPON ID	PATIENT ID	PATIENT NAME	PROV NUMBER	PROV SUB-ID	AMT BILLED	AMT ALLOWED	GOV PAID	ID RECOUP	ACTUAL RECOUP	ADJ AMOUNT
22221	19951000627827			N	A	99	999999999	999999999	SMITH,LESLIE,X	555555555	0000	\$1,860.00	\$1,090.56	\$1,075.56	\$0.00	\$0.00	\$0.00
Region Totals																	
												\$1,860.00	\$1,090.56	\$1,075.56	\$0.00	\$0.00	\$0.00

Inactive-Area 30

SET #	ICN	USR CD	S ?	DUP FLG	RSK IND	RS FI	SPON ID	PATIENT ID	PATIENT NAME	PROV NUMBER	PROV SUB-ID	AMT BILLED	AMT ALLOWED	GOV PAID	ID RECOUP	ACTUAL RECOUP	ADJ AMOUNT
55	19932980656126			N	A	99	999999999	999999999	SMITH,LESLIE,X	555555555	0002	\$95,435.32	\$201,551.67	\$226.30	\$0.00	\$0.00	\$0.00
Region Totals																	
												\$95,435.32	\$201,551.67	\$226.30	\$0.00	\$0.00	\$0.00
Contractor Totals																	
												\$97,295.32	\$202,642.22	\$1,301.85	\$0.00	\$0.00	\$0.00
Report Totals																	
												\$100,884.23	\$203,983.96	\$2,618.59	\$1,000.00	\$1,000.00	\$1,115.44

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Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒RISK ⇒ RISK SUMMARY
PRINTED REPORT TITLE:	Risk Summary Report
REPORT DESCRIPTION:	This report summarizes by Region the amounts billed, paid and Government paid amounts, as well as the amounts identified for recoupment, amounts actually recouped, and adjustment amounts. The fields displayed on the report are: Owner FI; Region; Amount Billed; Amount Allowed; Government Paid Amount; Amount Identified for Recoupment; Amount Actually Recouped; and Adjustment Amount.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters (Claim Set Status, Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus Dupe Flag Indicator, Solicited Indicator, Exclude Base, PTC Dates, Care Dates, Set Level User Defined Codes, Claim Level User Defined Codes, Responsible FI, Region, Risk Indicator, and Enrollment Code.
REPORT NOTES:	The data used by this report format is claim level data. For non-institutional claims, the billed, paid and net Government paid amounts are claim level not line-item level dollar amounts.

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Report Descriptions And Examples

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RISK SUMMARY REPORT

Status Code = All
Adjust Type = All
Owner Type = All
Exclude Base Claims = No
Claim Type = All
Match Type = All
Dupe Flag = All
Set Number = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Risk Ind = All
Solicited = All
Set User Codes = All
Claim User Codes = All
Enroll Codes = All

55 - East West Claims						
	Amt Billed	Amt Allowed	Govt Paid	ID Recoup	Actual Recoup	Adj Amt
Area 55	\$12,120.92	\$6,207.16	\$6,157.16	\$0.00	\$0.00	\$0.00
Contractor Totals	\$12,120.92	\$6,207.16	\$6,157.16	\$0.00	\$0.00	\$0.00
99 - Inactive Contractor						
	Amt Billed	Amt Allowed	Govt Paid	ID Recoup	Actual Recoup	Adj Amt
Inactive-Area 20	\$3,505.00	\$2,041.97	\$2,026.97	\$0.00	\$0.00	\$0.00
Inactive-Area 30	\$721,760.08	\$602,283.44	\$602,283.44	\$0.00	\$0.00	\$0.00
Contractor Totals	\$725,265.08	\$604,325.41	\$604,310.41	\$0.00	\$0.00	\$0.00
Grand Totals	\$737,386.00	\$610,532.57	\$610,467.57	\$0.00	\$0.00	\$0.00

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Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒PROVIDER ⇒ CLAIM COUNTS
PRINTED REPORT TITLE:	Provider Claim Count Report Grouped By Provider Number and Sub-ID
REPORT DESCRIPTION:	This report provides a total count by Provider Tax ID and Provider Sub-ID of all claims associated with selected providers. The fields displayed are: Provider Tax ID; Provider Sub-ID; and Total Number of Claims.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Last (update) Date, Set Range (Claim Set Status; Adjustments, Set Owner Type; Claim Type, Match Type, Date Type, Set Range, FI, Region) plus Dupe Flag Indicator, PTC Dates, Responsible FI, Region, Provider Tax IDs, and Enrollment Code.
REPORT NOTES:	The data used by this report format is claim level data.

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Report Descriptions And Examples

Status Code = All
 Adjust Type = All
 Owner Type = All
 Claim Type = All
 Match Type = All
 SetNumFrame
 Dupe Flag = All
 Owner Fl = All
 Owner Region = All
 Resp Fl = All
 Resp Region = All
 Provider Tax Codes = All
 Enroll Codes = All

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**PROVIDER CLAIM COUNT REPORT
 GROUPED BY PROVIDER NUMBER AND SUB ID**

Tax ID : 55555555	#Claims
--------------------------	----------------

Sub ID: 0000		
	<u>Sub Id Totals:</u>	81
Sub ID: 0001		
	<u>Sub Id Totals:</u>	14
Sub ID: 0002		
	<u>Sub Id Totals:</u>	6
Sub ID: 0003		
	<u>Sub Id Totals:</u>	4
Sub ID: 0004		
	<u>Sub Id Totals:</u>	2
Sub ID: 0005		
	<u>Sub Id Totals:</u>	2
Sub ID: 0008		
	<u>Sub Id Totals:</u>	2
Sub ID:		
	<u>Sub Id Totals:</u>	7
	<u>Tax Id Totals:</u>	111

Tax ID :	#Claims
-----------------	----------------

Sub ID:		
	<u>Sub Id Totals:</u>	107
	<u>Tax Id Totals:</u>	94

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Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒PROVIDER ⇒ CLAIM DETAIL
PRINTED REPORT TITLE:	Provider Claim Detail Report Grouped By Provider Number And Sub ID
REPORT DESCRIPTION:	This report provides a listing of claims grouped by Provider Tax ID and Sub-ID, associated with selected providers. The fields displayed are: Provider Tax ID; Provider Sub-ID; ICN; Time Stamp; Claim Level User Defined Code; Solicited Indicator; Set #; Duplicate Flag Indicator; Sponsor ID; Patient ID; Patient Name; Amount Govt Paid; PTC Date; Responsible FI; Total Number of Claims and Total Paid Amounts by Provider Sub-ID; and Total number of Claims and Total Paid Amounts by Provider Tax ID.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Last (update) Dates (Owner Type, Claim Set Status; Adjustments, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus Dupe Flag Indicator, Solicited Indicator, PTC Dates, Responsible FI, Region, Set Level User Defined Codes, Claim Level User Defined Codes, and Provider Tax IDs, and Enrollment Codes.
REPORT NOTES:	The data used by this report format is claim level data.

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Chapter 9, Addendum D
Report Descriptions And Examples

Status Code = All
Adjust Type = All
Claim Type = All
Owner Type = All
Match Type = All
Dupe Flag = All
Set Number = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Provider Tax Codes = All
Solicited = All
Set User Codes = All
Claim User Codes = All
Enroll Codes = All

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**PROVIDER CLAIM DETAIL REPORT
GROUPED BY PROVIDER NUMBER AND SUB ID**

Prov Tax ID 55555555

Sub ID 0008

ICN	TIME	USER CODE	S ?	SET#	DUP FLG	SPON ID	PATIENT ID	PATIENT NAME	AMT GOVT PAID	PTC DATE	RESP FI	
19941300621078	000000			63		999999999	999999990	SMITH,LESLIE,X	\$21,915.94	6/30/1994	50	
19941360665510	000000			63	N	999999999	999999990	SMITH,LESLIE,X	\$21,915.94	6/10/1994	99	
								#CLAIMS				
								SUB ID TOTALS	2	TOTAL AMT PAID		
									\$43,831.85			

Sub ID

19940424543435	999999			35		999999999	999999990	SMITH,LESLIE,X	\$42,877.69	10/14/1994	50	
19940424543435	999999			15		999999999	999999990	SMITH,LESLIE,X	\$8,353.93	10/14/1994	50	
19940424543435	999999			26697		999999999	999999990	SMITH,LESLIE,X	\$4,322.84	7/18/1995	50	
19940424543435	999999			74334		999999999	999999990	SMITH,LESLIE,X	\$2,042.84	11/12/1996	50	
19940424543435	999999			66804		999999999	999999990	SMITH,LESLIE,X	\$5,721.12	8/28/1996	50	
19940424543435	999999			71410		999999999	999999990	SMITH,LESLIE,X	\$1,658.54	10/16/1996	50	
19940424543435	999999			74409		999999999	999999990	SMITH,LESLIE,X	\$1,045.74	11/08/1996	50	
								#CLAIMS				
								SUB ID TOTALS	7	TOTAL AMT PAID		
									\$66,022.70			
								TAX ID TOTALS	9	\$109,854.55		

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TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D Report Descriptions And Examples

REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒PROVIDER ⇒ CPT-4
PRINTED REPORT TITLE:	Provider CPT-4 Report Grouped By Provider Tax ID and Sub ID (CPT-4 Claim Level Match Types Only)
REPORT DESCRIPTION:	<p>This report shows line items which appear on non-institutional claims which carry a CPT-4 match type ('C') at the claim level (see REPORT NOTES below). Due to the way the Duplicate Claims System assigns match types to claims and sets, this report must be used very carefully. Users have the option in this report of selecting actual duplicate claims only. The user may think that the report is showing only actual duplicate line items identified by the CPT-4 match type criteria. In fact, the report is showing the line-items of actual ('Y') non-institutional duplicate claims which have been assigned a match type of CPT-4 (see REPORT NOTES below). As a result, line items identified using the OTHER match type may appear on this report along with the line items identified under the CPT-4 criteria which caused the claim to be assigned the match type of CPT-4. This report will not show any line items identified under the EXACT or NEAR match criteria since line items identified using the EXACT and NEAR match would force the claim(s) to be assigned a higher level match type than CPT- 4. This report looks for only those actual duplicate non-institutional claims with a match type of CPT- 4 and then lists the line items on those claims.</p> <p>This report can be used by Program Integrity staff to obtain a listing of the claims carrying a match type of CPT-4 and their associated line items. Using the Provider Claim Count Report, users can identify the provider numbers associated with high volumes of non-institutional claims involving line items whose last two digits of the procedure code have been changed. Then using the Provider CPT-4 Report and entering those provider numbers identified, the user can generate a listing of the non- institutional claims with line item details associated with those provider numbers.</p> <p>The fields displayed on this report are: ICN; Time Stamp; Claim Level User Defined Code; Solicited Indicator; Set #; Duplicate Flag Indicator; Sponsor ID; Patient ID; Patient Name; Line Item Match Type; Line Item Number; CPT-4 Code; Amount Paid CPT-4; PTC Date; and Responsible FI. The report is grouped by Provider Number and Sub-ID and provides sub-totals for each provider Sub-ID and grand totals for each provider Tax-ID. The sub-totals and grand totals sum the number of line items and the total Paid dollars.</p>

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D Report Descriptions And Examples

REPORT PARAMETER OPTIONS:

Users may customize the report by selecting: All "Standard" parameters minus Match Type, Claim Type, Last Dates, Set Range (Set Owner Type, Claim Set Status, Adjustments, Date Type, FI, Region) plus Dupe Flag Indicator, Solicited Indicator, PTC Dates, Responsible FI, Region, Set Level User Defined Codes, Claim Level User Defined Codes, and Provider Tax ID.

Users may customize the report by selecting: All claims or actual duplicate claims only (to be counted as an actual duplicate claim, it must have a "Y" Duplicate Flag value and be in a PENDING, VALIDATE, or CLOSED set); status (All, Open, Pending, Closed, Validate); only sets that have adjustments associated with them; multi-FI sets, single FI sets, or both; **set** match type (All, Exact, Near, Date Overlap, CPT-4, Other); a single processed-to-completion date or a range of processed-to-completion dates; a single load date or a range of load dates; one or all FIs; one, several or all regions within selected FIs. Users may also select one, several or all Provider Tax ID numbers to be included in the report.

REPORT NOTES:

Match types are applied at the line-item, claim, and set levels based on a hierarchy. The most stringent match type applicable is assigned at each level. The hierarchy for institutional claims is as follows: Exact, Near, Date Overlap and Other. For non-institutional claims, the hierarchy is as follows: Exact, Near, CPT-4, and Other. For both claim types, Exact Match criteria is the most stringent with Near Match next. Other Match is the least stringent. When the Duplicate Claims System identifies non-institutional potential duplicates, it is doing so at a **line item** level. When a line item is identified as a potential duplicate, the system labels the **line item** with the Match Type used to identify it as a potential duplicate. If a non-institutional **claim** contains line items identified as potential duplicates using more than one match type criteria (one line item identified under Exact Match criteria and another line item under CPT-4 criteria), the system uses the match type hierarchy and labels the **claim** with the most stringent match type appearing on the line items. If the **set** contains **claims** labeled with different match types (one claim labeled 'Near' and another labeled 'CPT-4'), the system uses the match type hierarchy and labels the **set** with the most stringent match type appearing on the claims.

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Chapter 9, Addendum D
Report Descriptions And Examples

Status Code = All
 Adjust Type = All
 Owner Type = All
 Dupe Flag = All
 Match Type = All
 Owner FI = All
 Owner Region = All
 Resp FI = All
 Resp Region = All
 Provider Tax Codes = All
 Set User Codes = All
 Solicited = All
 Claim User Codes = All

Date: 4/29/05
 Page 1

**PROVIDER CPT-4 REPORT
 GROUPED BY PROVIDER TAX ID AND SUB ID
 (CPT-4 CLAIM LEVEL MATCH TYPES ONLY)**

ICN	TIME	USER CODE	S ?	SET#	DUP FLG	PATIENT ID	PATIENT NAME	LI Match	LINE Item #	CPT-4 Code	AMT PAID CPT-4 CODE	PTC DATE	RESP FI
Tax ID:													
Sub ID:													
19941362501086	000000			226		9999999990	SMITH,LESLIE,X	C	1	90812	\$90.00	10/13/1994	50
19942692501409	000000			226	N	9999999990	SMITH,LESLIE,X	C	1	90844	\$80.11	10/09/1994	50
19941362501086	000000			227		9999999990	SMITH,LESLIE,X	C	2	90812	\$90.00	10/13/1994	50
19942692501409	000000			227	N	9999999990	SMITH,LESLIE,X	C	2	90844	\$80.11	10/09/1994	50
19940462508505	000000			251	N	9999999990	SMITH,LESLIE,X	C	4	99221	\$90.70	3/10/1994	50
19942022508010	000000			251		9999999990	SMITH,LESLIE,X	C	4	99291	\$150.00	8/04/1994	50
19941640617670	000000			4899	N	9999999990	SMITH,LESLIE,X	C	1	98330	\$366.80	8/04/1994	50
19941640617670	000000			4899	N	9999999990	SMITH,LESLIE,X	C	2	98335	\$133.00	8/04/1994	50
19942340621783	000000			4899		9999999990	SMITH,LESLIE,X	C	1	98310	\$183.50	11/14/1994	99
19942340621783	000000			4899		9999999990	SMITH,LESLIE,X	C	2	98315	\$133.00	11/14/1994	99
									#LINE ITEMS		TOTAL AMT PAID		
									SUB ID TOTALS		10 \$1,397.22		
									TAX ID TOTALS		10 \$1,397.22		

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TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒ CLAIM REPORTS ⇒ REASON CODE EXPLANATION ⇒ INDIVIDUAL CLAIMS
PRINTED REPORT TITLE:	Reason Code Explanation Report Individual Claims
REPORT DESCRIPTION:	This report provides a listing of the explanations associated with reason codes on individual claims. The Duplicate Claims System requires that an explanation be entered when certain reason codes are used to describe why a claim is or is not a duplicate claim. This report prints the reason code explanation associated with a claim. Individual claim data is grouped within their respective sets. The fields displayed on this report are: Owner FI; Region; Set Number; Set Status; Current Load Date; ICN; Time Stamp; Responsible FI; PTC Date; Dupe Flag Indicator; Reason Code; and Reason Code Explanation.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters (Claim Set Status, Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus Responsible FI, Region, Reason Codes, and Base Claims.
REPORT NOTES:	The data used by this report format is claim level data.

**REASON CODE EXPLANATION REPORT
INDIVIDUAL CLAIMS**

Status Code = All
 Owner Type = All
 Claim Type = All
 Adjust Type = All
 Match Type = All
 Owner FI = All
 Owner Region = All
 Resp FI = All
 Resp Region = All
 Include Base? = N
 Set Number = All
 Reason Codes = All

**50 - Acme Claims Processing
Undetermined Region**

SET #	STATUS	CURRENT LOAD DATE	ICN	TIME	S?	RESP FI	PTC DATE	DUP FLG	RSN CODE	REASON CODE EXPLANATION
35	O	12/16/1996	19940424543435	9999999		50	10/14/1994	Y	D900	This is to test the Reason Code Explanation

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TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒ CLAIM REPORTS ⇒ REASON CODE EXPLANATION ⇒ ENTIRE SET
PRINTED REPORT TITLE:	Reason Code Explanation Report Entire Set
REPORT DESCRIPTION:	This report provides a listing of the explanations associated with reason codes by set number. The Duplicate Claims System requires that an explanation be entered when certain reason codes are used to describe why a claim is or is not a duplicate claim. This report prints the reason code explanations associated with the claims in a set. Individual claim data is grouped within their respective sets. The fields displayed on this report are: Owner FI; Region; Set Number; Set Status; Current Load Date; ICN; Time Stamp; Responsible FI; PTC Date; Dupe Flag Indicator; Reason Code; and Reason Code Explanation.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters (Claim Set Status, Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus Responsible FI, Region, Reason Codes, and PTC Date.
REPORT NOTES:	The data used by this report format is claim level data.

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Chapter 9, Addendum D
Report Descriptions And Examples

Status Code = All
 Owner Type = All
 Claim Type = All
 Adjust Type = All
 Match Type = All
 Owner FI = All
 Owner Region = All
 Resp FI = All
 Resp Region = All
 Reason Codes = All
 Set Number = All

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**REASON CODE EXPLANATION REPORT
 ENTIRE SET**

50 - Acme Claims Processing

Undetermined Region

SET #	STATUS	CURRENT LOAD DATE
35	O	12/16/1996

ICN	TIME	S?	RESP FI	PTC DATE	DUPE FLAG	RSN CODE	REASON CODE
19940424543435	999999		50	10/14/1994	Y	D900	This is to test the Reason Code Explanation

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TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒ ADJUSTMENTS
PRINTED REPORT TITLE:	Claims With Associated Adjustments
REPORT DESCRIPTION:	This report provides a listing of claims, grouped in their respective sets, with any associated adjustment claims which have been submitted. Only sets which contain one or more claims that have associated adjustments will be listed. The fields displayed on the report are: Owner FI; Region; Set Number; ICN; Time Stamp; Dupe Flag Indicator; Reason Code; Responsible FI; Sponsor ID; Patient ID; Patient Name; Provider ID; Provider Sub-ID; Claim Level Paid; Line Item Number; Line Item Paid Amount; Adjustment Flag; Adjustment Line Item; and Adjustment Paid Amount.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Adjustments (Claim Set Status, Set Owner Type, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus PTC Dates, Responsible FI, Region, Claim Level User Defined Codes.
REPORT NOTES:	The data used by this report format is claim and line item level data.

CLAIMS WITH ASSOCIATED ADJUSTMENTS

Status Code = All
SetAdjustFrame = All
Owner Type = All
Claim Type = All
Match Type = All
Set Number = All
Owner Fl = All
Owner Region = All
Resp Fl = All
Resp Region = All
Claim User Codes = All

SET #	TED Icn	TED Time	DUP ?	RSN Code	Resp FI	Spon ID	Patient ID	Patient Name	Prov ID	Prov Sub Id	Government Paid Amt	Line Item	Govt PD Amt CPT4
15	19941882424012	000000	N	BASE	50	999999999	999999990	SMITH,LESLIE,X	555555555	0000	431.50	0	0.00
									Adjust Flag	Adjust Line Item	Adjust Govt Paid Amount		
									N	0	-431.50		
									N	0	328.17		
15	19941882424012	000000			50	999999999	999999990	SMITH,LESLIE,X	555555555		8353.00	0	0.00
									Adjust Flag	Adjust Line Item	Adjust Govt Paid Amount		
										0	328.17		
15	19941882424013	000000			50	999999999	999999990	SMITH,LESLIE,X	555555555	0000	350.00	0	0.00
22	19933335170207	000000	Y	D203	50	999999999	999999990	SMITH,LESLIE,X	555555555	0000	1090.44	0	0.00
									Adjust Flag	Adjust Line Item	Adjust Govt Paid Amount		
									Y	0	-1115.44		
22	19942575143500	000000	N	BASE	50	999999999	999999990	SMITH,LESLIE,X	555555555	0000	1087.54	0	0.00
									Adjust Flag	Adjust Line Item	Adjust Govt Paid Amount		
										0	0.00		
35	19940424543435	000000	N	BASE	50	999999999	999999990	SMITH,LESLIE,X	555555555	0000	8574.15	0	0.00
									Adjust Flag	Adjust Line Item	Adjust Govt Paid Amount		
										0	-49102.03		
										0	-1005.40		

50 - Acme Claims Processing

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TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIMS ⇒WORK SHEETS ⇒ INSTITUTIONAL
PRINTED REPORT TITLE:	Institutional Claims Worksheet
REPORT DESCRIPTION:	<p>This report resembles the paper duplicate claims reports provided to contractors in the past. This report lists institutional claim sets in OPEN status and provides space for entering by hand: 1) a "Y" or an "N" to indicate if the claim has been determined to be a duplicate or not; 2) a reason code for why the claim is or is not a duplicate; and 3) a recoupment or refund amount. This report provides the contractor with the ability to distribute the claim sets requiring research and duplicate determinations among several personnel. Once completed, these reports can be returned to the system operator for data entry. This report is limited to only institutional claims. The fields displayed on the report are: Owner FI; Region; ICN; Set Level User Defined Code; Solicited Indicator; Set Number; PTC Date; Responsible FI; Sponsor ID; Patient ID; Patient Name; Provider Nbr; Provider Sub-ID; Diagnosis; DRG; Amount Billed; Amount Allowed; Government Paid Amount; Dupe Flag?; Reason Code; ID Recoupment Amount. The report identifies and prints all of the sets meeting the criteria selected on the report parameter screen. The report groups the claims in ascending set number order.</p>
REPORT PARAMETER OPTIONS:	<p>Users may customize the report by selecting: All "Standard" parameters minus Claim Set Status, Claims (Claim Set Status, Set Owner Type, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus PTC Dates; Adjustments; Care Dates; Solicited Flag; Responsible FI; and Region.</p>
REPORT NOTES:	The data used by this report format is claim level data.

INSTITUTIONAL CLAIMS WORKSHEET

Adjust Type = All
Owner Type = All
Match Type = All
Solicited = All
Set Number = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All

50 - Acme Claims Processing

Undetermined Region

ICN	USR CD	S ?	SET #	PTC DATE	RS FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER NUMBER	PROV SUB-ID	DIAG	DRG	AMT BILLED	AMT ALLOWED	AMT GOVT PAID	DUPE? (Y/N)	RSN CD	RECOUP/ RFND AMT
19962924725072			77425	10/17/96	50	999999999	999999990	SMITH,LESLIE,X	555555555	0000	4240	104	\$57,297.50	\$24,076.93	\$24,076.93	-----	-----	-----
19962924725072			77425	11/26/96	50	999999999	999999990	SMITH,LESLIE,X	555555555	0000	4240	104	\$60,264.50	\$24,320.22	\$24,184.42	-----	-----	-----

55 - East West Claims

Area 55

ICN	USR CD	S ?	SET #	PTC DATE	RS FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER NUMBER	PROV SUB-ID	DIAG	DRG	AMT BILLED	AMT ALLOWED	AMT GOVT PAID	DUPE? (Y/N)	RSN CD	RECOUP/ RFND AMT
19943551605817			10697	1/26/95	55	999999999	999999990	SMITH,LESLIE,X	555555555	0000	8442	222	\$6,060.46	\$3,103.58	\$3,078.58	-----	-----	-----
19950241642021			10697	1/27/95	50	999999999	999999990	SMITH,LESLIE,X	555555555	0000	8442	222	\$6,060.46	\$3,103.58	\$3,078.58	-----	-----	-----

99 - Inactive Contractor

Inactive-Area 30

ICN	USR CD	S ?	SET #	PTC DATE	RS FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER NUMBER	PROV SUB-ID	DIAG	DRG	AMT BILLED	AMT ALLOWED	AMT GOVT PAID	DUPE? (Y/N)	RSN CD	RECOUP/ RFND AMT
199329806561126			55	1/11/94	99	999999999	999999990	SMITH,LESLIE,X	555555555	0002	7470	000	\$95,435.32	\$201,551.67	\$201,551.67	-----	-----	-----
19942280665422			55	9/7/94	99	999999999	999999990	SMITH,LESLIE,X	555555555	0002	7470	000	\$313,162.38	\$301,141.72	\$301,141.72	-----	-----	-----
19942490640195			55	9/12/94	99	999999999	999999990	SMITH,LESLIE,X	555555555	0002	7470	000	\$313,162.38	\$99,590.05	\$99,590.05	-----	-----	-----

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TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIMS ⇒WORKSHEETS ⇒ NON-INSTITUTIONAL
PRINTED REPORT TITLE:	Non-Institutional Claims Worksheet
REPORT DESCRIPTION:	<p>This report resembles the paper duplicate claims reports provided to contractors in the past. This report lists the sets of non-institutional line items in OPEN status and provides space for entering by hand: 1) a "Y" or an "N" to indicate if the claim has been determined to be a duplicate or not; 2) a reason code for why the claim is or is not a duplicate; and 3) a recoupment or refund amount. This report provides the contractor with the ability to distribute the claim sets requiring research and duplicate determinations among several personnel. Once completed, these reports can be returned to the system operator for data entry. This report is limited to only non-institutional claims. The fields displayed on the report are: Owner FI; Region; ICN; Claim Level User Defined Code; Solicited Indicator; Set Number; Responsible FI; Sponsor ID; Patient ID; Patient Name; Provider Number; Provider Sub-ID; Diagnosis; Line Item Number; CPT-4 Code; Line Item Amount Billed; Line Item Paid Amount; "Dupe? (Y/N)"; Reason Code; and Identified Recoupment or Refund Amount. The report identifies and prints all of the sets meeting the criteria selected on the report parameter screen. The report groups the claims in ascending set number order.</p>
REPORT PARAMETER OPTIONS:	<p>Users may customize the report by selecting: All "Standard" parameters minus Status, Claim Type (Adjustments, Set Owner Type, Match Type, Date Type, Set Range, FI, Region) plus PTC Dates, Care Dates, Responsible FI, and Region.</p>
REPORT NOTES:	<p>The data used by this report format is line item level data.</p>

NON-INSTITUTIONAL CLAIMS WORKSHEET

Adjust Type = All
Owner Type = All
Match Type = All
Solicited = All
Set Number = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All

50 - Acme Claims Processing

Undetermined Region

ICN	USR CD	S ?	SET #	RS FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER NUMBER	PROV SUB-ID	DIAG	LI	CPT-4 CODE	AMT BILLED CPT-4 CD	GOVTPD CPT-4 CD	DUPE? (Y/N)	RSN CD	RECOUP/ RFND AMT
19953624101154			79860	50	999999999	999999999	SMITH,LESLIE,X			78906	1	99214	\$78.60				
19953624101154			79860	50	999999999	999999999	SMITH,LESLIE,X			78906	2	74000	\$14.20				
19962044104011			79862	50	999999999	999999999	SMITH,LESLIE,X			5269	1	42100	\$510.00	\$81.28			
19962494100571			79862	50	999999999	999999999	SMITH,LESLIE,X			5269	1	42100	\$300.00	\$254.03			
19962494100571			79862	50	999999999	999999999	SMITH,LESLIE,X			5269	2	42100	\$210.00	\$81.28			

99 - Inactive Contractor

Inactive-Area 20

ICN	USR CD	S ?	SET #	RS FI	SPON ID	PATIENT ID	PATIENT NAME	PROVIDER NUMBER	PROV SUB-ID	DIAG	LI	CPT-4 CODE	AMT BILLED CPT-4 CD	GOVTPD CPT-4 CD	DUPE? (Y/N)	RSN CD	RECOUP/ RFND AMT
19951000627827			22221	99	999999999	999999999	SMITH,LESLIE,X			42490	1	99214	\$70.00	\$53.45			
19951000627827			22221	99	999999999	999999999	SMITH,LESLIE,X			42490	2	93000	\$75.00	\$31.32			
19951000627827			22221	99	999999999	999999999	SMITH,LESLIE,X			42490	3	93307	\$400.00	\$255.77			
19951000627827			22221	99	999999999	999999999	SMITH,LESLIE,X			42490	4	93320	\$200.00	\$134.97			

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Report Descriptions And Examples

REPORT CATEGORY:	Claim Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒CLAIM REPORTS ⇒ CLAIM LEVEL USER CODES
PRINTED REPORT TITLE:	Claim Level User Defined Field Definitions
REPORT DESCRIPTION:	This report displays the Owner FI; Contract Number; the Claim Level User Defined Codes; their definitions, and whether they are active or inactive.
REPORT PARAMETER OPTIONS:	Users may not customize this report.
REPORT NOTES:	The data used by this report format is claim level data.

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Chapter 9, Addendum D
Report Descriptions And Examples

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**CLAIM LEVEL USER DEFINED
FIELD DEFINITIONS**

Owner FI	Contract #	Code	Description	Active ?
50	MDA90504C0050	B4	testing	Y
50	MDA90504C0050	B4	testing	Y

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PRIVACY REGULATION.

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Summary/Management
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒ INST BY DUPLICATE TYPE
PRINTED REPORT TITLE:	Institutional Summary Report Potentials/Actuals/Non-Duplicates By Contractor (grouped by Region)
REPORT DESCRIPTION:	This summary/management report shows the total number of institutional potential duplicates, actual duplicates, non-duplicates, and those not yet worked by the contractor for the initial or current load date selected or load date range specified by the user. The report lists the number of claims and the amount paid by match type. The report also shows the number of actual duplicates, non-duplicates, and potential duplicate claims as a percentage of the total number of potential duplicates loaded. For this report, potential duplicates are the universe of all non-base claims. Actual duplicates are those claims with a "Y" dupe flag in pending, validate or closed status. Non-duplicates are those non-base claims with an "N" dupe flag in pending, validate or closed status. Potential duplicates not worked are non-base claims in open status irrespective of any dupe flag value. The dollar totals on the report are for non- base claims only.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Claim Set Status; Claim Types; Match Types; Last Dates; Set Range (Adjustments, Set Owner Type, Date Type, FI, Region) plus Responsible FI, and Region, and Risk Indicator.
REPORT NOTES:	The data used by this report format is claim level data. It should be noted that the total number of claims and percentages shown on this report may differ from that shown on the "Actual vs. Potential" graph report. Any discrepancy will be due to the fact that this report will count a claim more than once if it appears in two or more sets owned by the same region but which have different match types. The graph, alternatively, will not count a claim more than once if it appears in two or more sets owned by the same region.

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**INSTITUTIONAL SUMMARY REPORT
POTENTIALS/ACTUALS/NON-DUPLICATES BY FI/CONTRACTOR**

Adjust Type = All
Owner Type = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Risk Ind = All

Match Type	Number of Potential Dupes	Potential Dupes \$	Number of Actual Dupes	Actual Dupes % of Potential	Actual Dupes Amount Paid Govt Contr	Number of Non-Dupe Claims	Non -Dupes % of Potential	Non Dupes Amount Paid Govt Contr	Number of Potential Not Worked Claims	Not Worked % of Potential	Potential Not Worked Amount Paid Govt Contr	
50 - Acme Claims Processing												
Undetermined Region												
Date Overlap	27	\$331,343.09	1	3.70%	\$1,090.44	0	0.00%	\$0.00	24	88.89%	\$326,774.08	
Exact	13	\$78,437.14	0	0.00%	\$0.00	0	0.00%	\$0.00	13	100.00%	\$78,437.14	
Near	16	\$130,078.81	0	0.00%	\$0.00	0	0.00%	\$0.00	14	87.50%	\$121,374.88	
Other	3	\$9,895.12	0	0.00%	\$0.00	0	0.00%	\$0.00	2	66.67%	\$2,635.22	
Region Totals	59	\$549,754.16	1		\$1,090.44	0		\$0.00	53		\$529,221.32	
Contractor Totals	59	\$549,754.16	1		\$1,090.44	0		\$0.00	53		\$529,221.32	
55 - East West Claims												
Area 55												
Exact	1	\$3,078.58	0	0.00%	\$0.00	0	0.00%	\$0.00	1	100.00%	\$3,078.58	
Region Totals	1	\$3,078.58	0		\$0.00	0		\$0.00	1		\$3,078.58	
Contractor Totals	1	\$3,078.58	0		\$0.00	0		\$0.00	1		\$3,078.58	
73 - HAL Systems Inc												
Area 73A												
Date Overlap	2	\$24,591.92	0	0.00%	\$0.00	0	0.00%	\$0.00	2	100.00%	\$24,591.92	
Region Totals	2	\$24,591.92	0		\$0.00	0		\$0.00	2		\$24,591.92	
Contractor Totals	2	\$24,591.92	0		\$0.00	0		\$0.00	2		\$24,591.92	
Grand Totals	62	\$24,591.92	1		\$1,090.44	0		\$0.00	56		\$556,891.82	

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TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Summary/Management
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒ NONINST BY DUPLICATE TYPE
PRINTED REPORT TITLE:	Non-Institutional Summary Report Potentials/Actuals/Non-Duplicate by FI/Contractor
REPORT DESCRIPTION:	<p>This summary/management report shows the total number of non-institutional potential duplicates, actual duplicates, non-duplicates, and those not yet worked by the contractor for the initial or current load dates selected or load date range specified by the user. The report lists the number of claims and the allowed amounts paid by match type. The report also shows the number of actual duplicates, non-duplicates, and potential duplicate claims as a percentage of the total number of potential duplicates loaded.</p> <p>This report does not count unique claims but rather all non-base claims appearing in sets with a particular match type, i.e., the total number of non-base claims appearing in CPT-4, Exact, Near, and Other match type sets. Since a non-institutional claim may appear in more than one set, the counts of the claims appearing on this report may be inflated. The dollars shown on this report, however, will not be inflated since a line-item will never appear in more than one set. As a result, the dollars appearing on this report are the paid amounts for the line items appearing in the sets in which their host claim appears. While the host claim may be counted more than once, the dollar amounts associated with the line items will not be counted more than once.</p> <p>For this report, potential duplicates are the universe of all non-base claims. Actual duplicates are those claims with a "Y" dupe flag in pending, validate or closed status. Non-duplicates are those non-base claims with an "N" dupe flag in pending, validate or closed status. Potential duplicates not worked are non-base claims in open status irrespective of any dupe flag value. The dollar totals on the report are for non-base claims only.</p>
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Claim Set Status, Claim Types, Match Types, Last Dates, Set Range (Adjustments, Set Owner Type, Date Type, Region) plus Responsible FI, Region, and Risk Indicator.
REPORT NOTES:	<p>The data used by this report format is claim level and line-item data.</p> <p>It should be noted that the total number of claims and percentages shown on this report may differ from that shown on the "Actual vs. Potential" graph report. Any discrepancy will be due to the fact that this report will count a claim more than once if it appears in two or more sets owned by the same region but which have different match types. The graph, alternatively, will not count a claim more than once if it appears in two or more sets owned by the same region.</p>

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**NON-INSTITUTIONAL SUMMARY REPORT
POTENTIALS/ACTUALS/NON-DUPLICATES BY FI/CONTRACTOR**

Adjust Type = All
Owner Type = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Risk Ind = All

Match Type	Number of Potential Dupes	Potential Dupes \$	Number of Actual Dupes	Actual Dupes % of Potential	Actual Dupes Amount Paid Govt Contr	Number of Non-Dupe Claims	Non -Dupes % of Potential	Non Dupes Amount Paid Govt Contr	Number of Potential Not Worked Claims	Not Worked % of Potential	Potential Not Worked Amount Paid Govt Contr	
50 - Acme Claims Processing												
Undetermined Region												
Date Overlap	3	\$963.00	0	0.1200%	\$0.00	0	0.00%	\$0.00	3	100.00%	\$963.00	
Exact	21	\$6,278.51	0	0.00%	\$0.00	0	0.00%	\$0.00	21	100.00%	\$6,153.43	
Near	23	\$13,874.63	0	0.00%	\$0.00	0	0.00%	\$0.00	23	100.00%	\$13,874.63	
Other	15	\$21,843.67	0	0.00%	\$0.00	0	0.00%	\$0.00	15	100.00%	\$21,843.67	
Region Totals	62	\$42,959.81	0		\$0.00	0		\$0.00	62		\$42,834.73	
Contractor Totals	62	\$42,959.81	0		\$0.00	0		\$0.00	62		\$42,834.73	
99 - Inactive Contractor												
Inactive-Area 20												
Near	2	\$4,560.31	0	0.00%	\$0.00	0	0.00%	\$0.00	2	100.00%	\$4,560.31	
Region Totals	2	\$4,560.31	0		\$0.00	0		\$0.00	2		\$4,560.31	
Contractor Totals	2	\$4,560.31	0		\$0.00	0		\$0.00	2		\$4,560.31	
Grand Totals	64	\$47,520.12	1		\$1,090.44	0		\$0.00	64		\$47,395.04	

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TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒ SET AGING REPORT
PRINTED REPORT TITLE:	Set Aging Report
REPORT DESCRIPTION:	This report provides the total number of sets in Open, Pending, Validate, and Closed Status grouped by region and either initial or current load date (depending on which is selected) as of the date the report is run. The report also shows the percentage each total represents of the total number of sets counted. The fields displayed on the report are: Owner FI; Region; Initial or Current Load Date; Number and Percentage of Open Sets; Number and Percentage of Pending Sets; Number and Percentage of Validate Sets; Number and Percentage of Closed Sets; and the Total Number of Sets. The report provides sub-totals for each contract region and grand totals for each contractor.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Status, Last Dates, Set Range (Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, FI, Region).
REPORT NOTES:	The data used by this report format is set level data.

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SET AGING REPORT

Adjust Type = All
Owner Type = All
Claim Type = All
Match Type = All
Owner FI = All
Owner Region = All

Contractor Name	Region	Current Load Dt	Open Sets	Open Sets%	Pending Sets	Pending Sets%	Validate Sets	Validate Sets%	Closed Sets	Closed Sets%	Total Sets
50 - Acme Claims Processing	Undetermined Region										
		09/1996	35	87.50	0	0.00	5	12.50	0	0.00	40
		10/1996	72	100.00	0	0.00	0	0.00	0	0.00	72
		11/1996	6	100.00	0	0.00	0	0.00	0	0.00	6
		12/1996	68	93.15	0	0.00	0	0.00	5	6.85	73
		01/1997	49	96.08	0	0.00	2	3.92	0	0.00	51
Region Total Sets			230		0		7		5		242
Region Avg %				95.04		0.00		2.89		2.07	
Contractor Total Sets			230		0		7		5		242
Contractor Avg %				95.04		0.00		2.89		2.07	
55 - East West Claims	Area 55	10/1996	2	100.00	0	0.00	0	0.00	0	0.00	2
Region Total Sets			2		0		0		0		2
Region Avg %				100.00		0.00		0.00		0.00	
Contractor Total Sets			2		0		0		0		2
Contractor Avg %				100.00		0.00		0.00		0.00	
73 - HAL Systems Inc	Area 73A	10/1996	3	100.00	0	0.00	0	0.00	0	0.00	3
Region Total Sets			3		0		0		0		3
Region Avg %				100.00		0.00		0.00		0.00	
Contractor Total Sets			3		0		0		0		3
Contractor Avg %				100.00		0.00		0.00		0.00	
99 - Inactive Contractor	Inactive-Area 20	12/1996	3	100.00	0	0.00	0	0.00	0	0.00	3
Region Total Sets			3		0		0		0		3
Region Avg %				100.00		0.00		0.00		0.00	
99 - Inactive Contractor	Inactive-Area 30	12/1996	3	100.00	0	0.00	0	0.00	0	0.00	3
Region Total Sets			3		0		0		0		3
Region Avg %				100.00		0.00		0.00		0.00	
Contractor Total Sets			6		0		0		0		6
Contractor Avg %				100.00		0.00		0.00		0.00	
Grand Total Sets			241		0		7		5		253
Grand Avg %				95.26		0.00		2.77		1.98	

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TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒ CLAIM AGING REPORT
PRINTED REPORT TITLE:	Claim Aging Report
REPORT DESCRIPTION:	This report provides the total number of non-base claims in Open Status (Not Worked), the total number of actual duplicate claims ('Y' Duplicate Flag Value in Pending, Validate and Closed status) and the total number of non-duplicate claims ('N' Duplicate Flag Value in Pending, Validate and Closed status) as of the date the report is run. The report also provides the total paid amounts of the non-base claims in Open Status (Not Worked), the total amounts identified for recoupment and actually recouped of the actual duplicate claims, and the total paid amounts of the non-duplicate claims. The report shows claim counts but for non-institutional claims the paid amount totals are the sum of the line-item paid amounts in the system. The report is grouped by Initial or Current Load Date (depending on which is selected) and region and provides sub-totals by region and grand totals by contractor.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Status; Last Dates; Set Range (Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, FI, Region) plus Responsible FI and Region.
REPORT NOTES:	The data used by this report format is claim level data.

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

Adjust Type = All
Claim Type = All
Owner Type = All
Match Type = All
Owner Fl = All
Owner Region = All
Resp Fl = All
Resp Region = All

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CLAIM AGING REPORT

Load Date	Not Worked #Claims	Not Worked Allowed Amount	Actual Dupes #Claims	Actual Dupes ID Recoup	Actual Dupes Actual Recoup	Non-Dupes #Claims	Non Dupes Allowed Amount
50 - Acme Claims Processing							
<Unassigned Region>							
09/1996	0	\$0.00	1	\$1,000.00	\$1,000.00	0	\$0.00
12/1996	2	\$99,997.86	0	0.00	\$0.00	0	\$0.00
01/1997	2	\$335.31	0	0.00	\$0.00	0	\$0.00
Region	4		1			0	
Totals		\$100,333.17		\$1,000.00	\$1,000.00		\$0.00
Contractor	4		1			0	
Totals		\$100,333.17		\$1,000.00	\$1,000.00		\$0.00
Grand Totals	4		1			0	
		\$100,333.17		\$1,000.00	\$1,000.00		\$0.00

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TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒ ARCHIVED SET REPORT
PRINTED REPORT TITLE:	Archived Set Report
REPORT DESCRIPTION:	This report provides the total number of sets in the History Database in Validate and Closed Status grouped by region and Initial Load Date as of the date the report is run. While the report contains columns for Open status and Pending status, these will always be 0% since sets in Open and Pending status are never archived to the History Database. The report also shows the percentage each total represents of the total number of sets counted. The fields displayed on the report are: Owner FI; Region; Initial Load Date; Number and Percentage of Open Sets; Number and Percentage of Pending Sets; Number and Percentage of Validate Sets; Number and Percentage of Closed Sets; and the Total Number of Sets. The report provides sub-totals for each contract region and grand totals for each contractor.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Status, Last Dates, Current Load Dates, Set Range (Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, FI, Region).
REPORT NOTES:	The data used by this report format is set level data.

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

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SET AGING REPORT

Adjust Type = All
Owner Type = All
Claim Type = All
Match Type = All
Owner FI = All
Owner Region = All

Contractor Name	Region	Current Load Dt	Validate Sets	Validate Sets%	Closed Sets	Closed Sets%	Total Sets
22 - Excel Health Care	East Region	02/2005	0	0.00	1	100.00	1
Region Total			0	0.00	1	100.00	1
Contractor Total			0	0.00	1	100.00	1
23 - Seven Health Care	Undetermined Region	06/2004	0	0.00	1	100.00	1
		11/2004	0	0.00	2	100.00	2
		12/2004	0	0.00	1	100.00	1
Region Total			0	0.00	4	100.00	4
Contractor Total			0	0.00	4	100.00	4
Grand Total			0	0.00	5	100.00	5

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TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒ REASON CODE REPORT
PRINTED REPORT TITLE:	Reason Code Report
REPORT DESCRIPTION:	This report provides a list of actual duplicate and non-duplicate reason codes and the total number claims to which each code was assigned. The report counts actual duplicate claims ('Y' Duplicate Flag value) and non-duplicate claims ('N' Duplicate Flag value) in Pending, Validate and Closed sets.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Claim Set Status (Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus Dupe Indicator, Solicited Indicator, Exclude Base, PTC Dates, Set Level User Defined Code, Claim Level User Defined Code, Responsible FI, Region, and Risk Indicator.
REPORT NOTES:	The data used by this report format is claim level data.

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Chapter 9, Addendum D
Report Descriptions And Examples

Adjust Type = All
Owner Type = All
Claim Type = All
Match Type = All
Dupe Flag = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Set Number = All
Exclude Base Claims = No
Solicited = All
Set User Codes = All
Claim User Codes = All
Risk Ind = All

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REASON CODE REPORT

Reason Code	Reason Code Description	Number of Claims
BASE	Initial submission	5
D203	Claims submitted by beneficiary and provider	1
Total Claims		6

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TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒ REASON CODE BY INIT LOAD DATE
PRINTED REPORT TITLE:	Reason Code Report by Initial Load Date
REPORT DESCRIPTION:	This report provides a list of actual duplicate and non-duplicate reason codes and the total number claims to which each code was assigned. The report counts actual duplicate claims ('Y' Duplicate Flag value) and non-duplicate claims ('N' Duplicate Flag value) in Pending, Validate and Closed sets. The report is grouped by Initial Load Date.
REPORT PARAMETER OPTIONS:	This report provides a list of actual duplicate and non-duplicate reason codes and the total number claims to which each code was assigned. The report counts actual duplicate claims ('Y' Duplicate Flag value) and non-duplicate claims ('N' Duplicate Flag value) in Pending, Validate and Closed sets. The report is grouped by Initial Load Date.
REPORT NOTES:	Users may customize the report by selecting: All "Standard" parameters minus Claim Set Status (Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus Dupe Flag Indicator, Solicited Indicator, Exclude Base, PTC Dates, Set and Claim Level User Defined Codes, Responsible FI, Region, and Risk Indicator.

TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

Adjust Type = All
Owner Type = All
Exclude Base Claims = No
Claim Type = All
Match Type = All
Dupe Flag = All
Owner FI = All
Owner Region = All
Resp FI = All
Resp Region = All
Set Number = All
Solicited = All
Set User Codes = All
Claim User Codes = All
Risk Ind = All

Date: 5/3/05
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**REASON CODE REPORT
BY INITIAL LOAD DATE**

**Initial Load Date
09/1996**

Reason Code		Number of Claims
BASE	Initial submission	5
D203	Claims submitted by beneficiary and provider	1
Total		6
Grand Total		6

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TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒ MODIFY FI
PRINTED REPORT TITLE:	Changed Owner FI Sets
REPORT DESCRIPTION:	<p>This report identifies multi-contractor sets which have had their ownership changed through the use of the "Modify FI" function on the system menu bar. It does <u>not</u> show multi-contractor sets which have had their ownership changed by the mass change process. The fields displayed on the report are: Set Number; Contractor; Changed Date; and User. The report shows each instance ownership of a multi-contractor set was changed; the name of the new owner contractor, the date ownership was changed, and the application User ID of the user who made the change. The first record listed for each set on the report shows the User as 'INITLOAD'. This means that the set was initially loaded by the system.</p>
REPORT PARAMETER OPTIONS:	<p>Users may customize the report by selecting: All "Standard" parameters minus Set Owner Type and Last Date (Claim Set Status Adjustments, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus PTC Dates.</p>
REPORT NOTES:	<p>The data used by this report format is set level data.</p> <p>Single-line entries with "INITLOAD" as the user may appear on this report. These single-line entries will appear for sets where a user has begun the process of changing (modifying) ownership of the multi-contractor set, enters the reason for making the change, presses the UPDATE CHANGES button, but decides to "rollback" the changes, i.e., does not complete changing the set's ownership. Such sets will be listed on this report as a single-line entry with "INITLOAD" as the user.</p>

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Chapter 9, Addendum D
Report Descriptions And Examples

Status Code = All
Adjust Type = All
Claim Type = All
Match Type = All
Set Number = All
Owner FI = All
Owner Region = All

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CHANGED OWNER FI SETS

Set Number	FI/Contractor	Changed Date	User
33290		02/08/2005	INITLOAD
33290		02/08/2005	eidrhha
33290		02/09/2005	eidrhha
33290		03/21/2005	pprsqt01
33290		03/21/2005	pprsqt01
33290		03/24/2005	rajsinha
33290		03/24/2005	eidrhha
33290		03/25/2005	npinto

33504		02/08/2005	INITLOAD
33504		02/09/2005	eidrhha
33504		03/24/2005	rajsinha
33504		03/24/2005	rajsinha
33504		03/25/2005	npinto

33676		02/08/2005	INITLOAD
33676		03/22/2005	pprsqt01
33676		03/24/2005	rajsinha
33676		03/25/2005	npinto

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TRICARE Operations Manual 6010.56-M, February 1, 2008

Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒ SET STATUS COUNT HISTORY
PRINTED REPORT TITLE:	Set Status Count History
REPORT DESCRIPTION:	This report provides a count and percentage of sets within each status as of a date or range of dates grouped by contract.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: Owner FI, Region, and As of Dates.
REPORT NOTES:	The data used by this report format is set level data.

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Chapter 9, Addendum D
Report Descriptions And Examples

SET STATUS COUNT HISTORY

Date: 5/12/05
Page 1

Owner FI = 66

Owner Region = All

AS OF DATE = ALL

East Region

East Region

ON	OPEN SETS	%	PENDING SETS	%	VALIDATE SETS	%	CLOSED SETS	%	TOTAL	%
02/03/2005	0	0.00%	2	100.00%	0	0.00%	0	0.00%	2	100.00%
02/04/2005	0	0.00%	2	100.00%	0	0.00%	0	0.00%	2	100.00%
02/11/2005	1	50.00%	1	50.00%	0	0.00%	0	0.00%	2	100.00%
02/12/2005	1	50.00%	1	50.00%	0	0.00%	0	0.00%	2	100.00%
02/16/2005	1	50.00%	1	50.00%	0	0.00%	0	0.00%	2	100.00%
02/17/2005	1	50.00%	1	50.00%	0	0.00%	0	0.00%	2	100.00%
02/17/2005	1	50.00%	1	50.00%	0	0.00%	0	0.00%	2	100.00%
02/18/2005	5	62.50%	3	37.50%	0	0.00%	0	0.00%	8	100.00%
02/18/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
02/18/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
02/19/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
03/24/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
04/01/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
04/04/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
04/05/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
04/07/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
04/15/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
04/18/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
04/18/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
04/19/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
04/20/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
04/24/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
04/25/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
04/26/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
04/27/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
04/28/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
04/29/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
05/01/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
05/02/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
05/03/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
05/04/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
05/05/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
05/06/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
05/07/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
05/09/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
05/10/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%
05/11/2005	6	60.00%	4	40.00%	0	0.00%	0	0.00%	10	100.00%

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Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒ PERFORMANCE STANDARD
PRINTED REPORT TITLE:	Performance Standard
REPORT DESCRIPTION:	This report will be used to measure contractor compliance with the performance standard. The performance standard requires that no more than 10% of the sets remaining in OPEN status at the end of a month shall have load dates over 30 days old. The report shows the Reporting Month; Beginning Inventory; Receipts; Monthly Inventory; the total number of sets "Moved" during the reporting month; the total number of sets Moved within 30 days of set load dates; Ending Inventory; the total number of sets in Ending Inventory Over 30 Days old; the Percent Moved Within 30 Days; and the Percent Remaining Over 30 Days. The data is grouped by contract.

FIELD DESCRIPTIONS

FIELD NAME	DEFINITION
Reporting Month:	The month and year for which the statistics are applicable.
Beginning Inventory:	The total number of sets in OPEN status at the beginning of the reporting month.
Receipts:	The total number of new sets loaded or the number of sets which changed to OPEN status during the reporting month.
Monthly Inventory:	The sum of the Beginning Inventory and Receipts.
Moved:	The total number of sets moved for OPEN status to PENDING, VALIDATE, or CLOSED status during the reporting month.
Moved Within 30 Days:	Of those sets moved during the reporting month, the number moved within 30 days of their load date.
Ending Inventory:	The Monthly Inventory minus the number Moved. The result is the total number of remaining sets in OPEN status.
Ending Inventory Over 30 Days:	The total number of claim sets remaining in OPEN status with load dates over 30 days old.
% Moved In 30 Days:	Of those sets moved, the percentage moved within 30 days of their load date.
% Remaining Over 30 Days:	The percentage of claim sets remaining in OPEN status with load dates over 30 days old.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: a single reporting month or a range of reporting months; one or all FIs; one, several or all regions within selected FIs.
REPORT NOTES:	The data used by this report format is set level data.

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Chapter 9, Addendum D
Report Descriptions And Examples

MonthRange = All
Owner FI = 66
Owner Region = All

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PERFORMANCE STANDARD

East Region

East Region

Reporting Month	Beginning Inventory	Receipts	Monthly Inventory	Moved	Moved Within 30 Days	Ending Inventory	Ending Inventory Over 30 Days	% Moved in 30 Days	% Remaining Over 30 Days
02/2005	0	0	0	0	0	6	1	0.00%	16.67%
03/2005	6	1	7	1	0	6	6	0.00%	100.00%
04/2005	6	0	6	0	0	6	6	0.00%	100.00%
05/2005	6	0	6	0	0	6	6	0.00%	100.00%

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Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒ DOLLAR TOTALS
PRINTED REPORT TITLE:	Dollar Totals
REPORT DESCRIPTION:	This report summarizes the total dollars identified for recoupment and actually recouped, as well as the total paid amount of the applicable adjustments by Regional contract. The report reflects the total dollars on the system at the time the report is run. The fields displayed on the report are: Owner FI; Region; Total Amount Identified For Recoupment; Total Amount Actually Recouped; and the Total Paid Amount of the Associated Adjustments. The totals reflect only those sets in Pending, Validate, or Closed status.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Claim Set Status (Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus Set Range, Set and Claim Level User Defined Codes, Responsible FI, Region, and Enrollment Codes.
REPORT NOTES:	The data used by this report format is set level data.

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Report Descriptions And Examples

Adjust Type = All
 Owner Type = All
 Claim Type = All
 Match Type = All
 Set Number = All
 Owner FI = All
 Owner Region = All
 Resp FI = All
 Resp Region = All
 Set User Codes = All
 Claim User Codes = All
 Enroll Codes = All

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DOLLAR TOTALS

50 - Acme Claims Processing

	Total Amount Identified For Recoupment	Total Amount Actually Recouped	Total Amount Identified for Recoupment
Undetermined Region	\$1,000.00	\$1,000.00	\$1,000.00
Totals	\$1,000.00	\$1,000.00	\$1,000.00

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Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒ LOAD DATE REPORT
PRINTED REPORT TITLE:	Initial Load Date Report
REPORT DESCRIPTION:	This report provides a listing of set initial load dates grouped by contract.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Set Range (Claim Set Status, Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, FI, Region) plus Enrollment Codes.
REPORT NOTES:	The data used by this report format is set level data.

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Chapter 9, Addendum D
Report Descriptions And Examples

Status Code = All
Adjust Type = All
Owner Type = All
Match Type = All
Claim Type = All
Owner FI = All
Owner Region = All
Enroll Codes = All

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INITIAL LOAD DATE REPORT

50 - Acme Claims Processing

Undetermined Region	Initial Load Date	Number Of Sets
	9/24/96	107
Totals by Region		107
Totals By Contractor		107

55 - East West Claims

Area 55	Initial Load Date	Number Of Sets
	9/24/96	1
Totals by Region		1
Totals By Contractor		1

73 - HAL Systems Inc

Area 73A	Initial Load Date	Number Of Sets
	9/24/96	1
Totals by Region		1
Totals By Contractor		1

99 - Inactive Contractor

Inactive-Area 20	Initial Load Date	Number Of Sets
	9/24/96	1
Totals by Region		1
Inactive-Area 30	Initial Load Date	Number Of Sets
	9/24/96	1
Totals by Region		1
Totals By Contractor		2
Grand Totals		111

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Report Descriptions And Examples

REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒ USER ACTIVITY DETAIL
PRINTED REPORT TITLE:	User Activity Detail Report
REPORT DESCRIPTION:	This report provides a listing of transaction dates and times and associated User IDs grouped by set number. The report shows changes in Set Status; FI; User ID; Amount Identified For Recoupment; Amount Actually Recouped; and the Adjustment Amount.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: Set Range, Transaction Dates, and User IDs.
REPORT NOTES:	The data used by this report format is set level data.

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Report Descriptions And Examples

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USER ACTIVITY DETAIL REPORT

User ID = eidrha
Set Number = All
Transact Date = All

Set#	Stat	FI	Region	Init Load Date	Trans Date Time	User	ID'D Recoup Amt	Actual Recoup Amt	Adjusted Amount
3	O	65	MDA90603C0015	11/22/2004	11/22/04 11:00AM	CLAIMADD	\$0.00	\$0.00	\$0.00
3	O	65	MDA90603C0015	11/22/2004	11/22/04 11:00AM	CLAIMADD	\$0.00	\$0.00	\$0.00
3	C	65	MDA90603C0015	11/22/2004	1/25/05 11:45AM	eidrha	\$0.00	\$0.00	\$0.00
11166	O	65	MDA90603C0015	11/24/2004	1/12/05 12:02PM	eidrha	\$0.00	\$0.00	(\$19.05)
11166	P	65	MDA90603C0015	11/24/2004	1/13/05 07:06AM	eidrha	\$19.05	\$19.05	\$11.05
11711	O	65	MDA90603C0015	11/24/2004	11/24/04 04:09PM	CLAIMADD	\$0.00	\$0.00	\$0.00
11711	O	65	MDA90603C0015	11/24/2004	11/24/04 04:09PM	CLAIMADD	\$0.00	\$0.00	\$0.00
11711	C	64	MDA90603C0011	11/24/2004	3/25/05 08:37AM	SYSTEM	\$10.07	\$10.07	\$10.07
11711	O	64	MDA90603C0011	11/24/2004	3/25/05 08:39AM	SYSTEM	\$0.00	\$0.00	\$0.00
11711	C	64	MDA90603C0011	11/24/2004	3/25/05 08:40AM	SYSTEM	\$10.07	\$10.07	\$10.07
11711	V	64	MDA90603C0011	11/24/2004	3/25/05 08:44AM	SYSTEM	\$10.07	\$10.07	\$10.07
11711	O	64	MDA90603C0011	11/24/2004	3/25/05 08:46AM	eidrha	\$0.00	\$0.00	\$0.00
11711	V	64	MDA90603C0011	11/24/2004	3/25/05 08:48AM	SYSTEM	\$10.07	\$10.07	\$10.07
11711	V	64	MDA90603C0011	11/24/2004	3/25/05 08:49AM	eidrha	\$10.07	\$10.07	\$10.07
23741	C	64	MDA90603C0011	12/07/2004	2/3/05 08:31AM	jdoe	\$45.56	\$45.56	\$45.56
23741	C	64	MDA90603C0011	12/07/2004	2/3/05 08:31AM	jdoe	\$45.56	\$45.56	\$45.56
25471	V	65	MDA90603C0015	12/07/2004	3/22/05 07:22AM	eidrha	\$34.03	\$8.00	(\$34.03)
25471	P	65	MDA90603C0015	12/07/2004	4/7/05 01:39PM	MARSHALL	\$34.03	\$8.00	\$0.00
25668	O	65	MDA90603C0015	12/07/2004	12/7/04 01:27AM	CLAIMADD	\$0.00	\$0.00	\$0.00
25668	O	65	MDA90603C0015	12/07/2004	12/7/04 10:27AM	CLAIMADD	\$0.00	\$0.00	\$0.00
25668	P	65	MDA90603C0015	12/07/2004	12/28/04 10:44AM	eidrha	\$9.80	\$5.00	\$0.00
							\$238.38	\$181.52	\$99.44

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Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Summary/Management Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SUMMARY/MANAGEMENT REPORTS ⇒ USER ACTIVITY SUMMARY
PRINTED REPORT TITLE:	User Activity Summary Report
REPORT DESCRIPTION:	This report provides a summary of the transactions performed by individual user ID. The report provides the total number of updates performed by a USER ID, the total number of sets updated by that USER ID, and the net change in status in the following categories: sets moved from OPEN to PENDING and PENDING to OPEN; OPEN to VALIDATE and VALIDATE to OPEN; OPEN to CLOSED and CLOSED to OPEN; PENDING to CLOSED and CLOSED to PENDING; PENDING to VALIDATE and VALIDATE to PENDING; and VALIDATE to CLOSED and CLOSED to VALIDATE. This report can provide management with a summary view of user activity by individual USER ID.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: Set Range, Transaction Dates, and User IDs.
REPORT NOTES:	The data used by this report format is set level data.

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Report Descriptions And Examples

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Page 1

User ID = All

Transact Date = All

10000 >= Set Number <= 20000

**USER ACTIVITY SUMMARY
REPORT**

Net Change In Status From

USER	Total Updates	Sets Updated	O-P	O-V	O-C	P-C	P-V	V-C
tmazzull	5	5	3	0	2	0	0	0
pprsqt01	2	2	2	0	0	0	0	0
eidrhha	35	13	1	3	-2	-1	1	2
pprsqt04	6	2	0	0	2	0	0	0
rparker	11	3	3	0	0	0	1	0
MARSHALL	1	1	0	0	0	0	0	0
pprsqt02	4	2	0	0	2	1	0	-1
fsyed	1	1	1	0	0	0	0	0
npinto	1	1	0	0	0	0	0	0
Totals	66	30	10	3	4	0	2	1

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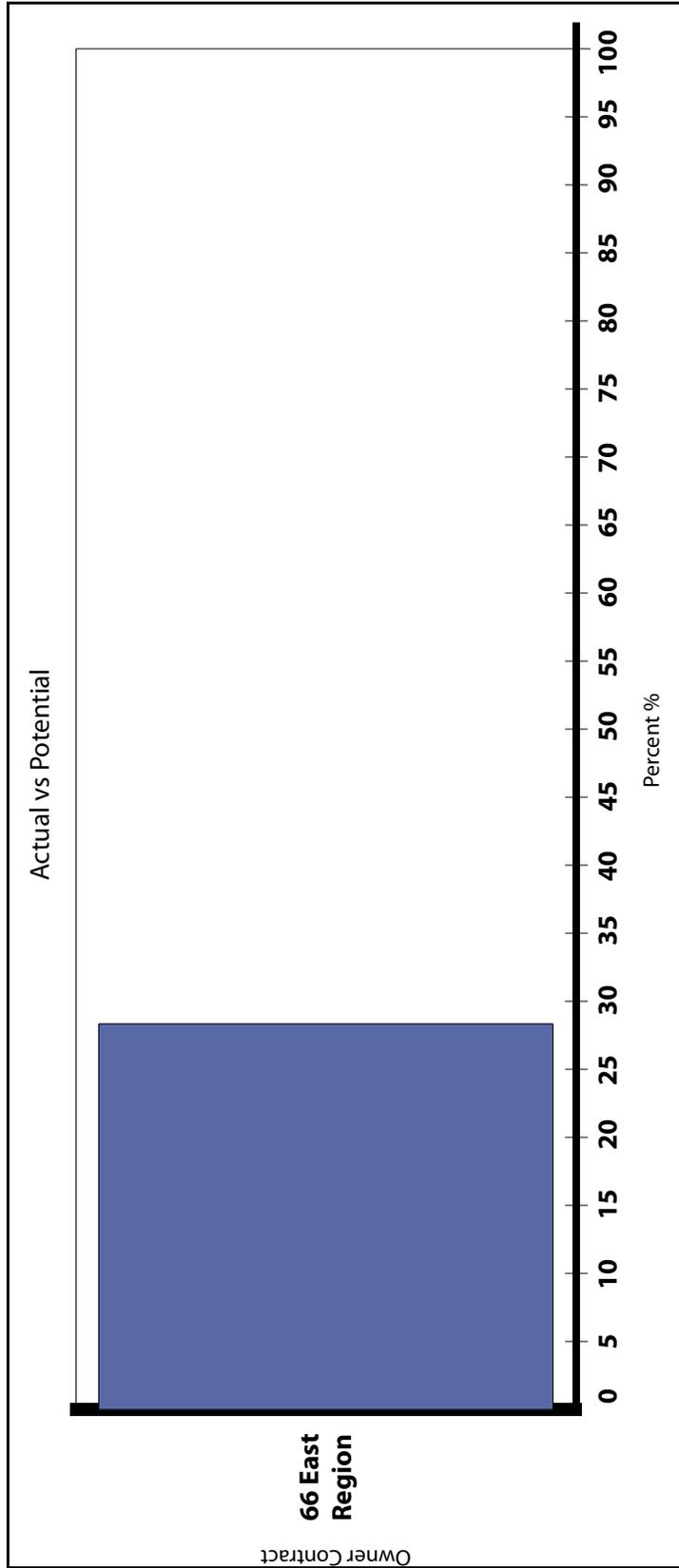
Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Graphs
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒GRAPHS ⇒ ACTUAL VS. POTENTIAL
PRINTED REPORT TITLE:	Total Actual Duplicates as a Percentage of Total Potential Duplicates
REPORT DESCRIPTION:	This report provides the user with a graph which shows the total number of distinct actual duplicate claims ('Y' Duplicate Flag values in Pending, Validate, or Closed status) as a percentage of the total number of distinct potential duplicates in the system (all non-base claims). The data displayed is grouped by region.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters minus Claim Set Status and Set Range (Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, FI, Region).
REPORT NOTES:	The data used by this report format is set level data. If a claim appears in more than one set and the sets are owned by different regions, the claim will be counted once for each region.

Date: 5/9/05
Page 1

**TOTAL ACTUAL DUPLICATES AS A PERCENTAGE OF TOTAL
POTENTIAL DUPLICATES**

Adjust Type = All
Match Type = All
Owner Type = All
Claim Type = All
Owner FI = All
Owner Region = All



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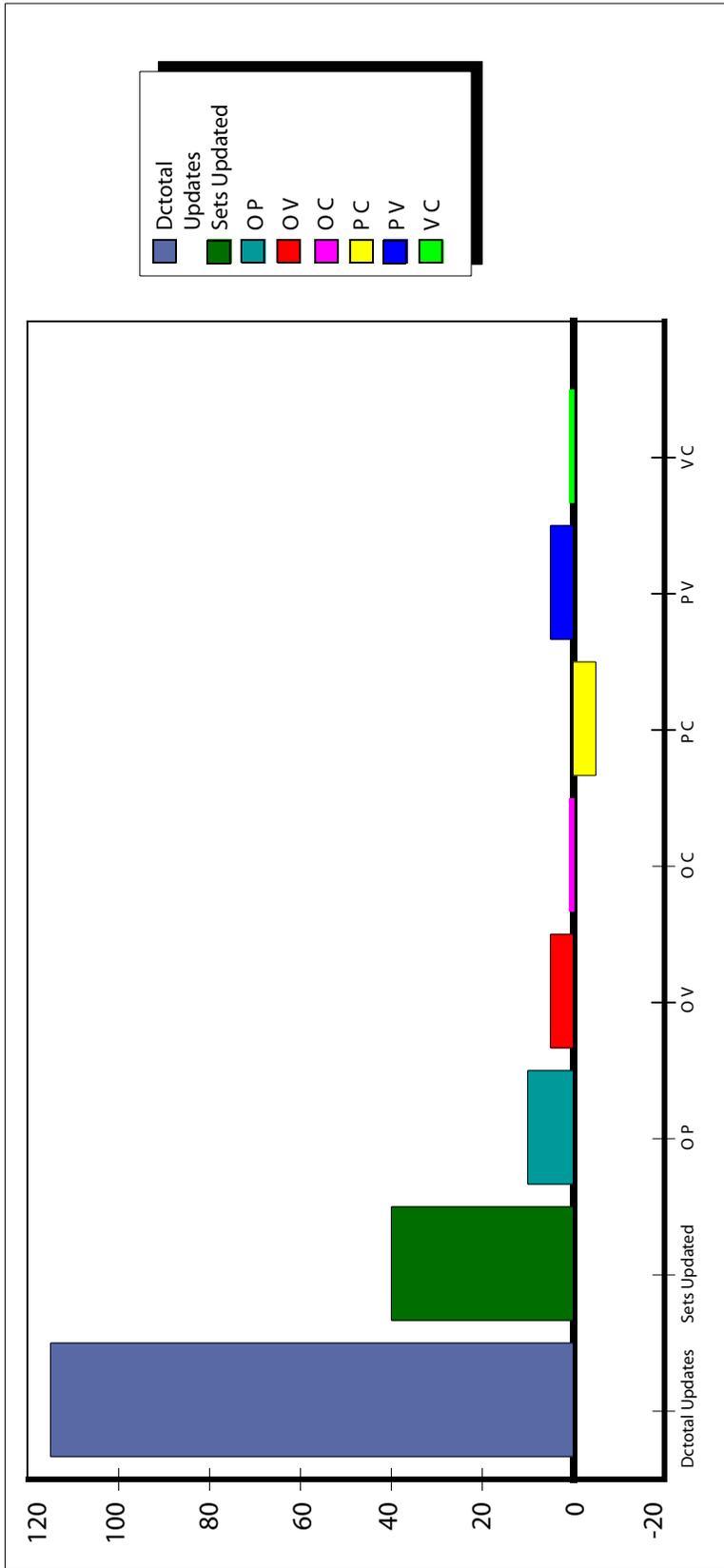
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Chapter 9, Addendum D
Report Descriptions And Examples

REPORT CATEGORY:	Graphs
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒GRAPHS ⇒ USER ACTIVITY SUMMARY
PRINTED REPORT TITLE:	User Activity Summary Report
REPORT DESCRIPTION:	This report provides the user with a graphical representation of the data in the User Activity Detail Report. The graph provides a summary of the transactions performed by individual user ID. The report provides the total number of updates performed by a USER ID, the total number of sets updated by that USER ID, and the net change in status in the following categories: sets moved from OPEN to PENDING and PENDING to OPEN; OPEN to VALIDATE and VALIDATE to OPEN; OPEN to CLOSED and CLOSED to OPEN; PENDING to CLOSED and CLOSED to PENDING; PENDING to VALIDATE and VALIDATE to PENDING; and VALIDATE to CLOSED and CLOSED to VALIDATE. This report can provide management with a summary view of user activity by individual USER ID.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: Set Range, Transaction Dates, and User IDs.
REPORT NOTES:	The data used by this report format is set level data. This report is best viewed on screen or printed to a color printer.

**USER ACTIVITY SUMMARY
REPORT**

User ID = All
Set Number = All
Transact Date = All



USER ID : eidrhha

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- END -

Chapter 9

Addendum E

Download Files

DCSET.TXT (SET LEVEL DATA)	START	LENGTH	
Set Number	001	11	key
Record Type	012	1	
Set Status	013	1	
Set Match Type	014	1	
Multi-FI Ind	015	1	
Owner FI	016	2	
Contract Number	018	13	
Current Load Date	031	10	
Initial Load Date	041	10	
Last Update Date	051	10	
Amt Id Recoup	061	14	
Amt Actual Recoup	075	14	
Set Adjust Amt	089	14	
Adjust Ind	103	10	
User Id	113	8	
Set Level User Defined Code	121	2	
Provisional Acceptance Flag	123	1	

DCCLM.TXT (CLAIM DETAIL)	START	LENGTH	
Set Number	001	11	key
TED ICN	012	17	key
TED Time	029	6	key
Amount Billed Total	035	14	
Amount Allowed Total	049	14	
Amt Paid Govt Contrtr	063	14	
Sponsor ID	077	9	
Sponsor ID Type Code	086	1	
Patient Date of Birth	087	10	
Patient Name	097	27	
Patient Age	124	6	
DOD Patient ID	130	10	
Patient Zip/Country	140	9	
Patient Region Code	149	2	
Ptnt Catchment Area Ind	151	1	
Enrollment Code	152	2	
Prov Catchment Area Ind	154	1	
Multi Provider Id	155	4	
Provider Zip/Country	159	9	
Provider Region Code	168	2	
Provider Tax Number	170	9	

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DCCLM.TXT (CLAIM DETAIL) (CONTINUED)	START	LENGTH
Provider Network Status Code	179	1
National Provider ID	180	10
Provider Group NPI	190	10
Special Rate Code	200	2
Special Processing Code 1	202	2
Special Processing Code 2	204	2
Special Processing Code 3	206	2
Special Processing Code 4	208	2
Type of Institution	210	2
Admit Date	212	10
Inst Care Begin Date	222	10
Inst Care End Date	232	10
Principal Diagnosis Cd	242	6
DRG Code	248	3
Discharge Status Code	251	2
Responsible FI	253	2
Processing FI	255	2
Resp. Contract Nbr	257	13
Proc. Contract Nbr	270	13
PTC Date	283	10
Cycle Number	293	8
Batch Sequence Nbr	301	2
Voucher Sequence Nbr	303	2
Bill Frequency Code	305	1
Mass Change Level	306	6
Risk Indicator	312	1
Claim Match Type	313	1
Claim Form Type	314	1
Dup Claim Indicator	315	1
Reason Code	316	4
Solicited Indicator	320	1
Claim Level User Defined Code	321	2
Claim Id Recoup	323	14
Claim Actual Recoup	337	14
Claim Adjustment Amount	351	14
Provisional Acceptance Flag	365	1
Multi Set Indicator	366	1

DCUTLADJ.TXT (ADJUSTMENT)	START	LENGTH	
Set Number	001	11	key
TED ICN	012	17	key
TED Time	029	6	key
Occurrence Count	035	6	key
Adjustment ID	041	8	key
Adjust Indicator	049	1	
Adjust Date	050	10	
CPT-4 Code	060	5	
Amt Allowed CPT-4 Code	065	12	

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DCUTLADJ.TXT (ADJUSTMENT)	START	LENGTH	
Non-Inst Care Begin Dt	077	10	
Responsible FI	087	2	
Cycle Number	089	8	
Provisional Acceptance Flag	097	1	

DCUTLZTN.TXT (LINE ITEM)	START	LENGTH	
Set Number	001	11	key
TED ICN	012	17	key
TED Time	.029	6	key
Occurrence Count	035	6	key
Line Item Dupe Indicator	041	1	
Line Item Match Type	042	1	
CPT-4 Code	043	5	
Place of Service	048	2	
Type of Service	050	2	
Non-Inst Care Begin Dt	052	10	
Non-Inst Care End Dt	062	10	
Amt Billed CPT-4 Code	072	12	
Amt Allowed CPT-4 Code	084	12	
Amount Paid Govt Contractor	096	12	
Line Item ID Recoup Amount	108	12	
Provider Number	120	9	
Provider Sub-ID	129	4	
National Provider ID	133	10	
Provider Group NPI	143	10	
Provider Zip Code	153	9	
Provider Specialty	162	10	
Provider Network Status Ind	172	1	
Enrollment Code	173	2	
Special Processing Code 1	175	2	
Special Processing Code 2	177	2	
Special Processing Code 3	179	2	
Special Processing Code 4	181	2	
Pricing Code	183	2	
CPT-4 Modifier 1	185	2	
CPT-4 Modifier 2	187	2	
CPT-4 Modifier 3	189	2	
CPT-4 Modifier 4	191	2	
Provider Region Code	193	2	
Provider Catchment Area Ind	195	1	

DCSETCMT.TXT (SET COMMENT)	START	LENGTH	
Set Number	001	11	key
Comment Line Type	012	1	key
Comment Line Sequence #	013	6	key
Comment Line Text	019	255	

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DCSETLOG.TXT (SET TRANS LOG)	START	LENGTH	
Set Number	001	11	key
Transaction Date	012	26	key
User ID	038	8	
Set Status	046	1	
Amt Id Recoup	047	14	
Amt Actual Recoup	061	14	
Owner FI	075	2	
Adjust Amt	077	14	
Contract Number	091	13	
Current Load Date	104	10	
Initial Load Date	114	10	

DCCMNT.TXT (CLAIM COMMENT)	START	LENGTH	
Set Number	001	11	key
TED ICN	012	17	key
TED Time	029	6	key
Comment Line Text	035	255	

DCSETUSR.TXT (SET USER DEF CODES)	START	LENGTH	
Owner FI	001	2	key
Contract Number	003	13	key
Set Level User Defined Code	016	2	key
User Defined Text	018	30	
Active/Inactive Indicator	048	1	

DCCLMSR.TXT (CLAIM USER DEF)	START	LENGTH	
Owner FI	001	2	key
Contract Number	003	13	key
Claim Level User Defined Code	016	2	key
User Defined Text	018	30	
Active/Inactive Indicator	048	1	

DCCOUNT.TXT (SET COUNTS)	START	LENGTH	
As of Date	001	26	key
Owner FI	027	2	key
Contract Number	029	13	key
Open Status Number	042	11	
Pending Status Number	053	11	
Closed Status Number	064	11	
Validate Status Number	075	11	

DCCONTRACT.TXT (CONTRACT)	START	LENGTH	
Contractor Number	001	13	key
Contract Description	014	20	
FI Number	034	2	

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DCFI.TXT (CONTRACT)	START	LENGTH	
FI/Contractor Number	001	2	key
Abbreviation	003	8	
FI/Contractor Name	011	60	

DCREASON.TXT (REASON CODE)	START	LENGTH	
Reason Code	001	4	key
Reason Description	005	60	
Explain Code	065	1	
Display Key	066	1	

DCENROLL.TXT (ENROLLMENT CODE)	START	LENGTH	
Enrollment Code	001	2	key
Enrollment Description	003	40	

- END -

Education Requirements

The education of TRICARE beneficiaries, TRICARE providers, and Military Health System (MHS) staff and providers will be accomplished through a collaborative effort between the TRICARE Management Activity (TMA) Communications and Customer Service (C&CS) Directorate, the Managed Care Support Contractors (MCSCs), and other TRICARE contractors. This collaboration will ensure information and education about the TRICARE Program, policies, health care delivery requirements, and changes and/or addition to benefits are effectively provided. Educational activities include research and analysis to determine targeted audience and the provision of educational materials, and training programs and briefings in accordance with the [Section 2](#). The Government will furnish all printed educational materials, except for regional providers. The MCSC and/or other TRICARE contractors will be responsible for the individual distribution of Government-furnished materials.

1.0 EDUCATION PLAN

The MCSC shall submit an annual education plan to inform and educate TRICARE beneficiaries, TRICARE and MHS staff, and providers on all aspects of TRICARE programs. C&Cs and the TRICARE Regional Office (TRO) will review the plan, and provide concurrence or appropriate feedback for recommended changes.

2.0 INTERFACE REQUIREMENTS

2.1 TMA C&CS will meet with each MCSC and TRICARE contractor within 60 calendar days after contract award to develop and establish a Memorandum of Understanding (MOU). The MOU will establish the review and approval process for annual education plans, and identify the TMA process for obtaining education materials. The MOU shall also address the ordering and bulk shipment of materials. The MOU shall be effective No Later Than (NLT) 30 days following the meeting between TMA C&CS and the contractor.

2.2 The contractor shall participate in monthly TRICARE beneficiary and provider education meetings. The contractor shall operate within a working group, comprised of the TROs education representatives, [TRICARE Overseas Program \(TOP\)](#) education representative and the TRICARE Beneficiary Publications Office/C&CS. As advisors, the contractors shall provide unique perspectives, ideas, and recommendations regarding the development and maintenance of TRICARE educational materials to the group. Educational materials include printed product, videos, DVDs and other collateral material that will be distributed to TRICARE beneficiaries and other stakeholders on behalf of the Government in support of the TRICARE program. The goal of the monthly meetings is to present status updates on production, address issues, and provide new information and new ideas for products and/or initiatives. All requests for educational materials shall be submitted by the contractor via the appropriate TRO for review and consideration. Approval shall be based on justification that supports the specific efforts of educating TRICARE beneficiaries about their health care plan, the achievement of a uniform image and consistency in

the provision of TRICARE Program information, and available funding. The contractor shall provide one primary and alternate representative for attendance and participation in the monthly meetings, to be held approximately 12 times per contract year in the Washington, DC area. Meetings may be attended via teleconference, video telecommunications, or in person, as directed by the Government.

3.0 REQUIRED EDUCATIONAL MATERIALS

The Government will furnish all printed educational materials. Materials developed by the Government and distributed in support of the TRICARE program will be selected on the basis of recommendations by contractors, program managers, the Services, TMA leadership and others with interests and concerns about the information being provided to TRICARE beneficiaries and other stakeholders. Materials are not limited to printed products and may include CDs, videos, DVDs and other collateral material. C&CS and the TROs will review all recommendations and will prioritize products in accordance with funding availability. The Government will have final approval authority. The MCS and/or other TRICARE contractors will be responsible for the distribution of Government-furnished materials to MHS beneficiaries. The Government will provide all enrollment materials for distribution by the MCSC to MHS beneficiaries. The enrollment form will be provided electronically.

4.0 DISSEMINATION OF INFORMATION

4.1 NLT 30 days prior to the start of health care delivery, and annually thereafter, the MCSC shall mail one TRICARE Handbook to all MHS beneficiary households in the region based on Defense Enrollment Eligibility Reporting System (DEERS) data. The MCSC shall furnish enrollment information and forms, network provider information, Health Care Finder (HCF) information, claims forms, claim completion instructions, the TRICARE Handbook, the Provider Handbook, DEERS information and other informational materials upon request to beneficiaries, sponsors, providers, and Congressional Offices. The MCSC shall establish and maintain effective communications with all beneficiaries (see [Section 4](#)). The MCSC shall forward to TMA/C&CS and the TMA Regional Director (RD) copies of informational bulletins and/or EOB stuffers mailed to beneficiaries.

4.2 Annually, the MCSC shall be responsible for all provider education, which may include producing and distributing an annual Provider Handbook, newsletters, and/or bulletins. Copies of all products distributed to providers, will be provided to TMA C&CS, Congressional offices, Beneficiary Counseling and Assistance Coordinators (BCACs), Debt Collection Assistance Officers (DCAOs), and Health Benefits Advisors (HBAs) in the region. The MCSC may use any method of distribution that ensures timely response by all providers. The Government reserves the right to evaluate the success of the MCSC provider relations effort via scientific surveys and other data collection efforts with the network providers.

4.3 The MCSC shall distribute quarterly newsletter to all TRICARE Prime enrollees, including active duty personnel, dual-eligible beneficiaries, congressional offices, and HBAs. The MCSC shall also distribute one Standard and one TRICARE For Life (TFL) annual newsletter to non-enrolled beneficiaries using information contained in DEERS or provided by beneficiaries. Newsletters will be no more than six double-sided pages in length (8½" x 11"). The MCSC may use any method of distribution that ensures timely **delivery to all recipients.**

4.4 The TDEFIC contractor shall maintain a supply of beneficiary newsletters and bulletins. The TDEFIC contractor shall provide a copy of the most recent information to any interested beneficiary, upon request.

5.0 ORDERING EDUCATION MATERIALS

Initial requests for desired educational materials shall be submitted in accordance with [paragraph 2.2](#) to TMA C&CS during the development of the MOU after initial award of the MCS contract. Within 30 days of the request C&CS will host a meeting with the TRICARE Beneficiary Publication Committee. The contractor shall provide one representative for attendance and participation in the work group meeting to be held in the Washington, DC area. Meetings may be attended via teleconference, video telecommunications or in person, as directed by the Government. Requests for additionally designed educational materials not included in the initial request shall be submitted to TMA C&CS in accordance with [paragraph 2.2](#). As stated, for each contract year, the committee will conduct one extensive meeting to determine the core educational materials to be developed for the following fiscal year. Contractors may be required by their TRO to participate in this extensive, possibly multi-day, meeting in Washington, DC area. Upon determination of the core products, MCSCs will submit request for copies required and delivery dates requested. The contractors shall provide TMA C&CS with a single Point Of Contact (POC) and address(es) for delivery of educational materials.

6.0 MEDICAL MANAGEMENT TRAINING

The contractor shall participate in Health Affairs (HA) sponsored medical management training as requested, to include coordination of training schedules and the development of the agenda and training materials. Each contractor will participate in two four-day training sessions per year in their respective region. The location of the training will be designated by HA.

- END -

6.0 CORRESPONDENCE COMPLETION AND QUALITY CONTROL

6.1 A piece of correspondence shall be considered answered when the contractor's response to the individual or office provides a detailed outline of all actions taken to resolve the problem(s) and includes, as appropriate:

- An explanation of the requirements leading to the benefit determination;
- A clear, complete response to all stated or implied questions;
- When necessary to understanding, copies of Explanation(s) of Benefits (EOB(s)), claim number(s) of the original claim(s), and the claim number(s) of adjustment claim(s) including sufficient details to establish an easily followed audit trail.
- Other documents for full explanation and clarity.
- Clear explanation of any additional actions that require an action or reply by the inquirer before the contractor can take final action on the matter.
- A referral form to the contractor's Program Integrity Unit if potential fraud or abuse is identified. A copy of the referral shall be filed with the correspondence.

6.2 When TMA staff requests the contractor to provide claims processing information required by TMA to answer inquiry correspondence, the contractor need not provide detailed explanations of TRICARE policy, but shall provide a regulatory citation in support of the benefit determination, the date the claim was first received, the date the EOB was mailed, and a detailed explanation of any delay. When requested, the contractor shall furnish TMA with copies of all claims, supporting documents, previous correspondence relating to the particular case, a recapitulation, and a narrative description of the claims processing history for that claim; e.g., date received, date completed, date paid, etc. In the case of a TRICARE Prime beneficiary, it may be necessary to provide information about special coverage, pamphlets, enrollment information, or copies of all or parts of a health care record.

6.3 The contractor shall ensure the correspondence it prepares is accurate, responsive, clear, timely, and that its tone conveys concern and a desire to be of service. To monitor correspondence, contractors shall establish a quality control procedure to ensure its correspondence reflects the elements previously listed. The findings of the quality control review shall be incorporated into training programs to upgrade the performance of all persons involved in correspondence preparation. Contractors are free to tailor the program to meet their needs. Service to the beneficiaries and providers, as reflected in the quality and timeliness of correspondence, is a key management responsibility.

7.0 REQUIRED REPORTS

The contractor shall have the capability to provide data for the following management reports:

7.1 An open correspondence reporting system which identifies priority correspondence over 10 days old and routine inquiries over 15 days old for management follow-up action. This report shall

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include the sponsor's name and SSN, the patient's name, the name of the correspondent, the date of the correspondence, the date the correspondence was received by the contractor, the current status of the correspondence, the date of the latest interim response, and the anticipated or final response statement. This report is for contractor use only and the contractor may use any reporting system it chooses, provided there are adequate controls to meet timeliness standards.

7.2 Correspondence statistics for prompt and accurate completion of the TRICARE Monthly Workload and Cycle Time/Aging Reports.

- END -

Behavioral Health Care Provider Locator And Appointment Assistance

1.0 GENERAL/PURPOSE

The Managed Care Support Contractors (MCSCs) shall offer a beneficiary assistance service to Active Duty Service Members (ADSMs) and enrolled Active Duty Family Members (ADFMs) in locating behavioral health care providers and making behavioral health care appointments.

2.0 REQUIREMENTS

2.1 The contractor shall offer to all ADSMs, to those ADFMs enrolled in TRICARE Prime or TRICARE Prime Remote for Active Duty Family Members (TPRADFMs), and to ADFMs enrolled in the TRICARE Overseas Program (TOP) who have temporarily returned to the Continental United States (CONUS) a telephone-based behavioral health care provider locator and appointment assistance service for making timely routine and urgent appointments with mental health providers. Beneficiaries are not required to use the provider locator and appointment assistance service. Calls to this service from non-enrolled ADFMs, retirees, and retirees' family members shall be referred to the contractor's normal Beneficiary Assistance telephone line.

2.2 The standards in [32 CFR 199.17\(p\)\(5\)](#) concerning waiting times for routine and urgent care appointments apply to behavioral health care delivery. The wait time for an initial urgent behavioral health care appointment with a mental health provider shall generally not exceed 24 hours, and the wait time for an initial routine behavioral health care appointment with a mental health provider shall not exceed one week. After the initial appointment, the provider's medical judgment will be the determining factor regarding the waiting time for follow-up appointments.

2.3 To the extent that it can be obtained in accordance with the waiting time access to care standards, ADSM behavioral health care will be provided by Military Treatment Facilities (MTFs). For private sector behavioral health care, ADSMs enrolled to a CONUS MTF must have a referral from an MTF health care provider, or ADSMs enrolled in TPR or non-enrolled ADSMs must obtain concurrence with the behavioral health treatment request from the Military Medical Support Office (MMSO) Service Point of Contact (SPOC). An ADSM enrolled in TOP shall be authorized routine and urgent behavioral health care outside an MTF only if it has been pre-arranged by the ADSM's Primary Care Manager (PCM) or respective enrollment authority (**TOP** MTF or **TOP** contractor).

2.4 The contractor shall ensure behavioral health care appointments meet the access standards in [paragraph 2.2](#) for 90% of appointment requests received during a quarter. This process shall include consideration of the availability of MTF, network, and non-network providers.

2.4.1 The contractor shall make the behavioral health provider locator and appointment assistance service available to all ADSMs and enrolled ADFMs via a toll-free dedicated telephone

number during all normal business hours for all time zones within the region. The contractor shall provide staff sufficient in number to ensure 95% of phone calls to the number are answered by a contractor staff member within 30 seconds. The contractor shall provide a means for a caller whose call is not answered within 30 seconds to leave a call-back number. Within 30 minutes, the contractor shall make one attempt to contact the caller at the call-back number.

2.4.2 The contractor shall provide staff at the toll-free number who are knowledgeable of all TRICARE requirements pertaining to the provider locator and appointment assistance service.

2.4.3 The contractor may ask a set of screening questions designed to assess the level of criticality of a caller's behavioral health issue. The contractor shall refer callers assessed as having an emergent condition to an appropriate mental health services number, such as a suicide prevention hotline, and then terminate the call.

2.5 The contractor shall offer two alternative forms of assistance to beneficiaries who call the dedicated toll-free number. The selection of the desired alternative shall be at the discretion of the ADSM or enrolled ADFM.

2.5.1 Under each alternative, providing contract information for non-network behavioral health care providers shall constitute prima facie prior authorization by the contractor for CONUS enrolled ADFMs to obtain care from those providers during the first eight self-referred behavioral health appointments of the fiscal year. The contractor shall maintain a record of all beneficiaries granted such prior authorizations and shall ensure they are not subject to Point of Service (POS) cost-sharing for services obtained under the scope of the authorizations. ADFMs enrolled in TOP who have temporarily returned to CONUS are not subject to POS cost-sharing for any self-referred behavioral health care.

2.5.2 Under each alternative, the contractor shall advise ADFM TRICARE Prime and TPRADFM enrollees that they may self-refer to a TRICARE network provider for the first eight behavioral health care outpatient visits each fiscal year, but they will be subject to POS cost-sharing for visits beyond the first eight unless the provider has obtained authorization from the contractor for additional visits. The contractor shall inform these ADFMs that appointments made by them using the contractor's provider locator and appointment assistance service are considered self-referrals unless they have a referral from their primary care manager or from a referring mental health provider. The contractor shall inform these ADFMs that it is their responsibility to keep track of the number of self-referred behavioral health sessions they have in a fiscal year. These ADFMs shall be informed that to avoid POS cost-sharing the care must be obtained from a network provider, unless they obtain prior authorization from the contractor for non-network care.

2.5.3 Alternative 1

2.5.3.1 The contractor shall provide the caller the telephone numbers of behavioral health care providers who are willing to give appointments to TRICARE patients within the access to care standards. Provider information given to ADSMs will be limited to MTF contact points unless (1) the ADSM has a referral from the MTF for behavioral health care or (2) in the case of ADSMs enrolled in TPR or non-enrolled ADSMs, the MMSO SPOC has concurred with a request for behavioral health care. For enrolled ADFMs, the contractor shall provide contact information for both MTF (if available) and TRICARE network providers. If neither of these sources is available within access standards, contact information for out-of-network providers shall be provided.

2.5.3.2 The contractor shall inform beneficiaries they may call back for additional assistance in the event they are unable to make an appointment that will occur within a time frame that is satisfactory to them. The contractor shall offer to make one attempt to call the beneficiary within three business days, at a time during normal working hours chosen by the beneficiary, to determine if the beneficiary has made an appointment within a time frame satisfactory to the beneficiary. If the contractor learns during this return call that the ADSM or ADFM has made an appointment, the contractor shall request information about the number of days from the appointment request until the date of the appointment.

2.5.4 Alternative 2

2.5.4.1 ADSMs having MTF or MMSO authorization for private sector behavioral health care and ADFMs who either do not desire an MTF appointment or for whom no MTF appointment is available, may request the contractor to establish a conference call between the contractor, the beneficiary, and a provider's office. The contractor shall participate in the three-way conversation only long enough to confirm that the provider is willing to provide an appointment to a TRICARE patient. The ADSM or ADFM will make the actual appointment with the provider. Before disengaging from the call, the contractor shall ask the beneficiary to call back for additional assistance in the event the beneficiary is unable to obtain an appointment that will occur within a time frame satisfactory to the beneficiary. The contractor shall establish conference calls with non-network providers only if there is an insufficient number of network providers available.

2.5.4.2 If while attempting to establish a conference call with a provider's office, the contractor reaches only the provider's answering service or answering machine, the contractor shall offer the beneficiary the opportunity to leave their contact information with the answering service or on the answering machine so that the provider can contact them to arrange an appointment. Unless the beneficiary requests termination of the process sooner, attempts at establishing a conference call with a live person in the office of a provider willing to provide an appointment to a TRICARE patient shall continue until successful or until the beneficiary has had the opportunity to leave their contact information for three providers, whichever comes first.

2.5.4.3 The contractor shall offer to make one attempt to call the beneficiary within three business days, at a time during normal working hours chosen by the beneficiary, to determine if the beneficiary has made an appointment within a time frame satisfactory to the beneficiary. If the contractor learns during this return call that the ADSM or ADFM has made an appointment, the contractor shall request information about the number of days from the appointment request until the date of the appointment.

2.6 Data Requirements List for Collection and Reporting

The contractor shall collect/measure data about the use of this provider locator and appointment service and provide the following quarterly reports to the Government, respective TRICARE Regional Office (TRO), and respective Contracting Officer (CO) by the 25th day of the month following the quarter:

- Total number of calls answered that were from beneficiaries eligible to use the assistance service.
- Total number of ADSMs who contacted the assistance telephone number.

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- Total number of enrolled ADFMs who contacted the assistance telephone number.
- Total number of ADSMs and ADFMs who, after contacting the assistance telephone number, stated they had an emergent behavioral health issue or were assessed through their answers given to a set of screening questions to have an emergent behavioral health issue.
- Number and percent of beneficiaries calling the assistance number who selected Alternative 1.
- Percent of beneficiaries selecting Alternative 1 who chose to be contacted in a follow-up call by the contractor.
- Number and percent of beneficiaries selecting Alternative 1 and choosing to be contacted in a follow-up call by the contractor who, during the follow-up call, stated they were unable to make an appointment that would occur within a time frame satisfactory to them.
- Average number of days from the date an appointment was made until the date the appointment was scheduled to occur as stated by beneficiaries during follow-up calls from the contractor to beneficiaries who had chosen Alternative 1 and who, subsequently, had secured an appointment.
- Number and percent of beneficiaries calling the assistance number who selected Alternative 2.
- Percent of beneficiaries selecting Alternative 2 who chose to be contacted in a follow-up call by the contractor.
- Number and percent of beneficiaries selecting Alternative 2 and choosing to be contacted in a follow-up call by the contractor who, during the follow-up call, stated they were unable to make an appointment that would occur within a time frame satisfactory to them.
- Average number of days from the date an appointment was made until the date the appointment was scheduled to occur as stated by beneficiaries during follow-up calls from the contractor to beneficiaries who had chosen Alternative 2 and who, subsequently, had secured an appointment.
- Number of times the contractor directed ADSMs or ADFMs to non-network providers due to lack of available appointments with MTF or network providers.

- END -

Chapter 13

Program Integrity

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1	General
2	Case Development And Action
3	Prevention And Detection
4	Evaluation
5	Reporting
6	Provider Exclusions, Suspensions, And Terminations
7	Provider Reinstatements
8	Threats Against Contractors
A	Figures
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Figure 13.A-2	Sample Letter To Beneficiary In External Audit Cases
Figure 13.A-3	Sample Letter To Provider/Pharmacy In External Audit Cases
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Figure 13.A-5	Special Notice To Beneficiary When The Beneficiary's Claims Are Suspended Due To Possible Beneficiary Fraud (Sample)
Figure 13.A-6	Special Notice To Beneficiary's When A Beneficiary's Claims Are Suspended Due To Possible Provider/Pharmacy Fraud (Sample)
Figure 13.A-7	Annual Letter Of Assurance (Sample)
Figure 13.A-8	Notice To Provider/Pharmacy Excluded Or Suspended By The Department Of Health And Human Services (DHHS) (Sample)
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Figure 13.A-18 Case Referral Evaluation (Sample)

with [paragraph 5.0](#). Identification means the contractor has been made aware of allegations of fraud/abuse by a beneficiary, provider, law enforcement, other source, or proactive measures. The contractor shall not report fraud and abuse cases which are suspected of violating Federal law directly to the Defense Criminal Investigating Service (DCIS), Military Criminal Investigation Organizations (MCIOs), Federal Bureau of Investigation (FBI) or any other investigative organization. All cases shall be reported to TMA PI in accordance with the procedures in this chapter.

Note: Up to 180 days is allowed to develop a case. Once a case is developed the case should be referred within 30 days of development completion. Exception to the 180 day referral must be requested in writing and approved by the Director, TMA PI or designee.

5.4 The contractor shall not respond to direct requests for documentation from investigative agencies, private payer plans, anti-fraud associations, or other entities. The contractor shall promptly notify the TMA PI of any requests made directly to the contractor. If the contractor responds directly to a request for documentation from an investigative agency or other entity, the costs of responding shall not be charged to the contract.

5.5 It is Department of Defense (DoD) policy that all employees, contractors and subcontractors shall cooperate fully with investigative agencies of the United States (US) upon the direction of the TMA PI. All requests for claims histories, medical and other records, regulatory/manual provisions, correspondence, audits and other documentation (e.g., newsletters, claims, checks) shall be provided by the contractor. Requests for witnesses and technical support will be completed by the contractor regardless of the time frames or dates of service identified in the request should this cross contractor jurisdiction or involve legacy contracts.

6.0 FRAUD AND ABUSE CASE REFERRAL CONTENT

6.1 General

[Addendum A, Figure 13.A-18](#) will be used by TMA to evaluate each referred case. Each case referred to TMA PI by the contractor shall be submitted in duplicate. The contractor is required to provide complete copies of any case files TMA PI requests (i.e., utilization reviews, patterns of practice, etc.) at no cost to the government.

6.2 Case Summary

The contractor shall submit a Case Summary when referring cases of potential fraud or abuse that describes at a minimum the following:

- The allegations citing all the applicable TRICARE regulatory provisions that have been violated in regards to each allegation.
- A description of the individual or institution suspected of committing or attempting to commit the alleged wrongful behavior, including all appropriate information, such as the beneficiary's name, sponsor's status and SSN, beneficiary's relationship to sponsor, provider's specialty (e.g., General Practitioner or Pharmacy) and identification number, address, telephone number, etc.

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Case Development And Action

- A description how the suspicious behavior was uncovered, e.g., audit, prepayment screen, beneficiary, pharmacy, provider complaint, tip, DoD Hotline, investigator notification, etc. In addition, indicate the date the allegations were identified.
- A description clearly summarizing the behavior which is suspected to be in violation of Federal law, regulation or policy; for example, billing for services, pharmaceuticals or supplies that were not provided, altering receipts or claim forms, duplicate billing, providing incorrect information when seeking preauthorization, etc. This shall include identifying specific facts that illustrate the pattern or summary conclusions. For example: submitted probable false claims to the contractor through the U.S. Post Office or via electronic mail, altered checks, misrepresented the description and coding of services, falsified the name of the actual provider of care, falsified the name of the actual pharmacy dispensing the prescription, altering medical records, etc.
- A description of all action taken during developmental stage, to include contacts made, information obtained, potential problematic issues, etc.
- A description of the estimate the number of claims or encounters, the length of time the suspicious behavior has occurred and the government's and contractor's loss.
- A description of the current status of claims or other requests submitted by the suspected provider, pharmacy or beneficiary, i.e., regular development, processing and payment or denial, claims suspension, prepayment review, etc.
- A description of any relevant documents provided, such as any correspondence with the provider, pharmacy or beneficiary, telephone conversation records, provider certification files, requests for medical records, educational letters, recoupment letters, etc.
- A description of previous and/or ongoing administrative measures (educational efforts, prepay review, etc.).
- A description of all actions taken to identify and determine the total TRICARE exposure, including coordination with other contractors. The Case Summary shall indicate the total monetary exposure to TRICARE and if actual patient harm has occurred.
- A description of any other facts that may establish a pattern of practice or indicate that the provider, pharmacy or beneficiary intended to defraud the government or the contractor.

6.3 Copies of Supporting Documents

The contractor shall include a copy of all relevant supporting document(s) when referring cases of potential fraud or abuse that includes at a minimum the following:

- A completed TRICARE Fraud and Abuse Report (TMA Form 435, [Addendum A, Figure 13.A-1](#)).
- Copies of the applicable TRICARE regulatory provisions violated.

FIGURE 13.A-17 CONTROLLED PRESCRIPTION DRUGS

1.0 CONTROLLED PRESCRIPTION DRUG SCHEDULES

The Controlled Substances Act of 1970 (Public Law 91-513) classifies drugs covered by the law in five schedules according to their potential for abuse and risk of bodily harm. The schedules follow:

1.1 Schedule I

Substances with a high potential for abuse and that have no current accepted medical use in treatment. These drugs circulate through, and are available through, illegal channels.

1.2 Schedule II

Drugs which have a high abuse potential with severe psychic or physical dependence liability. Drugs should have a current acceptable medical use in treatment. This schedule includes the narcotics, stimulants and depressants that are commonly obtained through legal channels but have high potential for drug dependency. The following control measures prevail that affect prescribing and dispensing of the drugs in this schedule:

- Prescription must be signed by the prescribing physician.
- Prescriptions are nonrefillable.

1.3 Schedule III and IV

The drugs or other substances in Schedules III or IV have less potential for abuse than the drugs or other substances in Schedules I and II. The drugs have currently acceptable medical use in treatment in the United States. Abuse of the drugs or other substances may lead to moderate or low physical dependence or high psychological dependence:

- Drugs may be prescribed orally (by phone) or written.
- Prescriptions may be refilled up to five times within six months of initial issuance if authorized by the prescribing physician and if state law permits. After the five or less authorized refills are received or after the expiration of six months from date of issuance (whichever comes first), the prescription is non-refillable and a new and separate written prescription, or an oral prescription if state law permits, is required. (Additional refill authorization cannot be added to the prescription. A new prescription must be developed.)

1.4 Schedule V

Includes certain narcotic drugs containing nonnarcotic active medical ingredients. The Schedule V drugs have less potential for concern of abuse than drugs in Schedule IV and use in treatment.

2.0 CONTROLLED PRESCRIPTION DRUG SYMBOLS

Controlled drugs are identified in the American Druggist Blue Book or Drug Topics Red Book by the following symbols:

- Schedule II: C-II
- Schedule III: C-III
- Schedule IV: C-IV
- Schedule V: C-V

FIGURE 13.A-17 CONTROLLED PRESCRIPTION DRUGS (CONTINUED)

3.0 UTILIZATION REVIEW RECOMMENDED CRITERIA AND PROCEDURES

Prescription drug claims should be developed for medical necessity prior to payment if the claim contains at least one controlled drug and exceeds one or more of the prepayment utilization review screening criteria developed by the contractor.

3.1 Claims For Controlled Drugs

Claims for controlled drugs that fail any prepayment screening criterion should be subjected to review. Subsequent drug claims should be suspended pending completion of the review.

3.2 Claims History

The claims history, particularly claims for services performed by the prescribing physician, should be reviewed. This review may demonstrate that the drugs are medically necessary and that drug abuse is unlikely, particularly in terminal patients. In that event, the drug claim(s) may be paid. If the claim history review does not resolve the question of possible abuse, recommend that the contractor submit the case to professional review.

3.3 Medical Review

If medical review determines that care is appropriate, the claim may be paid. If drug abuse is confirmed, the abused drugs will be denied. The beneficiary is to be notified that no payment will be made and that the decision is based on lack of medical necessity. If appropriate, the prescribing physician shall be notified. If there is a documented diagnosis of a morbid addictive state (rather than abuse), all narcotics shall be denied. The beneficiary is to be offered appropriate appeal rights and informed that his/her attending physician may discuss the case with the contractor's medical advisor or pharmacy consultant. For a period of six months, all drug claims for this beneficiary should be reviewed by a professional advisor before payment. The professional advisor may extend the period of review.

FIGURE 13.A-18 CASE REFERRAL EVALUATION (SAMPLE)

**CASE REFERRAL EVALUATION
TRICARE, PROGRAM INTEGRITY OFFICE**

Case Name: _____

Contractor: _____

Date TMA PI Received: _____

Case Referral Number: _____

Determine the following:

1. What are the allegations (What part of 32 CFR 199.9, section (b) or (c) has been violated.)?

2. Does the case referral identify a pattern of **fraud/abuse**? Did the contractor summarize those findings in order to determine probable method of fraud/abuse?

(NOTE: Patient harm by itself is a **utilization review/malpractice issue** and not fraud.)

- Pattern & findings summarized 5
- Pattern & findings not summarized 3
- Failed to develop case beyond a single indicator of fraud (or failed to document that development only resulted in single indicator of fraud) 1
- Case does not establish an egregious pattern of fraud (e.g., one level of E & M upcoding, excessive ultrasounds, etc.) 0

Rationale for rating less than 5:

3. Have the allegations been substantiated in the referral? Yes/No

(NOTE: If no, then no points are awarded)

How?

- Statistically valid random audit using accepted PI criteria. 5
- Alternate method of substantiating fraudulent pattern (e.g., 100% audit). 5
- Audit (e.g., calendar, beneficiary survey). 3
- Sample Claims (e.g., probe audit). 1

Rationale for rating less than 5:

Date: _____

Case Name: _____

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FIGURE 13.A-18 CASE REFERRAL EVALUATION (SAMPLE) (CONTINUED)

4. How has TRICARE been affected (monetarily, patient harm, etc.)?

- Actual patient Harm with fraud component: 5
- Dollar Damages:
 - >\$75,000 5
 - \$40,000 - \$75,000 3
 - <\$40,000 1

Note: Maximum score for this section is 5 points.

Provide actual dollar loss and extrapolated loss, if possible:

5. Were all applicable TRICARE regulatory provisions cited in the referral in regard to each substantiated allegation and were copies included with the referral?

- Yes 5
- Not all applicable provisions cited or incorrect provisions provided 3
- No 0

If not, print the applicable policy and/or regulation to include with the referral.

Rationale for rating less than 5:

6. Is this case referral complete in accordance with Chapter 13 requirements (the fraud/abuse is thoroughly documented, the pattern of fraud/abuse is supported by evidence, and all supporting documentation is included and well organized), and ready to send to DCIS?

- Yes 5
- Needs minimal work that can be completed by TMA Program Integrity 3
- Needs work by contractor 1
- Referral did not meet criteria 0

Note: If items from #5 were missing deduct points in that section; do NOT deduct points in this section.

Rationale for rating less than 5:

Date: _____

Case Name: _____

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FIGURE 13.A-18 CASE REFERRAL EVALUATION (SAMPLE) (CONTINUED)

7. Does referral comprehensively document all action taken to identify and capture total TRICARE exposure (e.g., all provider TINs identified, necessary coordination made with other contractors for additional billings information, etc.)? Provide documentation if no additional exposure found.

- Yes 5
- Not all exposure captured (e.g., captured TDEFIC exposure and failed to coordinate with other contractor in neighboring state) 3
- No 0

Rationale for rating less than 5:

8. Case Rating:

- 30 5
- 27-29 4
- 24-26 3
- 18-23 2
- 8-17 1

NOTE: Cases are rated on a scale of 1-5 with a score of 5 representing the best case referrals.

Rated by: _____
Title: _____
Reviewed By: _____
Date: _____

Form Date: January 1, 2008

[Form subject to change]

- END -

Chapter 14

Audits, Inspections, And Reports

Section/Addendum	Subject/Addendum Title
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1	Audits And Inspections
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2	Reports And Plans
---	-------------------

3	Special Reports
---	-----------------

Reports And Plans

1.0 SUBMISSION REQUIREMENTS

Reports and plans shall be submitted as required by the Contract Data Requirements Lists (CDRLs), DD Forms 1423, incorporated into the contract.

2.0 METHOD OF SUBMISSION

2.1 All deliverables shall be submitted to TMA via the E-commerce Extranet (<https://tma-ecomextranet.ha.osd.mil/>). This system allows the contractor to log on to a secure system and **upload the required** deliverables (contract plans, reports, etc.). The system is accessed via the Internet through a workstation browser. The application is "thin client" meaning that no software needs to be installed on the client workstation and no software is downloaded into the browser. Javascript and cookies need to be enabled in the browser to utilize the application. The application is best viewed at a resolution of 1024 x 768 pixels in an Internet Explorer (IE) browser. The system must be accessed using the Secure Socket Layer (SSL) protocol (https://) and is protected by individually assigned user name and password. Access to the Extranet must be requested using the E-Commerce Extranet Access Form which will be provided by the Government. While files are being submitted over the Internet they are encrypted within the secure layer. When files are stored on the TRICARE server, they are renamed with a randomly generated name of varying length. Access to information is granted to users at the contract level. Information submitted by one contractor will not be accessible to any other contractor.

2.1.1 Certain deliverables as identified by the government will require entry of **specific metric** data **from the deliverable** into a template **prior to uploading the deliverable**.

2.1.2 **All** deliverables will require submission into the Extranet in a format approved by the Government to include Microsoft® Office Excel, Word, PDF, or other specified format.

2.2 Delivery of deliverables to other agencies (**government and contractors**) as specified by the government **is the responsibility of the contractor**. **Deliver will be** in a method and format as determined by the government.

- END -

Special Reports

1.0 GENERAL

1.1 The contractor shall provide special programming reports to the TRICARE Management Activity (TMA) on an "as needed" basis. The TMA Procuring Contracting Officer (PCO) will not request a special programming report more than six times per contract period. The PCO will tell the contractor what information to include in the report. Examples of these reports include claims history data (either limited or complete) by provider, including one or more sub-identifiers; beneficiary; specific diagnosis(es); specific procedure code(s); and/or geographic region delineated by zip code(s). The contractor shall submit the reports by means of electronic medium or a disc as specified by the PCO. The contractor shall provide the completed reports to the PCO at TMA-Aurora within 60 calendar days of the date on the written request from the PCO.

1.2 If special reports are requested by TMA, the contractor must inform the PCO of the cost, if any. Upon approval of the cost estimate, the contractor shall complete the special report within the time requested by TMA unless a different delivery date is approved.

2.0 REPORTS TO MILITARY TREATMENT FACILITY (MTF) COMMANDERS

The contractor shall submit to MTF Commanders the following reports with information specific to their MTF or Prime Service Areas (PSAs) (frequencies shall be the same as those specified in the contract [Contract Data Requirements List \(CDRL\)](#)). Unless otherwise directed, the reports shall be provided directly to the MTF Commander by means of electronic medium or disk as specified by the MTF Commander. A copy of all MTF specific reports plus a summary report of all MTFs in the region shall be provided to the Regional Director (RD) at the same time the reports are provided to MTF Commanders. Only information concerning the specific RD's region should be provided. All reports shall be submitted in the formats required by the RD.

- Network Adequacy Status Report
- Enrollment Report (Active Duty Enrollees to MTF)
- Provider and Beneficiary Satisfaction Surveys
- Utilization Management Report
- Case Management Report
- Enrollment Program Progress Report
- Contingency Program Plan
- Referrals from Right of First Refusals (ROFRs)
- Clinical Support Agreement (CSA) Report

3.0 INTERNAL QUALITY MANAGEMENT/QUALITY IMPROVEMENT (QM/QI) PROGRAM

The contractor shall electronically submit documents describing the QM/QI Program to the RD and PCO within 30 calendar days of contract award. All updates or changes to the program are

to be submitted within 20 calendar days of the update or change.

4.0 INTERNAL QUALITY MANAGEMENT/QUALITY IMPROVEMENT (QM/QI) REPORT

If problems are identified through the contractor's internal QM/QI Program, the contractor shall electronically submit a QM/QI report to the RD and PCO within 10 days of the month when the problem was identified. The report shall include corrective actions planned/initiated. A monthly update/status report shall be submitted until all corrective actions have been achieved.

- END -

Chapter 16

TRICARE Prime Remote (TPR) Program

Section/Addendum	Subject/Addendum Title
------------------	------------------------

- | | |
|---|--|
| 1 | General |
| 2 | Health Care Providers And Review Requirements |
| 3 | Marketing, Enrollment, And Support Services |
| 4 | Contractor Responsibilities And Reimbursement |
| 5 | Reports |
| 6 | TRICARE Prime Remote For Active Duty Family Member (TPRADFM) Program |
| A | Points Of Contact (POCs) |
| B | Active Duty Care Guidelines |
| C | Dental Coverage For Active Duty Service Members (ADSMs) Enrolled In The TRICARE Prime Remote (TPR) Program |
| D | Service Point Of Contact (SPOC) Review For Fitness For Duty: Protocols And Procedures |

Health Care Providers And Review Requirements

1.0 NETWORK DEVELOPMENT

The TRICARE Prime Remote (TPR) program has no network development requirements.

2.0 UNIFORMED SERVICES FAMILY HEALTH PLAN (USFHP)

2.1 In addition to receiving claims from civilian providers, the contractor may also receive TPR Program claims from certain USFHP designated providers (DPs). The provisions of TPR will not apply to services furnished by a USFHP DP if the services are included as covered services under the current negotiated agreement between the USFHP DP and Office of the Assistant Secretary of Defense, Health Affairs (OASD(HA)). However, the contractor shall process claims according to the requirements in this chapter for any services not included in the USFHP DP agreement.

2.2 The USFHP, administered by the DPs listed below currently have negotiated agreements that provide the Prime benefit (inpatient and outpatient care). Since these facilities have the capability for inpatient services, they can submit claims that the contractor will process according to applicable TRICARE and TPR reimbursement rules:

- CHRISTUS Health, Houston, TX (which also includes):
 - St. Mary's Hospital, Port Arthur, TX
 - St. John Hospital, Nassau Bay, TX
 - St. Joseph Hospital, Houston, TX
- Martin's Point Health Care, Portland, ME
- Johns Hopkins Health Care Corporation, Baltimore, MD
- Brighton Marine Health Center, Boston, MA
- St. Vincent's Catholic Medical Centers of New York, New York City, NY
- Pacific Medical Clinics, Seattle, WA

3.0 VETERAN'S AFFAIRS

The contractor shall reimburse for services under the current national Department of Defense/Department of Veterans Affairs (DoD/DVA) Memorandum of Agreement (MOA) for "Referral of Active Duty Military Personnel Who Sustain Spinal Cord Injury (SCI), Traumatic Brain Injury (TBI), or Blindness to Veterans Affairs Medical Facilities for Health Care and Rehabilitative Services." (See [Section 4, paragraph 2.2](#) for additional information.) The contractor shall not

reimburse for services provided to TPR enrollees under any local Memoranda of Understanding (MOU) between the DoD (including the Army, Air Force and Navy/Marine Corps facilities) and the Department of Veteran's Affairs (DVA). Claims for these services will continue to be processed by the Military Services. However, the contractor shall process claims according to the requirements in this chapter for any services not included in the local MOU.

4.0 DEPARTMENT OF HEALTH AND HUMAN SERVICES (DHHS) [INDIAN HEALTH SERVICE (IHS), PUBLIC HEALTH SERVICE (PHS), ETC.]

Claims for services not included in the current MOU between the DoD (including the Army, Air Force and Navy/Marine Corps facilities) and the DHHS (including the IHS, PHS, etc.) shall be processed in accordance with the requirements in this chapter.

5.0 REVIEW REQUIREMENTS

5.1 Provision Of Documents

If the Service Point of Contact (SPOC) requests copies of supporting documentation related to care reviews, appeals, claims, etc., the contractor shall send the requested copies to the SPOC within four work days of receiving the request.

5.2 Primary Care

Active Duty Service Members (ADSMs) enrolled in the TPR program can receive primary care services under the Uniform HMO Benefit without a referral, an authorization, or a fitness-for-duty review by the ADSM's SPOC (see [Addendum A](#)). ADSMs with assigned Primary Care Managers (PCMs) will receive primary care services from their PCMs. ADSMs without assigned PCMs will receive primary care services from TRICARE-authorized civilian providers, where available--or from other civilian providers where TRICARE-authorized civilian providers are not available. If a contractor receives claims for primary care services that are not covered under TRICARE and/or that are furnished to a TPR enrollee by a provider who is not TRICARE-authorized or certified, the contractor shall pend the claim and supply required information ([Addendum D](#)) to the SPOC for coverage determination (refer to [Section 1, paragraph 4.0](#) for additional information). If the SPOC does not notify the contractor of the review determination or ask for an extension for further review within two workdays after submitting the request for a coverage determination, the contractor shall enter the designated authorization code into their system and release the claim for payment.

5.3 Non-Emergency Specialty Care, All Inpatient Care, Mental Health Care, And Other Care

The following care requires SPOC review: non-emergency specialty care, all inpatient hospitalization, mental health care, and invasive medical and surgical procedures (with the exception of laboratory services) furnished in ambulatory settings. The contractor shall not, however, delay claim processing for a SPOC review determination.

5.3.1 Referred Care

5.3.1.1 The requesting provider shall follow the contractor's referral procedures and shall contact the contractor for an authorization. If an authorization is required, the contractor shall enter the

information in [Addendum D](#), required by the SPOC for a fitness-for-duty review. The SPOC will respond to the contractor within two working days. When a SPOC referral directs evaluation or treatment of a condition, as opposed to directing a specific service(s), the Managed Care Support Contractor (MCSC) shall use its best business practices in determining the services encompassed within the Episode Of Care (EOC), indicated by the referral. The services may include laboratory tests, radiology tests, echocardiograms, holter monitors, pulmonary function tests, and routine treadmills associated with the EOC. A separate SPOC authorization for these services is not required. If a civilian provider requests additional treatment outside the original EOC, the MCSC shall contact the SPOC for approval. The contractor shall not communicate to the provider or patient that the care has been authorized until the SPOC review process has been completed. The contractor shall use the same best business practices as used for other Prime enrollees in determining EOC when claims are received with lines of care that contain both referred and non-referred lines. Laboratory tests, radiology tests, echocardiogram, holter monitors, pulmonary function tests, and routine treadmills logically associated with the original EOC may be considered part of the originally requested services and do not need to come back to the PCM for approval. Claims received which contain services outside the originally referred EOC on an ADSM must come back to the PCM for approval.

5.3.1.2 If the SPOC determines that the ADSM may receive the care from a civilian source, the SPOC will enter the appropriate code into the authorization/referral system. The contractor shall notify the ADSM of approved referrals. The ADSM may receive the specialty care from an MTF, a network provider, or a non-network provider according to TRICARE access standards, where possible. In areas where providers are not available within TRICARE access standards, community norms shall apply. (An ADSM may always choose to receive care at an MTF even when the SPOC has authorized a civilian source of care and even if the care at the MTF cannot be arranged within the Prime access standards subject to the member's unit commander [or supervisor] approval.) If the appointment is with a non-network provider, the contractor shall instruct the provider on payment requirements for ADSMs (e.g., no deductible or cost-share) and on other issues affecting claim payment (e.g., the balance billing prohibition).

5.3.1.3 If the contractor does not receive the SPOC's response or request for an extension within two work days, the contractor shall, within one work day after the end of the two work day waiting period, enter the contractor's authorization code into the contractor's claims processing system. The contractor shall document in the contractor's system each step of the effort to obtain a review decision from the SPOC. The first choice for civilian care is with a network provider; if a network provider is not available within Prime access standards, the contractor may authorize the care with a TRICARE-authorized provider. The contractor shall help the ADSM locate an authorized provider.

5.3.1.4 If the SPOC directs the care to a military source, the SPOC will manage the EOC. If the ADSM disagrees with a SPOC determination that the care must be provided by a military source, the ADSM may appeal only through the SPOC who will coordinate the appeal with the Regional Director (RD); the contractor shall refer all appeals and inquiries concerning the SPOC's fitness-for-duty determination to the SPOC.

5.3.1.5 If the ADSM's PCM determines that a specialty referral or test is required on an emergency or urgent basis (less than 48 hours from the time of the PCM office visit) the PCM shall contact the contractor for a referral and send required information to the SPOC for a fitness for duty review. The ADSM shall receive the care as needed without waiting for the SPOC determination, and the contractor shall adjudicate the claim according to TRICARE Prime provisions. If further specialty

care is warranted, the PCM shall request a referral to specialty care. The contractor shall contact the SPOC with a request for an additional SPOC review for the specialty care.

5.3.2 Care Received With No Authorization or Referral

5.3.2.1 The contractor may receive claims for care that require referral, authorization, and SPOC review, that have not been authorized or reviewed. If the claim involves care covered under TPR, the contractor shall pend the claim and supply the required information ([Addendum D](#)) to the SPOC for review. If the SPOC does not notify the contractor of the review determination or ask for an extension for further review within two workdays after submitting the request for coverage determination, the contractor shall then authorize the care. The contractor shall then release the claim for payment, and apply any overrides necessary to ensure that the claim is paid with no fees assessed to the active duty member. However, the contractor shall not make claims payments to sanctioned or suspended providers (see [Chapter 13, Section 6](#)).

5.3.2.2 If the contractor determines that the services on the claim are not covered under TRICARE Prime and/or that the provider of care is not TRICARE-authorized, or is not certified, the contractor shall pend the claim and supply required information ([Addendum D](#)) to the SPOC for a coverage determination as well as for a fitness-for-duty screening (refer to [Addendum B](#) for information and examples of covered services). If the SPOC does not notify the contractor of the review determination or ask for an extension for further review within two workdays after submitting the request for a coverage determination, the contractor shall then authorize the care. The contractor shall then release the claim for payment and apply any overrides necessary to ensure that the claim is paid. However, the contractor shall not make claims payments to sanctioned or suspended providers (see [Chapter 13, Section 6](#)).

Note: If the SPOC retroactively determines that the payment should not have been made, the contractor shall initiate recoupment actions according to [Chapter 10, Section 4](#).

6.0 ADDITIONAL INSTRUCTIONS

6.1 Wellness Examinations

The contractor shall reimburse charges for wellness examinations covered under TRICARE Prime (see the TRICARE Policy Manual (TPM), [Chapter 7, Section 2.2](#)) without SPOC review. The contractor shall supply information related to requests for follow-up or additional GYN care that requires SPOC review ([paragraph 5.2](#)) to the SPOC (see [Addendum B](#)).

6.2 Optometry And Hearing Examinations

The ADSM may directly contact the contractor for assistance in arranging for optometry and hearing examinations. The contractor shall refer ADSMs to SPOCs for information on how to obtain eyeglasses, hearing aids, and contact lenses as well as examinations for them, from the Military Health System (MHS) (see [Addendum B](#)).

6.3 No PCM Assigned

ADSMs who work and reside in areas where a PCM is not available may directly access the contractor for assistance in arranging for routine primary care and for urgent specialty or inpatient

care with a TRICARE-authorized provider. Since a non-network provider is not required to know the fitness-for-duty review process, it is important that the ADSM coordinate all requests for specialty and inpatient care through the contractor. The contractor shall contact the SPOC as required for reviews and other assistance as needed.

6.4 Emergency Care

For emergency care, refer to the TPM for guidelines.

6.5 Dental Care

Claims for all dental services, including adjunctive dental care will be processed and reimbursed by a single separate active duty dental claims processor. [Addendum C](#) provides guidelines for dental claims and inquiries. (See [Section 4, paragraph 2.2](#) for adjunctive dental care provided under the National DoD/DVA MOA.)

6.6 Immunizations

The contractor shall reimburse immunizations as primary care under the guidelines in the TRICARE Reimbursement Manual (TRM).

6.7 Ancillary Services

A SPOC authorization for health care includes authorization for any ancillary services related to the health care authorized.

7.0 ADSM MEDICAL RECORDS

7.1 For TPR-enrolled ADSMs with assigned PCMs, the contractor shall follow contract requirements for maintaining medical records.

7.2 ADSMs will be instructed by their commands to sign annual medical release forms with their PCMs to allow information to be forwarded as necessary to civilian and military providers. The contractor may use the current "signature on file" procedures to fulfill this requirement ([Chapter 8, Section 4, paragraph 6.0](#)). When an ADSM leaves an assignment as a result of a Permanent Change of Station (PCS) or other service-related change of duty status, the PCM shall provide a complete copy of medical records, to include copies of specialty and ancillary care documentation, to ADSMs within 30 calendar days of the ADSM's request for the records. The ADSM may also request copies of medical care documentation on an ongoing, EOC basis. The contractor shall be responsible for all administrative/copying costs. Network providers shall be reimbursed for medical records photocopying and postage costs incurred at the rates established in their network provider participation agreements. Participating and non-participating providers shall be reimbursed for medical records photocopying and postage costs on the basis of billed charges. ADSMs who have paid for copied records and applicable postage costs shall be reimbursed for the full amount paid to ensure they have no out of pocket expenses. All providers and/or patients must submit a claim form, with the charges clearly identified, to the contractor for reimbursement. ADSM's claim forms should be accompanied by a receipt showing the amount paid.

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Note: The purpose of the copying of medical records is to assist the ADSM in maintaining accurate and current medical documentation. The contractor shall not make payment to the provider who photocopies medical records to support the adjudication of a claim.

7.3 ADSMs without assigned PCMs are responsible for maintaining their medical records when receiving care from civilian providers.

8.0 PROVIDER EDUCATION

The contractor shall familiarize network providers and, when appropriate, other providers with the TPR Program, special requirements for ADSM health care, and billing procedures (e.g., no cost-share or deductible amounts, balance billing prohibition, etc.). On an ongoing basis, the contractor shall include information on ADSM specialty care procedures and billing instructions in routine information and educational programs according to contractual requirements.

- END -

Contractor Responsibilities And Reimbursement

1.0 CONTRACTOR RECEIPT AND CONTROL OF CLAIMS

1.1 The contractor may establish a dedicated post office box to receive claims related to the TRICARE Prime Remote (TPR) Program. This dedicated post office box, if established, may also be the one used for handling Supplemental Health Care Program (SHCP) claims.

1.2 The contractor shall follow appropriate SHCP requirements for claims received for medical care furnished to Active Duty Service Members (ADSMs) not enrolled in the TPR Program.

2.0 CLAIMS PROCESSING

2.1 Jurisdiction

2.1.1 The contractor shall process inpatient and outpatient medical claims for health care services provided worldwide to the contractor's TPR enrollees, **except in the case of care provided overseas (i.e., outside of the 50 United States and the District of Columbia). Civilian health care while traveling or visiting overseas shall be processed by the TRICARE Overseas Program (TOP) contractor, regardless of where the beneficiary is enrolled.**

2.1.2 The contractor shall forward claims for ADSMs enrolled in TPR in other regions to the contractors for the regions in which the members are enrolled according to provisions in [Chapter 8, Section 2](#).

2.1.3 The contractor shall process claims received for ADSMs who receive care in their regions, but who are not enrolled in TPR, according to the instructions applicable to the SHCP.

2.1.4 The contractor shall forward ADSM dental (including adjunctive dental) claims and inquiries to the appropriate active duty dental claims processor (see [Addendum C](#)). (Adjunctive dental claims for care under the National Department of Defense (DoD)/Department Veteran Affairs (DVA) shall be processed by the contractor, see [paragraph 2.4](#))

2.2 Claims for Care Provided Under the National DoD/DVA Memorandum of Agreement (MOA) for Spinal Cord Injury (SCI), Traumatic Brain Injury (TBI), and Blind Rehabilitation

2.2.1 Effective January 1, 2007, the contractor shall process claims for ADSM care provided by the DVA for SCI, TBI, and Blind Rehabilitation. Claims shall be processed in accordance with this chapter and the following.

2.2.2 Claims received from a DVA health care facility for ADSM care with any of the following diagnosis codes (principal or secondary) shall be processed as an MOA claim: V57.4; 049.9; 139.0; 310.2; 323.x; 324.0; 326; 344.0x; 344.1; 348.1; 367.9; 368.9; 369.01; 369.02; 369.05; 369.11; 369.15;

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369.4; 430; 431; 432.x; 800.xx; 801.xx; 803.xx; 804.xx; 806.xx; 851.xx; 852.xx; 853.xx; 854.xx; 905.0; 907.0; 907.2; and 952.xx.

2.2.3 The contractor shall verify whether the MOA DVA-provided care has been authorized by Military Medical Support Office (MMSO). MMSO will send authorizations to the contractor by fax. If an authorization is on file, the contractor shall process the claim to payment. The contractor shall not deny claims for lack of authorization. Rather, if a required authorization is not on file, the contractor will place the claim in a pending status and will forward appropriate documentation to MMSO for determination (following the procedures in [Addendum B](#) for MMSO SPOC referral and review procedures).

2.2.4 MOA claims shall be reimbursed as follows:

2.2.4.1 Claims for inpatient care shall be paid using DVA interagency rates. The interagency rate is a daily per diem to cover an inpatient stay and includes room and board, nursing, physician, and ancillary care. These rates will be provided to the contractor by the TRICARE Management Activity (TMA) (including periodic updates as needed). There are three different interagency rates to be paid for rehabilitation care under the MOA. The Rehabilitation Medicine rate will apply to TBI care. Blind rehabilitation and SCI care each have their own separate interagency rate. Additionally, it is possible that two or more separate rates may apply to one inpatient stay. If the DVA-submitted claim identifies more than one rate (with the appropriate number of days identified for each separate rate), the contractor shall pay the claim using the separate rates. (For example, a stay for SCI may include days paid with the SCI rate and days paid at a surgery rate.)

2.2.4.2 Claims for outpatient services shall be paid at the appropriate TRICARE allowable rate (e.g., CHAMPUS Maximum Allowable Charge (CMAC)) with a 10% discount applied.

2.2.4.3 Claims for the following care shall be paid at the interagency rate if one exists and, if not, then at billed charges: transportation; prosthetics; orthotics; durable medical equipment (DME); adjunctive dental care; home care; personal care attendants; and extended care (e.g., nursing home care).

2.2.4.4 Since this is care for ADSMs, normal TRICARE coverage limitations do not apply to services rendered for MOA care. As long as a service has been authorized by MMSO, it will be covered regardless of whether it would have ordinarily not been covered under TRICARE policy.

2.2.5 All TRICARE Encounter Data (TED) records for this care must include Special Processing Code 17 - DVA medical provider claim.

3.0 CLAIM REIMBURSEMENT

3.1 For network providers, the contractor shall pay TPR medical claims at the CHAMPUS allowable charge or at a lower negotiated rate.

3.2 No deductible, cost-sharing, or copayment amounts shall be applied to ADSM claims.

3.3 If a non-participating provider requires a TPR enrollee to make an "up front" payment for health care services, in order for the enrollee to be reimbursed, the enrollee must submit a claim to the contractor with proof of payment and an explanation of the circumstances. The contractor shall

process the claim according to the provisions in this chapter. If the claim is payable without SPOC review the contractor shall allow the billed amount and reimburse the enrollee for the charges on the claim. If the claim requires SPOC review the contractor shall pend the claim to the SPOC for determination. If the SPOC authorizes the care, the contractor shall allow the billed amount and reimburse the enrollee for charges on the claim.

3.4 If the contractor becomes aware that a civilian provider is trying to collect “balance billing” amounts from a TPR enrollee or has initiated collection action for emergency or authorized care, the contractor shall follow contract procedures for notifying the provider that balance billing is prohibited. If the contractor is unable to resolve the situation, the contractor shall pend the file and forward the issue to the SPOC for determination. The SPOC will issue an authorization to the contractor for payments in excess of the applicable TRICARE payment ceilings provided the SPOC has requested and has been granted a waiver from the Deputy Director, TMA, or designee.

3.5 If required services are not available from a network or participating provider within the medically appropriate time frame, the contractor shall arrange for care with a non-participating provider subject to the normal reimbursement rules. The contractor initially shall make every effort to obtain the provider’s agreement to accept, as payment in full, a rate within the 100% of CMAC limitation. If this is not feasible, the contractor shall make every effort to obtain the provider’s agreement to accept, as payment in full, a rate between 100% and 115% of CMAC. If the latter is not feasible, the contractor shall determine the lowest acceptable rate that the provider will accept. The contractor shall then request a waiver of CMAC limitation from the Regional Director (RD), as the designee of the Deputy Director, TMA, before patient referral is made to ensure that the patient does not bear any out-of-pocket expense. The waiver request shall include the patient name, TPR location, services requested (Current Procedural Terminology, 4th Edition [CPT-4] codes), CMAC rate, billed charge, and anticipated negotiated rate. The contractor must obtain approval from the RD before the negotiation can be concluded. The contractors shall ensure that the approved payment is annotated in the authorization/claims processing system, and that payment is issued directly to the provider, unless there is information presented that the ADSM has personally paid the provider.

4.0 THIRD PARTY LIABILITY (TPL)

TPL processing requirements ([Chapter 10](#)) apply to all claims covered by this chapter. However, the contractor shall not delay adjudication action on a claim while awaiting completion of the TPL questionnaire and compilation of documentation. Instead, the contractor shall process the claim(s) to completion. When the contractor receives a completed TPL questionnaire and/or other related documentation, the contractor shall forward the documentation as directed in [Chapter 10](#).

5.0 END OF PROCESSING

The contractor shall issue Explanations of Benefits (EOBs) and provider summary vouchers for TPR claims according to TRICARE Prime claims processing procedures.

6.0 TED VOUCHER SUBMITTAL

The contractor shall report the TPR Program claims on vouchers according to TRICARE Systems Manual (TSM), [Chapter 2, Section 2.3](#). The TED for each claim must reflect the appropriate

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data element values.

7.0 STANDARDS

All TRICARE Program claims processing standards apply to TPR claims, see [Chapter 1, Section 3](#).

- END -

Reports

1.0 WORKLOAD AND CYCLE TIME REPORTS

The contractor shall produce monthly workload and cycle time reports for the TPR Program in accordance with the contract deliverable requirements.

2.0 TPR CLAIMS LISTING

Throughout the period of the contract, the contractor shall have the ability to produce, when requested by the TRICARE Management Activity (TMA), an electronic listing of all TPR claims processed to completion for any given month(s). The listing shall include the following data elements: Service Point of Contact (SPOC) Referral Number, TPR Defense Medical Information System Identification (DMIS-ID) code, Internal Control Number (ICN), Active Duty Service Member's (ADSM's) Social Security Number (SSN), and the date the claim was processed to completion (PTC).

- END -

ADFM's do not match, the ADFM's shall be advised by letter that they are not eligible for enrollment in TPRADFM but they remain eligible for TRICARE Standard, Extra, or Prime as appropriate.

10.5 When the contractor receives an enrollment application for TPRADFM from a family member of an activated Federalized National Guard/Reserve member ordered to active duty for a period of more than 30 days, the contractor shall ensure the family members are registered as eligible on DEERS.

10.6 The contractor shall match the TPR residence addresses on the application of the activated federalized National Guard/Reservist member and the family members. If the residence addresses match, to include zip code only match, the contractor shall deem the family members as eligible for TPRADFM and enroll the family member in the program.

10.7 If the TPR residence addresses on the application of the activated federalized National Guard/Reserve member and the family members do not match, the family members shall be advised by letter they are not eligible for enrollment in TPRADFM and they shall remain eligible for TRICARE Standard, Extra, or Prime as appropriate.

10.8 Enrollments or disenrollments will occur upon change of duty location out of the remote area, transfer into a MTF/clinic Prime Service Area (PSA), retirement, or separation from the Service. The ADFM or ADSM is responsible for notifying the contractor when an enrollment transfer is needed. The contractor shall follow enrollment portability and transfer procedures in [Chapter 6, Section 2](#).

10.9 The contractor shall enroll the ADFM in the DEERS Online Enrollment System (DOES) and enter the TPRADFM's enrollment status into DOES. The contractor shall use the DMIS-ID code(s) designated by the RD for that region to enroll ADFM's into TPRADFM (see the TRICARE Systems Manual (TSM)). If the contractor has not established a network of PCMs in a remote area, a TPR designated ADFM will be enrolled without a PCM assigned. A generic PCM code shall be used for TPRADFM enrollees without assigned PCMs. The ADFM without an assigned PCM will be able to use a local TRICARE participating or authorized provider for primary health care services without preauthorization.

10.10 The contractor shall provide TPRADFM enrollment information in the formats indicated in the contract requirements.

11.0 PCM ASSIGNMENT

At the time of enrollment, an ADFM will select (or will be assigned) a PCM within the access standard. The MCSC shall advise the ADFM of the availability of PCMs. If a PCM is not available, the ADFM shall be enrolled to TPRADFM without an identified PCM. An ADFM without an assigned PCM may use any TRICARE-authorized provider for primary care.

12.0 SUPPORT SERVICES

12.1 Inquiries

The contractor shall designate a point of contact for Government (RD, TMA, and Military Service) inquiries related to TPRADFM. The contractor may establish a dedicated unit for

responding to inquiries about TPRADFM, or may augment existing TPR service units already serving the ADSMs enrolled in TPR. The correspondence requirements and standards in [Chapter 1, Section 3](#), apply to TPRADFM written inquiries.

12.2 Toll-Free Telephone Service

The contractor shall provide toll-free telephone access for TPRADFM beneficiary inquiries.

13.0 CLAIMS PROCESSING

The regional contractor where the TPRADFM is enrolled shall process all claims for that enrollee, **except for care provided overseas (i.e., care outside of the 50 United States and the District of Columbia). Civilian health care while traveling or visiting overseas shall be processed by the TOP contractor, regardless of where the beneficiary is enrolled.** POS claims processing provisions do apply. The contractor shall provide TPRADFM claims information in the format for the Monthly Workload Reports and the Monthly Cycle Time Aging reports.

14.0 CLAIM REIMBURSEMENT

14.1 The payment provisions applicable under TPR for ADSM which allow for additional payment in excess of otherwise allowable amounts to providers who are not TRICARE-authorized or certified do not apply to TPRADFM. Such payments shall not be made unless such payments are otherwise allowed under the payment provisions for unauthorized providers contained in the TPM.

14.2 For network providers, the contractor shall pay TPRADFM claims at the negotiated rate. For participating providers the contractor shall pay up to the CHAMPUS Maximum Allowable Charge (CMAC), or billed charges, whichever is less. Contractors shall follow the requirements in [Chapter 8, Section 5](#) and the TRICARE Reimbursement Manual (TRM), [Chapter 5, Section 1](#), for claims for TPRADFM enrollees receiving care from non-participating providers.

14.3 If a non-participating provider requires a TPRADFM enrollee to make an “up front” payment for health care services, in order for the enrollee to be reimbursed, the enrollee must submit a claim to the contractor with proof of payment and an explanation of the circumstances.

14.4 If the contractor becomes aware that a civilian provider is “balance billing” a TPRADFM enrollee or has initiated collection action for emergency or authorized care, the contractor shall notify the provider that balance billing is prohibited.

14.5 If CMAC rates have been waived for TPR ADSM enrollees under [Section 4, paragraph 3.5](#), the TPRADFM enrollee shall not be extended the same waived CMAC rates. If required services are not available from a network or participating provider within the medically appropriate time frame, the contractor shall arrange for care with a non-participating provider subject to the normal reimbursement rules. The contractor shall make every effort to obtain the provider’s agreement to accept, as payment in full, a rate within 100% of the CMAC limitation. If this is not feasible, the contractor shall make every effort to obtain the provider’s agreement to accept, as payment in full, a rate between 100% and 115% of CMAC. By law the contractor shall not negotiate a rate higher than 115% of CMAC for TPRADFM care rendered by a non-participating provider. The contractor shall ensure that the approved payment is annotated in the authorization/claims processing system.

Active Duty Care Guidelines

These guidelines are intended as a sampling of treatment situations. They are not all-inclusive and are provided to help providers and the contractor determine what types of health care services require a fitness-for-duty review by the Service Point Of Contact (SPOC) ([Addendum A](#)). Providers and Health Care Finders (HCFs) are encouraged to contact the SPOC in specific situations for information and clarification on health care for Active Duty Service Members (ADSMs). The contractor shall conduct the Prime medical necessity reviews as required by contract.

HEALTH CARE SERVICE	SPOC REVIEW REQUIRED	*WHERE IS CARE PROVIDED?
Primary care medical services	No	Primary Care Manager (PCM) (or TRICARE-authorized civilian provider) or Military Treatment Facility (MTF).
Emergency/Urgent consults and tests required within 48 hours	Yes, but care will not be delayed while waiting for SPOC response	TRICARE-authorized civilian provider.
	Follow-up specialty care requires SPOC review	TRICARE-authorized civilian provider if approved by SPOC, or MTF.
Periodic health assessments offered under Prime enhanced benefit	No	PCM (or TRICARE-authorized Civilian Provider), or MTF.
Periodic eye and hearing examinations	No	TRICARE-authorized civilian provider or MTF as designated by SPOC.
Eye glasses/contacts	Yes	MTF or Service Labs; SPOC will provide information to ADSM.
Annual GYN/Pap exam	No	PCM (or TRICARE-authorized civilian provider), or MTF.
	SPOC to review follow-on visits	PCM (or TRICARE-authorized civilian provider if approved by SPOC), or MTF.
Service specific physical exams (for DoD/Service forms)	Yes	TRICARE-authorized civilian provider or MTF as designated SPOC).
HIV testing incidental to an Episode Of Care (EOC)	No	PCM (or TRICARE-authorized civilian provider).
Maternity Care: Routine--	First OB visit requires SPOC review; Routine OB follow-up visits and clinically indicated evaluations not related to complications (such as ultrasounds done for dating determinations) do not require SPOC review. Care for complications of pregnancy, including care that requires invasive procedures or hospitalization(s) require SPOC review.	TRICARE-authorized civilian provider.
Complicated pregnancies--		

* An ADSM may always choose to receive care from a military source even when the SPOC authorizes civilian care.

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Active Duty Care Guidelines

HEALTH CARE SERVICE	SPOC REVIEW REQUIRED	*WHERE IS CARE PROVIDED?
Hearing appliances	Yes	MTF; SPOC will provide information to ADSM.
Orthotics	Yes	TRICARE-authorized civilian provider.
Physical Therapy	Yes	TRICARE-authorized civilian provider
Service-required immunizations	No	PCM (or TRICARE-authorized civilian provider), or MTF.
Routine dental care and dental procedures	Yes	Civilian dentist (active duty dental claims processor processes and pays claims).
Health Care Service	SPOC Review Required	*Where Care Is Provided?
Counseling by a marriage & family therapist	Yes	TRICARE-authorized civilian provider.
Mental health counseling, psychiatric care and testing	Yes	TRICARE-authorized civilian provider or MTF.
Invasive surgical-medical procedures - inpatient/outpatient, non-emergency	Yes	TRICARE-authorized civilian provider or MTF as designated by SPOC.
Family planning (tubal ligation/vasectomy)	Yes	TRICARE-authorized civilian provider or MTF as designated by SPOC.
Infertility evaluation	No	PCM (or TRICARE-authorized civilian provider).
	Yes (for follow-up specialty care/surgery)	TRICARE-authorized civilian provider or MTF as designated by SPOC.
Drug, alcohol & follow-on care for substance abuse	Yes	TRICARE-authorized civilian provider or MTF if designated by SPOC.
Transplants	Yes	Specialized Treatment Service (STS) (or authorized Civilian Transplant Center if STS not available).
Experimental protocols, as allowed by the Uniform Benefit	Yes	TRICARE-authorized civilian provider or MTF as designated by SPOC.
Specialty dental care (crowns, bridges, endodontics, etc.)	Yes	Civilian dentist (active duty dental claims processor processes and pays claims).
Adjunctive dental care	Yes	TRICARE-authorized civilian provider (active duty dental claims processor processes and pays claims).
Ambulatory surgery or inpatient care	Yes	TRICARE-authorized civilian provider or MTF as designated by SPOC.
(retrospective)	TRICARE-authorized civilian provider	
All inpatient care	Yes	TRICARE-authorized civilian provider.

* An ADSM may always choose to receive care from a military source even when the SPOC authorizes civilian care.

- END -

General

1.0 INTRODUCTION

1.1 The Supplemental Health Care Program (SHCP), with specific exceptions discussed in this chapter, allows for payment of claims for civilian services rendered pursuant to a referral by a provider in a Military Treatment Facility (MTF), as well as for Civilian Health Care (CHC) received in the United States by eligible Uniformed Service members. The SHCP exists under authority of 10 USC 1074(c) and [32 CFR 199.16\(a\)\(3\)](#). The use of the SHCP for pay for care referred by MTF providers is governed by Assistant Secretary of Defense (Health Affairs) (ASD(HA)) Policy Memorandum 96-005, "Policy on Use of Supplemental Care Funds by the Military Departments" (October 18, 1995). That policy states, in pertinent part:

"Circumstances where supplemental funds may be used to reimburse for care rendered by non-governmental health care providers to non-active duty patients are limited to those where a medical treatment facility (MTF) provider orders the needed health care services from civilian sources for a patient, and the MTF provider maintains full clinical responsibility for the episode of care. This means that the patient is not disengaged from the MTF that is providing the care."

1.2 Eligible Active Duty Service Members (ADSMs) may include members in travel status (leave, TDY/TAD, permanent change of station), Navy/Marine Corps service members enrolled to deployable units and referred by the unit Primary Care Manager (PCM) (not an MTF), eligible Reserve Component (RC) personnel, Reserved Officer Training Corps (ROTC) students, cadets/midshipmen, and eligible foreign military.

1.3 The provisions of this Chapter do not apply to services rendered to enrollees in the TRICARE Prime Remote program (see [Chapter 16](#)) or to ADSMs enrolled overseas (see [Chapter 24](#)).

1.4 The fact that civilian services have been rendered to an individual who is enrolled to an MTF PCM does not mean that those services were MTF referred care. If a claim is received for an ADSM MTF enrollee and no authorization is on file, the MTF must be contacted to determine if the care was MTF referred.

2.0 SERVICE POINT OF CONTACT (SPOC)/MILITARY SERVICE PARTICIPATION

2.1 For care that is not referred by an MTF, the SPOC for members of the Army, Air Force, Navy, Marine Corps, and Coast Guard will be the Military Medical Support Office (MMSO). The MMSO is established to provide a means to identify, manage and provide medical oversight of CHC furnished to service members. MMSO's functions include preauthorization of care when required, medical oversight for specialty care, the coordination and management of civilian routine and emergency hospital admissions; the initiation or coordination of medical boards; and the coordination of other military personnel-related actions. The Public Health Service (PHS) and

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National Oceanic and Atmospheric Administration (NOAA) have their own SPOCs for their service members. A list of Uniformed Service SPOCs is provided in [Addendum A](#). The SPOCs will interact directly with the Managed Care Support Contractor (MCSC) using telephone, facsimile and automation links when available. [Addendum C](#) describes the protocols and procedures for coordination of authorizations with MMSO.

2.2 Contractors will also receive claims for MTF patients who may require medical care that is not available at the MTF (e.g., MRI) and the MTF refers a patient for civilian medical care (this include all civilian care provided to an ADSM MTF enrollee). In these cases, the contractor shall contact the referring MTF for any necessary medical oversight or authorization of care.

3.0 CONTRACTOR RESPONSIBILITIES

3.1 The contractor shall provide payment for inpatient and outpatient services, for MTF-referred civilian care within the 50 United States and the District of Columbia ordered by an MTF provider for an MTF patient for whom the MTF provider maintains responsibility. After payment of the claim, the contractor shall furnish the Services with information regarding payment of the claim as specified in the contract.

3.2 The contractor shall provide payment for inpatient and outpatient medical services for CHC received in the 50 United States and the District of Columbia by eligible uniformed service members in accordance with the provisions of this chapter. After payment of the claim, the contractor shall furnish reports as specified in the contract.

4.0 SHCP DIFFERENCES

4.1 ADSMs have no cost-shares, copayments or deductibles. If they have been required by the provider to make "up front" payment they may upon approval be reimbursed in full for amounts in excess of what would ordinarily be reimbursable under TRICARE. **Application of Other Health Insurance (OHI) is generally not considered (Section 3, paragraph 1.2.3).**

4.2 Non-Availability Statement (NAS) requirements do not apply.

4.3 If Third Party Liability (TPL) is involved in a claim, claim payment will not be delayed **while** the TPL information is **developed (see Section 3, paragraph 1.3).**

4.4 The contractor shall provide MTF-referred patients the full range of services offered to TRICARE Prime enrollees.

5.0 SERVICE PROJECT OFFICERS

Each Service will designate a Service Project Officer to be the Service's official **POC** with TMA and the contractor to resolve any overall service-related matters regarding the program (refer to [Addendum A](#) for the list of Service Project Officers).

- END -

inquiries, the contractor shall provide MTFs/claims offices, the Service Project Officers, TMA, and the SPOC a specific telephone number, different from the public toll-free number, for inquiries related to the SHCP Claims Program. The line shall be operational and continuously staffed according to the hours and schedule specified in the contractor's TRICARE contract for toll-free and other service phone lines. It may be the same line as required in support of TPR under [Chapter 16](#). The telephone response standards of [Chapter 1, Section 3](#), shall apply to SHCP telephonic inquiries.

8.1.1 Congressional Telephonic Inquiries

The contractor shall refer any congressional telephonic inquiries to the referring MTF or the SPOC, as appropriate, if the inquiry is related to the authorization or non-authorization of a specific claim or episode of treatment. If it is a general congressional inquiry regarding the SHCP claims program, the contractor shall respond or refer the caller as appropriate.

8.1.2 Provider And Other Telephonic Inquiries

The contractor shall refer any other telephonic inquiries it receives, including calls from the provider, service member or the MTF patient, to the referring MTF or the SPOC, as appropriate, if the inquiry pertains to the authorization or non-authorization of a specific claim. The contractor shall respond as appropriate to general inquiries regarding the SHCP.

8.2 Written Inquiries

8.2.1 Congressional Written Inquiries

For MTF-referred care, the contractor shall refer written congressional inquiries to the Service Project Officer of the referring MTF's branch of service if the inquiry is related to the authorization or non-authorization of a specific claim. For non-MTF referred care, the inquiry shall be referred to the SPOC. When referring the inquiry, the contractor shall attach a copy of all supporting documentation related to the inquiry. If it is a general congressional inquiry regarding the SHCP, the contractor shall refer the inquiry to the TMA. The contractor shall refer all congressional written inquiries within 72 hours of identifying the inquiry as relating to the SHCP. When referring the inquiry, the contractor shall also send a letter to the congressional office informing them of the action taken and providing them with the name, address and telephone number of the individual or entity to which the congressional correspondence was transferred.

8.2.2 Provider And Service Member (Or MTF Patient) Written Inquiries

The contractor shall refer provider and service member or MTF patient written inquiries to the referring MTF or the SPOC, as appropriate, if the inquiry pertains to the authorization or non-authorization of a specific claim. **The contractor shall respond as appropriate to general written inquiries** regarding the SHCP.

8.2.3 MTF Written Inquiries

The contractor shall provide a final written response to all written inquiries from the MTF within 10 work days of the receipt of the inquiry, or if appropriate, refer the inquiry to the SPOC upon receipt of the inquiry.

9.0 SHCP AGING CLAIMS REPORT

The Government intends to take action on all referrals to the SPOC as quickly as possible. To support this objective, the SPOC must be kept apprised of those claims on which the contractor cannot take further action until the SPOC has completed its reviews and approvals.

- END -

Dental Coverage For Active Duty Service Members (ADSMs)

1.0 Dental claims and preauthorizations for adjunctive dental care as defined in the TRICARE Policy Manual (TPM) will be managed by the Managed Care Support Contractors (MCSCs) for Continental United States (CONUS) Active Duty Service Members (ADSMs) and by the TRICARE Overseas Program (TOP) contractor for ADSMs outside the 50 United States and the District of Columbia. Contractors shall send all dental claims and inquiries for ADSMs to the appropriate Service Points Of Contact (SPOCs) listed below. The SPOC will notify the ADSM and dental provider when a request for dental care is not authorized or if dental care is denied, and will process appeals for dental care.

2.0 SERVICE POINTS OF CONTACT (SPOCs)

2.1 Army, Air Force, Navy, Marine Corps, Coast Guard, And National Guard

Officer in Charge
Military Medical Support Office (MMSO)
P.O. Box 886999
Great Lakes, IL 60088-6999

Telephone: 1-888-MHS-MMSO (647-6676)
FAX: (847) 688-7394

2.2 United States Public Health Service (USPHS) And National Oceanographic And Atmospheric Administration (NOAA)

Medical Affairs Branch
Beneficiary Medical Programs
5600 Fishers Lane, Room 4C-06
Rockville, MD 20857

Payment issues and Care Authorizations: (800) 368-2777
FAX: (800) 733-1303

- END -

Chapter 18

Demonstrations

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Department Of Defense (DoD) Cancer Prevention And Treatment Clinical Trials Demonstration

1.0 PURPOSE

The purpose of this demonstration is to improve TRICARE-eligible family member access to promising new cancer therapies, assist in meeting the National Cancer Institute's (NCI) clinical trial goals, and to assist in the formulation of conclusions regarding the safety and efficacy of emerging therapies in the prevention and treatment of cancer. The Department of Defense's (DoD's) financing of these sponsored studies will include Phase II and Phase III protocols approved under the NCI for all types of cancer.

2.0 BACKGROUND

2.1 On November 16, 1998 (Vol 63, No. 220) the **Federal Register** announced the one year extension of a demonstration project in which the DoD provides TRICARE reimbursement for eligible beneficiaries who receive cancer treatment under approved NCI clinical trials. A **Federal Register** Notice was published on January 5, 2000, extending the DoD Cancer Prevention and Treatment Clinical Trials Demonstration until such time the Interagency Agreement between DoD and the NCI is terminated. Extending the demonstration will allow for an evaluation of costs associated with this demonstration project.

2.2 The NCI sponsors and actively coordinates an extensive clinical trials program for the evaluation of prevention, early detection, treatment, and supportive care for various types of cancer. The NCI's program includes sponsorship of studies in single institutions, as well as large, multi-center, randomized trials in cooperative networks. The trials encompass studies of cancers occurring in virtually all anatomical sites and in all stages of development. The NCI clinical trials program has been the means by which the oncology community has developed most of the formal clinical evidence for the efficacy of the various prevention, early detection, and management approaches in treating cancer.

2.3 In support of NCI's efforts to further the science of cancer treatment, the DoD expanded its breast cancer demonstration to include all NCI-sponsored Phase II and Phase III clinical trials. This expanded demonstration will enhance current NCI efforts to determine safety and efficacy of promising cancer therapies by expanding the patient population available for entry into clinical trials and stabilizing the referral base for these clinical activities.

2.4 On June 21, 1999, the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) expanded the successful partnership with the NCI by allowing TRICARE eligible family members to participate in NCI sponsored clinical trials in cancer prevention in addition to cancer treatment. Cancer prevention clinical trials include screening and early detection clinical trials. This expansion of the current demonstration will enhance continued NCI efforts to determine safety and efficacy of

promising cancer prevention strategies by expanding the patient population available for entry into clinical trials and stabilizing the referral base for these clinical activities.

2.5 While this demonstration provides an exception to current TRICARE benefit limitations, the DoD hypothesizes that this increased access to innovative cancer strategies will occur at a cost comparable to that which the DoD has experienced in paying for conventional care under the TRICARE Standard program. The results of the demonstration will provide a framework for determining the scope of DoD's continued participation in the NCI's clinical research efforts.

3.0 POLICY

Note: Effective June 21, 1999, the DoD expanded the demonstration to include NCI sponsored cancer prevention, screening and early detection clinical trials.

3.1 Effective January 1, 1996, the cancer demonstration was authorized for those TRICARE-eligible patients selected to participate in NCI sponsored Phase II and Phase III studies for treatment of cancer. NCI sponsorship of clinical trials occurs through the Cancer Therapy Evaluation Program (CTEP), Cooperative Group Studies, NCI Grants or Cancer Center Studies. Evidence of NCI sponsorship in one of these categories will be that it is identified in the NCI comprehensive database, Physicians's Data Query (PDQ), or NCI supplements to that database; formal notification of approval from The Clinical Protocol Review and Monitoring Committee; or verification from the NCI project officer; or through protocols co-sponsored by the NCI and other federal agencies.

3.2 The DoD will cost-share all medical care and testing required to determine eligibility for an NCI-sponsored trial, including the evaluation for eligibility at the institution conducting the NCI-sponsored study. DoD will cost-share all medical care required as a result of participation in NCI sponsored studies. This includes purchasing and administering all approved chemotherapy agents (except for NCI-funded investigational drugs), all inpatient and outpatient care, including diagnostic and laboratory services not otherwise reimbursed under an NCI grant program if the following conditions are met:

- The provider seeking treatment for a TRICARE-eligible family member in an NCI approved protocol has obtained preauthorization for the proposed treatment before initial evaluation; and
- Such treatments are NCI sponsored Phase II or Phase III protocols; and
- The patient continues to meet entry criteria for said protocol; and
- The institutional and individual providers are TRICARE-authorized providers.

3.3 The DoD will not provide reimbursement for care rendered in the National Institutes of Health Clinical Center or costs associated with non-treatment research activities associated with the clinical trials. **Costs associated with non-treatment research activities may include administrative costs, such as, record keeping costs, publication costs, etc.**

3.4 Cost-shares and deductibles applicable to TRICARE also apply under this Demonstration. For TRICARE Prime enrollees, including those enrolled in Uniformed Services Family Health Plan (USFHP), applicable copays apply.

Note: Those patients enrolled in the previous breast cancer demonstration prior to January 1, 1996 (the effective date of the expanded cancer demonstration), will continue to have cost-shares and deductibles waived through the completion of their protocol. Waiver of the cost-shares and deductibles apply regardless of whether they were randomized to the experimental or conventional arm of the protocol.

3.5 Retroactive authorizations can be authorized in accordance with the provisions outlined in [32 CFR 199.4\(g\)\(19\)](#). A retroactive authorization for coverage of a cancer clinical trial can be issued to those beneficiaries who began participation in such trial before termination of the cancer demonstration. such retroactive authorization for coverage under the cancer demonstration rules can be issued even after termination of the Demonstration.

3.6 The demonstration will expire on March 31, 2008. Requirements of this chapter as related to cancer demonstration cease at 12:00 midnight on March 31, 2008, except for claims for demonstration enrollees whose treatment is in progress when the Demonstration expires. The Demonstration retains responsibility for these claims until the beneficiary is discharged from the cancer clinical trial. For cancer clinical trials benefit, see TRICARE Policy Manual (TPM), [Chapter 7, Section 24.1](#).

3.7 The records management requirements described in [Chapter 2](#) apply to cancer demonstration records.

4.0 APPLICABILITY

4.1 The Demonstration applies to all TRICARE-eligible beneficiaries. Active duty members continue to be eligible for Direct Care (DC) system services. The demonstration does not apply to Continued Health Care Benefit Program (CHCBP) enrollees.

4.2 Since demonstration benefits are not the same as TRICARE benefits, all inquiries and claims related to the Demonstration, including claims for conventional therapy under Phase III protocols shall be submitted to the appropriate contractor, referencing the DoD Cancer Prevention and Treatment Clinical Trials Demonstration.

4.3 Since the DoD has no authority regarding the NCI protocol eligibility for the sponsored study, if a patient does not meet the criteria for enrollment, appeal rights do not apply.

5.0 GENERAL DESCRIPTION OF ADMINISTRATIVE PROCESS

5.1 The attending oncologist or physician shall determine the eligible patient's needs and consult with the contractor/NCI to determine which, if any, Phase II or Phase III, NCI-sponsored studies are appropriate for the patient.

5.2 Following the identification of an appropriate sponsored study within the terms of the Demonstration, the attending oncologist or physician shall apply for Demonstration benefits to the case manager's office specially designated at the contractor.

5.3 Following a validation of the eligibilities of the patient and the sponsored study under the terms of the Demonstration, the contractor shall issue a written decision to both the patient and the applicant provider.

5.4 All claims for approved care under the Demonstration shall be submitted to the contractor for adjudication.

6.0 TRICARE MANAGEMENT ACTIVITY (TMA) AND CONTRACTOR RESPONSIBILITIES

6.1 TMA will provide:

6.1.1 Demonstrations will be non-financially underwritten transactions and follow vouchering rules set forth in the contract.

6.1.2 Case management and claims adjudication functions via specific contractual arrangement(s) with one or more Demonstration claims processors.

6.1.3 Periodic review and evaluation of the Demonstration claims adjudication process.

6.1.4 Specific written guidance to the Demonstration claims processor(s) regarding case management services and claims adjudication services to be provided by the claims processor under the terms of the Demonstration.

6.1.5 Public affairs functions to properly inform and periodically update the patient and provider communities regarding the terms of the Demonstration.

6.2 The contractor shall:

6.2.1 Provide a registered nurse to serve as case manager for inquiries and actions pertinent to the Demonstration.

6.2.2 Ensure the provider has submitted a letter on the facility's letterhead certifying:

6.2.2.1 The protocol is an NCI sponsored study; and

6.2.2.2 The index patient meets all entry criteria for said protocol; and

6.2.2.3 Notification will be provided to the contractor's Demonstration case manager of the patient's registration date when treatment actually begins; and

6.2.2.4 Notification will be provided to the contractor's Demonstration case manager if the patient becomes ineligible for the study prior to treatment.

6.2.3 Verify the letter from the facility includes the patient's name, sponsor's Social Security Number (SSN), the title and phase of the protocol, and the NCI number of the protocol and/or other appropriate evidence of NCI sponsorship.

6.2.4 Subscribe to the NCI's Comprehensive Cancer Database known as the PDQ, to assist in determining whether a particular study meets the requirements of the Demonstration and whether the patient is eligible for a particular protocol. For those studies that are not listed on the PDQ, the contractor will work with NCI staff to verify NCI sponsorship.

6.2.4.1 Unlike the other NCI sponsorship categories listed in [paragraph 3.1](#), protocols for Cancer Center Studies are not individually reviewed by the NCI. Instead, the NCI designates specific institutions as meeting NCI criteria for clinical and comprehensive cancer centers. Cancer center protocols receive approval through an NCI approved institutional peer review and quality control system at the institution. Protocols which have been through this process receive formal notification of approval from The Clinical Protocol Review and Monitoring Committee and, therefore, are considered NCI sponsored, but may not appear in the PDQ. A provider who is seeking to enter a patient into a Cancer Center Study must provide evidence of NCI sponsorship by forwarding the formal notification of approval from this specific committee. Formal notification of approval by the Clinical Protocol Review and Monitoring Committee will be required for approval of treatment in Cancer Center Studies which are not otherwise sponsored through the CTEP program, NCI cooperative groups, or NCI grants.

6.2.4.2 Certain protocols listed in the PDQ may not be clearly identified in terms of NCI sponsorship. Clinical trials conducted as part of an NCI grant, or those identified with a "V" number, must be verified for NCI sponsorship with the NCI project officer. Physicians who are holders of the grant at the institution must provide written clarification that the proposed treatment is a protocol under their NCI grant. The grant title and number must be specified.

6.2.4.3 Requests for treatment in clinical trials overseas must be verified as to NCI sponsorship with the NCI project officer.

6.2.4.4 Protocols that are co-sponsored by the NCI and other Federal Agencies must be verified by the NCI project officer.

6.2.5 Verify the patient's eligibility on the Defense Enrollment Eligibility Reporting System (DEERS).

6.2.5.1 If the patient is authorized to receive the care under the Demonstration, but DEERS reflects that the patient is not eligible, a statement shall be added to the authorization letter indicating before benefits can be paid, the patient must be listed as eligible on DEERS.

6.2.5.2 The patient shall be referred to the pass/ID card section of the military installation nearest their home for an eligibility determination.

6.2.5.3 If a patient is listed on DEERS as being eligible as of the date the cancer therapy begins, all services provided as a result of participation in an NCI sponsored study shall be covered. This also applies to patients whose treatment is in progress when the Demonstration expires.

6.2.6 Issue an authorization ([Figure 18.2-2](#)) or denial ([Figure 18.2-3](#)) letter to the applicant provider and patient once a determination is made regarding a particular protocol.

6.2.7 Establish and maintain a database of patients participating in the Demonstration. The database shall include the patient's name, sponsor's SSN, name and number of protocol, type of cancer, hospital name, and address and total cost.

6.2.8 Furnish a list of enrollees in the Demonstration to the contractor's Program Integrity Unit with instructions to run an annual post-payment report to determine if hospitals are receiving additional unlawful payments as a result of also receiving payment under TRICARE. If such payment

exists, it shall be the responsibility of the contractor to initiate recoupment action for any Demonstration benefits paid in error. This function will be supervised by the TMA Program Integrity Office (PI).

6.3 The contractor may at its discretion establish a dedicated toll-free telephone number to receive inquiries from both patients and providers regarding the Demonstration. If a dedicated toll-free telephone number is established for this demonstration, the phone shall be staffed seven hours a day during normal business hours. In the absence of a dedicated toll-free number for Demonstration inquiries, contractors shall use their primary toll-free telephone inquiry system (see [Chapter 11, Section 7](#) and [Chapter 20, Section 4](#)).

6.4 The contractor may at its discretion establish a dedicated mailing address where Demonstration inquiries and claims shall be sent for expedited response and/or claims adjudication. In the absence of a dedicated mailing address for Demonstration inquiries and claims, contractors shall use their primary address(es) for written correspondence and claims (see [Chapter 11, Sections 5, 6](#), and [Chapter 20, Section 4](#)).

7.0 CLAIMS PROCESSING REQUIREMENTS

7.1 Verify TRICARE-eligibility on the DEERS prior to payment.

7.2 Both institutional and professional charges shall be reimbursed based on billed charges.

7.2.1 The cancer center shall submit all charges on the basis of fully itemized bills. Each service and supply shall be individually identified and submitted on the appropriate claim forms.

7.2.2 All claims for medical care required as a result of participation in an NCI sponsored study for cancer prevention or treatment that is not a TRICARE benefit, shall be processed and paid under the demonstration.

7.3 Cost-shares and deductibles applicable to TRICARE will also apply under the Demonstration. For TRICARE Prime enrollees, including those enrolled in USFHP, applicable copays will apply.

7.3.1 The contractor shall query the DEERS Catastrophic Cap and Deductible Data (CCDD) to determine the status of deductible and catastrophic cap met amounts for TRICARE-eligible beneficiaries at the time the costs are listed on the voucher for processing and payment.

7.3.2 The contractor shall determine what expenses to apply to the deductible and catastrophic cap and reports these to the CCDD. These expenses shall be reported at the same time the costs are listed on the voucher for processing, prior to payment of the claim.

7.3.3 The contractor shall use query type 80. Type 80 (nonclaim update) is used to request crediting of amounts since this is a manual process.

7.4 Double coverage provisions apply. Acceptable evidence of processing by the double coverage plan is outlined in TRICARE Reimbursement Manual (TRM), [Chapter 4](#). In double coverage situations, the Demonstration shall pay the balance after the other health insurance has paid.

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7.5 Claims for this demonstration will be paid from the applicable non-underwritten bank accounts (see [Chapter 3](#)), and submitted through normal TRICARE Encounter Data (TED) processing as required in the TRICARE Systems Manual (TSM) with the applicable coding for clinical trials **demonstration with enrollment effective before April 1, 2008.**

7.6 Claims for this demonstration may be submitted either by Electronic Media Claim (EMC), through the dedicated demonstration mailing address, or through the appropriate regional claims processing address(es).

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**FIGURE 18.2-1 SAMPLE OF AUTHORIZATION LETTER TO BE ISSUED TO INSTITUTION
VERIFYING TRICARE ELIGIBILITY FOR SAID PATIENT TO BE ENROLLED IN NCI
SPONSORED STUDIES**

Hospital Name
Street Address
City, ST Zip

Dear _____:

This responds to your request for TRICARE eligibility verification, prior to enrollment of a TRICARE beneficiary in an NCI sponsored study for the prevention/treatment of cancer.

This is to inform you the following patient is eligible for TRICARE benefits and may be considered for enrollment in the NCI sponsored study. Enrollment in the study is a voluntary decision and can be made only by the patient.

Name of Patient: _____

Sponsor's Social Security Number: _____

If you have any questions or concerns, you may contact me at the address in the letterhead.

Sincerely,

Title

Enclosure

FIGURE 18.2-2 SAMPLE OF AUTHORIZATION LETTER FOR DOD CANCER PREVENTION AND TREATMENT CLINICAL TRIALS DEMONSTRATION

Name of Inquirer

Title

Hospital Name (Phase of cancer prevention or treatment protocol;

Street Address type of cancer; title of protocol)

City, ST Zip

Patient: **(Name of Patient) (Relationship to Sponsor, Sponsor Name, Rank, Branch of Service, Sponsor Status, Sponsor's SSN)**

Dear _____:

Our office has completed review of your **(Date of Letter)** application on behalf of **(Name of Patient)** for benefits under the Department of Defense Cancer (DoD) Prevention and Treatment Clinical Trials Demonstration. Based on our finding the proposed protocol **(NCI Number of Approved Protocol)** is an NCI sponsored study, and meets the terms of the Demonstration, we are pleased to authorize this care for **(Name of Patient)**.

The DoD intends to pay institutional and professional charges for cancer prevention and treatment for the patient named above if:

1. The provider seeking treatment for a TRICARE-eligible family member in an NCI approved cancer protocol has obtained preauthorization for the proposed clinical trial before initial evaluation; and
2. Such treatments are provided according to the NCI approved Phase II or Phase III cancer prevention or treatment protocol; and
3. The patient continues to meet entry criteria for said protocol; and
4. The institutional and individual providers are TRICARE-authorized providers.

Both institutional and professional charges will be reimbursed based on billed charges. The cancer center must submit all charges on the basis of fully itemized bills. Each service and supply must be individually identified. All cost-shares and deductibles applicable to TRICARE will also apply under this Demonstration as will copays for TRICARE Prime and USFHP enrollees. Questions regarding claims and reimbursement methodology will be provided by the contractor Demonstration case manager.

Because Demonstration benefits are not the same as TRICARE benefits, claims must be submitted to the appropriate contractor, referencing the DoD Cancer Prevention and Treatment Clinical Trials Demonstration.

A copy of this letter must accompany any claim submitted for Demonstration reimbursement of care related to this patient's cancer prevention and treatment. Any treatment under protocols other than the one specifically approved in this letter must receive preauthorization.

Name of Facility

Re: Patient Name

Date

FIGURE 18.2-2 SAMPLE OF AUTHORIZATION LETTER FOR DOD CANCER PREVENTION AND TREATMENT CLINICAL TRIALS DEMONSTRATION

Thank you for allowing the DoD to participate in the care of your patient.

Sincerely,

Title

cc:

-Beneficiary's Name and Mailing Address

FIGURE 18.2-3 SAMPLE OF DENIAL LETTER FOR DOD CANCER PREVENTION AND TREATMENT CLINICAL TRIALS DEMONSTRATION

Name of Inquirer

Title

Hospital Name (Phase of cancer prevention or treatment protocol; type of cancer; title

Street Address of protocol)

City, ST Zip

Patient: **(Name of Patient) (Relationship to Sponsor, Sponsor Name, Rank, Branch of Service, Sponsor Status, Sponsor's SSN)**

Dear _____:

Thank you for your **(Date of Letter or Facsimile)** application requesting care for **(Name of Patient)** under the terms of the Department of Defense (DoD) Cancer Prevention and Treatment Clinical Trials Demonstration.

The Demonstration is authorized to fund cancer prevention and treatment when conducted under a Phase II or Phase III, NCI-sponsored study. Following review of the data you submitted for **(Name of Patient)**, we have determined that **(list one or more of the following two reasons for denial)**:

1. **(List Name of Protocol)** is not an NCI sponsored study.
2. **(List Name of Protocol)** is not Phase II or Phase III in design.

Therefore, it is our decision that this patient's proposed care does not qualify for reimbursement under the terms of the Demonstration. Since the Demonstration has no authority regarding the NCI sponsored studies, if a patient does not meet the criteria for enrollment, appeal rights do not apply.

I am sincerely sorry that we are unable to assist **(Name of Patient)** with these expenses.

Sincerely,

Title

cc:

-Patient's Name and Mailing address

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Department Of Defense (DoD) Cancer Prevention And Treatment Clinical Trials Demonstration

FIGURE 18.2-4 SAMPLE OF NOTIFICATION LETTER TO BE ISSUED TO GEOGRAPHICAL CONTRACTOR OF PATIENT'S ENROLLMENT IN THE DOD CANCER PREVENTION AND TREATMENT CLINICAL TRIALS DEMONSTRATION

FI/Contractor Name

Street Address

City, ST Zip

Dear _____:

This letter is to notify you the following patient has enrolled in the Department of Defense (DoD) Cancer Prevention and Treatment Clinical Trials Demonstration:

Name of Patient: _____

Sponsor's Social Security Number: _____

All claims associated with this patient's treatment while enrolled in the clinical trial shall be processed by this office, with the exception of individual prescription drug claims. If claims are received for services provided to this patient, please forward the claims to the following address: **(Appropriate Address)**.

If you have any questions or concerns, you may contact me at the address in the letterhead or call **(Appropriate Telephone Number)**.

Sincerely,

Title

- END -

Department Of Defense (DoD) In-Utero Fetal Surgical Repair Of Myelomeningocele Clinical Trial Demonstration

1.0 PURPOSE

This demonstration will improve access to patients with fetuses who have a prenatal diagnosis of myelomeningocele; and to assist in meeting clinical trial goals under the Management of Myelomeningocele Study (MOMS) Protocol, in the formulation of conclusions regarding the safety and efficacy of intrauterine repair of fetal myelomeningocele.

2.0 BACKGROUND

2.1 The current state of the medical literature does not allow for a TRICARE benefit for in-utero surgical intervention for myelomeningocele as it is considered unproven. This determination is based on a Blue Cross Blue Shield (BCBS) technology assessment conducted in February 1999, which examined health outcomes resulting from prenatal correction to fetal malformations known to interfere with organ development (in a potentially fatal manner), and surgical techniques for which prenatal corrections have been developed and applied in humans. Because the evidence for in-utero repair of myelomeningocele was too scant, BCBS did not conduct a detailed analysis. Likewise, TRICARE Management Activity's (TMA's) December 1999 and October 2001 medical reviews of literature did not reveal any new evidence to justify TRICARE coverage for in-utero surgical repair of myelomeningocele.

2.2 On February 13, 2003 (Vol 68, No 30), the **Federal Register** announced a demonstration project in which the DoD provide TRICARE reimbursement for active duty members, former members, and their dependents to receive prenatal and postnatal surgical intervention for the repair of myelomeningocele under approved National Institute of Child Health and Human Development (NICHD) clinical trial.

2.3 The NICHD agreed to sponsor and actively coordinate an unblinded randomized controlled clinical trial program for the evaluation of the safety and efficacy of intrauterine repair of fetal myelomeningocele. Two hundred eligible patients whose fetuses have been diagnosed with myelomeningocele at 16 to 25 weeks' gestation who are at the age of 18 years or older would be screened for enrollment via telephone by the Biostatistics Center (BCC) at George Washington University in Rockville, Maryland, to undergo an initial evaluation. The NICHD program includes sponsorship in three participating MOMS Centers (Vanderbilt University Medical Center in Nashville, the University of California at San Francisco, and Children's Hospital of Philadelphia) where final evaluation and screening will be performed.

2.4 Approximately 60,000 TRICARE births occur at the Military Treatment Facilities (MTF) each year. Approximately 40,000 TRICARE births occur in the civilian hospitals. According to the Center of Disease Control, in 2001 there were 20.09 cases of spina bifida per 100,000 births; approximately 19

cases would occur annually in TRICARE. This Demonstration Project is projected to have approximately 6 to 16 TRICARE patients that has a fetus with a prenatal diagnosis of spina bifida participating in the protocol each year. DoD financing of this procedure will assist in meeting clinical goals and arrival at conclusions regarding the safety and efficacy of intrauterine repair of fetal myelomeningocele.

3.0 POLICY AND ELIGIBILITY

3.1 Effective March 17, 2003, the myelomeningocele demonstration is authorized for all eligible DoD beneficiaries including Active Duty Service Members (ADSMs) selected to participate in the NICHD-sponsored clinical trial for the treatment of myelomeningocele as outlined in the Myelomeningocele Clinical Trial Demonstration Protocol (MCTDP) ([Figure 18.3-1](#)).

3.2 The DoD will cost-share all medical care and testing required to determine eligibility for the NICHD-sponsored clinical trial, including the evaluation of eligibility at the institution conducting the NICHD-sponsored study, except to the extent that these services are covered by Other Health Insurance (OHI) of the beneficiary, or through grant support from the NICHD to participating institutions.

3.3 DoD will cost-share all medical care required as a result of participation in NICHD sponsored clinical trials. This includes purchasing and administering all approved pharmaceutical agents, perioperative, preoperative and postoperative x-ray or magnetic resonance imaging procedures and ultrasound procedures, physical examination, laboratory investigations, surgical interventions, postoperative management, and peripartum medical or surgical interventions including management of complications not otherwise reimbursed under NICHD grant program or beneficiaries' OHI if the following conditions are met:

3.4 The providers have obtained preauthorization for the proposed treatment before initial evaluation. If a preauthorization was not obtained before the initial evaluation, preauthorization can take place once the referral sheet from the MOMS Centers is received. A preauthorization for enrollment will suffice to cover each incidental expense or claim related to participation in the NICHD sponsored trial extending through the duration of the clinical trial. A preauthorization is required even when the beneficiary has OHI and must include verification with the NICHD that the patient has been enrolled in the NICHD-sponsored trial; and such treatments are those indicated in NICHD sponsored protocols; and the patient continues to meet entry criteria for said protocol.

3.5 The DoD will not provide reimbursement for costs associated with any non-treatment research activities associated with the clinical trial. This includes, but is not limited to:

- Data collection activities;
- Management and analysis of the data;
- Salaries of the research nurses;
- Travel to and from participating fetal surgery centers, per diem and hotel accommodation cost.

Note: These research costs will not be the responsibility of the patient participating in the trial but will be covered by NICHD grant program or the grantee Institution. If travel costs to and from

Expanded Eligibility Under The National Defense Authorization Act For Fiscal Years 2004 And 2005 (NDAA FY 2004 And 2005)

1.0 PURPOSE

The National Defense Authorization Act for Fiscal Year (NDAA FY 2004) includes two specific provisions at Sections 703 and 704 which, while not creating any new classes of beneficiaries or changes in coverage, do serve to expand the period of TRICARE eligibility previously applicable to certain existing classes of beneficiaries under current provisions. The NDAA FY 2005 (Public Law [PL] 108-375) provisions at Sections 703 and 706 extends eligibility for the program changes from the NDAA for FY 2004 provisions at Sections 703 and 704. The NDAA FY 2005 provides a permanent expansion of TRICARE eligibility to the existing classes of beneficiaries.

2.0 BACKGROUND

The Emergency Supplemental Appropriations Act for Defense for FY 2004 (PL 108-106), signed by the President on November 6, 2003 and the NDAA FY 2004 (PL 108-136) Title VII, Subtitle A, signed by the President on November 24, 2003 establishes enhanced TRICARE and medical benefits for reserve members. The NDAA FY 2005 further extended eligibility and made these benefits permanent.

3.0 POLICY AND ELIGIBILITY

3.1 Section 703 expands the period of time that a reservist is considered to be on active duty for the purpose of TRICARE eligibility.

3.1.1 A Reserve Component (RC) member who is issued a delayed-effective-date active duty order on November 6, 2003 or later will now be considered as being on active duty for more than 30 days beginning on the later of the date that is:

- The date of issuance of the order, or
- Ninety (90) days before the date on which the period of active duty is to commence.

3.1.2 Affected individual members of the RC and their family members are eligible for TRICARE under this section. This eligibility includes eligibility for TRICARE Prime Remote (TPR) for the service member, as a matter of the TRICARE Management Activity (TMA) policy, and eligibility for TRICARE Prime Remote for Active Duty Family Members (TPRADFMs) for their family members. The previous end date of December 31, 2004 is rescinded. The NDAA FY 2005 Section 703 extended eligibility by law and provided permanent authority for this benefit.

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Expanded Eligibility Under The National Defense Authorization Act For Fiscal Years 2004 And 2005 (NDAA FY 2004 And 2005)

3.2 Section 704 extends to 180 days the period of time that the Transitional Assistance Medical Program (TAMP) will apply for the purpose of TRICARE eligibility. The 180 days will begin on the date the member is separated from active duty. This extension of eligibility to a period of 180 days only applies to separations from active duty that take effect on or after November 6, 2003.

- The separated individual service members and their family members are eligible for TRICARE under this section. This eligibility does not include eligibility for TPR for the former service member, and does not include eligibility for TPRADFM for their family members. The previous end date of December 31, 2004 is rescinded. The NDAA FY 2005 Section 706 extended eligibility by law and provided permanent authority for this benefit.

3.3 The memorandum from the Under Secretary of Defense for Personnel and Readiness attached at [Figure 18.4-1](#) summarizes the changes contained in the NDAA FY 2004 legislation and gives specific policy guidance addressing each of these new program enhancements. This memorandum contains current information as the provisions of the NDAA FY 2004 were further extended by the NDAA FY 2005 which provided permanent authority for these benefits.

4.0 GENERAL DESCRIPTION OF ADMINISTRATIVE PROCESS

The revised periods of TRICARE eligibility for the affected individuals will be reflected on the Defense Enrollment Eligibility Reporting System (DEERS). Contractors will continue to rely upon DEERS for eligibility determination.

5.0 TMA AND CONTRACTOR RESPONSIBILITIES

5.1 TMA shall ensure that DEERS changes have been effectuated to reflect correct eligibility information for all affected individuals.

5.2 The contractor shall verify the patient's eligibility on the DEERS.

5.3 In the event that the contractor should become aware that payment has been made for services rendered during a period for which the patient was subsequently determined to be ineligible (e.g., the alerted reserve member was found upon medical screening to be not medically fit for active duty), recoupment action shall be initiated.

**FIGURE 18.4-1 UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS
MEMORANDUM**



PERSONNEL AND
READINESS

UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, D.C. 20301-4000
JAN 7 2004



MEMORANDUM FOR ASSISTANT SECRETARY OF THE ARMY (M&RA)
ASSISTANT SECRETARY OF THE NAVY (M&RA)
ASSISTANT SECRETARY OF THE AIR FORCE (SAF/MR)

SUBJECT: Health Care Benefits for Reserve Component Members and Their Dependents:
Second Addendum to Mobilization/Demobilization Personnel and Pay Policy for
Reserve Component Members Ordered to Active Duty in Response to the World
Trade Center and Pentagon Attacks

- References:
- (a) National Defense Authorization Act for FY 2004, Sections 701, 703, and 704.
 - (b) USD(P&R) Memorandum, Mobilization/Demobilization Personnel and Pay Policy for Reserve Component Members Ordered to Active Duty in Response to the World Trade Center and Pentagon Attacks, September 20, 2001.
 - (c) Addendum to Mobilization/Demobilization Personnel and Pay Policy for Reserve Component Members Ordered to Active Duty in Response to the World Trade Center and Pentagon Attacks, July 19, 2002.

TRICARE Management Activity is working hard to quickly implement the provisions in the Emergency Supplemental Appropriations Act for Defense for FY 2004, and the National Defense Authorization Act for FY 2004 that will improve access to health care services for many Reserve Component service members and their families. Several of the provisions took effect November 6, 2003 and will expire December 31, 2004.

This memorandum provides additional guidance, based on reference (a), to be followed regarding medical/dental screening and care for both Reserve Component members identified for active duty in support of the current partial mobilization operations, and the families of those members. The attached policy guidance supplements the guidance previously provided in references (a) and (b). Service Secretaries may prescribe implementing instructions consistent with this guidance, the guidance provided in references (a) and (b), and for areas not addressed.

Our work group is quickly and thoroughly evaluating the requirements of the law, determining the definitions of eligibility and benefits, and taking the steps necessary to implement the changes. This is not a simple process, but we are committed to making it happen as quickly as possible to ensure eligible members have access to TRICARE health benefits and that they receive clear, consistent, accurate and timely information on these benefits.

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Expanded Eligibility Under The National Defense Authorization Act For Fiscal Years 2004 And 2005
(NDAA FY 2004 And 2005)

**FIGURE 18.4-1 UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS
MEMORANDUM**

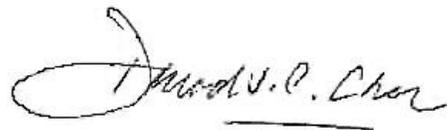
Some beneficiaries may need to obtain health care services before the Reserve Component Health Benefits Pilot program is implemented. For this reason, we encourage those members of the Reserve Component who are to be called to active duty or who are deployed in support of a contingency operation, and who are eligible for benefits under sections 703 or 704.

To save health care related receipts, claims and explanation of benefit forms for themselves and their families dating from November 6, 2003. This is necessary in the event that the sponsor is determined to be eligible for retroactive reimbursement from the Department of Defense. We will communicate by mail with affected Reserve Component members regarding eligibility definitions, information on covered health care services and the date that eligible sponsor and family members may submit claims and the required receipts for reimbursement.

Section 701 authorizes medical or dental screening and care for Ready Reserve members, as needed to ensure the member meets deployment standards and mandates that members be notified of eligibility for such screening and care when they are notified that they are to be called or ordered to active duty for a a period of more than 30 days. To the extent practicable, it is expected that such a notice will be included with other information provided to the member at the time of notification of the call or order to active duty.

Section 703 provides an earlier eligibility date for TRICARE benefits for certain members of Reserve Components and their family dependents. The member will be eligible for TRICARE Prime or supplemental health care, depending on location. TRICARE options available to the dependents will be TRICARE Prime (if in a Prime area), or TRICARE Prime Remote for Active Duty Family Members (TPRADFM) (if not in a Prime area). Family members who choose to not enroll in TRICARE Prime or TPRADFM may use the TRICARE Extra or TRICARE Standard, and are eligible for the Nationwide TRICARE Reserve Family Member Demonstration Project. Military Services may want to advise the member of the advantages of continuing existing (civilian) health and dental insurance on themselves and their families until they have reached the 31st day of active duty.

Section 704 extends the period of coverage under the Transitional Assistance Medical Program. Affected persons will be eligible for TRICARE Prime (if in a Prime area), TRICARE Extra, or TRICARE Standard and are eligible for the Nationwide TRICARE Reserve Family Member Demonstration Project. As with the current TAMP, affected person will not be eligible for TRICARE Prime Remote or TRICARE Prime Remote for Active Duty Family Members.



David S. C. Chu

Attachment:

As stated

cc:

Director, Joint Staff

Commandant, USCG (G-WT)

**ADDENDUM II
TO**

**“Mobilization/Demobilization Personnel and Pay Policy for Reserve Component Members
Ordered to Active Duty in Response to the World Trade Center and
Pentagon Attacks,” September 20, 2001**

GUIDANCE

Based on applicable legal authority, including sections 701, 703 and 704 of the National Defense Authorization Act for Fiscal Year 2004 regarding health care for Reserve component members and their families, the following policy guidance is provided.

- 1. Section 701: Medical or Dental Screening or Care at no Cost for Ready Reserve Members:**
 - a. A member of the Ready Reserve may at any time, while in a military duty status, be provided any medical or dental screening or care that is necessary to ensure that the member meets applicable medical and dental standards for deployment. Such screening and care may be provided in accordance with policies and procedures of the Military Service and Reserve Component concerned.
 - b. Whenever a member of the Ready Reserve receives notice that the member is to be called or ordered to active duty for a period of more than 30 days, the member shall also be provided notice that the member is eligible for medical or dental screening or care necessary to ensure than the member meets applicable medical and dental standards for deployment. The notification that the member is to be called or ordered to active duty for a period of more than 30 days may be in verbal or written form from a person authorized to provide such notification. This requirement to provide notice of eligibility for medical or dental screening or care is applicable to all notices on or after November 6, 2003, to members that they are to be called or ordered to active duty. It is expected that the required notification will be incorporated into other materials provided to the member regarding the call or order to active duty.
 - c. Any medical or dental screening or care provided to a member of the Ready Reserve, as authorized by this authority, shall not be charged to the member.
 - d. Upon issuance of a mobilization alert order to a unit or an individual, individuals who receive or are covered by such order shall, if it has not been previously provided, be given notice that the members are eligible for medical and dental screening and care under this authority.

- 2. Section 703: Earlier Eligibility Date for TRICARE Benefits for Members of Reserve Components**
 - a. A member of the Reserve Components who is issued a delayed-effective-date active-duty order, or is covered by such an order, that is for a period of active duty of more than 30 days, in support of a contingency operation, as defined in 10 USC 101(a)(13)(B), shall be eligible, along with the member’s dependents, for TRICARE, on either the date of issuance of such an order, or 90 days prior to the

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- date of active duty prescribed in the order, whichever is later (as amplified in paragraph d., with example provided in paragraph e., below).
- b. Each Military Service is responsible for providing electronically to DEERS a file of eligible records. The file shall include SSN, Date of Notification, and Projected Active Duty Start Date in the attached reporting format for "early Identification of Service Members Called Up in Support of a Named Contingency." Services will ensure security of transmitted data.
 - c. Services shall notify DEERS of any change in or cancellation of projected active duty start dates.
 - d. To preclude the issuance of orders to active duty for a period of more than 30 days to members not medically qualified to perform such duty (which has in the past contributed to a "medical hold" backlog). Services will include a statement on all individual orders that advises the member that: the member is ordered to active duty for a period of less than 30 days for medical/dental screening and/or care; if the member is not determined to be medically qualified for deployment, the member will be released from active duty and returned to prior status; and if the member is determined to be medically qualified for deployment, the member is further ordered to active duty for a period not to exceed a specified duration, unless sooner released by proper authority. This specified period of active duty shall exclude the medical/dental screening period, but be calculated to reflect that such active duty period was served. To accommodate both the medical hold issue and the TRICARE benefit, the effective date of the orders to active duty for a period of more than 30 days is deemed to be the 31st day after the effective date of the initial phase of the orders (the medical/dental screening period). From this 31st day, the calculation of 90 days of TRICARE eligibility shall be made.
 - e. Example of the time sequence outlined above: On January 1, 2004, a member receives an order to active duty for a period of 30 days for medical/dental screening, with a reporting date of April 1, to be followed, if the member is fit for deployment, by a period of active duty for not to exceed 365 days, minus the number of days served during the initial phase of the orders. In this example, the effective date of the orders to active duty for more than 30 days is May 1. The TRICARE eligibility period begins 90 days prior to May 1. If on April 15, the member is found to be fit for deployment, the member will proceed to a period of active duty for not to exceed 350 days.
 - f. If a member is not determined to be qualified for deployment and is released from active duty, the Service is responsible for notifying DEERS of the termination of the member's and dependents' eligibility for TRICARE. The member and family will be covered until the member is determined not to be eligible for deployment.
 - g. This eligibility is effective with respect to all delayed-effective-date active-duty orders issued on or after November 6, 2003, and is valid through December 31, 2004, unless further extended by law.

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DEFINITION: Delayed-effective-date active-duty order: An official document prescribing the order to active duty of a Reserve Component member, or members, on a specified date, for a period of more than 30 days, in support of a contingency operation as defined in 10 USC 101(a)(13)(B). Such an order may be either a) individual mobilization orders; or b) a unit alert order, with an annex approved by a senior authorized individual for the unit or higher HQ, that contains the identification of all individuals to whom individual mobilization orders will be issued in accordance with the unit alert order.

3. Section 704: Temporary Extension of Transitional Assistance Medical Program (TAMP):

- a. All members of the Reserve Components who have served on active duty for more than 30 days in support of a contingency operation are authorized TAMP benefits for 180 days, beginning on the date on which the member is separated from such active duty.
- b. This 180-day period of TAMP eligibility applies to all covered Reserve component members who separate from active duty on or after November 6, 2003. This authorization is valid through December 31, 2004, unless further extended by law. Accordingly, with no further extension by law, as of January 1, 2005, the period for which a member is authorized TAMP benefits upon release from active duty for more than 30 days in support of a contingency operation shall be adjusted as necessary to comply with the normal duration of TAMP benefits. (The normal duration is 60 days for members with less than six years of cumulative active service and 120 days for members with six or more years of cumulative active service.)

Attachment:
As stated

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EARLY IDENTIFICATION OF SERVICE MEMBERS CALLED UP IN SUPPORT OF A NAMED CONTINGENCY

RECORD/FIELD AND DATA ITEM	CODING AND REMARKS	RECORD POSITION	LENGTH CLASS	SEL RES	IRR/ING	STBY RES	RET RES
	<p>Transaction record shall include personnel identification information, transaction information and all data elements for section being submitted.</p> <p align="center">(Submit transactions daily.)</p>						
PERSONNEL IDENTIFICATION INFORMATION							
1. Social Security Number (SSN) (DoD Std: Person Social Security Identifier)	Enter nine numeric digits omitting hyphens for the Service member's social security number.	1-9	9 N	X	X		X
2. Reserve Component	Enter a two character code from the following list that identifies the Reserve Component affiliated with:	10-11	2A	X	X		X
a. Military Service (DoD) Std: Uniformed Service Organization Code)	<p>The branches of the Armed Forces of the United States established by Congress, in which persons are appointed, enlisted or inducted for military service and that operates and is administered within a military or executive department.</p> <p>A = U.S. Army (USA) N = U.S. Navy (USN) M = U.S. Marine Corps (USMC) F = U. S. Air Force (USAF) C = U.S. Coast Guard (USCG)</p>	10	1 A	X	X		X
b. Service Component (DoD Std: Uniformed Service Organization Component Type Code)	G = National Guard of the United States V = Reserve	11	1 A	X	X		X
Section 1. CONTINGENCY INFORMATION							
3. Filler		12-57		X	X		X
TRANSACTION INFORMATION							
4. Transaction Type Code	<p>The code that represents the type of transaction being processed.</p> <p>EA = Early Identification (E-ID) Begin Transaction. EC = Change Transaction. If orders are amended to delay the active duty start date, submit a change transaction if the new projected active duty date is within 60 days of being effective. If projected active duty start date is beyond 60 days of being effective, submit an "EE" (End Transaction) for the current eligibility status and submit when appropriate an "EA" (Begin Transaction) for the next new period of entitlement. EE = E-ID End Transaction EX = E-ID Cancel Transaction--Data erroneous submitted. Cancel event.</p>	58-59	2 A	X	X		X
Section 2. Early Identification (E-ID) of Service Members Called Up in Support of a Named Contingency (TRICARE Eligibility)							
5. E-ID Notification Date	<p>The calendar date the delayed-effective-date active duty order is issued.</p> <p>ENTER: Year, Month, and Day (YYYYMMDD)</p>	60-67	8 N	X	X		X

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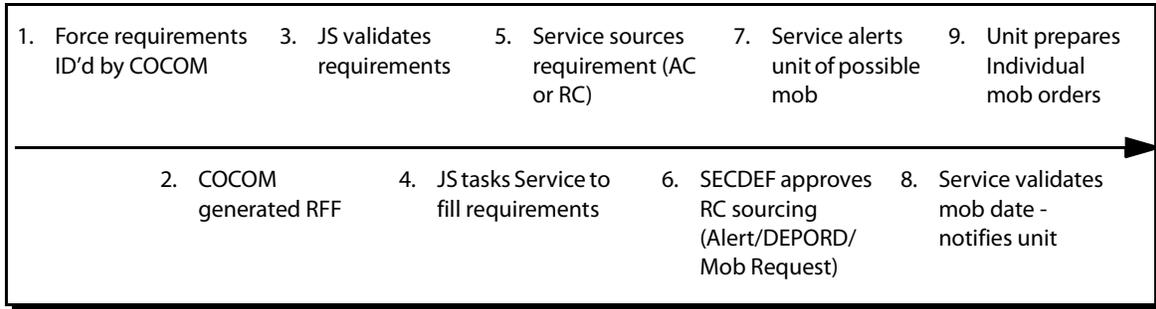
RECORD/FIELD AND DATA ITEM	CODING AND REMARKS	RECORD POSITION	LENGTH CLASS	SEL RES	IRR/ING	STBY RES	RET RES
6. E-ID Projected Active Duty Start Date	The calendar date the member is projected to begin the first day of active duty. This start date will begin the initial phase of call up orders during which medical screening will normally occur. ENTER: Year, Month, and Day (YYYYMMDD)	68-75	8 N	X	X		X
7. E-ID Stop Date	The calendar date the member is removed from current E-ID call up status. Early Identification TRICARE eligibility ends. Service member will not go on active duty as projected. ENTER: Year, Month, and Day (YYYYMMDD)	76-83	8 N	X	X		X
8. E-ID Named Contingency Code	The unique code assigned to the named contingency for which the member received Early Identification. RA will provide each service the appropriate code for the named contingency in the mobilization guidance or by memorandum.	84-86	3 AN	X	X		X
9. Filler	Reserved for future use.	87-100	13 AN	X	X		X

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MOBILIZATION SEQUENCE - RELATED TO SECTION 703, NDAA FY 2004



7. Unit Alert Order/Notification:

USA - Alert Message/Order; may not have proposed mob date; sometimes 1 level higher than level to be mobilized.

USN - Mainly defer to #9 (Individual Mob Orders)

USMC - Receipt for Planning Message

USAF - Notification Message

9. Individual Mobilization Orders:

Contains individual information and report to active duty date for those members being called to active duty.

Delayed-effective-date-active-duty-order: An official document prescribing the order to active duty of a Reserved component member, or members, on a specified date, for a period of more than 30 days, in support of a contingency operation as defined in 10 USC 101(a)(13)(B). Such an order may be either a) individual mobilization orders; or b) a unit alert order, with an annex approved by a senior authorized individual for the unit or higher HQ, that contains the identification of all individuals to whom individual mobilization orders will be issued in accordance with the unit alert order.

- END -

Department Of Defense (DoD) Enhanced Access To Autism Services Demonstration

1.0 PURPOSE

The Enhanced Access to Autism Services Demonstration (“Demonstration”) will test the feasibility and advisability of permitting TRICARE reimbursement for Educational Interventions for Autism Spectrum Disorders (EIA) delivered by paraprofessional providers, under a modified corporate services model, in the absence of state or industry oversight. The Demonstration will provide information that will enable the Department of Defense (DoD) to determine if: there is increased access to these services; the services are reaching those most likely to benefit from them; and the quality of those services is meeting a standard of care currently accepted by the professional community of providers of these and related services.

2.0 BACKGROUND

2.1 The Military Health System (MHS) is a \$33 billion dollar enterprise, consisting of 76 military hospitals, over 500 military health clinics, and an extensive network of private sector health care partners, which provides medical care for over nine million beneficiaries including Active Duty Service Members (ADSMs) and Active Duty Family Members (ADFM). Preliminary, but internally reliable counts of the number of military-dependent children with autism reveals that among the more than 1.2 million children of active duty personnel, approximately 8,500 carry one of the autism spectrum disorder diagnoses.

2.2 Autistic spectrum disorders affect essential human behaviors such as social interaction, the ability to communicate ideas and feelings, imagination, and the establishment of relationships with others. A number of treatments, therapies and interventions have been introduced to ameliorate the negative impact of autism on these areas of concern. EIA services have been shown to reduce or eliminate specific problem behaviors and teach new skills to individuals with autism. The Demonstration will permit TRICARE reimbursement for EIA services (referred to as Intensive Behavioral Interventions in the December 4, 2007 **Federal Register** notice on the Demonstration) such as applied behavior analysis (ABA), delivered by paraprofessional providers, under a modified corporate services model, in the absence of state or industry oversight. Neither the TRICARE Basic Program nor the Extended Care Health Option (ECHO) program currently authorize reimbursement for providers working within this type of unregulated corporate structure. Should the Demonstration result in a determination to make a permanent change to the TRICARE benefit to permit reimbursement of services provided by EIA Tutors under a corporate services model, such decision would require a change to the Code of Federal Regulations (CFR).

3.0 DEFINITIONS

3.1 Applied Behavior Analysis (ABA)

The design, implementation, and evaluation of systematic environmental changes to produce socially significant change in human behavior through skill acquisition and the reduction of problematic behavior. ABA includes direct observation and measurement of behavior and the identification of functional relations between behavior and the environment. Contextual factors; establishing operations, antecedent stimuli, positive reinforcers, and other consequences are used to produce the desired behavior change.

3.2 Autism Spectrum Disorders (ASDs)

Collective term indicating Autistic Disorder (AD), Pervasive Developmental Disorder Not Otherwise Specified (PDDNOS), and Asperger's Disorder (AS) as defined by the American Psychiatric Association's (APA's) Diagnostic and Statistical Manual, Fourth Edition (DSM-IV-TR). For the purposes of the Demonstration, Childhood Disintegrative Disorder (CDD) is also subsumed under the ASD term.

3.3 Behavior Plan (BP)

A plan designed to modify behavior through the use of evidence-based practices and techniques. It is based on the direct observation and measurement of behavior as well as a functional behavioral assessment.

3.3.1 A BP for a child receiving EIA services under this Demonstration must be developed by the Individual Corporate Services Provider (ICSP) directing the delivery of EIA services to the child or EIA Supervisor serving as the principal supervisor for the beneficiary's intervention services delivered through an Organizational Corporate Services Provider (OCSP); and

3.3.2 Must be submitted to the beneficiary's Primary Care Provider (PCP) or Specialized ASD Provider prior to instituting services on an ongoing basis (evaluation of the beneficiary to produce an initial BP are excluded from this requirement) provided by EIA Tutors or EIA Tutors-in-Training and again at least once every six months; and

3.3.3 Must identify long and intermediate-term habilitative and behavioral goals and short-term behavioral objectives that are behaviorally defined; and

3.3.4 Must identify the criteria that will be used to measure achievement of behavioral objectives; and

3.3.5 Must clearly state the schedule of services planned and the individuals providers to deliver those services; and

3.3.6 Must specify a tutor staffing pattern for services that reflects the use of multiple tutors to provide intensive services (i.e., greater than 20 hour per week) to a single child to enhance generalization of learned behaviors; and

3.3.7 Must specify the predominant location at which EIA services are to be delivered as in the home, specialized clinic/facility, at school, other location, or in no predominant location; and

3.3.8 Must include a description of how (if at all) EIA services described in the BP are related to (supportive, complementary, etc.) other special education services targeted at ameliorating the core deficits of ASD provided under the child's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) developed in accordance with the Individuals with Disabilities Education Improvement Act (IDEA); and

3.3.9 Must summarize pertinent issues and recommendations for modifying the BP resulting from quarterly treatment progress meetings held with the child's primary caregivers.

3.4 Core Deficits Of ASD

The main signs and symptoms of autism involve language, social behavior, and behaviors concerning objects and routines:

3.4.1 Communication Deficits. Lack of speech especially when it is associated with the lack of desire to communicate and lack of nonverbal compensatory efforts such as gestures.

3.4.2 Social Skills Deficits. Children with ASDs universally demonstrate a decreased drive to connect with others and share complementary feeling states. Children with ASDs often do not appear to seek connectedness; they are content being alone, ignore their parents' bids for attention, and seldom make eye contact or bid for others' attention with gestures or vocalizations.

3.4.3 Restricted, Repetitive, and Stereotyped Patterns of Behavior, Interests, and Activities. Children with ASDs can demonstrate atypical behaviors in a variety of areas including peculiar mannerisms, unusual attachments to objects, obsessions, compulsions, self-injurious behaviors, and stereotypes. Stereotypes are repetitive, nonfunctional, atypical behaviors such as hand flapping, finger movements, rocking, or twirling.

3.5 Educational Interventions For Autism Spectrum Disorders (EIA)

With regard to interventions for ASDs, the American Academy of Pediatrics (AAP) recently defined education as the fostering of acquisition of skills and knowledge to assist a child to develop independence and personal responsibility; it encompasses not only academic learning but also socialization, adaptive skills, communication, amelioration of interfering behaviors, and generalization of abilities across multiple environments. EIA consists of individualized behavioral interventions employed to systematically increase adaptive behaviors and to modify maladaptive or inappropriate behaviors and are most often used on a one-to-one basis. These interventions are intended to:

3.5.1 Help young children with ASD achieve independent, full inclusion in a primary general education setting; and

3.5.2 Produce measurable outcomes that diminish behaviors that interfere with the development and use of language and appropriate social interaction skills or broaden an otherwise severely restricted range of interests; and

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3.5.3 Increase the child's ability to participate in other therapies and environments.

3.5.4 EIA interventions for children with autism have certain things in common:

- Intervention designed and overseen directly by qualified, well-trained professionals;
- Detailed assessment of each child's skills as well as child and family preferences to determine initial treatment goals;
- Selection of goals that are meaningful for the child and the family;
- Ongoing objective measurement of the child's progress;
- Frequent review of progress data so that goals and procedures can be "fine tuned" as needed;
- Interventions that address developmentally appropriate goals in all skill areas (e.g., communication, social, self-care, play and leisure, motor, and academic skills);
- Target skills are broken down into small parts or steps that are manageable for the child;
- An emphasis on skills that will enable a child to be independent and successful in both the short and the long run;
- Use of multiple behavior analytic procedures -- both adult-directed and child-initiated -- to promote learning in a variety of ways;
- Many opportunities -- specifically planned and naturally occurring -- for each child to acquire and practice skills every day, in structured and unstructured situations;
- Intervention provided consistently and with an intensity requisite to behavioral goals;
- Abundant positive reinforcement for useful skills and socially appropriate behaviors;
- An emphasis on positive social interactions, and on making learning fun;
- No reinforcement for behaviors that are harmful or prevent learning;
- Use of techniques to help trained skills carry over to various places, people, and times and to enable children to acquire new skills in a variety of settings;
- Parent training so family members can teach and support skills during typical family activities;
- Regular meetings between family members and those designing and implementing the intervention program.

3.5.5 Only EIA services with particular characteristics as elaborated in [paragraph 6.2](#) are covered under the Demonstration.

3.6 EIA Progress Report (EPR)

Is a report on progress made towards achieving the long and intermediate-term habilitative and behavioral goals and short-term behavioral objectives that were identified in the BP

3.6.1 An EPR for a child receiving EIA services under this Demonstration must be developed by the EIA Supervisor directing the delivery of EIA services to the child. If more than one EIA Supervisor is directing delivery of services to the child then a single EPR that reflects the activities of all EIA tutors will be developed by the sponsor-designated lead EIA Supervisor; and

3.6.2 Must be submitted by the EIA Supervisor along with the required BP to the beneficiary's PCP or Specialized ASD Provider and upon the termination of services under the direction of that EIA Supervisor with a child; and

3.6.3 Must report on the progress achieved on behavioral objectives identified in the BP; and

3.6.4 Must document a child's progress towards achieving behavioral objectives through analysis and reporting of quantifiable behavioral data including, but not limited to the following:

- The frequency, quality and intensity of expression of targeted behaviors in natural situations (e.g., in unstructured situations in the home or classroom rather than during treatment) outside of EIA teaching activities; and
- The degree to which a child's responses are unprompted versus prompted; and
- The generalization of learning to significant age-appropriate behaviors that were not the immediate objectives of EIA; and
- Additional elaborative benchmarks and criteria as the Director, TRICARE Management Activity (TMA) or designee determines necessary to insure quality of delivered services.

3.6.5 Must describe the data collection procedures; and

3.6.6 Must provide a narrative summary of the data supporting findings of progress or lack of progress in meeting long and intermediate-term habilitative and behavioral goals and short-term behavioral objectives.

3.6.7 An EPR is not required to be submitted along with that EIA Supervisor's first BP for a child receiving services.

3.7 Functional Behavioral Assessment And Analysis

The process of identifying the variables that reliably predict and maintain problem behaviors. The functional behavioral assessment and analysis process typically involves:

3.7.1 Identifying the problem behavior(s);

3.7.2 Developing hypotheses about the antecedents and consequences likely to trigger or support the problem behavior;

3.7.3 Performing an analysis of the function of the behavior by testing the hypotheses.

3.8 Individualized Education Program (IEP)

IEP means a written statement for a child with a disability that is developed, reviewed, and revised in accordance with IDEA of 2004, Public Law (PL) 108-446 Sec. 614.

3.9 Individualized Family Service Plan (IFSP)

IFSP means a written statement for an infant or toddler with developmental needs as defined by the IDEA of 2004, PL 108-446 Sec. 636.

3.10 Provisional Demonstration Eligibility

To avoid delaying receipt of services under this Demonstration while completing the Demonstration eligibility process, in particular completion of intelligence testing, clinical review of a beneficiary's diagnosis, and registration in the ECHO, the regional Managed Care Support Contractor (MCSC) may grant otherwise eligible-apparent beneficiaries a provisional eligibility status for a period of not more than 120 days during which ECHO and Demonstration benefits will be authorized and payable. This provisional status is portable across the 50 United States and the District of Columbia.

Note: The provisional status will terminate upon completion of the eligibility process or at the end of the 120 day period, whichever occurs first. The government liability for Demonstration benefits will terminate at the end of the 120 day period. The government will not recoup claims paid for authorized ECHO or Demonstration benefits provided during the provisional period.

3.11 Special Education (as defined in IDEA)

The term "special education" means specially designed instruction to meet the unique needs of a child with a disability, including--instruction conducted in the classroom, in the home, in hospitals and institutions, and in other settings and instruction in physical education.

4.0 PROVIDERS

4.1 Primary Care Provider (PCP)

PCP is the term used in the Demonstration to collectively refer to:

4.1.1 A Primary Care Manager (PCM) under the TRICARE Prime or TRICARE Prime Remote for Active Duty Family Member (TPRADFM) programs; and

4.1.2 A PCP under the TRICARE Standard program; and

4.1.3 Describes a Military Treatment Facility (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.

4.2 Individual Corporate Services Provider (ICSP)

4.2.1 Is an individual EIA Supervisor, not incorporated, meeting specified criteria that permit the EIA Supervisor to receive reimbursement for services provided by EIA Tutors implementing their intervention plan.

4.2.2 The ICSP is responsible for meeting all requirements ascribed to an EIA Supervisor found in [paragraph 4.4](#) as well those in the Participation Agreement ([Addendum A](#)) and include, but are not limited to:

4.2.2.1 Submitting to the MCSC all necessary documents to support an application for TRICARE authorization; and

4.2.2.2 Entering into a Participation Agreement approved by the Director, TMA or designee, which complies with the Participation Agreement requirements established by the Director; and

4.2.2.3 Certifying that all EIA Tutors and EIA Tutors-in-Training employed by or contracted with the ICSP;

- Meet the education, training, experience, and competency requirements; and
- If required, have completed a criminal background check the results of which meet standards as specified in [paragraph 4.5.7](#) prior to the EIA Tutor providing any EIA services, other than joint services with an EIA Supervisor, to TRICARE beneficiaries; and

4.2.2.4 Maintaining for a period of 36 months after the direct employment or contractual relationship between the ICSP and EIA Tutor has ended, documentation detailed enough to permit independent verification that an EIA Tutor has met all applicable requirements; and

4.2.2.5 Submitting certification on a fiscal year quarterly basis and maintaining documentation of on-going supervision requirements of EIA Tutors and EIA Tutors-in-Training as described in [paragraph 4.2.3](#); and

4.2.2.6 Submitting notification when:

- An EIA Tutor-in-Training has fully met all TRICARE requirements for an EIA Tutor as elaborated in [paragraph 4.5](#); and
- When an EIA Tutor meets the threshold for reducing the intensity of on-going supervision as defined in [paragraph 4.5.8](#).

4.2.2.7 Submitting claims to the appropriate TRICARE MCSC using assigned Healthcare Common Procedure Coding System (HCPCS) codes as described in [paragraphs 8.1, 8.2, and 8.3](#); and

4.2.2.8 Certifying on the BP that services designed for delivery to TRICARE beneficiaries meet all requirements of covered EIA services as defined in [paragraph 6.2](#); and

4.2.2.9 Ensuring BPs and EPRs are completed and forwarded at least 15 business days before authorization for continued EIA services is due to expire to the beneficiary's PCP or Specialized ASD Provider and parent/caregiver.

4.2.3 Supervising EIA Tutors and EIA Tutors-in-Training

4.2.3.1 An ICSP supervising an EIA Tutor or EIA Tutor-in-Training shall maintain records of supervision provided. BACB approved feedback forms are one appropriate tool (see http://www.bacb.com/Downloadfiles/experience_supervsn/50331_Supervision_form.pdf). Any other documentation maintained for this purpose must contain at least the information within the BACB form cited in this paragraph as well as the EIA Tutor or Tutor-in-Training unique identifier as defined in [paragraph 4.5.2](#). The ICSP shall retain supervision documentation for audit purposes for a period of 36 months after termination of the Participation Agreement by either party; and

4.2.3.2 Is responsible for submitting documentation of ongoing supervision of EIA Tutors quarterly to the party or parties directed by the Director, TMA or designee. Required is documentation of:

- The number of hours of directly supervised fieldwork during that reporting period; and
- The lifetime total cumulative hours of indirectly supervised fieldwork for EIA Tutors or EIA Tutors-in-Training with less than 500 hours of indirectly supervised fieldwork; and
- The number of delivered service hours billed to TRICARE for that reporting period provided by the EIA Tutor; and
- The name of the supervisor, the EIA Tutor unique identifier (see [paragraph 4.5.2](#)) and signatures of the tutor and supervisor. The supervisor must review the forms with the tutor, retain a copy and provide a copy for the tutor.

4.2.4 Additional information related to EIA Supervisors and their role as Corporate Services Providers (CSPs) may be found under [paragraph 6.0](#).

4.3 Organizational Corporate Services Provider (OCSP)

4.3.1 For the purposes of the Demonstration an OCSP is a corporation, foundation, or public entity that meets the TRICARE definition of a CSP under [32 CFR 199.6\(e\)\(2\)\(ii\)\(B\)](#) that predominantly renders services of a type uniquely allowable as an ECHO benefit. An OCSP may employ directly or contract with EIA Supervisors and EIA Tutors.

4.3.2 To provide services under the Demonstration, an OCSP must enter into a Participation Agreement approved by the Director, TMA or designee, which complies with the Participation Agreement requirements established by the Director and includes, but is not limited to the requirement to:

4.3.2.1 Submit to the MCSC all necessary documents to support an application for TRICARE authorization as a CSP; and

4.3.2.2 Certify that all EIA Tutors and EIA Tutors-in-Training employed by or contracted with the OCSP;

- Meet the education, training, experience, and competency requirements elaborated in [paragraph 4.5](#); and
- If required, have completed a criminal background check the results of which meet standards as specified in [paragraph 4.5.7](#) prior to the EIA Tutor providing any EIA services, other than joint services with an EIA Supervisor, to TRICARE beneficiaries; and

4.3.2.3 Maintain for a period of 36 months after the direct employment or contractual relationship between the OCSP and EIA Tutor has ended:

- Documentation detailed enough to permit independent verification that an EIA Tutor has met all TRICARE participation requirements as elaborated in [paragraph 4.5](#); and
- That documents ongoing supervision of EIA Tutors and EIA Tutors-in-Training as described in [paragraph 4.2.3.1](#).

4.3.2.4 Submit certification on a fiscal year quarterly basis and maintaining documentation of on-going supervision requirements of EIA Tutors and EIA Tutors-in-Training as described in [paragraph 4.2.3](#); and

4.3.2.5 Submit notification when:

- An EIA Tutor-in-Training has fully met all TRICARE requirements for an EIA Tutor; and
- When an EIA Tutor meets the threshold for reducing the intensity of on-going supervision as defined in [paragraph 4.5.8](#).

4.3.2.6 Submitting claims to the appropriate TRICARE MCSC using assigned HCPCS codes as described in [paragraphs 8.1, 8.2, and 8.3](#); and

4.3.2.7 Ensure that each beneficiary receiving EIA services for which the OCSP seeks TRICARE reimbursement has been assigned a principal EIA Supervisor employed by or contracted to the OCSP who leads development of the BP, EPR and quarterly family treatment progress meetings; and

4.3.2.8 Certify on the BP that services designed for delivery to TRICARE beneficiaries meet all requirements of covered EIA services as defined in [paragraph 6.2](#); and

4.3.2.9 Ensure BPs and EPRs are completed and forwarded at least 15 business days before authorization for continued EIA services is due to expire to the beneficiary's PCP or Specialized ASD Provider and parent/caregiver.

4.3.3 An OCSP that receives TRICARE reimbursement for the services of directly employed or contracted EIA Tutors and also seeks TRICARE reimbursement for the services of a provider who otherwise would meet qualifications for an EIA Supervisor, may receive reimbursement for those services only if the provider is a TRICARE authorized EIA Supervisor.

4.4 EIA Supervisor

4.4.1 TRICARE authorized provider of EIA services meeting the qualifications and requirements elaborated in [paragraph 4.4](#). An EIA Supervisor may also provide supervisory oversight to EIA Tutors and certain other EIA Supervisors. As a service provider an EIA Supervisor consults, provides training to caregivers, conducts behavioral evaluations of children with ASD, and directs behavioral plan development for TRICARE beneficiaries. As a supervisor an EIA Supervisor is a clinical teacher who educates, observes, assesses, and supervises the educational activities and service delivery of EIA Tutors. At the point in which more than one EIA Supervisor acting in the capacity of an ICSP are simultaneously billing for services of EIA Tutors to a single beneficiary, the beneficiary's sponsor shall designate a lead EIA Supervisor who is responsible for submitting unified BPs, EPRs, and shall organize and direct required quarterly family treatment progress meetings.

4.4.2 A TRICARE authorized EIA Supervisor must meet one or more of the following requirements:

4.4.2.1 Be a Board Certified Behavior Analyst (BCBA), as certified by the Behavior Analyst Certification Board (BACB) (see <http://www.bacb.com/> for details of certification); or

4.4.2.2 Be a Board Certified Associate Behavior Analyst (BCABA), as certified by the BACB, who is supervised by a BCBA; or

4.4.2.3 Be an individual who is currently approved by the BACB to take the BCBA examination; and

- Submits a copy of the approval notification on BACB letterhead that is dated not more than two years prior to the date of application for TRICARE authorization; and
- Who is supervised by or supervises EIA providers jointly with a BCBA; or

4.4.2.4 Be an individual who meets the minimum degree requirements to be eligible to sit for the BCBA examination; and

- Submits documentation of having completed at least 169 classroom hours of graduate level instruction in the content areas identified by the BACB; and
- Submits documentation of having completed 75% of the experience requirements to be eligible to sit for the BCBA examination; and
- Who is supervised by a BCBA; or

4.4.2.5 Be an individual who meets the degree requirements for BCBA examination, has eight years of professional experience in implementing, designing, and overseeing behavior analysis services for individuals with autism:

- Submits letters from employers and/or other reasonable proof documenting eight years of professional experience in implementing, designing, and overseeing behavior analysis services for individuals with autism; and
- Has submitted on his behalf a confidential evaluation of professional competence in implementing, designing, and overseeing behavior analysis services for individuals with autism, recommendation as a competent supervisor of trainees in the field and attestation of professional ethics from each of three BCBA's; and
- Who is supervised by a BCBA; or
- If seeking waiver of the supervision requirement, submit the attestations of three BCBA's that in their professional judgments the individual does not require on-going supervision of his work from a BCBA.

4.4.3 The applicant for TRICARE authorization shall submit evidence that professional liability insurance in the amounts of \$1 million per claim and \$3 million in aggregate, unless there are state requirements that are in different amounts, is maintained in the EIA Supervisor's name.

4.4.4 The MCSC shall obtain a criminal history review as described in [Chapter 4, Section 1, paragraph 9.0](#) and confirm that there are no findings which would not support TRICARE authorization for the applicant.

4.4.5 BCBA supervision requirements for EIA Supervisors requiring supervision for TRICARE authorization.

4.4.5.1 Supervision should focus on ensuring that the quality of the services provided meets the minimum standards of the profession as defined by the current BACB Task List, the BACB Professional Disciplinary Standards, the BACB Guidelines for Responsible Conduct for Behavior Analysts, current BACB rules and regulations, and evidenced-based standards of practice as emerge in the professional literature in the field (documents can be accessed at <http://www.bacb.com/>).

4.4.5.2 Supervisory interactions should include review, discussion, and recommendations focusing on the following topics: case background information, planned behavioral assessment

procedures, assessment outcomes, data collection procedures, possible intervention procedures and materials, intervention outcome data, modifications of intervention procedures, ethical issues associated with behavior change services or employment, and professional development needs and opportunities.

4.4.5.3 These sessions should involve prior submission of materials by the supervisee concerning their professional work, as requested by the BCBA supervisor, and must involve submission and review of BPs developed by the supervisee for the care of TRICARE beneficiaries.

4.4.5.4 Formal supervision sessions shall occur only through two-way interactions involving real-time visual and auditory contact (e.g., face-to-face meetings, videoconferencing or web-camera sessions).

4.4.5.5 Depending on the nature of the supervised provider's work, some portion of these sessions should include observation of appropriate professional skills, including direct observation of actual practice with individuals.

4.4.5.6 Supervision sessions shall occur not less than once each month, and each session shall last not less than one hour. During each calendar year, at least two of these monthly supervision sessions should be conducted in-person.

4.4.5.7 Supervision shall be documented. BACB approved feedback forms are one appropriate tool (see http://www.bacb.com/Downloadfiles/experience_supervsn/50331_Supervision_form.pdf). Any other documentation maintained for this purpose must contain at least the information within the BACB form. The supervisor must review the forms with the EIA Supervisor receiving supervision, retain a copy and provide a copy for the EIA Supervisor. The EIA Supervisor receiving supervision as a requirement of TRICARE authorization shall maintain supervision documentation for audit by the party or parties directed by the Director, TMA or designee.

4.4.5.8 Informal contacts between formal supervision sessions are encouraged and may include telephonic, e-mail, and postal communication, but these exchanges should not be considered and documented as formal supervision.

4.4.6 Responsible conduct of EIA Supervisors:

4.4.6.1 TRICARE authorized EIA Supervisors must adhere to BACB Guidelines for Responsible Conduct Sections 1-5 (available at <http://www.bacb.com/pages/conduct.html>). For the purposes of the Demonstration, the term "behavior analyst" used in the BACB Guidelines for Responsible Conduct shall apply to EIA Supervisors. Failure to adhere to these guidelines may result in revocation of TRICARE authorization; and

4.4.6.2 Must report to the MCSC within 30 days sanctions issued by the BACB for violation of published disciplinary standards (available at http://www.bacb.com/pages/prof_standards.html); and

4.4.6.3 Loss of BACB certification for any reason may result in revocation of TRICARE authorization. An EIA Supervisor who loses BACB certification during the period of the

Demonstration must notify the MCSC and provide a detailed explanation for the change in status within 30 days of the effective change in certification status.

4.4.6.4 A decision by the MCSC to revoke TRICARE authorization is final and may not be appealed.

4.4.7 Roles and responsibilities of an EIA Supervisor who is an employee of or contractor to an OCSP include, but are not limited to:

4.4.7.1 Submitting information/documentation required to become TRICARE authorized as an EIA Supervisor; and

4.4.7.2 Maintaining documentation of receiving on-going supervision by or performing joint supervision with a BCBA as is required of certain EIA Supervisors as described in [paragraph 4.4.5](#); and

4.4.7.3 Serves as a principal supervisor to EIA Tutors and Tutors-in-Training employed by or contracted to the OCSP; and

4.4.7.4 Serving as the lead in the development of the BP, EPR and quarterly family treatment progress meetings for TRICARE beneficiaries receiving services through the OCSP.

4.4.7.5 The EIA Supervisor is not required to enter into a Participation Agreement with TRICARE unless he/she also is an ICSP.

4.4.8 EIA Supervisors may provide services in any state in which they are legally permitted to provide educational services consistent with their training and professional scope of practice. Remote direct supervision as defined in [paragraphs 4.5.9.2.3](#) and [4.5.9.2.5](#) will be considered to have occurred in the state in which the TRICARE beneficiary received EIA services that are being supervised. Therefore, the EIA Supervisor must meet all applicable legal requirements for practicing in that state.

4.4.9 Additional information related to EIA Supervisors and their role as CSPs may be found under [paragraph 6.0](#).

4.5 EIA Tutor

4.5.1 A provider of EIA services qualified by meeting TRICARE requirements as outlined in [paragraph 4.5](#) who delivers services to TRICARE beneficiaries only under the supervision of an EIA Supervisor. EIA Tutors work one-on-one with children implementing the BP designed and maintained by the EIA Supervisor and gather quantifiable behavioral data necessary for the EIA Supervisor to evaluate the effectiveness of the BP in achieving identified goals and objectives. An EIA Tutor may not conduct behavioral evaluations, establish a child's BP, or bill independently for services provided to TRICARE beneficiaries.

4.5.2 Each EIA Tutor must have a unique identifier consisting of four letters followed by four numbers (first initial, last initial, two letter US State or Territory code for place of birth (ZZ for any

other location), followed by day and month of birth date (DD/MM). This unique identifier will be provided:

- When the ICSP or OCSP certifies to the MCSC that an EIA Tutor meets qualifications for providing services to TRICARE beneficiaries; and
- In identifying EIA Tutors on required quarterly documentation of on-going supervision and biyearly Behavior Plans provided by the ICSP or OCSP; and
- In invoices for services provided to TRICARE for reimbursement of services.

4.5.3 Education of the EIA Tutor must be or have been in:

- A United States or Canadian institution of higher education fully or provisionally accredited by a regional, state, provincial or national accrediting body; or
- An institution of higher education located outside the United States or Canada that, at the time the applicant was enrolled and at the time the applicant graduated, maintained a standard of training equivalent to the standards of training of those institutions accredited in the United States; and
- The EIA Tutor must have completed a minimum of 12 semester hours (or their equivalent) of college coursework and currently be enrolled in course of study leading to an associate's or bachelor's degree (psychology, education, social work, behavioral sciences, human development or related fields); or
- Have completed a minimum of 48 semester hours (or their equivalent) of college coursework.

4.5.4 Classroom training of the EIA Tutor of:

4.5.4.1 Forty (40) hours are required and may have been completed during or apart from the educational experiences required in the Participation Agreement. The training must have been provided by:

4.5.4.1.1 A United States or Canadian institution of higher education fully or provisionally accredited by a regional, state, provincial or national accrediting body; or

4.5.4.1.2 A Joint Commission or Commission on Accreditation of Rehabilitation Facilities accredited health care facility; or

4.5.4.1.3 A private agency whose primary business activity is the delivery of services to children with developmental disabilities and whose governing board includes one or more BCBA's; or

4.5.4.1.4 Web-based instruction not provided by an accredited institution of higher education; and

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4.5.4.1.5 In the instance of [paragraphs 4.5.4.1.2, 4.5.4.1.3, and 4.5.4.1.4](#), the training curriculum has been approved by the BACB or a currently certified BCBA.

4.5.4.2 At a minimum the training must cover the following topics:

4.5.4.2.1 Introduction to ASD, AS, and ABA and typical child development;

4.5.4.2.2 Principles of ABA including reinforcement, prompting and fading, shaping, chaining, maintenance and generalization, extinction and punishment;

4.5.4.2.3 Discrete trial training, natural environment training and discrimination training;

4.5.4.2.4 Basic functional behavioral assessment;

4.5.4.2.5 Introduction to verbal behavior and its analysis including mands, tacts, echoics, intraverbals, and feature, function and class;

4.5.4.2.6 Instructional control procedures including pairing with reinforcement, environmental manipulations, and pacing;

4.5.4.2.7 Treating challenging behavior including functional assessment and function-based interventions, introduction to preventive interventions, least restrictive/intrusive model of intervention, and antecedent modification strategies;

4.5.4.2.8 Behavioral data collection, graphing, and basic data analysis;

4.5.4.2.9 Legal, ethical, and safety issues including working with families and vulnerable populations;

4.5.4.2.10 Provider standards and ethics;

4.5.4.2.11 The impact of children with ASD on family members and family function;

4.5.5 Experience of the EIA Tutor.

4.5.5.1 Directly and indirectly supervised fieldwork experiences as defined in [paragraph 4.5.9](#) and meeting either of the following are required.

4.5.5.1.1 Fifty (50) hours directly supervised fieldwork and a minimum of 500 hours indirectly supervised fieldwork. Indirectly supervised fieldwork must have been completed prior to providing EIA services to TRICARE beneficiaries under this Demonstration; or

4.5.5.1.2 Forty (40) hours directly supervised fieldwork (all hours must be in-person contact between prospective EIA Tutor and supervisor) over no more than 12 weeks must have been initiated and completed within the 12 months prior to providing EIA services to TRICARE beneficiaries under this Demonstration.

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4.5.5.2 Documentation of experience must include:

- An up-to-date resume of work experience. The names of the private or public agencies/employers, dates of service and approximate hours per week shall be included. It should also include a detailed job description of the type of work and the job responsibilities of the applicant in serving children with developmental disabilities;
- The supervisors name(s) and current contact information;
- Letters of reference or written verification of work experience in each setting including job title and dates of service; and
- If applicable, practicum/internship hours must be documented by an official transcript.

4.5.6 Competency to provide services to TRICARE beneficiaries is demonstrated by:

4.5.6.1 Proficiency in therapeutic methodology and understanding of ABA principles per written and field evaluations; and

4.5.6.2 Competency in the direct, hands-on delivery of services utilizing the ABA methodologies, techniques, processes, and procedures specified in the EIA Tutor classroom training requirement described in [paragraph 4.5.4.2](#).

4.5.6.3 Documentation that competencies have been tested and the EIA Tutor has performed adequately shall be retained for a period of 36 months after the direct employment or contractual relationship between the EIA Supervisor and EIA Tutor has ended.

4.5.7 Criminal background check required on EIA Tutors.

4.5.7.1 Shall include Federal Criminal, State Criminal, County Criminal and Sex Offender reports for the state and county in which the providers are currently working and residing.

4.5.7.2 Does not need to be repeated if the EIA Tutor has already undergone a criminal background check with the current employer. However, components of the CBC as required in [paragraph 4.5.7.1](#) that have not been previously performed must be completed prior to providing services under the Demonstration.

4.5.7.3 TRICARE reimbursement of services provided by an EIA Tutor is conditional on successful completion of the criminal background check prior to the EIA Tutor providing any EIA services, other than joint services with an EIA Supervisor, to TRICARE beneficiaries; and

4.5.7.4 Certification by the ICSP or OCSP that the tutor has not been convicted of any prohibited offenses, including:

- Incest.
- Unlawful sexual contact.

- Abandonment of child.
- Endangering the welfare of a child.
- Child abuse or neglect.
- Spousal abuse.
- Crimes against children (including child pornography).
- Crimes involving violence including rape, sexual assault and homicide committed at any time.
- Physical assault, battery and drug related offenses committed within the past five years.

4.5.7.5 If the tutor has been convicted of any offense for which a reasonable person would question the individual's suitability to work with disabled children, the ICSP or OCSP must submit to the MCSC a letter describing mitigating factors and why the tutor is suitable to work with children. Other convictions and arrests for offenses which may make a person unsuitable for employment may contain (but are not limited to) the following characteristics:

- Offenses against the person where physical harm or death has taken place.
- Offenses involving weapons, explosive devices or threat of harm.
- Offenses involving public indecency and obscenity which may have been the result of plea bargain situations.
- Offenses that show a disregard of others, such as reckless endangering, arson.
- Cruelty to animals or deviant behavior.

4.5.7.6 The decision of the MCSC to deny permission for a tutor to provide EIA Services to TRICARE beneficiaries must be PROVIDED to the initiating supervisor within 14 days and may not be appealed.

4.5.7.7 If an EIA Tutor or Tutor-in-Training is found on audit NOT to meet the requirements for a criminal background check as described in [paragraph 4.5.7](#), that EIA Tutor or Tutor-in-Training shall be required by the ICSP or OCSP to immediately cease providing EIA services under the Demonstration.

4.5.8 Ongoing supervision of EIA Tutors.

4.5.8.1 Who have completed 500 hours of indirectly supervised fieldwork is required. During each 40 hours of services provided to an individual child:

- A minimum of one hour of direct supervision; and

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- A minimum of one hour of indirect supervision is required.

4.5.8.2 Who have NOT YET completed 500 hours of indirectly supervised fieldwork is required. During each 40 hours of services provided to an individual child:

- A minimum of two hours of direct supervision; and
- A minimum of two hours of indirect supervision is required.

4.5.9 Nature of supervision for EIA Tutor experience and ongoing supervision requirements.

4.5.9.1 The supervisor must be a TRICARE authorized EIA Supervisor as defined in this section. The supervisor may not be a relative, subordinate or employee of the tutor.

4.5.9.2 In direct supervision.

4.5.9.2.1 The supervisor must observe the tutor engaging in behavior analytic activities in the natural environment in real-time; and

4.5.9.2.2 Observation should concentrate on tutor-child interactions; and

4.5.9.2.3 Must be conducted in-person or via real-time media such as web-cameras or videoconferencing; and

4.5.9.2.4 The supervisor must provide specific feedback to tutors on their performance.

4.5.9.2.5 In extraordinary circumstances where in-person or real-time interactions between supervisor and supervisee are limited, use of video recordings of the tutor engaging in behavior analytic activities and sent to the supervisor for analysis and subsequent discussion and training are permissible.

- Approval of the use of supervision via video recordings is required when more than half of yearly direct supervision is conducted by this method; and
- Is granted via written request by the MCSC on a case-by-case basis; and
- The use of devices to record or transmit audio or video images of beneficiaries while receiving services for which TRICARE is payer requires prior written informed consent (or of the parent/guardian if the child is under 18 years of age).

4.5.9.3 Indirect supervision entails review and analysis of case specific issues with the intent at troubleshooting problems, offering suggestions for improvement in practice, and providing further opportunities for learning and mentoring.

- Indirect supervision may be conducted in small groups of 10 or fewer participants for no more than half of the indirect supervision hours required; and
- The remainder of the total indirect supervision must consist of one-to-one contact, which may be conducted via real-time media such as web-cameras,

videoconferencing, or similar means in lieu of the supervisor being physically present.

4.6 EIA Tutor In-Training

4.6.1 A provider of EIA services who has fulfilled all of the requirements to qualify as an EIA Tutor except for the experience requirement as described in [paragraphs 4.5.5.1.1](#) or [4.5.5.1.2](#); and

4.6.2 Is delivering services under the supervision of an EIA Supervisor.

4.6.3 All other requirements of EIA Tutors are applicable to EIA Tutors-in-Training.

4.7 Jointly Delivered Services

EIA Supervisor-EIA Tutor: Services delivered jointly, in-person, to a TRICARE beneficiary by an EIA Supervisor with an EIA Tutor or EIA Tutor-in-Training, as may be provided during directly supervised fieldwork as defined in [paragraph 4.5.9.2](#), are reimbursable to the ICSP or OCSP as services provided by the EIA Supervisor using HCPCS code H5108.

4.8 Specialized ASD Provider

A TRICARE authorized provider who is:

4.8.1 A physician board-certified or board-eligible in behavioral developmental pediatrics, neurodevelopmental pediatrics, pediatric neurology or child psychiatry;

4.8.2 A physician or Ph.D. educated psychologist working primarily with children with:

- One or more years of supervised fellowship training that included 40 or more hours of clinical experience in comprehensive evaluations for ASD as evidenced by the name, location and dates of the qualifying fellowship; or
- One or more years of supervised on-the-job training that included the performance of ASD diagnostic evaluations an average of twice each month as evidenced by the position, location and dates of the qualifying on-the-job training.

4.9 All documentation cited in [paragraph 4.0](#) for submission must be provided to the MCSC unless otherwise stated.

5.0 ELIGIBILITY

5.1 Eligibility for services under ECHO described in [32 CFR 199.5](#) identifies serious physical disability as a qualifying condition. The TRICARE Policy Manual (TPM), [Chapter 9, Section 2.3](#) specifies the criterion as a condition which precludes unaided performance of one or more major life activities including: breathing, cognition, hearing, seeing, and age appropriate ability essential to bathing, dressing, eating, grooming, speaking, stair use, toilet use, transferring, and walking. Children diagnosed with AD, PDDNOS, AS, and CDD will meet this ECHO requirement for a qualifying condition if, based on deficits associated with the disorder, the child is receiving special

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education and other supportive services as defined in [paragraph 5.2.3](#) under an IEP or IFSP, except as otherwise indicated.

5.2 Beneficiaries aged 18 months and older eligible for services under the Demonstration must meet all of the following requirements and have their PCP or a Specialized ASD Provider submit information necessary to allow the MCSC to confirm eligibility:

5.2.1 Registered or in process of registering in the ECHO; and

5.2.2 Diagnosed with AD, PDDNOS, AS, or CDD, as defined by the DSM-IV-TR.

5.2.2.1 The qualifying diagnosis may be made by any TRICARE authorized PCP or a Specialized ASD Provider.

5.2.2.2 If a diagnosis of ASD had already been made at the time the Demonstration was made available to beneficiaries the child is NOT required to be re-diagnosed with ASD or to complete diagnostic testing as described in [paragraph 5.2.2.3](#) to participate in the Demonstration. However, all children seeking services under the Demonstration must meet the requirements in [paragraph 5.2.3](#).

5.2.2.3 Standardized diagnostic testing as described in this paragraph is recommended for all children participating in the Demonstration, but is required only for those children in which the provider making a qualifying diagnosis of AD or PDDNOS is not a Specialized ASD Provider.

5.2.2.3.1 Standardized diagnostic instruments for autism accepted by TRICARE are:

- Autism Diagnostic Observation Schedule
- Autism Diagnostic Interview-Revised
- Pervasive Developmental Disorders Behavior Inventory (PDDBI)

5.2.2.3.2 Standardized diagnostic instruments utilized to fulfill this requirement other than those cited in this paragraph must be considered to have reliable evidence (see [32 CFR 199.2\(b\)](#)) supporting their use in making the clinical diagnosis of AD or PDDNOS.

5.2.2.3.3 The results of diagnostic testing shall be reviewed by the child's PCP or Specialized ASD Provider and provided to the MCSC to determine eligibility for the Demonstration if required. If clinical review of the qualifying diagnosis is required under the Demonstration, a copy of the completed diagnostic instrument shall be provided to the MCSC for their use in performing the review.

5.2.3 Documented in an IEP or IFSP to be receiving special education and such developmental, corrective, and other supportive services (including psychological services, physical and occupational therapy, social work services, counseling services, including rehabilitation counseling) as may be required to assist a child with a disability to benefit from special education. The term does not include a medical device that is surgically implanted, or the replacement of such device; or

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5.2.4 If the child is homeschooled and not required by state law to have an IEP or IFSP the child's PCP or Specialized ASD Provider must certify that the child's disability related to ASD results in dysfunction severe enough to require special education and other supportive services as described in [paragraph 5.2.3](#).

5.2.5 The child's nonverbal intelligence quotient, as measured by a standardized test of intelligence, is not below a score of 35.

5.2.5.1 Intelligence testing performed prior to the initiation of the Demonstration is acceptable in meeting this requirement.

5.2.5.2 A child may be considered to have provisional Demonstration eligibility and receive EIA services while intelligence testing is being completed.

5.2.5.3 Results of intelligence testing meeting the requirement or a letter from the beneficiary's PCP or Specialized ASD Provider certifying that the child is unable to participate in intelligence testing is required to continue participation in the Demonstration after the provisional eligibility period.

5.2.5.4 For children unable to participate in intelligence testing, the beneficiary's PCP or Specialized ASD Provider is required to recertify the beneficiary's continued inability to participate in intelligence testing every six months.

5.2.5.5 Standardized diagnostic instruments for intelligence accepted by TRICARE (or most current edition if updated) are (all instruments are not appropriate for all age groups – expert advice prior to completing testing is recommended):

- Wechsler Intelligence Scale for Children, Fourth Edition (WISC-IV)
- Wechsler Preschool and Primary Scale of Intelligence, Third Edition (WPPSI-III)
- Differential Ability Scales (DAS II)
- Mullen Scales of Early Learning-AGS Edition (for children under three or with lower mental ages)
- Stanford-Binet Intelligence Scale, Fifth Edition (SB5)
- Bayley Scales of Infant Development (BSID)
- Leiter International Performance Scale-Revised (LIPS-R)

5.2.6 For children 18 months through eight years of age standardized testing of language skills and adaptive behavior must be completed.

5.2.6.1 Standardized testing of language skills and adaptive behavior completed within the 24 months prior to initiation of EIA services under the Demonstration meets the requirement of [paragraph 5.2.6](#).

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5.2.6.2 Testing must be completed within 12 months of initiating services under the Demonstration if the requirement is not fulfilled per [paragraph 5.2.6.1](#).

5.2.6.3 Standardized tests in selected functional areas accepted by TRICARE (or most current edition if updated) are:

5.2.6.3.1 Language skills:

- Reynell Developmental Language Scales (RDLS)
- Test of Pragmatic Language, Second Edition (TOPL-2)
- Preschool Language Scale, Fourth Edition (PLS-4)
- Clinical Evaluation of Language Fundamentals-Preschool (CELF-P)
- Clinical Evaluation of Language Fundamentals, Fourth Edition (CELF-4)
- Test of Language Development: Primary, Third Edition (TOLD-P:3)

5.2.6.3.2 Adaptive behavior:

- Vineland Adaptive Behavior Scales, Second Edition (VABS-II)

5.3 Eligibility for benefits under the Demonstration ceases as of 12:01 a.m. of the day following the day of the earliest occurrence of the following events:

5.3.1 Eligibility for the ECHO program ends; or

5.3.2 One hundred twenty (120) days from the date of issuance of the Detailed Explanation of Non-Concurrence (DENC) if a qualifying diagnosis is not established per [paragraph 7.1.2](#).

5.4 The MCSC will notify the beneficiary in writing of the results of an eligibility determination.

5.5 A determination that a TRICARE beneficiary is not eligible for benefits under the Demonstration is considered a factual determination based on a requirement of the law or regulation and as such is not appealable. Denial of Demonstration services and supplies to an ineligible beneficiary is not appealable.

5.6 Absence of eligibility for EIA services under the Demonstration does not preclude beneficiaries from receiving otherwise allowable services under ECHO or the TRICARE Basic program.

6.0 POLICY

6.1 Delivery of services through a modified corporate services model:

6.1.1 Under [32 CFR 199.6\(e\)\(2\)\(ii\)\(B\)](#), an ECHO outpatient care provider includes an individual, corporation, foundation, or public entity that predominantly renders services of a type uniquely allowable as an ECHO benefit.

6.1.2 The TRICARE CSP class under [32 CFR 199.6\(f\)](#) accommodates individuals who would meet the criteria for status as a TRICARE authorized individual professional provider as established by [32 CFR 199.6\(d\)](#), but for the fact that they are employed directly or contractually by a corporation or foundation that provides principally professional services which are within the scope of the TRICARE basic program benefit.

6.1.3 The Demonstration modifies the CSP requirements of [32 CFR 199.6\(f\)](#) to allow hands-on EIA Tutors who engage in the one-on-one treatment with the child, while employed or contracted by and supervised by an authorized EIA Supervisor.

6.1.4 TRICARE authorized ABA outpatient care providers (as defined in TPM, [Chapter 9, Section 17.1](#)) are generally individual practitioners, and many practices are not incorporated. As a result, they do not meet most of the requirements under [32 CFR 199.6\(f\)](#) to qualify as a CSP. This Demonstration requires EIA Supervisors to meet the following criteria to qualify as an ICSP under this Demonstration, and receive reimbursement for services provided by EIA Tutors implementing their BP.

6.1.4.1 Have entered into a Participation Agreement approved by the Director, TMA or designee, which complies with the Participation Agreement requirements established by the Director; and

6.1.4.2 Employ directly or contractually an individual who meets TRICARE qualifications for an EIA Tutor; and

6.1.4.3 Maintain all applicable business license requirements of state or local jurisdictions; and

6.1.4.4 Cooperate fully with a designated utilization and clinical quality management organization which has a contract with the DoD for the geographic area in which the provider does business; and

6.1.4.5 Render services for which direct or indirect payment is expected to be made by TRICARE only after obtaining TRICARE written authorization.

6.1.4.6 Payment for otherwise allowable services by EIA Tutors under this Demonstration project may be made to a TRICARE-authorized EIA Supervisor subject to the applicable requirements, exclusions and limitations of this Demonstration.

6.1.4.7 Otherwise allowable services may be rendered at the authorized EIA provider's place of business, in the beneficiary's home, at school, or other location that is suitable for the type of services being rendered under such circumstances as the Director, TMA or designee, determines to be necessary for the efficient delivery of such services.

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6.1.4.8 The Director, TMA or designee, shall determine whether the appropriate employment or contractual relationship exists between the EIA Supervisor and EIA Tutor. Such determination is conclusive and may not be appealed.

6.1.5 The Director, TMA or designee, may limit the term of a Participation Agreement for any category or type of provider established by this Demonstration project.

6.1.6 Both the EIA Supervisor who is an ICSP as well as the EIA Supervisor who is employed by or contracted to a corporation, foundation, or public entity that meets the TRICARE definition of a CSP under [32 CFR 199.6\(e\)\(2\)\(ii\)\(B\)](#) are required to be TRICARE authorized in order to provide services under the Demonstration. They both must;

6.1.6.1 Meet the minimum education, training, experience, competency and ongoing supervision requirements for EIA Supervisors as established by the Director, TMA or designee; and

6.1.6.2 Comply with all applicable organizational and individual licensing or certification requirements that are extant in the state, county, municipality, or other political jurisdiction in which the provider renders services; and

6.1.6.3 Submit proof that professional liability insurance in the amounts of \$1 million per claim and \$3 million in aggregate, unless there are state requirements that are in different amounts, is maintained in the EIA Supervisor's name.

6.1.7 EIA Supervisors and the Director, TMA or designee, may terminate the Participation Agreement for CSPs ([Addendum A](#)).

6.1.8 The Director, TMA or designee, may create discrete types within the allowable tutor category of provider established by this Demonstration to improve the efficiency of TRICARE management.

6.2 TRICARE will cost-share EIA services that:

6.2.1 Are primarily focused on implementation of basic principles of ABA and that target behaviors directly associated with the core deficits of ASD; and

6.2.2 Are focused on behavior in its own right as a target for change. The target behavior is directly observed and quantifiably measured in real-life environments; and

6.2.3 Utilize quantified behavioral data to identify functional relations between environmental events and behavior through systematic manipulations; and

6.2.4 Gather quantifiable behavioral data to track progress in reaching behavioral objectives identified in the BP and to direct the periodic modification of the intervention plan to ensure the child's progressive attainment of behavioral objectives; and

6.2.5 Include the generalization of learned behaviors as goals of the treatment; and

6.2.6 Periodically incorporate parent training so family members/caregivers can teach and support skills during typical family activities; and

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6.2.7 Require periodic meetings between family members/caregivers and those designing and implementing the intervention program.

6.3 The maximum cumulative Government cost-share of the total cost of providing benefits through both the Demonstration and the ECHO program (as implemented in [32 CFR 199.5](#)) shall not exceed \$2,500 per ECHO-registered beneficiary in any single month.

6.4 Training required of parents/caregivers.

6.4.1 One parent/caregiver in the beneficiary's immediate family as defined in [32 CFR 199.2](#), must complete classroom and practical training (i.e., hands-on training in the application and delivery of EIA services) in each year in which EIA services are provided under this Demonstration. The same family member does not need to meet this requirement every year the beneficiary receives services under the Demonstration.

6.4.2 Classroom and practical training must focus at a minimum on the following topics: how to implement the BP at home; how behavioral change is measured and how can progress in the child receiving services be tracked; how can parents/caregivers support the principles and methods of EIA service delivered; and how to promote generalization of behaviors learned as a result of EIA services. Additional guidelines for content of and models for caregiver training may be provided as the Director, TMA or designee, determines to be necessary.

6.4.3 Classroom training is required and must be provided by:

6.4.3.1 A United States or Canadian institution of higher education fully or provisionally accredited by a regional, state, provincial or national accrediting body; or

6.4.3.2 A Joint Commission or Commission on Accreditation of Rehabilitation Facilities accredited health care facility; or

6.4.3.3 A private agency whose primary business activity is the delivery of services to children with ASD and whose governing board includes one or more BCBA's; or

6.4.3.4 An EIA Supervisor; or

6.4.3.5 Web-based instruction not provided by an accredited institution of higher education; and

6.4.3.6 In the instance of [paragraphs 6.4.3.2, 6.4.3.3, 6.4.3.4, and 6.4.3.5](#), the training curriculum has been approved by the BACB or a currently certified BCBA.

6.4.3.7 Waiver of the classroom training requirement is permitted when the sponsor certifies to the MCSC that a parent/caregiver in the beneficiary's immediate family has previously received classroom training in the content and to the degree required in the Demonstration.

6.4.4 Practical training is required and:

6.4.4.1 Must be provided by an EIA supervisor.

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6.4.4.2 An EIA Supervisor may be reimbursed for parent training (as described in TPM, [Chapter 9, Section 8.1](#)).

6.4.4.3 Practical training may be conducted in groups of no more than three trainees at a time and shall be calculated as two hours of group training meets one hour of the training requirement.

6.4.4.4 Waiver of practical training is permitted for caregivers who can document to the MCSC that they:

- Meet the definition of an EIA Supervisor as defined in the EIA Supervisor Provider Application; or
- Have ever been approved by the BACB to take the BCBA or BCABA examinations; or
- Have had 30 hours of hands-on training in providing services directly to children and/or adults with autism under the supervision of a BCBA or an individual with a minimum of a Master's degree in ABA or closely related field and eight years of professional experience in implementing, designing, and overseeing behavior analysis services for individuals with autism;

6.4.4.5 There is no implied obligation for TRICARE authorized EIA Supervisors to provide caregiver practical training under this Demonstration.

6.4.5 The Government cost-share is a maximum of \$2,500 per month per beneficiary. Each year in no instance shall the total amount of the Government cost-share paid for training required of parents/caregivers under the Demonstration exceed \$1,500 per individual and \$4,500 per family during each year in which EIA services are received by the beneficiary.

6.4.6 For parents/caregivers of children receiving services under the Demonstration:

6.4.6.1 Six hours of classroom training are required in the first year EIA services are provided.

6.4.6.2 Six hours of practical training is required during each year in which services are provided.

6.4.6.3 For caregivers of children 18 months through eight years of age only, 10 hours of practical training are required in the first year EIA services are received.

6.5 Testing and assessment required to establish a diagnosis of ASD shall be considered for coverage under the Basic Program. Testing intended to further characterize the clinical characteristics of a beneficiary diagnosed with ASD shall be considered for coverage under the ECHO to the extent it is not covered under the Basic Program.

6.6 TRICARE will not cost-share:

6.6.1 The training necessary for an EIA Tutor or EIA Tutor-in-Training to meet the training requirements defined in [paragraph 4.5.4](#).

6.6.2 Program development or administrative fees for the creation of BPs or EPRs that are separate from costs associated with evaluation of the TRICARE beneficiary.

6.6.3 Meetings for the purposes of treatment planning or required quarterly treatment progress meetings with the TRICARE beneficiary's caregivers.

6.6.4 For more than one service in any one time period (e.g., training of parents and direct services) cannot be billed as separate services provided during the same time period.

7.0 OTHER MCSC RESPONSIBILITIES

7.1 Clinical review of qualifying diagnosis.

7.1.1 A qualifying diagnosis made by other than a Specialized ASD Provider requires clinical review:

7.1.1.1 The clinical review shall be conducted by a Specialized ASD Provider.

7.1.1.2 The review shall be of the evidence submitted in support of the diagnosis of ASD consistent with practice recommendations from the American Academy of Neurology (Filipek et al. 1999) and the AAP (Johnson & Myers 2007)—to include health, developmental and behavioral histories, physical examination, developmental evaluation, direct observation of behavior, standardized developmental testing, and rule-out of other conditions as dictated by the clinical presentation of the child.

7.1.1.3 The clinical review shall be conducted within 14 days of the MCSC receiving all documents necessary to determine eligibility in the Demonstration and only if all other eligibility criteria are met.

7.1.1.4 If clinical review fails to confirm sufficient evidence supporting the diagnosis of ASD, the beneficiary will be provided a DENC that:

- Details the specific aspect(s) of the diagnosis or diagnostic process that does not meet DSM-IV criteria or conform with medically accepted practices as described in [paragraph 7.1.1.2](#); and
- Is approved by the Specialized ASD Provider who performed the clinical review; and
- Shall be provided to the beneficiary no later than 21 calendar days of the MCSC receiving all documents necessary to determine eligibility in the Demonstration; and

7.1.1.5 The beneficiary will be provided information describing eligibility criteria for the Demonstration, the differences between a PCP and Specialized ASD Provider and written advice on how to identify and contact Specialized ASD Providers that may be available for consultation.

7.1.1.6 Clinical review of the qualifying diagnosis is not required if the beneficiary does not qualify for participation in the Demonstration based on any other eligibility criteria required for that beneficiary.

7.1.2 Continued participation in the Demonstration is contingent upon:

7.1.2.1 MCSC clinical review confirming a qualifying diagnosis; or

7.1.2.2 Subsequent qualifying diagnosis made by a Specialized ASD Provider.

7.2 Review of BP and EPR: The MCSC shall confirm that a BP and EPR (if required) have been reviewed and accepted by the beneficiary's PCP or Specialized ASD Provider prior to authorization of services to be delivered under the Demonstration. PCP or Specialized ASD Provider review of the BP and EPR (if required) is necessary for prior authorization of services for each six months during which services are delivered.

7.3 Except at initiation of services, the MCSC shall obtain sponsor certification of the following every six months on behalf of each dependent receiving benefits under the Demonstration as a requirement for continuation of services:

7.3.1 The name and relationship to the beneficiary of the family member fulfilling the parent/caregiver training requirement; and

7.3.2 The number of hours of classroom and practical training completed by the identified family member during the previous six months; and

7.3.3 If the family member has completed the required training for the 12 month training requirement period; and

7.3.4 The total number of family members receiving TRICARE reimbursed training in the previous 12 months; and

7.3.5 If the caregivers have had any substantive concerns about the ethical behavior or competence of any individuals providing EIA services to the beneficiary.

7.3.5.1 The MCSC must respond to expressed family concerns about the ethical behavior or competence of EIA service providers by developing a plan of action with the family to address their concerns.

7.3.5.2 Based on the family's input, the nature of the concerns, and evidence a plan of action might potentially involve contacting the EIA Supervisor, continued monitoring of services delivered, filing of a formal complaint to the BACB or other professional monitoring entity, termination of TRICARE authorization, or discontinuing reimbursement of services provided by an EIA Tutor, among other possible actions.

7.3.5.3 A letter or letters outlining the plan of action and the outcomes of any actions taken by the MCSC or other parties in response to the issue of concern will be provided to the beneficiary at regular intervals.

7.4 The MCSC must maintain all documents created by them and submitted to them used to establish eligibility for the Demonstration; and

7.4.1 A losing contractor, when informed in writing by the beneficiary's sponsor of a transfer of location, or on receipt of a request from the gaining contractor, will forward all documents to the gaining contractor within ten calendar days; or

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7.4.2 The gaining contractor, on receipt of a beneficiary's signed enrollment application, shall request Demonstration eligibility documents from the losing contractor within five calendar days.

7.5 A finding of non-compliance on required audits of TRICARE EIA Tutor qualification requirements as elaborated in [paragraph 4.5](#) and/or EIA Tutor-in-Training on-going supervision as elaborated in [paragraph 4.2.3](#) will trigger audit of compliance for all for the EIA Tutors and Tutor-in-Training employed or contractor to the ICSP or OCSP.

8.0 ADMINISTRATION

8.1 EIA services provided directly to a beneficiary by an EIA Supervisor, inclusive of those services provided when an EIA Tutor or an EIA Tutor-in-Training is present, will be invoiced by the ICSP or OCSP using HCPCS code "S5108, Home care training to home care client, per 15 minutes." The maximum allowable charge for S5108 is \$18.00 per each 15 minute increment.

8.2 EIA services provided directly by an EIA Tutor to a beneficiary will be invoiced by the ICSP or OCSP using HCPCS code "H2019, Therapeutic behavioral services, per 15 minutes." The maximum allowable charge for H2019 is \$9.00 per each 15 minute increment.

8.3 EIA practical training of family members by an EIA Supervisor will be invoiced by the ICSP or OCSP using HCPCS code "S5110, Home care training, family, per 15 minutes." The maximum allowable charge for S5110 is \$18.00 per each 15 minute increment.

8.4 Claims for EIA classroom training will be reimbursed when submitted to the MCSC by the sponsor of the beneficiary enrolled in the Demonstration in accordance with the TPM, [Chapter 9, Section 8.1](#).

8.5 The allowable charges in paragraph 9.0. will be closely monitored and adjusted as the Director, TMA determines necessary.

9.0 APPLICABILITY

9.1 The provisions of this Demonstration are limited to those TRICARE-eligible beneficiaries as stated in [paragraph 5.0](#).

9.2 This Demonstration is limited to EIA services provided within the 50 United States and the District of Columbia.

9.3 For this Demonstration, all provisions of the ECHO program as described in [32 CFR 199.5](#) will continue to apply unless specifically modified by the Demonstration notice, and the provisions of the ECHO program in the TRICARE Manuals will continue to apply unless modified by this section.

10.0 EFFECTIVE DATE

This Demonstration is effective for claims for services provided on or after March 15, 2008.

- END -

Participation Agreement For Corporate Services Provider
(CSP)

NAME OF EIA SUPERVISOR:

OFFICE ADDRESS:

TELEPHONE:

CHAMPUS PROVIDER BILLING NO.

ARTICLE 1

RECITALS

1.1 IDENTIFICATION OF PARTIES

This Corporate Services Provider (CSP) Participation Agreement (“Participation Agreement”) is between the United States of America through the Office of the Assistant Secretary of Defense (Health Affairs) (OASD(HA)), TRICARE Management Activity (TMA), a field activity of the OASD(HA) and _____, doing business as _____ (hereinafter Educational Interventions for Autism Spectrum Disorders (EIA) Supervisor).

1.2 AUTHORITY FOR EIA SUPERVISORS AS AUTHORIZED PROVIDERS

The authority to designate EIA Supervisors as authorized TRICARE providers resides with the Department of Defense (DoD) Demonstration authority under 10 U.S.C. 1092. This authority ceases upon termination of the Enhanced Access to Autism Services Demonstration Project (“Demonstration”) as determined by the Director, TMA or designee.

1.3 PURPOSE OF PARTICIPATION AGREEMENT

The purpose of this Participation Agreement is to:

- (a) Establish the undersigned EIA Supervisor as an authorized provider of EIA services;
- (b) Establish the terms and conditions that the undersigned EIA Supervisor must meet to be an authorized CSP under the Demonstration.

ARTICLE 2

REFERENCES

2.1 GENERAL AGREEMENT

The EIA Supervisor agrees to render educationally and behaviorally necessary and appropriate covered EIA services within the scope of his/her practice to eligible beneficiaries as required in the TRICARE Operations Manual (TOM), [Chapter 18, Section 9](#).

2.2 REQUIREMENTS

By reference, the EIA Supervisor agrees to comply with all requirements established for EIA Supervisors who are CSPs as set forth in the TOM, [Chapter 18, Section 9](#).

ARTICLE 3

PAYMENT PROVISIONS

3.1 ALLOWABLE CHARGE

The following allowable charges have been established for the DoD Enhanced Access to Autism Services Demonstration (TOM, [Chapter 18, Section 9](#)):

(a) EIA services provided directly to a beneficiary by an EIA Supervisor, inclusive of those services provided when an EIA Tutor or an EIA Tutor-in-Training is present, will be invoiced by the ICSP or OCSP using HCPCS code "S5108, Home care training to home care client, per 15 minutes." The maximum allowable charge for S5108 is \$18.00 per each 15 minute increment.

(b) EIA services provided directly by an EIA Tutor to a beneficiary will be invoiced by the ICSP or OCSP using HCPCS code "H2019, Therapeutic behavioral services, per 15 minutes." The maximum allowable charge for H2019 is \$9.00 per each 15 minute increment.

(c) EIA practical training of family members by an EIA Supervisor will be invoiced by the ICSP or OCSP using HCPCS code "S5110, Home care training, family, per 15 minutes." The maximum allowable charge for S5110 is \$18.00 per each 15 minute increment.

(d) In accordance with the TRICARE Policy Manual (TPM), [Chapter 9, Section 8.1](#), claims for EIA classroom training of parent(s)/caregiver(s) will be reimbursed when submitted to the appropriate Managed Care Support Contractor (MCSC) by the sponsor of the beneficiary enrolled in the Demonstration.

3.2 ADMINISTRATION

The EIA Supervisor as the provider of services agrees:

(a) Not to charge a beneficiary for the following:

- (1) Services for which the provider is entitled to payment from TRICARE;
- (2) Services for which the beneficiary would be entitled to have TRICARE payment made had the provider complied with certain procedural requirements;
- (3) Services not necessary and appropriate for the educational and behavioral management of the presenting disorder;
- (4) Services for which a beneficiary would be entitled to payment but for a reduction or denial in payment as a result of quality review; and
- (5) Services rendered during a period in which the provider was not in compliance with one or more conditions of authorization:

(b) To submit invoices to the appropriate TRICARE MCSC in accordance with the TOM, [Chapter 18, Section 9, paragraph 8.0](#);

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Participation Agreement For Corporate Services Provider (CSP)

(c) To collect from the TRICARE beneficiary those amounts that the beneficiary has a liability to pay for the TRICARE deductible and cost-share/co-payment;

(d) To provide to the Director, TMA or designee (e.g., MCSC), prompt written notification of the provider's employment of an individual who, at any time during the twelve months preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity by an agency or organization which is responsible, directly or indirectly, for decisions regarding DoD payments to the provider;

(e) To cooperate fully with a designated utilization and clinical quality management organization which has a contract with the DoD for the geographic area in which the provider renders services;

(f) To comply with all applicable TRICARE authorization requirements before rendering designated services or items for which TRICARE cost-share/co-payment may be expected;

(g) To meet such other requirements as the Secretary of Defense may find necessary in the interest of health and safety of the individuals who are provided care and services.

3.3 ACCESS TO AND MAINTENANCE OF RECORDS

The EIA Supervisor as the provider of services agrees:

(a) To permit access by the Director, TMA or designee, to the clinical record of any TRICARE beneficiary, to the financial and organizational records of the provider, and to reports of evaluations and inspections conducted by state or private agencies or organizations; and

(b) To maintain clinical and other records related to individuals for whom TRICARE payment was made for services rendered by the provider, or otherwise under arrangement, for a period of 60 months from the date of service;

(c) To maintain contemporaneous evaluation and intervention services records that substantiate the rationale for the planned course of treatment, the methods, modalities or means of intervention, periodic evaluation of the efficacy of treatment, and the outcome at completion or discontinuation of services as described separately in this agreement.

ARTICLE 4

TERM, TERMINATION, AND AMENDMENT

4.1 TERM

The term of this agreement shall begin on the date this agreement is signed and shall continue in effect until terminated by either party or until replaced by an updated Participation Agreement as may be required in [paragraph 4.2](#).

4.2 RESUBMISSION OF PARTICIPATION AGREEMENT

An EIA Supervisor must resubmit a Participation Agreement if the new qualification under which the EIA Supervisor may be TRICARE authorized changes that supervisor's requirement for supervision him/herself.

4.3 TERMINATION OF AGREEMENT BY TMA

(a) The Director, TMA or designee, may terminate this agreement upon written notice, for cause, if the EIA Supervisor is found not to be in compliance with the provisions set forth in [32 CFR 199.6](#), or is determined to be subject to the administrative remedies involving fraud, abuse, or conflict of interest as set forth in [32 CFR 199.9](#). Such written notice of termination shall be an initial determination for purposes of the appeal procedures set forth in [32 CFR 199.10](#).

(b) In addition, the Director, TMA or designee, may terminate this agreement without cause by giving the EIA Supervisor written notice of its intent to terminate this agreement 45 days prior to the effective date of such termination.

4.4 TERMINATION OF AGREEMENT BY THE EIA SUPERVISOR

The EIA Supervisor may terminate this agreement by giving the Director, TMA or designee, written notice of such intent to terminate at least 45 days in advance of the effective date of termination. Effective the date of termination, the EIA Supervisor will no longer be recognized as an authorized provider, and reinstatement shall be disallowed for any other category of extramedical individual provider. Subsequent to termination, the EIA Supervisor may only be reinstated as an authorized extramedical provider by entering into a new Participation Agreement as an EIA Supervisor.

4.5 AMENDMENT BY TMA

(a) The Director, TMA or designee, may amend the terms of this Participation Agreement by giving 120 days notice in writing of the proposed amendment(s) except when necessary to amend this agreement from time to time to incorporate changes to the 32 CFR 199. When changes or modifications to this agreement result from changes to the 32 CFR 199 through rulemaking procedures, the Director, TMA or designee, is not required to give 120 days written notice. Any such changes to 32 CFR 199 shall automatically be incorporated herein on the date the regulation amendment is effective.

(b) The EIA Supervisor, not wishing to accept the proposed amendment(s), including any amendment resulting from changes to the 32 CFR 199 accomplished through rulemaking procedures, may terminate its participation as provided for in this Article. However, if the EIA Supervisor notice of intent to terminate its participation is not given at least 30 days prior to the effective date of the proposed amendment(s), then the proposed amendment(s) shall be incorporated into this agreement for services furnished by the EIA Supervisor between the effective date of the amendment(s) and the effective date of termination of this agreement.

ARTICLE 5

EFFECTIVE DATE

5.1 DATE SIGNED

This Participation Agreement is effective on the date signed by the Director, TMA or designee.

TMA

EIA Supervisor

By: Typed Name and Title

By: Typed Name and Title

Executed on _____, 20____

- END -

General

1.0 PURPOSE

The purpose of this chapter is to ensure compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, including the Administrative Simplification provisions, by TRICARE contractors.

2.0 BACKGROUND

2.1 HIPAA

The HIPAA of 1996 was introduced as the Kassebaum/Kennedy Bill and was enacted on August 21, 1996, as Public Law (PL) 104-191. PL 104-191 is, "An Act to amend the Internal Revenue Code of 1986 to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance, and for other purposes."

2.2 Administrative Simplification

Through subtitle F of Title II of the Act, Congress added to Title XI of the Social Security Act a new Part C entitled, "Administrative Simplification." The purpose of this part is to improve the Medicare and Medicaid programs under titles XVIII and XIX of the Social Security Act respectively and improve the efficiency and effectiveness of the health care system in general by encouraging the development of a health information system through the establishment of standards and requirements to enable the electronic exchange of certain health information.

2.3 Other Provisions

The law requires the Secretary, Health and Human Services (HHS) to adopt standards for financial and administrative transactions, and data elements for those transactions, to enable health information to be exchanged electronically. It requires the Secretary, HHS to adopt standards for unique health identifiers for all individuals, employers, health plans, and health care providers and to adopt standards for security for health care information systems and for electronic signatures. Congress also instructed the Secretary, HHS to promulgate privacy standards for the protection of Individually Identifiable Health Information (IIHI) should Congress fail to do so. The law establishes civil monetary penalties for violations of the provisions of Part C and establishes penalties for a knowing misuse of unique health identifiers and IIHI.

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Chapter 19, Section 1

General

2.4 TRICARE Operations Manual (TOM)

This chapter incorporates, where required, instructions for each HIPAA-related final rule as they are published by the Department of Health and Human Services (DHHS).

- END -

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Chapter 19, Section 2

Standards For Electronic Transactions Final Rule

ENTITY	COVERED ENTITIES			NON-COVERED ENTITY	BUSINESS ASSOCIATE OF THE TRICARE HEALTH PLAN?
	HEALTH PLAN?	PROVIDER?	CLEARING-HOUSE?	EMPLOYER?	
TRICARE Retiree Dental Program (TRDP) Contractor	Y	N	N	N	N
Pharmacy Data Transaction System (PDTS) Contractor	N	N	N	N	Y
Designated Provider (DP) Contractors	Y	Y	N	N	N
Military Medical Support Office (MMSO)	N	N	N	N	Y
DoD Senior Pharmacy Inquiry Line Contractor	N	N	N	N	Y
Continued Health Care Benefit Program (CHCBP) Contractor	N	N	N	N	Y
TRICARE Quality Monitoring Contractor (TQMC)	N	N	N	N	Y
Contractor for Data Analysis for the DP Contracts	N	N	N	N	Y
TRICARE Overseas Program (TOP) Contractor	N	N	N	N	Y
TMA (Supporting Systems: DEERS Catastrophic Cap and Deductible (CCDD), payment record databases (TRICARE Encounter Data (TED) records, TED Provider (TEPRV) records, and TED Pricing (TEPRC) records), management databases (MHS Data Repository and its associated data marts)	N	N	N	N	Y
TRICARE Mail Order Pharmacy (TMOP)	N	Y	N	N	N
TRICARE Retail Pharmacy Benefits (TRPB) Contractor	N	N	N	N	Y
TRICARE Regional Offices (TROs)	N	N	N	N	Y
TRICARE Area Offices (TAOs)	N	N	N	N	Y

4.0 TRANSACTION REQUIREMENTS FOR TRICARE CONTRACTORS

4.1 General

4.1.1 Transactions shall be implemented in accordance with the transaction implementation specifications and any addenda, named by the Secretary, HHS, as standards (see [paragraph 1.3](#)).

4.1.2 Standard transactions received by contractors from trading partners that are correct at the interchange control structure level (envelope) and that are syntactically correct at the standard level and at the implementation guide level and are semantically correct at the implementation guide level must be accepted. Front-end business or application level edits for transaction content, such as an edit for a recognized provider number, shall not be the cause of rejecting an otherwise syntactically correct transaction. Front-end business or application level edits shall be applied after the transaction has been accepted. Claims failing front-end business or application edits, after passing syntax and semantic edits, shall be rejected, developed or denied in accordance with established procedures for such actions.

4.2 Transactions Exchanged Between Contractors And Providers (Network And Non-Network Providers, MTFs (CHCS))

4.2.1 Transactions exchanged between contractors and providers must be in standard format.

4.2.2 The contractors must be able to receive, process, and send the following transactions from and to providers:

4.2.2.1 Claims Transactions

[Receive 837 Transactions]

- The ASC X12N 837 - Health Care Claim: Professional, Version 4010.
- The ASC X12N 837 - Health Care Claim: Institutional, Version 4010.
- The ASC X12N 837 - Health Care Claim: Dental, Version 4010.

4.2.2.2 Coordination Of Benefits Transactions

[Receive 837 Coordination of Benefits Transactions]

- The ASC X12N 837 - Health Care Claim: Professional, Version 4010.
- The ASC X12N 837 - Health Care Claim: Institutional, Version 4010.
- The ASC X12N 837 - Health Care Claim: Dental, Version 4010.

4.2.2.3 Eligibility Inquiry And Response Transactions

[Receive 270 Transactions and Send 271 Transactions]

- The ASC X12N 270/271 - Health Care Eligibility Benefit Inquiry and Response, Version 4010.

4.2.2.4 Referral Certification And Authorization Transactions

[Receive 278 Requests and Send 278 Responses]

- The ASC X12N 278 - Health Care Services Review - Request for Review and Response, Version 4010.

4.2.2.5 Claim Status Request And Response Transactions

[Receive 276 Transactions and Send 277 Transactions]

- The ASC X12N 276/277 - Health Care Claim Status Request and Response, Version 4010.

4.2.2.6 Payment And Remittance Advice Transactions

[Send 835 Transactions]

- The ASC X12N 835 - Health Care Claim Payment/Advice, Version 4010.

Claims Processing For Dual Eligibles

1.0 GENERAL

Claims under the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) will be adjudicated under the rules set forth below. In general, TRICARE pays secondary to Medicare and any other coverage.

2.0 DETERMINING PAYMENTS DUE AFTER COORDINATION WITH MEDICARE

2.1 Special double coverage procedures are to be used for all claims for beneficiaries who are eligible for Medicare, including active duty dependents who are age 65 and over as well as those beneficiaries under age 65 who are eligible for Medicare for any reason. For specific instructions, refer to the TRICARE Reimbursement Manual (TRM), [Chapter 4, Section 4](#).

3.0 EXCEPTIONS TO TIMELY CLAIMS FILING

3.1 Medicare

The contractor may grant exceptions to the claims filing deadline if Medicare accepted the claim as timely. If submitted by the beneficiary, the claim must be submitted within 90 calendar days from the date of Medicare's adjudication to be considered for a waiver.

3.2 Other Health Insurance (OHI)

Reference [Chapter 8, Section 3, paragraph 2.5](#).

4.0 CLAIMS DEVELOPMENT REQUIREMENTS

4.1 Medicare Providers

4.1.1 The contractor shall accept the Medicare certification of individual professional providers who have a like class of individual professional providers under TRICARE without further authorization. An exception to this general rule occurs if there is information indicating Medicare, TRICARE or other federal health care program integrity violations by the physician or other health care practitioner. In such cases the Managed Care Support Contractor (MCSC) shall seek guidance from TRICARE Management Activity (TMA) Program Integrity (PI) prior to accepting the Medicare certification as valid for TRICARE purposes. Individual professional providers without a like class (e.g., chiropractors) under TRICARE shall be denied.

4.1.2 TRICARE claims which TRICARE processes after Medicare, do not need to be developed to the individual provider level for home health or group practice claims.

4.1.3 Electronic "cross over" claims received from Medicare after Medicare completes its claims processing do not need a beneficiary or provider signature. For paper claims, when TRICARE is second pay to Medicare and a Medicare EOB is attached, the contractor does not need to develop for provider or beneficiary signature. Signature on file requirements of [Chapter 8, Section 4](#) apply.

4.2 Civilian Services Rendered To Military Treatment Facility (MTF) Inpatients

Civilian claims for TRICARE dual eligible beneficiaries shall be processed by Medicare first without consideration of the Supplemental Health Care Program (SHCP).

4.3 Preauthorizations/Authorizations

When TRICARE is the primary payer, the contractor shall be responsible for providing the preauthorization/authorization for the services listed in the TRICARE Policy Manual (TPM), [Chapter 1, Section 7.1](#), outpatient mental health visits in excess of eight visits, preadmission and continued stay that apply to inpatient mental health, the Partial Hospitalization Program (PHP), and a Substance Use Disorder Rehabilitation Facility (SUDRF) admission. The requirements include processing a preauthorization if submitted by the provider. In cases where a preauthorization is not submitted (e.g., Medicare benefits are exhausted), the contractor shall obtain the necessary information and complete a retrospective review. When Medicare is the primary payer, the contractor may use Medicare's determinations regarding medical necessity in addition to following the guidance in the TRM, [Chapter 4, Section 4](#).

5.0 UTILIZATION MANAGEMENT

Any utilization management provisions applied under the TRICARE Managed Care Support Services (MCSSS) contracts, except for those specifically required by the TPM, TRM, or TRICARE Operations Manual (TOM), shall not apply under TDEFIC. Region-specific requirements shall not apply.

6.0 END OF PROCESSING

6.1 Beneficiary Cost-Shares

End Of Processing. Beneficiary cost-shares shall be based on the **following when** TRICARE is the primary payer. If the services **were** received **by** a TRICARE Prime enrollee (as indicated on DEERS), the contractor shall apply the Prime copayments. For a TRICARE Standard beneficiary, if a provider is known to be a network provider (e.g., **Veteran Affairs Medical Center (VAMC)**), the Extra cost-shares shall be applied. In all other cases, the TRICARE Standard cost-shares shall be applied.

6.2 Application Of Catastrophic Cap

Only the actual beneficiary out-of-pocket liability remaining after TRICARE payments will be counted for purposes of the annual catastrophic loss protection.

interfaces to each of the TRICARE MHS Systems. This testing will verify the contractor's system integration, functionality, and implementation process. The incoming contractor shall be responsible for the preparation and completion of Integration Testing prior to the start of Benchmark Testing.

2.3.1.2 TMA Test Managers will work with the contractor to plan, execute and evaluate the Integration Testing efforts. The contractor shall identify a primary and a back-up Testing Coordinator to work with the TMA Test Managers. The Testing Coordinator is responsible for contractor testing preparations, coordination of tests, identification of issues and their resolution, and verification of test results. A web application will be available for use by contractor Test Coordinators to report and track issues and problems identified during integration testing.

2.3.2 Receipt Of Outgoing MCSC's Weekly Shipment Of History Updates And Dual Operations

2.3.2.1 Beginning with the 120th calendar day prior to the start of services delivery and continuing after the start of services delivery until all pertinent claims received by the outgoing contractor have been processed, the contractor shall convert the weekly shipments of the beneficiary history and deductible file updates from the outgoing contractor(s) within two work days following receipt. These files shall be validated by the incoming contractor before use. Tests for claims, update of catastrophic cap, and duplicate claims shall be performed within two workdays following conversion. Any issues identified by the incoming contractor shall be resolved with the outgoing contractor and the TMA COR shall be kept informed of all issues identified within two work days and the problem resolution. Following the start of services delivery, these files shall be loaded to history and used for claims processing on the first processing cycle following the check for duplicate **claims**.

2.3.2.2 During the period after the start of services delivery when the incoming contractor and the outgoing contractor are processing claims, both contractors shall maintain close interface on history update exchanges and provider file maintenance. During the first 60 calendar days of dual operations, the contractors shall exchange beneficiary history updates with each contractor's claims processing cycle run. Thereafter, the exchange shall not be less than twice per week until the end of dual processing.

2.3.3 Installation And Operation Of The DCS

The contractor shall have purchased, installed, configured, and connected the personal computers and printers required to operate the DCS NLT 60 days prior to the start of the services delivery. See [Chapter 9](#), for hardware, software, printer, configuration and communications requirements and contractor installation responsibilities. Approximately 30-45 days prior to services delivery, TMA will provide and install the DCS application software on the contractor designated personal computers and provide on-site training for users of the DCS in accordance with [Chapter 9](#). Following the start of services delivery, the DCS will begin displaying identified potential duplicate claim sets for which the contractor has responsibility. The contractor shall begin using the DCS to resolve potential duplicate claim sets in accordance with [Chapter 9](#) and the transition plan requirements.

2.4 Contractor Weekly Status Reporting

The contractor shall submit a weekly status report of phase-in and operational activities and inventories to TMA beginning the 20th calendar day following "Notice of Award" by TMA through the 180th calendar day after the start of services delivery (or as directed by the PCO based on the status of the transition and other operational factors). The status report will address only those items identified as being key to the success of the transition as identified in the Transition Specifications Meeting or in the contractor's start-up plan.

2.5 Public Notification Program - Provider And Congressional Mailing

The contractor shall prepare a mailing to all Congressional offices within the region being transitioned by the 45th calendar day prior to the start of services delivery according to the specifications of the official transition schedule. The proposed mailing shall be submitted to the PCO and the COR for review, and the TMA C&CS Directorate for approval NLT 90 calendar days prior to the start of services. The mailing shall discuss any unique processing requirements of the contractor and any other needed information dictated by the official transition schedule.

3.0 INSTRUCTIONS FOR BENCHMARK TESTING

3.1 General

3.1.1 Prior to the start of services delivery, the contractor shall demonstrate the ability of its staff and its automated eligibility checking, and claims processing systems to accurately process TRICARE claims in accordance with current requirements, including receipt and processing of Medicare cross-over claims. This will be accomplished through a comprehensive Benchmark Test. The Benchmark Test is administered by the contractor under the oversight of TMA and must be completed NLT 60 days prior to the start of services delivery under this contract.

3.1.2 A benchmark shall consist of up to 1,000 claims, testing a multitude of claim conditions, including TRICARE covered and non-covered services, certified and non-certified providers, eligible and non-eligible beneficiaries. This benchmark may require up to 17 consecutive calendar days at the contractor's site.

3.1.3 A benchmark test is comprised of one or more cycles or batches of claims. When more than one cycle is used, each cycle may be submitted on consecutive days. Each cycle after the initial one will include new test claims, as well as claims not completed during preceding cycles. All aspects of claims processing may be tested, e.g., receiving and sending electronic transactions, provider file development and maintenance including interface with the National Provider System when implemented, screening, coding, data entry, editing, pricing, data management, data linking, record building, access control, etc.

3.1.4 The contractor shall demonstrate its ability to conduct eligibility checking, and claims processing functions to include: claims control and development, accessing and updating DEERS for eligibility status, calculating cost-shares and deductibles, querying and updating internal and external family and patient deductible and cost-share files on the Catastrophic Cap and Deductible Database (CCDD), submitting and modifying provider and pricing records, applying allowable charge parameters, performing duplicate checking, applying prepayment utilization review criteria, adjusting previously processed claims, demonstrating recoupment and offset procedures

Audits, Inspections, And Reports

1.0 GENERAL

1.1 TRICARE Management Activity (TMA) requires the contractor to prepare and submit routine workload and management reports used to establish a uniform format for recording data on contractor operations and to provide historical data for continued evaluation of contractor performance. While the data contained in the reports are essential to TMA for purposes of program management, they are equally essential for a contractor's management of the program. A contractor is accountable for assuring that reports contain accurate and complete data. Each contractor shall prepare written procedures describing the source of information as well as the specific steps followed in the collection and preparation of data for each report. In addition, the contractor shall establish a Quality Assurance (QA) program to assure a high degree of reporting accuracy. All reports must be supported with sufficient documentation and audit trails by the contractor for TMA on-site and desk audit inspections. All plans, reports, etc. shall be titled as listed here. For reports where there is no data to report, the contractor shall submit a report indicating no data.

1.2 Unless otherwise specified, contractors shall electronically submit all contract plans, reports, etc. in Microsoft Office XP. All plans, reports, etc. shall be submitted to TMA via the E-commerce Extranet (<https://tma-ecomextranet.ha.osd.mil>). This system permits the contractor to log on to a secure system and upload the required documents. Access to the extranet must be requested using the E-commerce Extranet Access Form which will be provided by the government. The system is accessed via the Internet through a workstation browser. The application is "thin client" meaning that no software needs to be installed on the client workstation and that no software is downloaded into the browser. Javascript and cookies need to be enabled in the browser to utilize the application. The application is best viewed at a resolution of 1024 X 768 pixels in an Internet Explorer (IE) browser. The system must be accessed using the Secure Socket Layer (SSL) protocol (<https://>) and is protected by individually assigned username and password. While files are being submitted over the Internet they are encrypted within the secure layer. When files are stored on the TRICARE server, they are renamed with a randomly generated name of varying length. Access to information is granted to users at the contract level. Information submitted by one contractor will not be accessible to any other contractor.

2.0 AUDITS AND INSPECTIONS

The contractor shall follow the requirements for audits and inspections as shown in [Chapter 14, Section 1](#).

3.0 TRANSITION REPORTS

3.1 Incoming Contractor Weekly Status Report

The contractor shall follow the requirements as stated in [Section 5, paragraph 2.4](#).

3.2 Outgoing Contractor Weekly Status Report

The contractor shall follow the requirements as stated in [Section 5, paragraph 4.3.7](#).

4.0 WEEKLY REPORTS

4.1 Claims Processing Statistics Report

This report shall be submitted to TMA, by noon, Mountain Time (MT) of the first workday of the week following the week reported. The following data shall be reported:

Claims (sorted by aging category)

- opening,
- pending,
- new receipts,
- adjustments identified,
- transfers,
- claims processed,
- adjustments processed,
- closing pending claims,
- closing pending adjustments, and
- ending inventory total

4.2 Claims Aging Report By Status Location

The contractor shall follow the requirements as stated in the contract.

5.0 MONTHLY REPORTS

5.1 Health Insurance Portability and Accountability Act (HIPAA) Privacy Complaint Report

The contractor shall follow the requirements as stated in [Chapter 19, Section 3, paragraph 2.5](#).

5.2 Toll-Free Telephone Report

The contractor shall follow the requirements as stated in the contract.

5.3 Financial Reports

5.3.1 Beneficiary and Provider Satisfaction Report

No later than the 10th calendar day following the end of the reported month, the contractor shall electronically submit a report to the Procuring Contracting Officer (PCO) and the

Contracting Officer's Representative (COR) on the state of beneficiary and provider satisfaction during the previous reporting period. The report shall address separately of both beneficiary satisfaction and provider satisfaction and contain the contractor's measurement and calculation of satisfaction. For any negative trends, the contractor shall describe what actions are being taken to mitigate further negative trends.

5.4 Beneficiary Service Report

The contractor shall follow the requirements as stated in the contract.

5.5 Monthly Workload Report

The contractor shall submit to the TMA, Claims Operations Branch and the TRICARE Regional Director, a TRICARE Contractor Monthly Workload Report, TMA Form 742. The report will cover the period beginning on the first day of the report month, and ending on the last day of the report month. (Separate data for each state within the contractor's jurisdiction is not required on a monthly basis, but must be available upon request from TMA.) The Monthly Workload Report is due on the 45th calendar day following the start date of the contract and then on the 15th calendar day of each month (or the first workday following the 15th calendar day if the 15th is not a business day) following the report period throughout the duration of the contract. Any adjustments to previously submitted data require an explanation of the differences, including the cause, either in the "Remarks" section or in a separate report. At the discretion of TMA, or as required by law, contractor performance statistics contained in this report may be released to the public. The contractor shall follow the instructions for preparation as stated in the contract requirements.

5.6 Monthly Cycle Time/Aging Report

The contractor shall submit to the TMA, Claims Operations Branch and the TRICARE Regional Director, a TRICARE Contractor Monthly Cycle Time/Aging Report, TMA Form 743. The report will cover the period beginning on the first day of the report month, and ending on the last day of the report month. (Separate data for each state within the contractor's jurisdiction is not required on a monthly basis, but must be available upon request from TMA.) The Cycle Time/Aging Report is due on the 45th calendar day following the start date of the contract and then on the 15th calendar day of each month (or the first workday following the 15th calendar day if the 15th is not a business day) following the report period throughout the duration of the contract. Any adjustments to previously submitted data require an explanation of the differences, including the cause, either in the "Remarks" section or in a separate report. At the discretion of TMA, or as required by law, contractor performance statistics contained in this report may be released to the public. The contractor shall follow the instructions for preparation as stated in the contract requirements.

6.0 QUARTERLY REPORTS

6.1 Fraud And Abuse Summary Report

The contractor shall follow the requirements as stated in the contract.

6.2 Congressional Visit Summary Report

The contractor shall follow the requirements as stated in the contract.

6.3 Claims Audit Report

The contractor shall follow the requirements as stated in the contract.

7.0 SEMIANNUAL/ANNUAL REPORTS

7.1 Internal Quality Management (IQM)/Quality Improvement (QI) Report

The contractor shall report to the COR any updates or changes to the program, problems identified and corrective actions planned/initiated and the month in which the action occurred. All updates or changes to the program are to be submitted within 20 calendar days of the update or change. If there have been no changes/corrective actions then a negative submission is due 30 calendar days following the end of each contract option period.

7.2 Fraud Prevention Savings Report

The contractor shall submit a Fraud Prevention Savings Report. This report shall be submitted No Later Than (NLT) 30 calendar days after the end of the calendar year as stated in [Chapter 13, Section 5](#).

7.3 Federal Medical Care/Third Party Liability (TPL) Recovery Claims Report

The contractor shall follow the requirements as stated in [Chapter 10, Section 5, paragraph 8.0](#).

7.4 Annual Risk Assessment Letter of Assurance

The contractor shall follow the requirements as stated in [Chapter 19, Section 3, paragraph 2.2.3](#).

8.0 SPECIAL REPORTS

8.1 Quality Control (QC) Program

The contractor shall follow the requirements as stated in [Chapter 1, Section 4](#).

8.2 IQM/Quality Improvement Program (QIP)

The contractor shall submit an [IQM/QIP Plan](#) to the COR within 30 calendar days of award.

8.3 IQM/QI Report

The contractor shall submit an Internal Quality Management/Quality Improvement Report to the COR within 10 calendar days following the reported month of problems identified and corrective actions planned/initiated.

- END -

Enrollment System (DOES). The contractor shall perform all premium and billing functions in accordance with [paragraph 5.0](#). and its subordinate paragraphs. The TOP contractor shall perform these services for TRS members residing outside of the 50 United States and the District of Columbia. See TRICARE Systems Manual (TSM) [Chapter 2, Addendum L](#) for a full list of TRS Health Care Delivery Plan (HCDP) Coverage Code Values.

4.1 Purchasing Coverage

To purchase TRS coverage, qualified RC members must complete the TRS request (DD Form 2896) and submit it, along with an initial payment of the appropriate monthly premium, within deadlines specified in the following paragraphs. The contractor shall collect completed TRS requests submitted at TRICARE Service Centers (TSCs), by mail, and by other means determined by the contractor. The contractor shall not process new coverage transactions into DOES unless the initial payment received for the first month of coverage is the correct amount (within one dollar) for the type of coverage. The procedures for determining the effective date of coverage are specified in the following paragraphs.

4.1.1 Continuation Coverage

A qualified member may purchase TRS coverage with an effective date immediately following the termination of coverage under another TRICARE program in which the member is the sponsor. The TRS request required by [paragraph 4.1](#) must be either received in the TSC or postmarked NLT 60 days after the termination of other TRICARE coverage.

4.1.2 Qualifying Life Events

A qualified member may purchase TRS coverage in connection with a Qualifying Life Event (QLE) that results in a change of family composition. First, qualified members are responsible to report all changes in family composition to a military personnel office with Real-Time Automated Personnel Identification System (RAPIDS) capability to appropriately update DEERS. Second, the TRS request required by [paragraph 4.1](#) must be either received in the TSC or postmarked NLT 60 days after the date of the QLE. The following QLEs are processed through DEERS and are recognized by TRS. The effective date of coverage is the date the QLE occurred (i.e., date of marriage, Date of Birth (DOB), etc.).

- Marriage;
- Birth or adoption of child;
- Placement of a child in the legal custody of the member by an order of the court for a period of at least 12 months;
- Divorce or annulment;
- Death of a spouse or family member;
- Last family member becomes ineligible (e.g., child ages out).

4.1.3 Continuously Open Enrollment

A qualified member may purchase TRS coverage throughout the year. If the request and premium payment required by [paragraph 4.1](#) is received in the TSC or postmarked by the last day of the month, the effective date of TRS coverage shall either be the first day of the next month or the first day of the second following month as indicated on the TRS request. Requests for next

month that are postmarked in that month will be processed with an effective date of the first day of the month following the postmark date.

4.1.4 Survivor Coverage Under TRS

If a Reserve sponsor dies while in a period of TRS coverage, the surviving family members may purchase (or continue) TRS coverage for up to six months beyond the date of the member's death. The effective date of TRS survivor coverage is the day after the date of death. Applicable premium rates are specified in [paragraph 2.0](#).

4.1.4.1 If TRS member and family coverage was in effect on the date of the member's death, DEERS will automatically transfer covered family members to TRS survivor coverage and establish an end eligibility date in DEERS six months from the date of the member's death. Defense Manpower Data Center (DMDC) will issue letters to survivors advising them of their continued coverage and their option to terminate coverage, if so desired, by completing a TRS request.

4.1.4.2 If TRS member-only coverage was in effect on the date of the member's death, DEERS will terminate coverage effective the date of death. Eligible family members may purchase coverage by completing a TRS request. The TRS request required by [paragraph 4.1](#) must be either received in the TSC or postmarked NLT 60 days after the date of death of the Selected Reservist. DMDC will issue letters to survivors advising them of the option to purchase coverage.

4.2 Changes in TRS Coverage

Once TRS coverage is in effect, members may request the following types of changes.

4.2.1 Type of Coverage Changes

A qualified member may change TRS type of coverage following procedure for a QLE specified in [paragraph 4.1.2](#) or procedures for open enrollment specified in [paragraph 4.1.3](#). The contractor shall follow procedures specified in [paragraph 5.5](#) for premium adjustments resulting from changes in coverage.

4.2.2 Addition Of Family Members to TRS Member and Family Coverage

TRS members may request to add eligible family members to an existing TRS member and family coverage plan at any time. They must first establish eligibility for the family member(s) by going to a military personnel office with RAPIDS capability to appropriately update DEERS (currently <http://www.dmdc.osd.mil/rsl/owa/home>). The effective date of coverage for the added family member(s) shall follow procedures specified in [paragraphs 4.1.2](#) or [4.1.3](#). The TRS request must be either received in the TSC or postmarked NLT 60 days after that date.

4.2.3 TRS Newborn/New Child Policy

4.2.3.1 A newborn/new child of a TRS member with member and family coverage in place shall have automatic TRS coverage for a period of 60 days from birth/custody. The newborn shall have continued coverage beyond 60 days only if, (a) the TRS member registers the newborn/new child in DEERS, and (b) the TRS request is either received in the TSC or postmarked NLT 60 days after the date of birth/custody. If the member fails to complete these actions as specified, the coverage for

4.4.4.1 Termination of Existing Plan(s)

The contractor shall accept requests for termination of coverage from TRS members at anytime. The effective date of termination is the last day of the month in which the request was postmarked or received in the TSC.

4.4.4.2 Termination of an Individual's Coverage

The contractor shall accept requests for termination of coverage for individual family members from TRS members at anytime. The effective date of termination is the last day of the month in which the request was postmarked or received in the TSC, unless otherwise specified.

4.4.4.3 Cancelled Eligibility and Enrollment

When the contractor receives a Policy Notification Transaction (PNT) for a cancelled enrollment, the contractor will generate a letter notifying the covered member of the cancellation and refund any unused portion of the premium payment.

4.4.5 TRS Survivor Coverage Termination

If TRS coverage is continued as described in [paragraph 4.1.4.1](#) and the survivors do not wish to keep the coverage, the survivors must submit a request for receipt by the contractor NLT 60 days after the date of death in order to terminate coverage retroactive to the day after the member's death. Alternatively, the survivor may request to terminate coverage in accordance with [paragraph 4.4.4](#). Otherwise, DEERS will terminate TRS survivor coverage established under [paragraph 4.1.4](#) six months after the date of the member's death. Refunds of premiums will be handled as specified in [paragraph 4.4](#).

4.5 Exceptions

4.5.1 Reconsiderations of Members Actions

The contractor shall advise TRS members that all reconsideration requests for a refusal of a late submission of a request to enroll shall be submitted to the appropriate TRICARE Regional Director (RD) for determination. The TRICARE RD will issue decisions within ten calendar days of receipt for all reconsideration requests. If changes are to be made to a member's coverage as a result of a reconsideration determination, the TRICARE RD will send instructions to the contractor. The contractor shall carry out such instructions NLT 10 days after receipt from the TRICARE RD.

4.5.2 Administrative Issues

The TRICARE RD will notify the contractor when the government determines that an administrative situation occurred that prevented a member's request from being accepted for processing according to submission deadlines specified in this section.

5.0 PREMIUM BILLING AND COLLECTION

The contractor shall perform all premium and billing functions required for TRS. Members are responsible for all premium payments for the type of coverage elected (i.e., TRS member-only or

TRS member and family). All billing will be monthly; neither annual nor quarterly billings are authorized.

5.1 Jurisdiction for Premium Billing and Collection

5.1.1 The particular regional contractor servicing the address provided on the TRS request for the TRS member shall perform premium billing and collection functions for the TRS member.

5.1.2 As part of each monthly bill, the contractor shall provide the opportunity for the TRS member to submit a change of address to the servicing contractor. At any time the servicing contractor notices that a new address is in another TRICARE region or outside of the 50 United States, the contractor shall initiate the actions necessary in DOES to transfer premium collection and other applicable administrative services to the new servicing contractor. The jurisdiction shall be based on the TRS member's reported new address. Any TRS member may transfer regions at any time. The gaining contractor shall perform the premium collections for delinquent and future payments.

5.2 New Coverage

The contractor shall credit the TRS member for premium payments received for new coverage. All bills shall specify that the premium payment is due for receipt by the contractor NLT the last calendar day of the current month for the following month of coverage. In the case of a start date of coverage at anytime other than the first of a month, the first bill generated by the contractor shall include the prorated amount on a daily basis necessary to synchronize billing to the first of the month. The daily prorated amount shall be equal to 1/30th of the appropriate premium (rounded to the penny) regardless of how many days are actually in the month.

5.2.1 The contractor shall accept payments by personal check, cashier's check, money order, credit/debit card (e.g., Visa/MasterCard) and Electronic Funds Transfer (EFT). An EFT payment shall be processed on the first business day of the month of coverage. The contractor shall not generate bills if the TRS member elects to use either the EFT or automatic credit/debit card payment method. The contractor shall advise members at the time of EFT election that an insufficient funds fee of up to \$20 U.S. will be assessed, if sufficient funds are not available.

5.2.2 The contractor shall be responsible for initiating EFTs and automatic credit/debit card payments with the member's financial institution upon being requested to do so, in writing, by the TRS member. The contractor shall direct bill the TRS member when a problem occurs in initially setting up the EFT or when there are insufficient funds to process a monthly EFT. The contractor may apply a fee of up to \$20 U.S. for insufficient funds. The contractor shall include notice of the fee of up to \$20 U.S. when billing the member. If the contractor is unable to obtain the requested premium payment from the TRS member's account for any reason after an EFT is established, the TRS member will be responsible for paying the overdue premiums and any insufficient funds fee by means of direct billing.

5.2.3 Premium payments shall be made payable to the contractor servicing the member's coverage as specified in [paragraph 5.1](#).

General

1.0 GENERAL

The TRICARE Pharmacy (TPharm) Benefits Program offers worldwide services through:

- Direct Care (DC) pharmacies located at Military Treatment Facilities (MTFs);
- Retail network pharmacies;
- A Mail Order Pharmacy (MOP) program including specialty pharmacy services; and
- Retail non-network pharmacies.

The requirements/guidelines in this chapter apply only to the TPharm contractor.

2.0 ELIGIBILITY

2.1 The TPharm Benefits Program is available to all TRICARE eligible beneficiaries, including Uniformed Service members, TRICARE Prime Remote (TPR) enrollees, TRICARE Dual Eligibles, and TRICARE Reserve Select (TRS) members. Eligible beneficiaries need not enroll in order to use the pharmacy program. The contractor will use the Defense Enrollment Eligibility Reporting System (DEERS) to verify TRICARE eligibility prior to dispensing pharmaceuticals (or paying any claim) for all beneficiaries.

2.2 Foreign Force Members (FFMs) and their dependents from countries that are party to a North Atlantic Treaty Organization (NATO), Status of Forces Agreement (SOFA), or Partnership For Peace (PFP) SOFA are eligible to receive pharmaceuticals or Durable Medical Equipment (DME) dispensed through retail pharmacies subject to the same rules regarding payment as are applicable to U.S. active duty members and dependents of active duty members using the TRICARE Standard/CHAMPUS program. Refer to www.tricare.mil/foreignforces/index.cfm to verify coverage.

2.3 Guard or service members who are injured or become ill while serving on active duty or performing official drills with their unit may be eligible for continued care/treatment associated with the specific episode of care once their active duty or drill status has terminated.

Documentation from Military Medical Support Office (MMSO) will serve as proof of eligibility and pharmaceutical claims will be processed for reimbursement. MMSO, per [Chapter 17, Section 2, paragraph 1.2](#), has authority to approve claims for drugs not covered under standard benefit guidelines.

3.0 APPLICABILITY OF TRICARE REQUIREMENTS

Unless waived or superseded by the provisions of this chapter or the contract, all normal TRICARE requirements set forth in the TRICARE Operations Manual (TOM), TRICARE Policy Manual (TPM), TRICARE Reimbursement Manual (TRM), and TRICARE Systems Manual (TSM) apply. Sections or language in these Manuals that obviously have no direct application to the pharmacy contractor

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do not apply (e.g., requirements related to enrolling beneficiaries in TRICARE Prime, requirements related to medical benefit determinations, etc.). The requirements in the following TOM chapters **do not** apply to the pharmacy contractor:

- Chapter 4, Provider Certification and Credentialing;
- Chapter 5, Network Development;
- Chapter 6, Enrollment;
- Chapter 7, Utilization and Quality Management;
- Chapter 9, TRICARE Duplicate Claims System (DCS) - TED Version;
- Chapter 11, Beneficiary and Provider Services (BPS);
- Chapter 14, Audits, Inspections and Reports;
- Chapter 15, Regional Director (RD)/MTF and Contractor Interfaces;
- Chapter 16, TRICARE Prime Remote (TPR) Program;
- Chapter 17, Supplemental Health Care Program (SHCP);
- Chapter 20, TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC);
- Chapter 21, TRICARE Alaska; and
- Chapter 22, TRICARE Reserve Select (TRS)

4.0 PERFORMANCE/PROCESSING STANDARDS

Performance standards for the TPharm Benefits Program are located in Section C of the contract. Additionally, the contractor shall comply with the TRICARE Encounter Data (TED) timeliness and TED accuracy standards included in [Chapter 1, Section 3](#).

5.0 SPECIALTY PHARMACEUTICALS

Specialty pharmaceuticals typically covered by the pharmacy contract are listed in [Addendum A](#). Products may be added or removed as necessary.

- END -

copayment amount.)

4.0 MEDICAL NECESSITY AND PRIOR AUTHORIZATION

4.1 Medical Necessity Reviews

The Government will determine the formulary status of all drugs. When a drug is designated as non-formulary, the contractor shall check to see if a medical necessity determination for the non-formulary drug has previously been completed for a Direct Care (DC) dispensing. Medical necessity determinations for DC dispensings will be made available from the Pharmacy Data Transaction System (PDTS). If PDTS shows that medical necessity has previously been determined, the contractor shall dispense the prescription applying a formulary copayment.

4.1.1 If a medical necessity determination has not previously been completed, the contractor shall apply the non-formulary copayment to the dispensed prescription. At the request of the beneficiary or provider, the contractor shall conduct a medical necessity review using Government-provided review criteria. If the contractor establishes medical necessity, the prescription shall be dispensed with the formulary copayment amount applied.

4.1.2 The contractor will be given at least a 30-day notice before a drug is moved to a non-formulary status. Non-formulary drugs, medical necessity forms, and review criteria can be found at <http://www.tricare.mil/pharmacy>.

4.1.3 In general, in order to establish medical necessity for a pharmaceutical agent designated non-formulary under the Uniform Formulary Rule, one or more of the following criteria must be met for ALL of the available formulary alternatives:

4.1.3.1 The use of the formulary alternative is contraindicated;

4.1.3.2 The patient experiences, or is likely to experience, significant adverse effects from the formulary alternative, and the patient is reasonably expected to tolerate the non-formulary medication;

4.1.3.3 The formulary alternative results in therapeutic failure, and the patient is reasonably expected to respond to the non-formulary medication;

4.1.3.4 The patient previously responded to a non-formulary medication, and changing to a formulary alternative would incur unacceptable clinical risk; or

4.1.3.5 There is no formulary alternative.

4.2 Prior Authorizations

Some medications require prior authorization before being dispensed through the mail order program or by a retail network pharmacy. Medications requiring prior authorization include, but may not be limited to, those established as such by the Government, brand name medications with a generic equivalent, medications with age limitations, and medications requiring a quantity limit override. Before a prescription is dispensed, the contractor shall check to see if a prior authorization for the medication in question currently exists. Prior authorizations for DC dispensings will be made

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available by PDTS. If a valid authorization exists, the contractor shall dispense the prescription. If a prior authorization has previously not been completed, the contractor shall complete a prior authorization review before the prescription can be dispensed. Drugs requiring prior authorization, prior authorization forms, and review criteria can be found at www.tricare.osd.mil/pharmacy.

Note: Government review criteria are not available for all circumstances requiring prior authorization. If Government review criteria are not available, the contractor shall develop review criteria for these circumstances. For example, there is no Government-provided review criteria for quantity limit overrides.

- END -

Administration

1.0 GENERAL

All TRICARE requirements regarding administration shall apply to the TRICARE Overseas Program (TOP) unless specifically waived or superseded by this section or the TRICARE contract for health care support services outside the 50 United States and the District of Columbia (hereinafter referred to as the "TOP contract"). See [Chapter 1](#) for additional instructions regarding administration. Specific health care support services required for the performance of this contract are identified in this chapter, in the TRICARE Policy Manual (TPM), [Chapter 12](#), and the TOP contract.

2.0 CONTRACT ADMINISTRATION AND INSTRUCTIONS TO CONTRACTOR

2.1 The provisions of [Chapter 1, Section 2](#) are applicable to the TOP. Additionally, the TOP contractor shall coordinate with the TRICARE Management Activity (TMA) Contracting Officer (CO), the appropriate TMA Contracting Officer Representative (COR), and the appropriate TRICARE Area Office (TAO) Director on any TOP policy or contractual issue that requires additional government assistance to resolve.

2.2 The provisions of [Chapter 1, Section 2, paragraph 4.0](#) are superseded as described in [paragraphs 2.2.1](#) through [2.2.3](#).

2.2.1 A 14 calendar day notice will be provided by the TMA Procurement Contracting Officer (PCO) for all meetings hosted by TMA.

2.2.2 The TOP contractor shall provide annual representation at two contractor conferences (senior management level) and one Host Nation Provider Representative meeting at TMA. The contractor shall also provide up to four contractor representatives at up to four additional meetings at the direction of the CO per contract year.

2.2.3 The TOP contractor shall provide representation at quarterly TOP roundtable meetings to be held at TMA-Falls Church with TAO representation.

3.0 TRICARE PROCESSING STANDARDS

See [Chapter 1, Section 3](#) for instructions regarding TRICARE processing standards.

4.0 MANAGEMENT

The provisions of [Chapter 1, Section 4](#) are applicable to the TOP, except that the provisions of [Chapter 1, Section 4, paragraph 2.3](#) regarding zip code files are only applicable to Puerto Rico.

5.0 COMPLIANCE WITH FEDERAL STATUTES

See [Chapter 1, Section 5](#) for instructions regarding compliance with Federal statutes.

6.0 LEGAL MATTERS

See [Chapter 1, Section 6](#) for instructions regarding legal matters.

7.0 TRANSITIONS -- CONTRACT PHASE-IN

7.1 Start-Up Plan

The provisions of [Chapter 1, Section 7, paragraph 1.1](#) are applicable to the TOP, except that the contractor's comprehensive start-up plan shall be submitted with their contract proposal (instead of 10 calendar days following contract award). A revised start-up plan shall be submitted within 15 calendar days following the interface meetings.

7.2 Transition Specifications Meeting

See [Chapter 1, Section 7, paragraph 1.2](#) for instructions regarding transition specification meeting(s). Separate meetings may be scheduled with each outgoing TOP contractor.

7.3 Interface Meetings

The provisions of [Chapter 1, Section 7, paragraph 1.3](#) are applicable to the TOP, except that the requirement for interface meeting(s) with the outgoing Managed Care Support Contractor (MCSC) is replaced with a requirement for interface meetings with all outgoing overseas contractors. This includes the outgoing South Region MCSC (and its subcontractor for overseas claims processing), the outgoing TRICARE Global Remote Overseas (TGRO) contractor, the outgoing TRICARE Puerto Rico contractor, and all outgoing TAO regional enrollment/marketing contractors.

8.0 TRANSITIONS -- START-UP REQUIREMENTS

8.1 See [Chapter 1, Section 7, paragraphs 2.1, 2.2, and 2.3](#) for instructions regarding start-up requirements. For purposes of TOP implementation, all references to TRICARE Prime in [paragraph 2.2](#) shall apply to TOP Prime and TOP Prime Remote.

8.2 Within 30 calendar days following contract award, all Military Treatment Facilities (MTFs) shall provide the TOP contractor with the names and addresses of host nation providers/facilities in the MTF's Preferred Provider Network (PPN). The TOP contractor is not required to duplicate existing networks.

8.3 See [Chapter 1, Section 7, paragraphs 2.4.1 and 2.4.2](#) for instructions regarding Memorandums of Understanding (MOUs). In addition to the MOU requirements in these referenced paragraphs, the TOP contractor shall also execute an MOU with each TAO Director No Later Than (NLT) 60 calendar days prior to the start of health care delivery, with copies to the PCO and the COR within 10 calendar days following MOU execution.

2.5.5 Overseas ambulance service claims shall be paid following the instructions in [Section 7](#) and [Chapter 8, Section 1](#).

2.5.6 Payment may be made for ambulance services provided by commercial transport (see [Section 7](#) for additional processing instructions for these claims).

2.5.7 The provisions of [Chapter 3, Section 2, paragraph 2.2](#) are not applicable to the TOP. The TOP contractor may not require host nation providers who submit claims electronically to accept an electronic remittance advice and to receive payment by Electronic Funds Transfer (EFT). These electronic processes are optional for host nation providers since they may create a financial burden for the provider.

3.0 FINANCIAL ADMINISTRATION

3.1 The TOP contractor shall follow the Financial Administration non-financially underwritten funds requirements in [Chapter 3](#) with the following exceptions:

3.1.1 Foreign overseas drafts (local currency) and checks (U.S. currency) shall also reflect "TRICARE Overseas Program".

3.1.2 Foreign overseas drafts shall also reflect information that indicates the draft is valid for 190 days and if reissue is required/necessary, the draft must be returned to the overseas claims processing contractor with a request for reissuance. The contractor shall issue drafts/checks for Germany claims which look like local German drafts/checks.

3.2 The TRICARE Encounter Data (TED) for the overseas claims shall be reported on vouchers/batches according to the TRICARE Systems Manual (TSM), [Chapter 2](#) and as follows for remote sites:

3.2.1 Active Duty Family Member (ADFM) and ADSM remote site claims, excluding health care claims for emergent/urgent care for Navy and Marine Corps ADSM who are either deployed and or deployed on liberty status in a remote site shall be submitted on vouchers instead of batches and shall be paid from the current non-financially underwritten foreign bank account. They shall be submitted like all other claims currently processed from that account.

3.2.2 Navy deployed and/or deployed on liberty emergent or urgent care claims shall be submitted on a separate voucher. A separate bank account will be established for these beneficiaries. The Automated Standard Application for Payment (ASAP) account on the voucher header will identify the voucher as Navy.

3.2.3 Marine Corps deployed and/or deployed on liberty emergent or urgent care claims shall be submitted on a separate voucher. A separate bank account will be established for these beneficiaries. The ASAP account on the voucher header will identify the voucher as Marine Corps.

3.2.4 Retirees and their dependents living in a remote site health care claims shall be submitted on vouchers instead of batches and shall be paid from the current non-financially underwritten bank account. They shall be submitted on the same voucher as all other claims currently processed from that account.

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3.2.4.1 Claims for care rendered in the United States or the District of Columbia to TOP ADSM, ADFM, retirees and their dependents living in a remote overseas site shall be submitted on vouchers and shall be paid from the current non-financially underwritten bank account. They shall be submitted on the same voucher as all other claims currently processed from that account.

3.3 For other than remote site claims:

3.3.1 TRICARE Europe ADSM claims shall be submitted on batches and the contractor shall on a monthly basis, submit a request for payment of TRICARE Europe ADSM overseas claims in the format of a single bill delineated by military branch of service to Defense Finance and Accounting Service (DFAS), Europe. Each bill shall include total weekly charges separated by benefit dollars with administrative charges per claim. Additionally each bill shall be accompanied by a monthly summary report of total expenditures by currency (e.g., for the month of January \$600,000 worth of claims were paid, of the \$600,000, \$300,000 were paid in Euros, \$200,000 were paid in Kronas, etc.). A copy of this report identifying Public Health Service (PHS) and National Oceanic and Atmospheric Administration (NOAA) ADSM claims shall also be sent to the Public Health Service Point of Contact (POC), at Medical Affairs Branch, 5600 Fishers Lane, Room 4C-04, Rockville, MD 20874.

3.3.2 TOP eligible ADFM claims shall be submitted on vouchers and shall be paid from the current non-financially underwritten bank account. They shall be submitted on the same voucher as all other claims currently processed from that account.

3.3.3 Retirees and their dependents living overseas claims shall be submitted on vouchers and shall be paid from the current non-financially underwritten or TFL/accrual fund bank accounts. They shall be submitted on the same voucher as all other claims currently processed from that account.

3.3.4 TOP Prime (ADSM and ADFM) and TOP Standard beneficiary stateside claims for health care shall be submitted on vouchers and shall be paid from the current non-financially underwritten bank account. They shall be submitted on the same voucher as all other claims currently processed from that account.

3.3.5 Overseas health care claims for stateside beneficiaries whose health care is normally provided under one of the three regional Managed Care Support Contracts (MCSCs) (i.e., beneficiaries enrolled or residing in the 50 United States or the District of Columbia, who receive care while traveling or visiting abroad) shall be processed by the TOP contractor. Claims for these beneficiaries shall be paid from the current non-financially underwritten bank account. This provision does not apply to beneficiaries who are enrolled to the Uniformed Services Family Health Plan (USFHP) or the Continued Health Care Benefit Program (CHCBP). Claims for these beneficiaries are processed by their respective contractor regardless of where the care is rendered.

3.3.6 TRICARE Latin America/Canada (TLAC) and TRICARE Pacific ADSM claims shall be submitted on vouchers and shall be paid from the current non-financially underwritten bank account. They shall be submitted on the same voucher as all other claims currently processed from that account.

3.4 The TOP contractor shall provide TRICARE Overseas Currency reports identifying the gain or loss for the month reported to arrive by the 10th calendar day following the month reported. The

TRICARE Overseas Program (TOP) Eligibility And Enrollment

1.0 GENERAL

All TRICARE requirements regarding eligibility, enrollments, re-enrollments, disenrollments, and transfers shall apply to the TRICARE Overseas Program (TOP) unless specifically waived or superseded by the provisions of this section or the TRICARE contract for health care support services outside the 50 United States and the District of Columbia (hereinafter referred to as the "TOP contract"). See [Chapter 6](#); the TRICARE Policy Manual (TPM), [Chapter 10](#); and the TRICARE Systems Manual (TSM) for additional instructions.

2.0 ELIGIBILITY

2.1 Eligibility for TRICARE is verified via the Defense Enrollment Eligibility Reporting System (DEERS). The DEERS record will indicate the dates of eligibility. Except for newborns, only those beneficiaries who are shown as eligible on DEERS will be enrolled or receive benefits under the TOP. If a beneficiary's date of birth is within 365 days of the contractor's query to DEERS, the contractor shall consider the newborn to be eligible for TRICARE benefits. In addition to DEERS eligibility, TOP Active Duty Family Members (ADFM) are required to demonstrate Command Sponsorship to be eligible for TOP Prime and TOP Prime Remote enrollment unless a specific exception exists. The TOP contractor shall verify DEERS eligibility (and Command Sponsorship, where required) prior to enrolling beneficiaries into TOP.

Note: Family members of the Armed Forces of foreign North Atlantic Treaty Organization (NATO) nations are not eligible for the TOP.

3.0 ENROLLMENT PROCESSING

3.1 TOP Prime and TOP Prime Remote are available to Active Duty Service Members (ADSMs) and certain ADFMs in overseas locations as described below. These programs are similar, but not identical, to TRICARE Prime and TRICARE Prime Remote (TPR)/TRICARE Prime Remote for ADFMs (TPRADMs) in the United States. TOP Prime enrollees shall normally be enrolled to an Military Treatment Facility (MTF) Primary Care Manager (PCM), but enrollment to a host nation PCM may be authorized when MTF capacity is reached. TOP Prime enrollment procedures shall be established in the Memorandum Of Understanding (MOU) between the TOP contractor and the MTF Commander. TOP Prime Remote enrollees shall be enrolled to a remote Defense Medical Information System (DMIS) code with assignment to a host nation PCM or to the TOP contractor, according to the specific regional enrollment procedures established in the MOUs between the contractor and the TRICARE Area Office (TAO) Directors.

3.2 Unless a specific exception exists, enrollment to TOP Prime or TOP Prime Remote is available only to ADSMs who are permanently assigned overseas, and to ADFMs who are Command Sponsored and accompanying their sponsor on his/her overseas tour, or on orders in an overseas

location (see [paragraph 5.1](#) for additional information regarding Command Sponsorship). This includes activated Reserve Component (RC) ADSMs who are on orders to an overseas location for more than 30 days, and their Command Sponsored ADFMs who accompany the RC member on his/her overseas tour or are on orders in an overseas location.

3.3 Non-Command Sponsored ADFMs, retirees, and retiree family members are not eligible for TOP Prime or TOP Prime Remote enrollment in any overseas location. This long-standing limitation derives from the limited number and capacity of MTFs and staff in overseas locations, coupled with their mission-critical requirement to provide Prime coverage for ADSMs as their first priority, and to Command Sponsored ADFMs as their second priority. ADFMs who are not Command Sponsored or on military orders as described in this section will be covered by TOP Standard (see [Section 19](#)).

3.4 Enrollment may occur at any time after TOP eligibility has been established, and normally remains effective during the overseas tour of the sponsor. Annual re-enrollment is not required for TOP Prime or TOP Prime Remote. Once enrolled, ADFMs remain enrolled in these programs until they disenroll, transfer enrollment to another TRICARE region/program, or lose eligibility for TRICARE, TOP Prime, or TOP Prime Remote. ADSMs remain enrolled in these programs until they transfer enrollment to another TRICARE region/program, or lose eligibility for TRICARE.

3.5 The TOP contractor shall perform all enrollment-related activities for TOP Prime, TOP Prime Remote, TRICARE Plus, and TRICARE Reserve Select (TRS) in overseas locations. These activities include validation of eligibility, enrollment, re-enrollment, disenrollment, transfers, updating information in DEERS, clearing enrollment discrepancies, assign or change PCM, collecting Other Health Insurance (OHI) information, and related enrollment functions. The contractor shall use the approved TRICARE Enrollment Application for enrollment activities and shall reproduce the form as necessary to ensure ready availability to all potential enrollees.

Note: Overseas insurance plans such as German Statutory Health Insurance, Japanese National Insurance (JNI), and Australian Medicare, etc., are considered OHI.

3.6 Enrollments for TOP Prime or TOP Prime Remote are effective on the date the enrollment form is signed (and appropriate Command Sponsorship orders are received, when applicable), unless a retroactive enrollment has been authorized by the TAO Director or designee. For TOP emergency cases that should be placed under immediate case management, TOP MTF commanders and/or the TAO Directors may approve exceptions on a case-by-case basis for retroactive TOP enrollment. Except for administrative errors, the effective date for retroactive enrollments shall not be earlier than the first day of the month that the application is submitted (see the TPM, [Chapter 10, Section 2.1](#)).

3.7 The contractor shall follow guidance from the TAO Directors and the MTFs regarding PCM assignment when enrolling beneficiaries into TOP Prime. The MTF enrollment area encompasses a 40-mile radius or a one-hour drive time from the MTF. TOP Prime Remote beneficiaries will be enrolled to the appropriate DMIS code for the beneficiary's remote overseas location. TOP Prime Remote enrollees in Canada will follow guidance applicable to the US and Canada Reciprocal Health Care Agreement, and may be assigned to a Canadian Forces Health Facility for their primary care.

3.8 Newborns/adoptees are deemed to be enrolled for 60 days following birth/adoption when one other family member, to include the sponsor, is enrolled in TOP Prime/TOP Prime Remote.

Parents of newborns/adoptees are required to take specific action to enroll the newborn/adoptee within 60 calendar days of birth/adoption. For newborns and newly adopted children who are deemed enrolled, Point of Service (POS) cost-sharing does not apply through the deemed enrollment period, or until an enrollment decision is made by a responsible representative, whichever is earlier. If the newborn/adoptee is not formally enrolled to TOP Prime or TOP Prime Remote during the 60-day period, the newborn/adoptee will revert to TRICARE Standard effective the 61st day, unless the deemed enrollment period has been waived. TAO Directors may extend the deemed enrollment period for newborns/adoptees up to 120 days on a case-by-case or regional basis. TAO Directors shall advise TRICARE Management Activity (TMA) Contracting Officer (CO) in writing when a region-wide enrollment waiver has been authorized. The TMA CO will notify the TOP contractor of any waivers to the 60-day deemed enrollment period in writing at the time the waiver is implemented, and this information shall be incorporated into the Memorandum of Understanding (MOU) between the contractor and the TAO Director(s).

Note: Newborns/adoptees of RC members who are called to active duty for more than 30 consecutive days are eligible for TOP/TRICARE benefits the same as other TRICARE eligible beneficiaries.

3.9 The provisions of [Chapter 6, Section 1](#) and the TPM, [Chapter 10, Section 2.1](#) regarding Prime enrollment fees shall not apply to TOP Prime or TOP Prime Remote. There are no enrollment fees associated with TOP Prime or TOP Prime Remote.

4.0 ENROLLMENT POLICY FOR ADSMs

4.1 Except as described in [paragraph 4.2](#), all ADSMs who are permanently assigned to an overseas duty location must be enrolled into the TOP program that is available in their area. This includes RC ADSMs who are called to active duty for more than 30 consecutive days with a final assignment to an overseas duty station.

4.2 ADSMs assigned to operational forces with assigned organic medical assets may be enrolled to an operational forces' DMIS ID affiliated with its "Parent" DMIS. This includes activated RC members on duty in combatant theaters of operation with existing or imbedded organic medical treatment and support capabilities for health care. Enrollment to a Service or Region-specific operational forces' DMIS for all ADSMs should occur prior to deployment.

5.0 ENROLLMENT POLICY FOR ADFMs

5.1 ADFMs who have Permanent Change of Station (PCS) orders to accompany the sponsor overseas or service-funded orders to relocate overseas without the sponsor are eligible for TOP Prime or TOP Prime Remote enrollment. In order to enroll in these programs, ADFMs must meet the definition of Command Sponsorship in the Joint Federal Travel Regulation (JFTR), Volume I, Appendix A (available at <https://secureapp2/hqda.pentagon.mil/perdiem/>) unless one of the following exceptions exists:

5.1.1 If the ADSM and his/her Command Sponsored ADFM(s) are enrolled in TOP Prime or TOP Prime Remote, and the sponsor is reassigned on unaccompanied PCS orders to a location that does not permit Command Sponsored family members, the family member(s) may retain their TOP enrollment for a period based on the length of the sponsor's unaccompanied orders (but not to exceed two years). In order to retain TOP enrollment in this situation, the family member(s) must

continue to be Command Sponsored and may not relocate elsewhere during the sponsor's PCS move.

5.1.2 If the ADFM(s) are authorized to relocate to an overseas location per the sponsor's PCS orders in accordance with JFTR U5222, or per Noncombatant Evacuation Orders without the sponsor, then the ADFM(s) are eligible for enrollment in the appropriate TOP program consistent with their orders.

5.1.3 If the ADFM(s) resided in an overseas location prior to the activation/mobilization of a RC sponsor, then the ADFM(s) are eligible for enrollment in the appropriate TOP program based on the residential mailing address of the sponsor prior to activation/mobilization. The ADFM(s) must have had the same overseas residential address as the sponsor at the time of activation/mobilization.

5.1.4 If the ADFM(s) are currently enrolled in TOP Prime or TOP Prime Remote, and the family has a newborn or adopts a child, then the new family member will be eligible to enroll in the same TOP program.

5.1.5 If the ADFMs are eligible for Transitional Survivor benefits (see Enrollment Policy for Transitional Survivors below).

Note: Command Sponsorship is defined in the JFTR, Volume I, Appendix A at <https://secureapp2.hqda.pentagon.mil/perdiem/>.

5.2 ADFMs who choose to reside overseas but are not Command Sponsored as defined in the JFTR, and who do not meet any of the exceptions listed above, are not eligible for enrollment in TOP Prime or TOP Prime Remote. These ADFMs are eligible for TRICARE Standard, TRICARE Plus (where available) or MTF care on a space-available basis only.

5.3 Eligibility for TOP enrollment normally requires the family to be accompanied by the sponsor; therefore, a family member cannot relocate within the overseas region, relocate to another overseas region, or relocate from a overseas location to an overseas location and transfer enrollment except as specified under the exceptions in this section.

5.4 The TOP contractor shall verify that all of the above requirements are met (including DEERS eligibility check and validation of Command Sponsorship/military orders, if required) prior to enrolling an ADFM into TOP Prime or TOP Prime Remote.

5.5 The process for identifying ADFMs who are Command Sponsored may vary by Service. This is a Service personnel decision and as such, these processes may change over the life of the contract. The TOP contractor may accept any current, valid method of identifying Command Sponsorship to meet the TOP enrollment requirements (e.g., Navy ADFMs who are not listed on the sponsor's orders, but who are in receipt of a letter from the Navy Personnel Services Division (PSD)).

6.0 ENROLLMENT POLICY FOR TRANSITIONAL SURVIVORS

The general provisions of TPM, [Chapter 10, Section 7.1](#) regarding Transitional Survivors shall apply to the TOP. Specific guidelines for Overseas Transitional Survivor benefits are listed below.

Ambulance/Aeromedical Evacuation Services

1.0 GENERAL

All TRICARE requirements regarding ambulance/aeromedical evacuation services shall apply to the TRICARE Overseas Program (TOP) unless specifically waived or superseded by the provisions of this section or the TRICARE contract for health care support services outside the 50 United States and the District of Columbia (hereinafter referred to as the "TOP contract"). See [32 CFR 199.4](#) and the TRICARE Policy Manual (TPM), [Chapter 8, Section 1.1](#) for additional instruction.

2.0 CONTRACTOR RESPONSIBILITIES

2.1 The TOP contractor shall arrange for medically necessary ambulance/aeromedical evacuation services for TRICARE Overseas Program (TOP) Prime/TOP Prime Remote enrollees, Active Duty Service Members (ADSMs) who are deployed, in a temporary duty status, or in an authorized leave status in an overseas location, and all Prime enrolled Active Duty Family Members (ADFM) (regardless of enrollment location) who require ambulance/aeromedical evacuation services while traveling outside of the 50 United States and the District of Columbia (including ADFMs enrolled in TOP Prime, TOP Prime Remote, TRICARE Prime, or TRICARE Prime Remote for ADFMs) according to the processes identified in the TOP contract.

2.1.1 When arranging for ambulance/aeromedical evacuation for the beneficiaries identified in [paragraph 2.1](#), the contractor shall establish medical necessity, identify the most appropriate method of evacuation, schedule the evacuation with the most appropriate resource, authorize the services, arrange for medical records to accompany the patient, and coordinate the transfer with the receiving institution or provider.

2.1.2 For ADSM emergency medical evacuations (including ADSMs who are on temporary duty, in an authorized leave status, or deployed/deployed on liberty), the TOP contractor shall ensure that the ADSM's unit is aware of the medical evacuation. The TRICARE Area Office (TAO) shall be contacted for assistance if the member's unit information cannot be determined by the contractor.

2.1.3 Except for normal TRICARE cost-shares, these beneficiaries shall not be responsible for any up-front payments for emergency ambulance service (to include aeromedical evacuation, when medically necessary and appropriate). The contractor shall establish business processes (e.g., Guarantee of Payment to host nation ambulance provider) to ensure that these beneficiaries are not subjected to up-front payments in excess of normal TRICARE cost-shares.

Note: "Medical necessity" is defined in [32 CFR 199.2](#).

2.2 Upon request, the TOP contractor shall facilitate medically necessary ambulance/aeromedical evacuation services for all TRICARE-eligible beneficiaries not identified in [paragraph](#)

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2.1 (regardless of enrollment location or residence) according to the processes identified in the TOP contract. When facilitating ambulance/aeromedical evacuation for these beneficiaries, the contractor shall identify ambulance/aeromedical evacuation resources that service the patient's location; however, the contractor is not required to schedule the evacuation, coordinate with the receiving institution or provider, obtain medical records, or establish business processes (e.g., Guarantee of Payment) to limit up-front payments for these beneficiaries.

2.3 Since medical evacuations may involve transfers between TRICARE regions, the TOP contractor shall establish processes for coordinating medical evacuations with the stateside Managed Care Support Contractors (MCSCs). The TOP contractor shall also work cooperatively with the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) contractor to provide customer service support, and to facilitate the medically necessary evacuation of TRICARE dual-eligible beneficiaries back to the United States.

2.4 The TOP contractor shall ensure that ambulance/aeromedical evacuation services can be accomplished in an expeditious manner that is appropriate and responsive to the beneficiary's medical condition. The contractor may establish a dedicated unit for responding to such requests, or may augment existing service units. Contractor staff must be available for ambulance/aeromedical evacuation assistance 24 hours per day, seven days per week, 365 days per year. Ambulance/aeromedical evacuation telephone assistance must be available without toll charges to the beneficiary, regardless of their location.

2.5 The TOP contractor shall maximize the use of military medical transport services before considering other options. If military medical transport services are not available (or if services cannot be provided in a timely manner that is appropriate for the patient's medical condition), the contractor shall attempt to arrange services through the most economical commercial resource that is capable of providing appropriate services within the required time frame. Private, chartered evacuation services will only be used as a last resort when all other options have been exhausted. The contractor shall document their rationale and selection process for any commercial and/or private, chartered evacuation services. If multiple resources are identified that are capable of providing the needed services, the contractor shall select the resource that represents the best value to the government. Upon request, the contractor shall provide TRICARE Management Activity (TMA) with documentation supporting their rationale and selection process.

2.6 Upon transfer to a facility for stabilization and care, the TOP contractor shall coordinate with the appropriate MTF (for TOP Prime enrollees) or TAO (for TOP Prime Remote enrollees) to advise of the patient's transfer and to provide further assistance as appropriate.

2.7 The TOP contractor is required to comply with the provisions of TPM, [Chapter 8, Section 1.1](#), except that the TOP contractor shall utilize the coding requirements identified for ambulance charges but is not required to develop claims for diagnosis or transfer information for ambulance services received overseas. The TOP contractor shall utilize the diagnosis if provided, or may use available in-house methods such as claims history when processing the claim.

- END -

Claims Processing Procedures

1.0 GENERAL

1.1 The provisions of [Chapter 8, Section 1, paragraph 1.0](#) are applicable to the TRICARE Overseas Program (TOP).

1.2 The provisions of [Chapter 8, Section 1, paragraph 2.1](#) are applicable to the TOP. Additionally, a designated TOP Point of Contact (POC) may submit claims in accordance with [Section 12](#).

1.3 The provisions of [Chapter 8, Section 1, paragraph 2.2](#) are not applicable to the TOP, except in U.S. territories where Medicaid is available.

1.4 The provisions of [Chapter 8, Section 1, paragraph 2.3](#) are applicable the TOP; however, region or country-specific requirements regarding third party payments or payment addresses may be established by TRICARE Management Activity (TMA) at any time to prevent or reduce fraud.

Note: Benefit payment checks and Explanation Of Benefits (EOB) to Philippine providers (and other nation's providers as determined by the government) shall be mailed to the place of service identified on the claim. This policy applies even if the provider uses a Third Party Administrator (TPA). No provider payments may be sent to any other address. The government may discontinue TPA payments to other countries or specific agencies if it is determined that significant fraud is occurring on a regular basis.

1.5 The TOP contractor shall comply with the provisions of [Chapter 8, Section 1, paragraph 3.1](#) regarding acceptable claims forms.

1.6 The provisions of [Chapter 8, Section 1, paragraph 4.0](#) are applicable to the TOP.

1.7 The contractor's claims processing procedures shall integrate efforts to prevent and identify fraud/abuse.

2.0 JURISDICTION

2.1 In the early stages of TOP claims review, the TOP contractor shall determine whether claims received are within its contractual jurisdiction using the criteria below. TOP jurisdiction for health care and remote Active Duty Service Member (ADSM) dental care is identified in the TOP contract with TRICARE Management Activity (TMA).

2.2 Services rendered onboard a commercial ship while outside U.S. territorial waters are the responsibility of the TOP contractor. Claims for services provided on a commercial ship that is outside the territorial waters of the United States (U.S.) are to be processed as foreign claims regardless of the provider's home address. If the provider is certified within the U.S., reimbursement

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for the claim is to be based on the provider's home address. If the provider is not certified within the U.S., reimbursement will follow the procedures for foreign claims. This does not include health care for enrolled ADSM on a ship at sea or on a ship at home port.

2.3 The provisions of [Chapter 8, Section 2, paragraphs 1.0](#) and [2.0](#) are superseded as described in [paragraphs 2.3.1](#) through [2.3.11](#)

2.3.1 When a beneficiary is enrolled in TOP Prime or TOP Prime Remote, the TOP contractor shall process all health care claims for the enrollee, regardless of where the enrollee receives services. The contractor shall also process dental care claims for remote overseas ADSMs per the provisions of [Section 10](#). Referral/authorization rules apply.

2.3.2 Claims for Active Duty Family Members (ADFM) (including Reserve Component (RC) ADFMs whose sponsors have been activated for more than 30 days), retirees, and retiree family members whose care is normally provided under one of the three regional Managed Care Support Contracts (MCSCs) (i.e., beneficiaries enrolled or residing in the 50 United States and the District of Columbia) who receive civilian health care while traveling or visiting overseas shall be processed by the TOP contractor, regardless of where the beneficiary resides or is enrolled. Referral/authorization and Point Of Service (POS) rules apply for TRICARE Prime/TRICARE Prime Remote (TPR) enrollees.

Note: This provision does not apply to beneficiaries who are enrolled to the Uniformed Services Family Health Plan (USFHP) or the Continued Health Care Benefit Program (CHCBP). Claims for these beneficiaries are processed by their respective contractor regardless of where the care is rendered.

2.3.3 Claims for ADSMs residing in the 50 United States and the District of Columbia (including RC ADSMs activated for more than 30 days) who are on Temporary Additional Duty/Temporary Duty (TAD/TDY), deployed, deployed on liberty, or in an authorized leave status in an overseas location shall be processed by the TOP contractor, regardless of where the ADSMs resides or is enrolled. Referral/authorization rules apply.

2.3.4 Claims for TOP-enrolled ADSMs (including RC ADSMs activated for more than 30 days) on a ship or with an overseas home port overseas care shall not be processed by the member's military unit. These claims shall be processed by the TOP contractor.

2.3.5 Claims for RC ADSMs on orders for 30 consecutive days or less, who are injured while traveling to or from annual training or while performing their annual training who receive civilian medical care overseas, shall have their claims processed by the TOP contractor in coordination with the Military Medical Support Office (MMSO).

2.3.6 Claims for other than remote site ADSMs in Europe shall have their claims submitted on batches and paid in accordance with [Section 3, paragraph 3.3.1](#).

2.3.7 The TOP contractor shall process Pacific ADSM and TRICARE Latin America/Canada (TLAC) ADSM claims for self-referred care following the claims processing guidelines for TRICARE Europe ADSM claims, except that TLAC and Pacific ADSM claims shall be submitted on vouchers instead of batches, and TRICARE Pacific ADSM claims shall be processed without an authorization for urgent/emergent care.

8.0 EOB VOUCHERS

8.1 The TOP contractor shall follow the EOB voucher requirements in [Chapter 8, Section 8](#), where applicable, with the following exceptions and additional requirements:

8.1.1 The letterhead on all TOP EOB shall also reflect "TRICARE Overseas Program" and shall be annotated Prime or Standard.

8.1.2 TOP EOB may be issued on regular stock, shall provide a message indicating the exchange rate used to determine payment and shall clearly indicate that "This is not a bill".

8.1.3 TOP EOB shall include the toll-free number for beneficiary and provider assistance.

8.1.4 TOP EOB for overseas enrolled ADSM claims shall be annotated "ACTIVE DUTY."

8.1.5 For Point of Sale or Vendor pharmacy overseas claims, TOP EOB must have the name of the provider of service on the claim.

8.1.6 For beneficiary submitted pharmacy claims, TOP EOB shall contain the name of the provider of service, if the information is available. If the information is not available, the EOB shall contain "your pharmacy" as the provider of service.

8.1.7 The TOP contractor shall insert the provider's payment invoice numbers in the patient's account field on all provider EOBs, if available.

8.1.8 The following EOB message shall be used on overseas claims rendered by non-network host nation providers who are required to be certified, but have not been certified by the TOP contractor - "Your provider has not submitted documentation required to validate his/her training and/or licensure for designation as an authorized TRICARE provider".

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

9.0 DUPLICATE PAYMENT PREVENTION.

The TOP contractor shall follow the duplicate payment prevention requirements outlined in [Chapter 8, Section 9](#).

10.0 DOUBLE COVERAGE.

10.1 TOP claims require double coverage review as outlined in the TRM, [Chapter 4](#).

10.2 Beneficiary/provider disagreements regarding the contractor's determination shall be coordinated through the overseas TAO Director for resolution with the contractor.

10.3 Overseas insurance plans such as German Statutory Health Insurance, Japanese National Insurance (JNI), and Australian Medicare, etc., are considered OHI. When necessary, the TOP contractor may contact the appropriate TAO Director for assistance.

Note: If the Japanese insurance points are not clearly indicated on the claim/bill, the TOP contractor shall contact the submitter or the appropriate TOP POC for assistance in determining the Japanese insurance points prior to processing the claim.

11.0 THIRD PARTY LIABILITY (TPL)

The TOP contractor shall reimburse TOP claims suspected of TPL and then develop for TPL information. Upon receipt of the information, the contractor shall refer claims/documentation to the appropriate Judge Advocate General (JAG) office, as outlined in the [Chapter 10](#).

12.0 REIMBURSEMENT/PAYMENT OF OVERSEAS CLAIMS

When processing TOP claims, the TOP contractor shall follow the reimbursement payment guidelines outlined in the TRM, [Chapter 1, Section 34](#) and the cost-sharing and deductible policies outlined in the TRM, [Chapter 2, Section 1](#), and shall:

12.1 Reimburse claims for host nation services/charges for care rendered to TOP eligible beneficiaries which is generally considered host nation practice and incidental to covered services, but which would not typically be covered under TRICARE. An example of such services may be, charges from host nation ambulance companies for driving host nation physicians to accidents or private residences, etc.

12.1.1 For professional services rendered in the Philippines and Panama (and any other locations where the government has established foreign fee schedules), reimbursement shall be the lower of the billed amount or the government established fee schedules (TRM, [Chapter 1, Section 34](#)), unless a different reimbursement rate has been established as described below. Government-established fee schedules are non-appealable.

12.1.2 In locations where the government has established foreign fee schedules, the contractor shall make every effort to establish host nation network provider agreements that comply with the fee schedule and provide access to care. If access to care is impaired by the fee schedules established by the government, the contractor shall identify the locations where access is impaired and shall identify the best possible reimbursement rates needed to obtain access to health care services. The contractor shall notify the CO of access issues, submit documentation of efforts to establish network(s) within the established fee schedules, and request fee schedule modification for specific services or locations. If approved, any revised rates applied to the government's fee schedule will be applicable to all beneficiary categories.

12.1.3 In locations where the government has established foreign fee schedules, the TOP contractor may negotiate the best possible rate on a case-by-case basis to obtain access to care for TOP-enrolled ADSMs and ADFMs who require urgent/emergent care or one-time specialty care. The contractor shall document the extenuating circumstances and/or efforts to obtain access to services at the fee schedule rate(s). A monthly report of payments which exceed the established fee schedule shall be submitted to the CO/COR and shall be considered during contractor performance reviews.

12.2 Not reimburse for host nation care/services specifically excluded under TRICARE.

Program Integrity

1.0 GENERAL

All TRICARE requirements regarding program integrity shall apply to the TRICARE Overseas Program (TOP) unless specifically waived or superseded by this section or the TRICARE contract for health care support services outside the 50 United States and the District of Columbia (hereinafter referred to as the "TOP contract"). See [Chapter 13](#) for additional instructions. For purposes of TOP implementation, all references to TRICARE Prime in this chapter shall apply to TOP Prime/TOP Prime Remote, all references to TRICARE Standard shall apply to TOP Standard, and all references to Managed Care Support Contractors (MCSCs) shall apply to the TOP contractor.

1.1 In addition to the requirements outlined in [Chapter 13](#), the Government may implement additional requirements as necessary to prevent or detect fraud in overseas locations.

Note: TRICARE guidance regarding anti-fraud programs at Military Treatment Facilities (MTFs) is contained in Department of Defense Instruction (DoDI) 5505.12 (October 19, 2006). This instruction is located at: <http://www.dtic.mil/whs/directives/corres/rtf/550512x.rtf>.

1.2 The TRICARE Area Office (TAO) Directors shall report possible fraudulent or abuse practices by a TOP beneficiary/host nation provider to the TOP contractor, the appropriate TRICARE Management Activity (TMA) Contracting Officer's Representative (COR), and the TMA, Chief, Program Integrity Branch, including requests for the contractor to flag or watch providers suspected of fraud and abuse.

2.0 CONTRACTOR RESPONSIBILITIES

2.1 The TOP contractor is required to notify the TMA Program Integrity Office (PI) in writing of any new or ongoing fraud and abuse issues.

2.2 In cases involving check fraud, the TOP contractor is not required to reissue checks until the investigation is finalized, fraud has been determined, and the contractor has received the money back from the investigating bank.

2.3 The TOP contractor is responsible for performing on-site verification and provider certification in the Philippines. At a minimum, this on-site verification shall confirm the physical existence of a facility/provider office, verify the credentials/licensure of the facility/provider, verify the adequacy of the facility/provider office, and verify the capability of the facility/provider office for providing the expected level and type of care. This requirement may be expanded to other locations upon Contracting Officer (CO) direction.

2.3.1 The TOP contractor shall provide a current file of all certified Philippines providers via electronic format to the TAO Pacific Director No Later Than (NLT) 60 calendar days prior to the start

of health care delivery. The contractor is required to ensure these providers are designated on their provider file as certified/authorized overseas host nation providers and shall assign each provider a unique number following current contract requirements and shall provide that number to the appropriate TAO Director.

2.3.2 Updates/reconciliations of Philippine providers who have been certified or disapproved shall be provided by the TOP contractor to the Contracting Officer's Representative (COR) and the TAO Pacific Director. Separate reports shall be submitted for network and non-network providers. For new non-network providers, the contractor shall submit a cumulative report in an Excel format which includes those providers which are approved or denied, including copies of current licenses/credentials and the providers name, business address and billing address, including telephone and fax numbers, if available, date of certification/denial, and provider specialty if available. This report shall be submitted semiweekly. TMA may expand this process to other countries in the future.

2.3.3 If a claim is received for care rendered by a non-certified provider in the Philippines, the TOP contractor shall pend the claim and initiate on-site verification/provider certification action. Claims pended for this reason are excluded from normal claims processing cycle time standards. If the on-site verification/certification action is not completed within 45 calendar days, the TOP contractor shall deny claims based on lack of provider certification.

2.3.4 The TOP contractor shall use the following guidelines for prioritizing certification of Philippine providers as follows:

2.3.4.1 Reviewing new providers.

2.3.4.2 Reviewing the TOP contractor's current certified provider files.

2.3.4.3 Reviewing non-certified providers on claims which have been denied by the TOP contractor and the beneficiary/provider has followed-up on why the claim was denied.

2.3.4.4 Reviewing non-certified providers on claims which have been denied by the TOP contractor and the beneficiary/provider has NOT followed-up on why the claim was denied.

2.3.5 The TOP contractor shall forward new provider certification requests to the TAO Pacific Director two times per week, on Mondays and Wednesdays. If these days fall on a United States national holiday, the reports will be provided the next business day.

2.3.6 Recertification of Philippine providers shall be performed by the TOP contractor every three years and shall follow the above process. TMA shall, as necessary, require the contractor to add additional overseas countries for host-nation provider certification. Upon direction by the government, the contractor shall follow the process above outline for Philippines, to include prioritization of certification of new country providers.

2.3.7 The TOP contractor shall deny claims submitted from non-certified or non-confirmed host nation providers from the Philippines, advising the provider to contact the contractor for procedures on becoming certified.

2.3.8 For the Philippines, Panama and Costa Rica, the TOP contractor shall review billings on a monthly basis to determine if providers in these areas have exceeded the \$3000 per year billing cap

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for the previous 12 month period for pharmacy services. High volume providers (determined by total pharmacy services billings exceeding \$3000 in the previous 12 months) identified shall be sent the provider notification letter (see [Section 30, Figure 24.30-1](#) advising them of the TOP NDC submission requirements and payment for drugs as required in this section. The electronic report shall arrive NLT the 15th of the month in which it is due. TMA may expand this requirement to other countries during the life of the contract. As other countries are added, the report shall include these countries.

2.3.9 For those providers identified as high volume providers (determined by total pharmacy services billings exceeding \$3000 in the previous 12 months), the TOP contractor shall be required to submit a report by country and provider, which tracks the number of claims, dollar amounts billed vs. paid before the above process was implemented and compares it to the number of claims, dollar amounts billed vs. paid after the above process was implemented. The report shall arrive NLT the 15th of the month in which it is due. TMA may expand this requirement to other countries during the life of the contract. As other countries are added, the report shall include these countries.

2.3.10 The TOP contractor shall provide an electronic report, annually (by fiscal year), identifying all high volume overseas pharmacy providers that have exceeded the \$3000 per year billing cap for pharmacy services to the appropriate TMA COR. The reports shall identify the provider, the provider total billed amount, the total amount paid to the provider, and the total amount paid by the government. Upon receipt, the government shall review the report and may notify the contractor to issue a provider notification letter (see [Section 30, Figure 24.30-1](#)) to TMA identified overseas pharmacy providers in other countries than the Philippines, Panama and Costa Rica that have exceeded the \$3000 per year billing cap on pharmacy services. The report shall arrive by the 15th of October for the preceding fiscal year (October 1 through September 30). TMA may expand this requirement to other countries during the life of the contract. As other countries are added, the report shall include these countries.

2.3.11 For the Philippines, Panama and Costa Rica, providers exceeding the \$3000 per year billing cap for pharmacy service are required to submit claims using National Drug Coding (NDC).

2.3.12 For the Philippines and other nations as may later be determined by TMA, the TOP contractor shall quarterly determine the top 10% of institutional and individual professional providers based on claims volume. The contractor shall return a copy of all claims received from these providers to the provider's practice address requesting the providers signature on the attestation at [Section 30, Figure 24.30-3](#). Only the original signature of the provider is acceptable. For institutional providers, the signature shall be that of the institution's chief executive. Claims shall be pended for 35 calendar cays following the mailing of the attestation and a copy of the claim. If no response is received within 35 calendar days, the contractor shall deny the claim.

2.3.13 Upon direction from TMA, the contractor shall discontinue payments to Third Party Administrators (TPAs) in countries or specific agencies where significant fraud is occurring on a regular basis.

- END -

Acronyms And Abbreviations

3D	Three Dimensional
AA	Anesthesiologist Assistant
AA&E	Arms, Ammunition and Explosives
AAA	Abdominal Aortic Aneurysm
AAAHC	Accreditation Association for Ambulatory Health Care, Inc.
AAFES	Army/Air Force Exchange Service
AAMFT	American Association for Marriage and Family Therapy
AAP	American Academy of Pediatrics
AAPC	American Association of Pastoral Counselors
AARF	Account Authorization Request Form
AATD	Access and Authentication Technology Division
ABA	American Banking Association Applied Behavioral Analysis
ABMT	Autologous Bone Marrow Transplant
ABPM	Ambulatory Blood Pressure Monitoring
ABR	Auditory Brainstem Response
ACD	Augmentative Communication Devices
ACI	Autologous Chondrocyte Implantation
ACIP	Advisory Committee on Immunization Practices
ACO	Administrative Contracting Officer
ACOG	American College of Obstetricians and Gynecologists
ACOR	Administrative Contracting Officer's Representative
ACS	American Cancer Society
ACTUR	Automated Central Tumor Registry
AD	Active Duty
ADA	American Dental Association American Diabetes Association Americans with Disabilities Act
ADAMHA	Alcohol, Drug Abuse, And Mental Health Administration
ADAMHRA	Alcohol, Drug Abuse, And Mental Health Reorganization Act
ADCP	Active Duty Claims Program
ADD	Active Duty Dependent
ADFM	Active Duty Family Member
ADL	Activities of Daily Living
ADP	Automated Data Processing

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ADSM	Active Duty Service Member
AFOSI	Air Force Office of Special Investigations
AHA	American Hospital Association
AHLTA	Armed Forces Health Longitudinal Technology Application
AHRQ	Agency for Healthcare Research and Quality
AI	Administrative Instruction
AIDS	Acquired Immune Deficiency Syndrome
AIIM	Association for Information and Image Management
AIS	Automated Information Systems
AIX	Advanced IBM Unix
AJ	Administrative Judge
ALA	Annual Letter of Assurance
ALB	All Lines Busy
ALL	Acute Lymphocytic Leukemia
ALOS	Average Length-of-Stay
ALS	Action Lead Sheet Advanced Life Support
ALT	Autolymphocyte Therapy
AM&S	Acquisition Management and Support (Directorate)
AMA	Against Medical Advice American Medical Association
AMH	Accreditation Manual for Hospitals
AMHCA	American Mental Health Counselor Association
AML	Acute Myelogenous Leukemia
ANSI	American National Standards Institute
AOA	American Osteopathic Association
APA	American Psychiatric Association American Podiatry Association
APC	Ambulatory Payment Classification
API	Application Program Interface
APN	Assigned Provider Number
APO	Army Post Office
ART	Assisted Reproductive Technology
ARU	Automated Response Unit
ASA	Adjusted Standardized Amount American Society of Anesthesiologists
ASAP	Automated Standard Application for Payment
ASC	Accredited Standards Committee Ambulatory Surgical Center
ASCA	Administrative Simplification Compliance Act
ASCUS	Atypical Squamous Cells of Undetermined Significance

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ASD	Assistant Secretary of Defense Atrial Septal Defect Autism Spectrum Disorder
ASD(C3I)	Assistant Secretary of Defense for Command, Control, Communications, and Intelligence
ASD(HA)	Assistant Secretary of Defense (Health Affairs)
ASD (MRA&L)	Assistant Secretary of Defense for Manpower, Reserve Affairs, and Logistics
ASP	Average Sale Price
ATB	All Trunks Busy
ATO	Approval to Operate
AVM	Arteriovenous Malformation
AWOL	Absent Without Leave
AWP	Average Wholesale Price
B&PS	Benefits and Provider Services
B2B	Business to Business
BACB	Behavioral Analyst Certification Board
BBA	Balanced Budget Act
BBP	Bloodborne Pathogen
BBRA	Balanced Budget Refinement Act
BCABA	Board Certified Associate Behavior Analyst
BCAC	Beneficiary Counseling and Assistance Coordinator
BCBA	Board Certified Behavior Analyst
BCBS	Blue Cross Blue Shield
BC	Birth Center
BCC	Biostatistics Center
BI	Background Investigation
BIPA	Benefits Improvement Protection Act
BL	Black Lung
BLS	Basic Life Support
BMT	Bone M arrow Transplantation
BP	Behavioral Plan
BPC	Beneficiary Publication Committee
BPS	Beneficiary and Provider Services
BRAC	Base Realignment and Closure
BRCA	BReast CAncer
BS	Bachelor of Science
BSID	Bayley Scales of Infant Development
BSR	Beneficiary Service Representative
BWE	Beneficiary Web Enrollment
C&A	Certification and Accreditation
C&CS	Communications and Customer Service
C/S	Client/Server
CA	Care Authorization

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CA/NAS	Care Authorization/Non-Availability Statement
CABG	Coronary Artery Bypass Craft
CAC	Common Access Card
CAD	Coronary Artery Disease
CAF	Central Adjudication Facility
CAH	Critical Access Hospital
CAP/DME	Capital and Direct Medical Education
CAPD	Continuous Ambulatory Peritoneal Dialysis
CAPP	Controlled Access Protection Profile
CAT	Computerized Axial Tomography
CB	Consolidated Billing
CBC	Cypher Block Chaining
CBHCO	Community Based Health Care Organizations
CBSA	Core Based Statistical Area
CC	Common Criteria Criminal Control (Act)
CC&D	Catastrophic Cap and Deductible
CCDD	Catastrophic Cap and Deductible Data
CCEP	Comprehensive Clinical Evaluation Program
CCMHC	Certified Clinical Mental Health Counselor
CCN	Case Control Number
CCPD	Continuous Cycling Peritoneal Dialysis
CCR	Cost-To-Charge Ratio
CCTP	Custodial Care Transitional Policy
CD	Compact Disc
CDC	Centers for Disease Control and Prevention
CDCF	Central Deductible and Catastrophic Cap File
CDD	Childhood Disintegrative Disorder
CDH	Congenital Diaphragmatic Hernia
CD-I	Compact Disc - Interactive
CDR	Clinical Data Repository
CDRL	Contract Data Requirements List
CD-ROM	Compact Disc - Read Only Memory
CDT	Current Dental Terminology
CEIS	Corporate Executive Information System
CEO	Chief Executive Officer
CEOB	CHAMPUS Explanation of Benefits
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CFS	Chronic Fatigue Syndrome
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHAMPVA	Civilian Health and Medical Program of the Department of Veteran Affairs

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Acronyms And Abbreviations

CHBC	Criminal History Background Check
CHBR	Criminal History Background Review
CHC	Civilian Health Care
CHCBP	Continued Health Care Benefits Program
CHCS	Composite Health Care System
CHEA	Council on Higher Education Accreditation
CHKT	Combined Heart-Kidney Transplant
CHOP	Children's Hospital of Philadelphia
CI	Counterintelligence
CIA	Central Intelligence Agency
CIO	Chief Information Officer
CIPA	Classified Information Procedures Act
CJCSM	Chairman of the Joint Chiefs of Staff Manual
CL	Confidentiality Level (Classified, Public, Sensitive)
CLIA	Clinical Laboratory Improvement Amendment
CLIN	Contract Line Item Number
CLKT	Combined Liver-Kidney Transplant
CLL	Chronic Lymphocytic Leukemia
CMAC	CHAMPUS Maximum Allowable Charge
CMHC	Community Mental Health Center
CML	Chronic Myelogenous Leukemia
CMN	Certificate(s) of Medical Necessity
CMO	Chief Medical Officer
CMP	Civil Money Penalty
CMS	Centers for Medicare and Medicaid Services
CMVP	Cryptographic Module Validation Program
CNM	Certified Nurse Midwife
CNS	Central Nervous System Clinical Nurse Specialist
CO	Contracting Officer
COB	Close of Business Coordination of Benefits
COBC	Coordination of Benefits Contractor
COBRA	Consolidated Omnibus Budget Reconciliation Act
CoCC	Certificate of Creditable Coverage
COCO	Contractor Owned-Contractor Operated
COE	Common Operating Environment
CONUS	Continental United States
COO	Chief Operating Officer
COOP	Continuity of Operations Plan
COPA	Council on Postsecondary Accreditation
COPD	Chronic Obstructive Pulmonary Disease

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Acronyms And Abbreviations

COR	Contracting Officer's Representative
CORF	Comprehensive Outpatient Rehabilitation Facility
CORPA	Commission on Recognition of Postsecondary Accreditation
COTS	Commercial-off-the-shelf
CPA	Certified Public Accountant
CPE	Contract Performance Evaluation
CPI	Consumer Price Index
CPI-U	Consumer Price Index - Urban (Wage Earner)
CPNS	Certified Psychiatric Nurse Specialists
CPR	CAC PIN Reset
CPT	Chest Physiotherapy Current Procedural Terminology
CPT-4	Current Procedural Terminology, 4th Edition
CQMP	Clinical Quality Management Program
CQMP AR	Clinical Quality Management Program Annual Report
CQS	Clinical Quality Studies
CRM	Contract Resource Management (Directorate)
CRNA	Certified Registered Nurse Anesthetist
CRT	Computer Remote Terminal
CSA	Clinical Support Agreement
CSE	Communications Security Establishment (of the Government of Canada)
CSP	Corporate Service Provider Critical Security Parameter
CST	Central Standard Time
CSU	Channel Sending Unit
CSV	Comma-Separated Value
CSW	Clinical Social Worker
CT	Central Time Computerized Tomography
CTEP	Cancer Therapy Evaluation Program
CTCL	Cutaneous T-Cell Lymphoma
CVAC	CHAMPVA Center
CVS	Contractor Verification System
CY	Calendar Year
DAA	Designated Approving Authority
DAO	Defense Attache Offices
DBA	Doing Business As
DC	Direct Care
DCAA	Defense Contract Audit Agency
DCAO	Debt Collection Assistance Officer
DCID	Director of Central Intelligence Directive
DCII	Defense Clearance and Investigation Index
DCIS	Defense Criminal Investigating Service

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DCN	Document Control Number
DCP	Data Collection Period
DCR	Developed Character Reference
DCS	Duplicate Claims System
DCSI	Defense Central Security Index
DD (Form)	Department of Defense (Form)
DDAS	DCII Disclosure Accounting System
DDP	Dependent Dental Plan
DDS	DEERS Dependent Suffix
DE	Durable Equipment
DECC	Defense Enterprise Computing Center
DED	Dedicated Emergency Department
DEERS	Defense Enrollment Eligibility Reporting System
DENC	Detailed Explanation of Non-Concurrence
DepSecDef	Deputy Secretary of Defense
DES	Data Encryption Standard
DFAS	Defense Finance and Accounting Service
DG	Diagnostic Group
DGH	Denver General Hospital
DHHS	Department of Health and Human Services
DHP	Defense Health Program
DIA	Defense Intelligence Agency
DIACAP	DoD Information Assurance Certification And Accreditation Process
DII	Defense Information Infrastructure
DIS	Defense Investigative Service
DISA	Defense Information System Agency
DISCO	Defense Industrial Security Clearance Office
DISN	Defense Information Systems Network
DISP	Defense Industrial Security Program
DITSCAP	DoD Information Technology Security Certification and Accreditation Process
DLAR	Defense Logistics Agency Regulation
DLE	Dialyzable Leukocyte Extract
DM	Disease Management
DMDC	Defense Manpower Data Center
DME	Durable Medical Equipment
DMEPOS	Durable medical equipment, prosthetics, orthotics, and supplies
DMI	DMDC Medical Interface
DMIS	Defense Medical Information System
DMIS-ID	Defense Medical Information System Identification (Code)
DMLSS	Defense Medical Logistics Support System
DMZ	Demilitarized Zone
DNA	Deoxyribonucleic Acid

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DNA-HLA	Deoxyribonucleic Acid - Human Leucocyte Antigen
DO	Doctor of Osteopathy Operations Directorate
DOB	Date of Birth
DoD	Department of Defense
DoD AI	Department of Defense Administrative Instruction
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DoDIG	Department of Defense Inspector General
DoD P&T	Department of Defense Pharmacy and Therapeutics (Committee)
DOE	Department of Energy
DOEBA	Date of Earliest Billing Action
DOES	DEERS Online Enrollment System
DOHA	Defense Office of Hearings and Appeals
DOJ	Department of Justice
DOLBA	Date of Latest Billing Action
DP	Designated Provider
DPA	Differential Power Analysis
DPI	Designated Providers Integrator
DPO	DEERS Program Office
DRA	Deficit Reduction Act
DREZ	Dorsal Root Entry Zone
DRG	Diagnostic Related Group
DRPO	DEERS RAPIDS Program Office
DSAA	Defense Security Assistance Agency
DSC	DMDC Support Center
DSCC	Data and Study Coordinating Center
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSM-III	Diagnostic and Statistical Manual of Mental Disorders, Third Edition
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DSMC	Data and Safety Monitoring Committee
DSMO	Designated Standards Maintenance Organization
DSO	DMDC Support Office
DSU	Data Sending Unit
DTF	Dental Treatment Facility
DTR	Derived Test Requirements
DTRO	Director, TRICARE Regional Office
DUA	Data Use Agreement
DVA	Department of Veterans Affairs
DVAHCF	Department of Veterans Affairs Health Care Finder
DVD	Digital Video Disc
DWR	DSO Web Request

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Dx	Diagnosis
E-ID	Early Identification
E-NAS	Electronic Non-Availability Statement
E&M	Evaluation & Management
E2R	Enrollment Eligibility Reconciliation
EAL	Common Criteria Evaluation Assurance Level
EAP	Ethandamine phosphate
EBC	Enrollment Based Capitation
ECA	External Certification Authority
ECG	Electrocardiogram
ECHO	Extended Care Health Option
ECT	Electroconvulsive Therapy
ED	Emergency Department
EDC	Error Detection Code
EDI	Electronic Data Information Electronic Data Interchange
EDIPI	Electronic Data Interchange Person Identifier
EDIPN	Electronic Data Interchange Person Number
EDI_PN	Electronic Data Interchange Patient Number
EEG	Electroencephalogram
EEPROM	Erasable Programmable Read-Only Memory
EFM	Electronic Fetal Monitoring
EFMP	Exceptional Family Member Program
EFP	Environmental Failure Protection
EFT	Electronic Funds Transfer Environmental Failure Testing
EGHP	Employer Group Health Plan
E/HPC	Enrollment/Health Plan Code
EHHC	ECHO Home Health Care Extended Care Health Option Home Health Care
EHP	Employee Health Program
EIA	Educational Interventions for Autism Spectrum Disorders
EIDS	Executive Information and Decision Support
EIN	Employer Identification Number
EIP	External Infusion Pump
EKG	Electrocardiogram
ELN	Element Locator Number
ELISA	Enzyme-Linked Immunoabsorbent Assay
E/M	Evaluation and Management
EMC	Electronic Media Claim Enrollment Management Contractor
EMDR	Eye Movement Desensitization and Reprocessing
EMG	Electromyogram

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EMTALA	Emergency Medical Treatment & Active Labor Act
ENTNAC	Entrance National Agency Check
EOE	Evoked Otoacoustic Emission
EOB	Explanation of Benefits
EOBs	Explanations of Benefits
EOC	Episode of Care
EOG	Electro-oculogram
EOMB	Explanation of Medicare Benefits
ePHI	electronic Protected Health Information
EPO	Erythropoietin Exclusive Provider Organization
EPR	EIA Program Report
EPROM	Erasable Programmable Read-Only Memory
ER	Emergency Room
ERISA	Employee Retirement Income and Security Act of 1974
ESRD	End Stage Renal Disease
EST	Eastern Standard Time
ESWT	Extracorporeal Shock Wave Therapy
ET	Eastern Time
ETIN	Electronic Transmitter Identification Number
EWPS	Enterprise Wide Provider System
EWRAS	Enterprise Wide Referral and Authorization System
F&AO	Finance and Accounting Office(r)
FAR	Federal Acquisition Regulations
FASB	Federal Accounting Standards Board
FBI	Federal Bureau of Investigation
FCC	Federal Communications Commission
FCCA	Federal Claims Collection Act
FDA	Food and Drug Administration
FDB	First Data Bank
FDL	Fixed Dollar Loss
Fed	Federal Reserve Bank
FEHBP	Federal Employee Health Benefit Program
FEL	Familial Erythrophagocytic Lymphohistiocytosis
FEV ₁	Forced Expiratory Volume
FFM	Foreign Force Member
FHL	Familial Hemophagocytic Lymphohistiocytosis
FI	Fiscal Intermediary
FIPS	Federal Information Processing Standards (or System)
FIPS PUB	FIPS Publication
FISH	Fluorescence In Situ Hybridization
FISMA	Federal Information Security Management Act

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FL	Form Locator
FMCRA	Federal Medical Care Recovery Act
FOC	Full Operational Capability
FOIA	Freedom of Information Act
FPO	Fleet Post Office
FQHC	Federally Qualified Health Center
FR	Federal Register Frozen Records
FRC	Federal Records Center
FTE	Full Time Equivalent
FTP	File Transfer Protocol
FX	Foreign Exchange (lines)
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GAO	General Accounting Office
GBL	Government Bill of Lading
GDC	Guglielmi Detachable Coil
GFE	Government Furnished Equipment
GHz	Gigahertz
GIFT	Gamete Intrafallopian Transfer
GIQD	Government Inquiry of DEERS
GP	General Practitioner
GPCI	Geographic Practice Cost Index
H/E	Health and Environment
HAC	Health Administration Center
HAVEN	Home Assessment Validation and Entry
HBA	Health Benefits Advisor
HBO	Hyperbaric Oxygen Therapy
HCC	Health Care Coverage
HCDP	Health Care Delivery Program
HCF	Health Care Finder
HCFA	Health Care Financing Administration
HCG	Human Chorionic Gonadotropin
HCIL	Health Care Information Line
HCP	Health Care Provider
HCPC	Healthcare Common Procedure Code (formerly HCFA Common Procedure Code)
HCPCS	Healthcare Common Procedure Coding System (formerly Healthcare Common Procedure Coding System)
HCPR	Health Care Provider Record
HCSR	Health Care Service Record
HDC	High Dose Chemotherapy
HDC/SCR	High Dose Chemotherapy with Stem Cell Rescue

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HDL	Hardware Description Language
HEAR	Health Enrollment Assessment Review
HEDIS	Health Plan Employer Data and Information Set
HepB-Hib	Hepatitis B and Hemophilus influenza B
HHA	Home Health Agency
HHA PPS	Home Health Agency Prospective Payment System
HHC	Home Health Care
HHC/CM	Home Health Care/Case Management
HHRG	Home Health Resource Group
HHS	Health and Human Services
HI	Health Insurance
HIC	Health Insurance Carrier
HICN	Health Insurance Claim Number
HINN	Hospital-Issued Notice Of Noncoverage
HIPAA	Health Insurance Portability and Accountability Act (of 1996)
HIPPS	Health Insurance Prospective Payment System
HIQH	Health Insurance Query for Health Agency
HIV	Human Immunodeficiency Virus
HL7	Health Level 7
HLA	Human Leukocyte Antigen
HMAC	Hash-Based Message Authentication Code
HMO	Health Maintenance Organization
HNPCC	Hereditary Nonpolposis Colorectal Cancer
HPA&E	Health Program Analysis & Evaluation
HPSA	Health Professional Shortage Area
HPV	Human Papilloma Virus
HRG	Health Resource Group
HRT	Heidelberg Retina Tomograph Hormone Replacement Therapy
HSCRC	Health Services Cost Review Commission
HTML	HyperText Markup Language
HTTP	HyperText Transfer (Transport) Protocol
HTTPS	Hypertext Transfer (Transport) Protocol Secure
HUAM	Home Uterine Activity Monitoring
HUS	Hemolytic Uremic Syndrome
HVPT	Hyperventilation Provocation Test
IA	Information Assurance
IATO	Interim Approval to Operate
IAVA	Information Assurance Vulnerability Alert
IAVM	Information Assurance Vulnerability Management
IAW	In accordance with

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IC	Individual Consideration Integrated Circuit
ICASS	International Cooperative Administrative Support Services
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICF	Intermediate Care Facility
ICMP	Individual Case Management Program
ICMP-PEC	Individual Case Management Program For Persons With Extraordinary Conditions
ICN	Internal Control Number
ICSP	Individual Corporate Services Provider
ID	Identification Identifier
IDE	Investigational Device Exemption Investigational Device
IDEA	Individuals with Disabilities Education Act
IDET	Intradiscal Electrothermal Therapy
IDME	Indirect Medical Education
IE	Interface Engine Internet Explorer
IEP	Individualized Educational Program
IFSP	Individualized Family Service Plan
IG	Implementation Guidance
IGCE	Independent Government Cost Estimate
IHI	Institute for Healthcare Improvement
IHS	Indian Health Service
IIHI	Individually Identifiable Health Information
IIP	Implantable Infusion Pump
IM	Information Management Intramuscular
IND	Investigational New Drugs
INR	Intramuscular International Normalized Ratio
INS	Immigration and Naturalization Service
IOC	Initial Operational Capability
IOD	Interface Operational Description
IOLs	Intraocular Lenses
IOM	Internet Only Manual
IORT	Intra-Operative Radiation Therapy
IP	Inpatient
IPC	Information Processing Center (outdated term, see SMC)
IPN	Intraperitoneal Nutrition
IPPS	Inpatient Prospective Payment System
IPS	Individual Pricing Summary
IPSEC	Secure Internet Protocol
IQ	Intelligence Quotient

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IQM	Internal Quality Management
IRB	Institutional Review Board
IRR	Individual Ready Reserve
IRS	Internal Revenue Service
IRTS	Integration and Runtime Specification
IS	Information System
ISN	Investigation Schedule Notice
ISO	International Standard Organization
ISP	Internet Service Provider
IT	Information Technology
ITSEC	Information Technology Security Evaluation Criteria
IV	Initialization Vector Intravenous
IVF	In Vitro Fertilization
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCOS	Joint Chiefs of Staff
JFTR	Joint Federal Travel Regulations
JNI	Japanese National Insurance
JTF-GNO	Joint Task Force for Global Network Operations
JUSDAC	Joint Uniformed Services Dental Advisory Committee
JUSMAC	Joint Uniformed Services Medical Advisory Committee
JUSPAC	Joint Uniformed Services Personnel Advisory Committee
KB	Knowledge Base
KO	Contracting Officer
LAA	Limited Access Authorization
LAC	Local Agency Check
LAK	Lymphokine-Activated Killer
LAN	Local Area Network
LASER	Light Amplification by Stimulated Emission of Radiation
LCF	Long-term Care Facility
LDL	Low Density Lipoprotein
LDLT	Living Donor Liver Transplantation
LOC	Letter of Consent
LOD	Letter of Denial/Revocation
LOI	Letter of Intent
LOS	Length-of-Stay
LOT	Life Orientation Test
LPN	Licensed Practical Nurse
LSIL	Low-grade Squamous Intraepithelial
LSN	Location Storage Number
LTC	Long-Term Care
LUPA	Low Utilization Payment Adjustment

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LVEF	Left Ventricular Ejection Fraction
LVN	Licensed Vocational Nurse
LVRS	Lung Volume Reduction Surgery
MAC	Maximum Allowable Charge Maximum Allowable Cost
MAC III	Mission Assurance Category III
MAID	Maximum Allowable Inpatient Day
MB&RS	Medical Benefits and Reimbursement Systems
MCIO	Military Criminal Investigation Organization
MCS	Managed Care Support
MCSC	Managed Care Support Contractor
MCSS	Managed Care Support Services
MCTDP	Myelomeningocele Clinical Trial Demonstration Protocol
MD	Doctor of Medicine
MDI	Mental Developmental Index
MDR	MHS Data Repository
MDS	Minimum Data Set
MEC	Marketing and Education Committee
MEI	Medicare Economic Index
MEPS	Military Entrance Processing Station
MEPRS	Medical Expense Performance Reporting System
MFCC	Marriage and Family Counseling Center
MGCRB	Medicare Geographic Classification Review Board
MGIB	Montgomery GI Bill
MHO	Medical Holdover
MHS	Military Health System
MHSO	Managing Health Services Organization
MHSS	Military Health Services System
MI&L	Manpower, Installations, and Logistics
MIA	Missing In Action
MIDCAB	Minimally Invasive Direct Coronary Artery Bypass
MIRE	Monochromatic Infrared Energy
MMA	Medicare Modernization Act
MMP	Medical Management Program
MMSO	Military Medical Support Office
MMWR	Morbidity and Mortality Weekly Report
MNR	Medical Necessity Report
MOA	Memorandum of Agreement
MOMS	Management of Myelomeningocele Study
MOP	Mail Order Pharmacy
MOU	Memorandum of Understanding
MPI	Master Patient Index

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MR	Medical Review Mentally Retarded
MRA	Magnetic Resonance Angiography
MRI	Magnetic Resonance Imaging
MRPU	Medical Retention Processing Unit
MS	Microsoft®
MSA	Metropolitan Statistical Area
MSC	Military Sealift Command
MSIE	Microsoft® Internet Explorer
MSP	Medicare Secondary Payer
MST	Mountain Standard Time
MSUD	Maple Syrup Urine Disease
MSW	Masters of Social Work Medical Social Worker
MT	Mountain Time
MTF	Military Treatment Facility
MV	Multivisceral (transplant)
MVS	Multiple Virtual Storage
MWR	Morale, Welfare, and Recreation
N/A	Not Applicable
N/D	No Default
NAC	National Agency Check
NACI	National Agency Check Plus Written Inquiries
NACLC	National Agency Check with Law Enforcement and Credit
NADFM	Non-Active Duty Family Member
NARA	National Archives and Records Administration
NAS	Non-Availability Statement
NATO	North Atlantic Treaty Organization
NAVMED	Naval Medical (Form)
NBCC	National Board of Certified Counselors
NCCI	National Correct Coding Initiatives
NCF	National Conversion Factor
NCI	National Cancer Institute
NCPAP	Nasal Continuous Positive Airway Pressure
NCPDP	National Council of Prescription Drug Program
NCQA	National Committee for Quality Assurance
NCVHS	National Committee on Vital and Health Statistics
NDAA	National Defense Authorization Act
NDC	National Drug Code
NDMS	National Disaster Medical System
NED	National Enrollment Database
NETT	National Emphysema Treatment Trial

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NF	Nursing Facility
NHLBI	National Heart, Lung and Blood Institute
NHSC	National Health Service Corps
NICHD	National Institute of Child Health and Human Development
NIH	National Institutes of Health
NIPRNET	Nonsecure Internet Protocol Router Network
NIS	Naval Investigative Service
NISPOM	National Industrial Security Program Operating Manual
NIST	National Institute of Standards and Technology
NLT	No Later Than
NMES	Neuromuscular Electrical Stimulation
NMOP	National Mail Order Pharmacy
NMR	Nuclear Magnetic Resonance
NMT	Nurse Massage Therapist
NOAA	National Oceanic and Atmospheric Administration
NoPP	Notice of Private Practices
NOSCASTC	National Operating Standard Cost as a Share of Total Costs
NP	Nurse Practitioner
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPR	Notice of Program Reimbursement
NPS	Naval Postgraduate School
NQF	National Quality Forum
NRC	Nuclear Regulatory Commission
NTIS	National Technical Information Service
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claims Committee
O/ATIC	Operations/Advanced Technology Integration Center
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)
OASD (H&E)	Office of the Assistant Secretary of Defense (Health and Environment)
OASD (MI&L)	Office of the Assistant Secretary of Defense (Manpower, Installations, and Logistics)
OASIS	Outcome and Assessment Information Set
OB/GYN	Obstetrician/Gynecologist
OBRA	Omnibus Budget Reconciliation Act
OCE	Outpatient Code Editor
OCHAMPUS	Office of Civilian Health and Medical Program of the Uniformed Services
OCONUS	Outside of the Continental United States
OCR	Office of Civil Rights
OCSP	Organizational Corporate Services Provider
OD	Optical Disk

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OGC	Office of General Counsel
OGP	Other Government Program
OHI	Other Health Insurance
OHS	Office of Homeland Security
OIG	Office of Inspector General
OMB	Office of Management and Budget
OP/NSP	Operation/Non-Surgical Procedure
OPD	Outpatient Department
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
OSA	Obstructive Sleep Apnea
OSAS	Obstructive Sleep Apnea Syndrome
OSD	Office of the Secretary of Defense
OSHA	Occupational Safety and Health Act
OSS	Office of Strategic Services
OT	Occupational Therapy (Therapist)
OTC	Over-The-Counter
OUSD	Office of the Undersecretary of Defense
OUSD (P&R)	Office of the Undersecretary of Defense (Personnel and Readiness)
P/O	Prosthetic and Orthotics
P&T	Pharmacy And Therapeutics (Committee)
PA	Physician Assistant
PACAB	Port Access Coronary Artery Bypass
PACO ₂	Partial Pressure of Carbon Dioxide
PAO ₂	Partial Pressure of Oxygen
PAK	Pancreas After Kidney (transplant)
PAP	Papanicolaou
PatID	Patient Identifier
PAVM	Pulmonary Arteriovenous Malformation
PBM	Pharmacy Benefit Manager
PCMBN	PCM By Name
PCMRS	PCM Reassignment System
PC	Personal Computer Professional Component
PCA	Patient Controlled Analgesia
PCDIS	Purchased Care Detail Information System
PCM	Primary Care Manager
PCMRA	PCM Research Application
PCMRS	PCM Panel Reassignment (Application)
PCO	Procurement (Procuring) Contracting Officer
PCP	Primary Care Physician Primary Care Provider

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PCS	Permanent Change of Station
PD	Passport Division
PDA	Patent Ductus Arteriosus Personal Digital Assistant
PDDBI	Pervasive Developmental Disorders Behavior Inventory
PDDNOS	Pervasive Developmental Disorder Not Otherwise Specified
PDF	Portable Document Format
PDQ	Physicians's Data Query
PDR	Person Data Repository
PDS	Person Demographics Service
PDTS	Pharmacy Data Transaction System
PE	Physical Examination
PEC	Pharmacoeconomic Center
PEP	Partial Episode Payment
PEPR	Patient Encounter Processing and Reporting
PERMS	Provider Education and Relations Management System
PET	Positron Emission Tomography
PFCRA	Program Fraud Civil Remedies Act
PPF	Partnership For Peace
PPPWD	Program for Persons with Disabilities
Phen-Fen	Pondimin and Redux
PHI	Protected Health Information
PHIMT	Protected Health Information Management Tool
PHP	Partial Hospitalization Program
PHS	Public Health Service
PI	Program Integrity (Office)
PIA	Privacy Impact Assessment (Online)
PIC	Personnel Investigation Center
PIE	Pulsed Irrigation Evacuation
PIN	Personnel Identification Number
PIP	Personal Injury Protection Personnel Identity Protection
PIT	PCM Information Transfer
PIV	Personal Identity Verification
PKI	Public Key Infrastructure
PKU	Phenylketonuria
PL	Public Law
PLS	Preschool Language Scales
PM-DRG	Pediatric Modified-Diagnosis Related Group
PMR	Percutaneous Myocardial Laser Revascularization
PNET	Primitive Neuroectodermal Tumors
PNT	Policy Notification Transaction

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POA	Power of Attorney
POC	Pharmacy Operations Center Plan of Care Point of Contact
POL	May 1996 TRICARE/CHAMPUS Policy Manual 6010.47-M
POS	Point of Sale (Pharmacy only) Point of Service Public Official's Statement
POV	Privately Owned Vehicle
PPD	Per Patient Day
PPN	Preferred Provider Network
PPO	Preferred Provider Organization
PPS	Prospective Payment System Ports, Protocols and Services
PPV	Pneumococcal Polysaccharide Vaccine
PQI	Potential Quality Indicator Potential Quality Issue
PR	Periodic Reinvestigation
PRC	Program Review Committee
PRG	Peer Review Group
PRO	Peer Review Organization
ProDUR	Prospective Drug Utilization Review
PROM	Programmable Read-Only Memory
PRP	Personnel Reliability Program
PSA	Prime Service Area Physician Scarcity Area
PSAB	Personnel Security Appeals Board
PSCT	Peripheral Stem Cell Transplantation
PSI	Personnel Security Investigation
PST	Pacific Standard Time
PT	Pacific Time Physical Therapist Physical Therapy Prothrombin Time
PTA	Pancreas Transplant Alone Percutaneous Transluminal Angioplasty
PTC	Processed To Completion
PTCA	Percutaneous Transluminal Coronary Angioplasty
PTK	Phototherapeutic Keratectomy
PVCs	Premature Ventricular Contractions
QA	Quality Assurance
QC	Quality Control
QI	Quality Improvement Quality Issue

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QII	Quality Improvement Initiative
QIO	Quality Improvement Organization
QIP	Quality Improvement Program
QLE	Qualifying Life Event
QM	Quality Management
QUIG	Quality Indicator Group
RA	Remittance Advice
RAM	Random Access Memory
RAP	Request for Anticipated Payment
RAPIDS	Real-Time Automated Personnel Identification System
RC	Reserve Component
RCN	Recoupment Case Number Refund Control Number
RCS	Report Control Symbol
RD	Regional Director
RDBMS	Relational Database Management System
RDDDB	Reportable Disease Database
REM	Rapid Eye Movement
RFI	Request For Information
RFP	Request For Proposal
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RhoGAM	RRho (D) Immune Globulin
RN	Registered Nurse
RNG	Random Number Generator
RO	Regional Office
ROC	Resumption of Care
ROFR	Right of First Refusal
ROM	Read-Only Memory Rough Order of Magnitude
ROT	Read-Only Table
ROTC	Reserved Officer Training Corps
ROVER	RHHI Outcomes and Assessment Information Set Verification
RPM	Record Processing Mode
RRA	Regional Review Authority
RTC	Residential Treatment Center
RUG	Resource Utilization Group
RV	Residual Volume
RVU	Relative Value Unit
SAAR	System Authorization Access Request
SAD	Seasonal Affective Disorder
SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier

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SAO	Security Assistant Organizations
SAP	Special Access Program
SAS	Sensory Afferent Stimulation
SAT	Service Assist Team
SBCC	Service Branch Classification Code
SBI	Special Background Investigation
SCH	Sole Community Hospital
SCHIP	State Children's Health Insurance Program
SCI	Sensitive Compartmented Information Spinal Cord Injury
SCIC	Significant Change in Condition
SCOO	Special Contracts and Operations Office
SCR	Stell Cell Rescue
S/D	Security Division
SD (Form)	Secretary of Defense (Form)
SEP	Sensory Evoked Potentials
SES	Senior Executive Service
SelRes	Selected Reserve
SF	Standard Form
SGDs	Speech Generating Devices
SHCP	Supplemental Health Care Program
SI	Sensitive Information Small Intestine (transplant) Status Indicator
SIDS	Sudden Infant Death Syndrome
SII	Special Investigative Inquiry
SI/L	Small Intestine-Live (transplant)
SIOP-ESI	Single Integrated Operational plan-Extremely Sensitive Information
SIP	System Identification Profile
SIT	Standard Insurance Table
SMC	System Management Center
SNF	Skilled Nursing Facility
SNS	Sacral Nerve Root Stimulation
SOC	Start of Care
SOFA	Status Of Forces Agreement
SOIC	Senior Officer of the Intelligence Community
SON	Submitting Office Number
SOR	Statement of Reasons
SP	Special Processing Code
SPA	Simple Power Analysis
SPECT	Single Photon Emission Computed Tomography
SPK	Simultaneous Pancreas Kidney (transplant)
SPOC	Service Point of Contact

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SPR	SECRET Periodic Reinvestigation
SQL	Structured Query Language
SRE	Serious Reportable Event
SSA	Social Security Act Social Security Administration
SSAA	Social Security Authorization Agreement
SSAN	Social Security Administration Number
SSBI	Single-Scope Background Investigation
SSL	Secure Socket Layer
SSM	Site Security Manager
SSN	Social Security Number
SSO	Short-Stay Outlier
STF	Specialized Treatment Facility
STS	Specialized Treatment Services
STSF	Specialized Treatment Service Facility
SUDRF	Substance Use Disorder Rehabilitation Facility
SVO	SIT Validation Office
SVT	Supraventricular Tachycardia
SWLS	Satisfaction With Life Scale
TAD	Temporary Additional Duty
TAFIM	Technical Architecture Framework for Information Management
TAMP	Transitional Assistance Management Program
TAO	TRICARE Alaska Office TRICARE Area Office
TARO	TRICARE Alaska Regional Office
TB	Tuberculosis
TBD	To Be Determined
TBE	Tick Borne Encephalitis
TBI	Traumatic Brain Injury
TC	Technical Component
TCP/IP	Transmission Control Protocol/Internet Protocol
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Plan
TDY	Temporary Duty
TED	TRICARE Encounter Data
TEFRA	Tax Equity and Fiscal Responsibility Act
TEOB	TRICARE Explanation of Benefits
TEPRC	TRICARE Encounter Pricing (Record)
TEPRV	TRICARE Encounter Provider (Record)
TET	Tubal Embryo Transfer
TF	Transfer Factor
TFL	TRICARE For Life

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TFMDP	TRICARE (Active Duty) Family Member Dental Plan
TGRO	TRICARE Global Remote Overseas
TGROHC	TGRO Host Country
TIFF	Tagged Imaged File Format
TIL	Tumor-Infiltrating Lymphocytes
TIMPO	Tri-Service Information Management Program Office
TIN	Taxpayer Identification Number
TIPS	Transjugular Intrahepatic Portosystemic Shunt
TIS	TRICARE Information Service
TLAC	TRICARE Latin America/Canada
TLC	Total Lung Capacity
TMA	TRICARE Management Activity
TMA-A	TRICARE Management Activity - Aurora
TMAC	TRICARE Maximum Allowable Charge
TMI&S	Technology Management Integration & Standards
TMOP	TRICARE Mail Order Pharmacy
TMR	Transmyocardial Revascularization
TNEX	TRICARE Next Generation (MHS Systems)
TOB	Type of Bill
TOE	Target of Evaluation
TOL	TRICARE Online
TOM	August 2002 TRICARE Operations Manual 6010.51-M February 2008 TRICARE Operations Manual 6010.56-M
TOP	TRICARE Overseas Program
TPA	Third Party Administrator
TPC	Third Party Collections
TPharm	TRICARE Pharmacy
TPL	Third Party Liability
TPM	August 2002 TRICARE Policy Manual 6010.54-M February 2008 TRICARE Policy Manual 6010.57-M
TPN	Total Parenteral Nutrition
TPOCS	Third Party Outpatient Collections System
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote Active Duty Family Member
TPRADSM	TRICARE Prime Remote Active Duty Service Member
TPRC	TRICARE Puerto Rico Contract(or)
TQMC	TRICARE Quality Monitoring Contractor
TRDP	TRICARE Retiree Dental Program
TRI	TED Record Indicator
TRM	August 2002 TRICARE Reimbursement Manual 6010.55-M February 2008 TRICARE Reimbursement Manual 6010.58-M
TRO	TRICARE Regional Office
TRPB	TRICARE Retail Pharmacy Benefits

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TRRx	TRICARE Retail Pharmacy
TRS	TRICARE Reserve Select
TRSA	TRICARE Reserve Select Application
TSC	TRICARE Service Center
TSF	Target of Evaluation Security Functions
TSM	August 2002 TRICARE Systems Manual 7950.1-M February 2008 TRICARE Systems Manual 7950.2-M
TSP	Target of Evaluation Security Policy
TSR	TRICARE Select Reserve
TSRDP	TRICARE Select Reserve Dental Program
TSRx	TRICARE Senior Pharmacy
TSS	TRICARE Senior Supplement
TSSD	TRICARE Senior Supplement Demonstration
TTY	Teletypewriter
TUNA	Transurethral Needle Ablation
UAE	Uterine Artery Embolization
UB	Uniform Bill
UBO	Uniform Business Office
UCBT	Umbilical Cord Blood Stem Cell Transplantation
UCC	Uniform Commercial Code
UCCI	United Concordia Companies, Inc.
UCSF	University of California San Francisco
UIC	Unit Identification Code
UIN	Unit Identifier Number
UM	Utilization Management
UMO	Utilization Management Organization
UMP	User Maintenance Portal
UPIN	Unique Physician Identification Number
URF	Unremarried Former Spouses
URL	Universal Resource Locator
US	United States
USA	United States of America
USACID	United States Army Criminal Investigation Division
USAF	United States Air Force
USAO	United States Attorneys' Office
USC	United States Code
USCG	United States Coast Guard
USCO	Uniformed Services Claim Office
USD	Undersecretary of Defense
USD (P&R)	Undersecretary of Defense (Personnel and Readiness)
USDI	Undersecretary of Defense for Intelligence
USFHP	Uniformed Services Family Health Plan

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USHBP	Uniformed Services Health Benefit Plan
USMC	United States Marine Corps
USMTF	Uniformed Services Medical Treatment Facility
USN	United States Navy
USPDI	United States Pharmacopoeia Drug Information
USPHS	United States Public Health Service
USPS	United States Postal Service
USPSTF	U.S. Preventive Services Task Force
USS	United Seaman's Service
USTF	Uniformed Services Treatment Facility
UV	Ultraviolet
VA	Veteran Affairs (hospital) Veteran Administration
VAD	Ventricular Assist Device
VAMC	VA Medical Center
VATS	Video-Assisted Thoroscopic Surgery
VAX-D	Vertebral Axial Decompression
VD	Venereal Disease
VO	Verifying Office (Official)
VPN	Virtual Private Network
VPOC	Verification Point of Contact
VSAM	Virtual Storage Access Method
VSD	Ventricular Septal Defect
WAC	Wholesale Acquisition Cost
WAN	Wide Area Network
WATS	Wide Area Telephone Service
WC	Worker's Compensation
WEDI	Workgroup for Electronic Data Interchange
WIC	Women, Infants, and Children (Program)
WORM	Write Once Read Many
WRAMC	Walter Reed Army Medical Center
WTC	World Trade Center
WTRR	Wire Transfer Reconciliation Report
X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome
XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer

- END -

Adjustment, Identification Of (Receipt)

An adjustment may be generated by a telephonic, written or personal inquiry, appeal decision, or as the result of a contractor's internal review. The adjustment is identified when the contractor's staff determines the issue requires an additional payment, cancellation, or a change to the Beneficiary History and Deductible Files (see definition) or when notice is received from TRICARE Management Activity (TMA) that an adjustment is required. In the case of recoupments, the adjustment is "identified" for reporting purposes, with receipt of the payment by the contractor.

Administrative Fee, Pharmacy

The offered price that represents all administrative charges relative to prescription, prior authorization and medical necessity determination transaction processing.

All-Inclusive Per Diem Rate

The TMA-determined rate that encompasses the daily charge for inpatient care and, unless specifically excepted, all other treatment determined necessary and rendered as part of the treatment plan established for a patient.

Allowable Charge

The TRICARE-determined level of payment to physicians and other categories of individual professional providers based on one of the approved reimbursement methods set forth in the TRM. As used by TRICARE, the allowable charge shall be the lowest of the billed charge, the prevailing charge, or the maximum allowable prevailing charge.

Allowable Charge Complaint

A request for review of a contractor determination of allowable charge for covered services and supplies furnished under TRICARE. The allowable charge complaint does not fall within the meaning of an "appeal", in the technical sense, but does require a careful contractor review of the claim processing to ensure accuracy of the allowance made.

Allowable Charge Reduction

The difference between the reimbursement determination made by a contractor and the amount billed by the provider of care (prior to determination of applicable cost-shares and deductibles).

Allowable Cost

The TRICARE-determined level of payment to hospitals or other institutions, based on one of the approved reimbursement methods described in [32 CFR 199.14](#). Allowable cost may also be referred to as the TRICARE-determined reasonable cost.

Amount In Dispute

The amount of money, determined under 32 CFR 199, that TRICARE would pay for medical services and supplies involved in an adverse determination being appealed if the appeal were resolved in favor of the appealing party. See [32 CFR 199.10](#) for additional information concerning the determination of “amount in dispute” under the Regulation.

Appeal

A formal written request by a beneficiary, a participating provider, a provider denied authorized provider status under TRICARE, or a representative, to resolve a disputed question of fact. See 32 CFR 199 and the TRICARE Operations Manual (TOM).

Appropriate Medical Care

Services that have been:

1. Performed in connection with the diagnosis or treatment of disease or injury, pregnancy, mental disorder, or well-baby care which are in keeping with the generally accepted norms for medical practice in the United States;
2. Rendered by an authorized individual professional provider who is qualified to perform such medical services by reason of his or her training and education and is licensed or certified either by the state where the service is rendered or appropriate national organization, or who otherwise meets TRICARE standards; and
3. Furnished economically. “Economically” means that the services are furnished in the least expensive level of care or medical environment adequate to provide the required medical care regardless of whether or not that level of care is covered by TRICARE.

Authorization For Care

The determination that requested treatment is medically necessary, delivered in the appropriate setting, a TRICARE benefit, and that the treatment will be cost-shared by DoD through its contract.

Authorized Provider

A hospital or institutional provider, physician, or other individual professional provider, or other provider of services or supplies specifically authorized to provide benefits under TRICARE in [32 CFR 199.6](#). Any physician listed in [32 CFR 199.6](#) who holds a valid license to practice medicine in the state where he/she practices shall be an authorized provider. Providers not specifically listed in [32 CFR 199.6](#) are not considered authorized providers unless they are included in a TRICARE demonstration program.

Authorized Supplies, Pharmacy

Non-drug items (usually used in conjunction with the administration of a drug) approved by the DoD P&T Committee for inclusion in the formulary, and appearing on the formulary web site at <http://www.pec.ha.osd.mil>.

Automated Data Processing (ADP)

A system for recording and processing data on magnetic media, ADP cards, or any other method for mechanical/electronic processing and manipulation or storage of data.

Average Wholesale Price (AWP)

The wholesale list price of a drug, as published by First Data Bank. Most discounting formulas use AWP as a reference point (e.g., AWP - 18%) to determine actual cost. DSCP uses First Data Bank (FDB) to obtain access to this information.

Backup System

A separate, off-site automated data processing system with similar operating capabilities which will be activated/used in case of a major system failure, damage, or destruction. This includes back-up data sets, software and hardware requirements, and trained personnel.

Balance Billing

The practice of a provider billing a beneficiary the difference between the TRICARE allowed amount and the billed charges on a claim. Participating providers and network providers may not collect from all sources an amount which exceeds the TRICARE allowed amount. Non-participating providers may not collect an amount which exceeds the balance billing limit (115% of the allowed charge). If the billed charge is less than the balance billing limit, then the billed charge is the maximum amount that can be collected by the non-participating provider. (See the TRICARE Reimbursement Manual (TRM), [Chapter 3, Section 1.](#))

Basic Program

The primary medical benefits authorized under Chapter 55 of Title 10, United States Code (USC), and set forth in [32 CFR 199.4](#).

Benchmark

A TRICARE clerical and automated systems test using claims and other documents created or approved by TMA and processed by the contractor. The contractor's output is compared to predetermined results prepared or approved by TMA to determine the accuracy, completeness and operational characteristics of the contractor's clerical and automated systems components. The purpose of the benchmark is to identify clerical and automated systems deficiencies which must be corrected before claims can be processed in accordance with TMA requirements. The comprehensiveness of the benchmark will vary depending on the number and type of conditions tested.

Beneficiary History File

A system of records consisting of any record or subsystem of records, whether hard copy, microform or automated, which reflects diagnosis, treatment, medical condition, or any other personal information with respect to any individual, including all such records acquired or utilized

by the contractor in delivery of health care services, in the development and processing of claims, or in performing any other functions under a TRICARE contract.

1. Hard Copy Claim and Microform Files. These files may include:

- Claim forms (TRICARE or other claim form approved by TMA)
- DoD Document (DD) Form 1251, Non-Availability Statement (NAS)
- Reports and related documentation pertaining to professional review of treatment
- Powers of Attorney
- Other Statements of Legal Guardianship
- Receipts (Itemized Bills)
- Other Insurance Payment Information (or EOB)
- Medical Reports (Mental illness case files, **Durable Medical Equipment (DME)**, Medical Necessity Statement, Emergency Admission Statement, progress reports, nursing notes, operative reports, test results, etc.).
- Timely Filing Waiver
- Claim-Related Correspondence
- Appeals Case File
- Any other contractor developed documentation which is used for recording and documenting care and payment for care by network providers of care.

2. Automated History Files. The electronically maintained record of a beneficiary's medical care and related administrative data, including such data on charges, payments, deductible status, services received, diagnoses, adjustments, etc.

Beneficiary Liability

The legal obligation of a beneficiary, his or her estate, or responsible family member to pay for the costs of medical care or treatment received. Specifically, for the purposes of services and supplies covered by TRICARE, beneficiary liability includes any annual deductible amount, cost-sharing amounts, or, when a provider does not submit a claim on a participating basis on behalf of the beneficiary, amounts above the TRICARE-determined allowable cost or charge. Beneficiary liability also includes any expenses for medical or related services and supplies not covered by TRICARE.

Benefit

The TRICARE benefit consists of those services, payment amounts, cost-shares and copayments authorized by Public Law (PL) 89-614, 32 CFR 199 and the TRICARE Policy Manual (TPM).

Best Value Health Care

The delivery of high quality clinical and other related services in the most economical manner for the MHS that optimizes the Direct Care (DC) system while delivering the highest level of customer service.

Business Associate (HIPAA/Privacy Definition)

1. A person who on behalf of a covered entity or of an organized health care arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs, or assists in the performance of a function or activity involving the use or disclosure of Individually Identifiable Health Information (IIHI) or provides services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of IIHI from such covered entity or arrangement, or from another business associate of such covered entity or arrangement to the person.

2. A covered entity participating in an organized health care arrangement that performs a function or activity for or on behalf of such organized health care arrangement, or that provides a service to or for such organized health care arrangement, does not, simply through the performance of such function or activity or the provision of such service, become a business associate of other covered entities participating in such organized health care arrangement.

3. A covered entity may be a business associate of another covered entity.

For a full definition, refer to the Final Rule on Standards for Privacy of IIHI.

Capability Of A Provider

The scope of services the provider is both capable of performing and willing to perform under a TRICARE contract. For example, a neurologist who only performs sleep studies may not be considered to have capability to perform as a general neurology specialist.

Capacity Of A Provider

The amount of time or number of services a provider is able to perform in conjunction with a TRICARE contract. For example, a primary care physician whose practice is full has no available capacity for services.

Capped Rate

The maximum per diem or all-inclusive rate that TRICARE will allow for care.

Care Coordination

A comprehensive method of client assessment designed to identify client vulnerability, needs identification, and client goals which results in the development plan of action to produce an outcome that is desirable for the client. The goal is to provide client advocacy, a system for coordinating client services, and providing a systematic approach for evaluation of the effectiveness of the client's Life Plan.

Case Management

A collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services to meet an individual's health care needs using resources available to provide quality and cost-effective outcomes, which includes assisting in coordinating case management patients from one location to another. Case management is not restricted to catastrophic illnesses and injuries.

Catastrophic Cap

The National Defense Authorization Act for Fiscal Years 1988 and 1989 (PL 100-180) amended Title 10, USC, and established catastrophic loss protection for TRICARE beneficiary families on a government fiscal year basis. The law placed fiscal year limits or catastrophic caps on beneficiary liabilities for deductibles and cost-shares under the TRICARE Basic Program. Specific guidance may be found in the TRM, [Chapter 2, Section 2](#).

Catchment Areas

Geographic areas determined by the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) that are defined by a set of five digit zip codes, usually within an approximate 40 mile radius of military inpatient treatment facility. Beneficiaries not enrolled in TRICARE Prime residing in these areas will be required to receive inpatient mental health care from the Military Treatment Facility (MTF) or obtain a Non-Availability Statement (NAS) (see definition) that authorizes civilian inpatient care.

Certification and Accreditation (C&A) Process

The C&A process ensures that the trust requirement is met for information systems and networks. Certification is the determination of the appropriate level of protection required for information systems/networks. Certification also includes a comprehensive evaluation of the technical and non-technical security features and countermeasures required for each system/network. Accreditation is the formal approval by the Government to operate the contractor's IS/networks in a particular security mode using a prescribed set of safeguards at an acceptable level of risk. In addition, accreditation allows IS/networks to operate within the given operational environment with stated interconnections; and with appropriate level-of-protection for the specified period. The C&A requirements apply to all DoD ISs/networks and Contractor ISs/networks that access, manage, store, or manipulate electronic IS data. Specific guidance may be found in the TRICARE Systems Manual (TSM), [Chapter 1](#).

Certification For Care

The determination that the provider's request for care (level of care, procedure, etc.) is consistent with preestablished criteria. (Note: This is NOT synonymous with authorization for care).

Certified Provider

A hospital or institutional provider, physician, or other individual professional provider of services or supplies specifically authorized by [32 CFR 199.6](#). Certified providers have been verified by TMA or a designated contractor to meet the standards of [32 CFR 199.6](#), and have been approved to provide services to TRICARE beneficiaries and receive Government payment for services rendered to TRICARE beneficiaries.

CHAMPUS Maximum Allowable Charge (CMAC)

CMAC is a nationally determined allowable charge level that is adjusted by locality indices and is equal to or greater than the Medicare Fee Scheduled amount.

CHAMPVA

The Civilian Health and Medical Program of the Veterans Administration. This is a program of medical care for spouses and dependent children of disabled or deceased disabled veterans who meet the eligibility requirements of the DVA.

CHAMPVA Center (CVAC)

The component within the Department of Veterans Affairs (DVA), Health Administration Center (HAC) which processes all CHAMPVA claims.

Change Order

A written directive from the TMA Procuring Contracting Officer (PCO) to the contractor directing changes within the general scope of the contract, as authorized by the "changes clause" at FAR 52.243-1, Changes--Fixed Price.

Christian Science Nurse

An individual who has been accredited as a Christian Science Nurse by the Department of Care of the First Church of Christ, Scientist, Boston, Massachusetts, and listed (or eligible to be listed) in the Christian Science Journal at the time the service is provided. The duties of Christian Science nurses are spiritual and are nonmedical and nontechnical nursing care performed under the direction of an accredited Christian Science practitioner. There are two levels of Christian Science nurse accreditation:

- 1. Graduate Christian Science Nurse.** This accreditation is granted by the Department of Care of the First Church of Christ, Scientist, Boston, Massachusetts, after completion of a three year course of instruction and study.

2. Practical Christian Science Nurse. This accreditation is granted by the Department of Care of the First Church of Christ, Scientist, Boston, Massachusetts, after completion of a one year course of instruction and study.

Christian Science Practitioner

An individual who has been accredited as a Christian Science Practitioner for the First Church of Christ, Scientist, Boston, Massachusetts, and listed (or eligible to be listed) in the Christian Science Journal at the time the service is provided. An individual who attains this accreditation has demonstrated results of his or her healing through faith and prayer rather than by medical treatment. Instruction is executed by an accredited Christian Science teacher and is continuous.

Christian Science Sanatorium

A sanatorium either operated by the First Church of Christ, Scientist, or listed and certified by the First Church of Christ, Scientist, Boston, Massachusetts.

Claim

1. Any request for payment for health care services rendered which is received from a beneficiary, a beneficiary's representative, or a network or non-network provider by a contractor on any TRICARE-approved claim form or approved electronic medium. If two or more forms for the same beneficiary are submitted together, they shall constitute one claim unless they qualify for separate processing under the claims splitting rules. (It is recognized that services may be provided in situations in which no claims, as defined here, are generated. This does not relieve the contractor from collecting the data necessary to fulfill the requirements of the TED for all care provided under the contract.)

2. Any request for reimbursement of a dispensed pharmaceutical agent or diabetic supply item. For electronic media claims, one prescription equals one claim. For paper claims, reimbursement for multiple prescriptions may be requested on a single paper claim.

Claim File

The collected records submitted with or developed in the course of processing a single claim. It includes the approved TRICARE claim form and may include attached bills, medical records, record of telephone development, copies of correspondence sent and received in connection with the claim, the EOB, and record of adjustments to the claim. It may also include the record of appeals and appeal actions. The claim file may be in microcopy, hard copy, or in a combination of media.

Claim Form

A fixed arrangement of captioned spaces designed for entering and extracting prescribed information, including ADP system forms.

Claims Cycle Time

That period of time, recorded in calendar days, from the receipt of a claim into the possession/ custody of the contractor to the completion of all processing steps (See "Processed to Completion (or Final Disposition)" in this Appendix, and TSM, [Chapter 2, Section 2.4](#), "Date TED Record Processed to Completion").

Claims Payment Data

The record of information contained on or derived from the processing of a claim or encounter.

Clinical Support Agreement

An agreement between a contractor and an MTF Commander to provide needed clinical personnel at an MTF under a "task order" type requirement.

Code Set (HIPAA/Privacy Definition)

Any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes. A code set includes the codes and descriptors of the codes.

Code Set Maintaining Organization (HIPAA/Privacy Definition)

An organization that creates and maintains the code sets adopted by the Secretary (HHS) for use in the transactions for which standards are adopted.

Combined Daily Charge (HIPAA/Privacy Definition)

A billing procedure by an inpatient facility that uses an inclusive flat rate covering all professional and ancillary charges without any itemization.

Concurrent Review/Continued Stay Review

Evaluation of a patient's continued need for treatment and the appropriateness of current and proposed treatment, as well as the setting in which the treatment is being rendered or proposed. Concurrent review applies to all levels of care (including outpatient care).

Confidentiality Requirements

The procedures and controls that assure the confidentiality of medical information in compliance with the Freedom of Information Act, the Comprehensive Alcohol Abuse and Alcoholism Prevention and Rehabilitation Act, and the Privacy Act.

Conflict Of Interest

Includes any situation where an active duty member (including a reserve member while on active duty) or civilian employee of the United States Government, through an official federal position, has the apparent or actual opportunity to exert, directly or indirectly, any influence on the referral of MHS beneficiaries to himself or herself or others with some potential for personal gain or appearance of impropriety. Individuals under contract to a Uniformed Service may be involved in a conflict of interest situation through the contract position.

Consulting Physician Or Dentist

A physician or dentist, other than the attending physician, who performs a consultation.

Continued Health Care Benefit Program (CHCBP)

The CHCBP provides temporary continued health care benefits for certain former beneficiaries of the Military Health System (MHS). Coverage under the CHCBP is purchased on a premium basis.

Continuum of Care

All patient care services provided from "pre-conception to grave" across all types of settings. Requires integrating processes to maintain ongoing communication and documentation flow between the DC system and network.

Contract Performance Evaluation (CPE)

The review by TMA, of a contractor's level of compliance with the terms and conditions of the contract. Usually, an operational audit performed by TMA staff focuses on timeliness, accuracy, and responsiveness of the contractor in performing all aspects of the work required by the contract.

Contract Physician

A physician who has made contractual arrangements with a contractor to provide care or services to TRICARE beneficiaries. A contract physician is a network provider who participates on all TRICARE claims.

Contracting Officer's Representative (COR)

A government representative, appointed in writing by the contracting officer, who represents the contracting officer in technical matters.

Contractor

An organization with which TMA has entered into a contract for delivery of and/or processing of payment for health care services, performance of related support activities such as pharmacy services, quality monitoring or customer service.

Control Of Claims

The ability to identify individually, locate, and count all claims in the custody of the contractor by location, including those that may be being developed by physical return of a copy of the claim, and age including total age in-house and age in a specific location.

Controlled Substances

Those medications which are included in one of the schedules of the Controlled Substances Act of 1970 and as amended.

Coordination Of Benefits (COB)

A system to require collection of other health insurance benefits before making any TRICARE benefit payment, except for Medicaid, in compliance with requirements specified in 32 CFR 199 and the TRM.

Copayment

See the definition for "cost-share."

Cost Effective Provider Network Areas

Areas in which provider networks can be developed where the discounts received from providers and the effects of Utilization Management activities are greater than or equal to the administrative costs associated with maintaining the Provider Network and accomplishing all additional marketing, education, enrollment, and related administrative activities.

Cost-Share

The amount a beneficiary must pay for covered inpatient and outpatient services (other than the deductible, the annual TRICARE Prime enrollment fee, the balance billing amount, or disallowed amounts) as set forth in [32 CFR 199.4](#), [199.5](#), and [199.17](#). Active Duty Service Members (ADSMs) have no financial liability for the authorized health care services they receive. They do not pay cost-shares, deductibles, enrollment fees, or balance billed amounts. The contractor shall reimburse the full amount that a provider can collect, including any amount over CMAC up to the balance billing limit. Under TRICARE, cost-shares are expressed as either coinsurance or copayment. See the TRM, [Chapter 2](#), for additional information.

Correctional Institution (HIPAA/Privacy Definition)

Any penal or correctional facility, jail, reformatory, detention center, work farm, halfway house, or residential community program center operated by, or under contract to, the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, for the confinement or rehabilitation of persons charged with or convicted of a criminal offense or other persons held in lawful custody. Other persons held in lawful custody includes juvenile offenders adjudicated delinquent, aliens detained awaiting deportation, persons committed to mental institutions through the criminal justice system, witnesses, or others awaiting charges or trial. The term "correctional institution" includes military confinement facilities, but does not include internment

facilities for enemy prisoners of war, retained personnel, civilian detainees and other detainees provided under the provisions of DoDD 2310.1 (reference (b)).

■ **Covered Entity (HIPAA/Privacy Definition)**

A health plan, health care clearinghouse or health care provider who transmits any health information in electronic form in connection with a transaction. In the case of a health plan administered by the Department of Defense, the covered entity is the DoD Component (or subcomponent) that functions as the administrator of the health plan.

■ For details refer to the Transaction and Code Sets Regulation and the Standards for Privacy of IIII Regulation.

■ **Covered Functions (HIPAA/Privacy Definition)**

Those functions of a covered entity the performance of which makes the entity a health plan or health care provider.

Credentialing

The process by which providers are allowed to participate in the network. This includes a review of the provider's training, educational degrees, licensure, practice history, etc.

Credentials Package

Credentials packages are required for all clinical personnel supplied by the contractor who will be working in an MTF. Similar packages may be required for non-clinical personnel. The credentials package shall contain the following information.

1. All documents, verified per regulation/directive/instruction/policy, which are needed in order for the individual to provide the proposed services at the involved facility. This will include licensure from the jurisdiction in which the individual will be practicing and a National Practitioner Data Bank (NPDB) query as specified by the facility.

2. Credentials files for all personnel required by law to have a Criminal History Background Check (CHBC) will contain documentation showing that the required CHBC has been completed prior to awarding of privileges or the delivery of services.

- If a CHBC has been initiated, but not completed, the MTF commander has the authority to allow awarding of privileges and initiation of services if delivered under clinical supervision.
- The mechanism for accomplishing the CHBC may vary between MTFs and should be determined during phase-in/transition and be agreed to by the MTF Commander.
- Regardless of the mechanism for initiating and completing a CHBC, the cost shall be borne by the contractor.

3. TRICARE Provider ID number when provider is of a type which is recognized by TRICARE. Medicare Provider ID number when provider is of a type recognized by Medicare.
4. Evidence of compliance (or scheduled compliance) with the MTF specific requirements including all local Employee Health Program (EHP), Federal Occupational Safety Act and Health Act (OSHA), and Bloodborne Pathogens Program (BBP) requirements.

Custodial Care Prior To December 28, 2001

Care rendered to a patient:

1. Who is disabled mentally or physically and such disability is expected to continue and be prolonged, and
2. Who requires a protected, monitored, or controlled environment whether in an institution or in the home, and
3. Who requires assistance to support the essentials of daily living, and
4. Who is not under active and specific medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored, or controlled environment.

A custodial care determination is not precluded by the fact that a patient is under the care of a supervising or attending physician and that services are being ordered and prescribed to support and generally maintain the patient's condition, or provide for the patient's comfort, or ensure the manageability of the patient. Further, a custodial care determination is not precluded because the ordered and prescribed services and supplies are being provided by an RN, LPN, or LVN.

Note: The determination of custodial care in no way implies that the care being rendered is not required by the patient; it only means that it is the kind of care that is not covered under TRICARE. A program of physical and mental rehabilitation which is designed to reduce a disability is not custodial care as long as the objective of the program is a reduced level of care.

Custodial Care After December 28, 2001

The treatment or services, regardless of who recommends such treatment or services or where such treatment or services are provided, that can be rendered safely and reasonably by a person who is not medically skilled or is or are designed mainly to help the patient with the activities of daily living.

Cycle Time

The elapsed time, as expressed in calendar days (including any part of the first and last days counted as two days), from the date a claim, piece of correspondence, grievance, or appeal case was received by a contractor through the date PTC. (See claims cycle time for added detail.)

Data

Any information collected, derived, or created as a result of operations as a TRICARE contractor. All data is the property of the Government regardless of where it is maintained/stored.

Data Aggregation (HIPAA/Privacy Definition)

The combining of Protected Health Information (PHI) by a business associate with the PHI received by the business associate in its capacity as a business associate of another covered entity, to permit data analyses that relate to the health care operations of the respective covered entities.

Data Condition (HIPAA/Privacy Definition)

The circumstances under which a covered entity must use a particular data element or segment.

Data Content (HIPAA/Privacy Definition)

The data elements and code sets inherent to a transaction, and not related to the format of the transaction. Data elements that are related to the format are not data content.

Data Element (HIPAA/Privacy Definition)

The smallest named unit of information in a transaction.

Data Repository

A single point of electronic storage, established and maintained by the contractor, that enables the Government to electronically access all data maintained by the contractor relative to a TRICARE contract. This includes all claims/encounter data, provider data, authorization, enrollment, and derived data collected in relation to a TRICARE contract.

Data Set (HIPAA/Privacy Definition)

A semantically meaningful unit of information exchanged between two parties to a transaction.

Date Of Determination (Appeals)

The date of completion appearing on the reconsideration determination, formal review determination, or hearing final decision.

Days

Calendar days unless otherwise indicated.

Days Supply

The number of days that the dispensed quantity of drug should last, based on directions for use with a limit as the First Data Bank recommended maximum daily dose (unless specifically altered by DoD).

Deductible

The statutory requirement for payment by the beneficiary of an initial specified dollar amount of the TRICARE-determined allowable costs or charges for covered outpatient services or supplies provided in any one fiscal year.

Example 1: Under TRICARE Standard and TRICARE Extra, the deductible is \$50 (for family members of sponsors in pay grade E-4 and below) or \$150.00 (for family members of sponsors in pay grades above E-4, and retirees and their family members) For a family, the aggregate payment of \$100 (for family members of sponsors in pay grade E-4 and below) or \$300.00 (for family members of sponsors in pay grades above E-4, and retirees and their family members) by two or more beneficiaries will satisfy the deductible requirement.

Example 2: For TRICARE Prime enrollees, under the Point-of-Service option, the deductible is \$300 for individuals, \$600 for a family.

Defense Enrollment Eligibility Reporting System (DEERS)

The computer-based enrollment/eligibility system for verifying entitlement to health care services. See the 32 CFR 199 definition and the TSM, for specific information concerning DEERS.

De-Identified Data (HIPAA/Privacy Definition)

Health information that has been rendered not **IIHI** by removal of identifiers of the individual or of relatives, employers, or household members of the individual, such as names, geographic subdivisions smaller than a State, all elements of dates (except year) for dates directly related to an individual, telephone numbers, Social Security Numbers, etc. For full details refer to the DoD Health Information Privacy Regulation.

Demonstration

A study or test project with respect to alternative methods of payment for health and medical services, cost-sharing by eligible beneficiaries, methods of encouraging efficient and economical delivery of care, innovative approaches to delivery and financing services and prepayment for services provided to a defined population. Following completion and evaluation of the test project, it may or may not become part of the program.

Descriptor (HIPAA/Privacy Definition)

The text defining a code.

Designated Record Set (HIPAA/Privacy Definition)

A group of records maintained by or for a covered entity that is:

1. The medical records and billing records about individuals maintained by or for a covered health care provider;

2. The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or
3. Used, in whole or in part, by or for the covered entity to make decisions about individuals.

For purposes of this definition, the term record means any item, collection, or grouping of information that includes PHI and is maintained, collected, used, or disseminated by or for a covered entity.

Designated Standard Maintenance Organization (DSMO) (HIPAA/Privacy Definition)

An organization designated by the Secretary (HHS) under §162.910(a) of the Transaction and Code Sets Regulation.

Diagnosis Related Groups (DRGs)

A categorization of hospital patients into clinically coherent groups based on their consumption of resources. Patients are assigned to the groups based on their principal diagnosis (the reason for admission, determined after study), secondary diagnoses, procedures performed, and the patient's age, sex, and discharge status. A reimbursement system using DRGs assigns payment levels to each DRG based on the average cost of treating all patients in a given DRG.

Direct Data Entry (HIPAA/Privacy Definition)

The direct entry of data (for example, using dumb terminals or web browsers) that is immediately transmitted into a health plan's computer.

Direct Treatment Relationship (HIPAA/Privacy Definition)

A treatment relationship between an individual and a health care provider that is not an indirect treatment relationship as defined under the DoD Health Information Privacy Regulation.

Discharge Planning

The development of an individualized discharge plan for the patient prior to leaving an institution for home, with the aim of improving patient outcomes, reducing the chance of unplanned readmission to an institution, and containing costs.

Disclosure (HIPAA/Privacy Definition)

The release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

Domiciliary Care

Care provided to a patient in an institution or home-like environment because (1) providing support for the activities for daily living in the home is not available or is unsuitable; or (2) members of the patient's family are unwilling to provide the care.

Note: The terms “domiciliary” and “custodial care” represent separate concepts and are not interchangeable. Custodial care and domiciliary care are not covered under the TRICARE Prime, Extra, or Standard programs or the Extended Care Health Option (ECHO).

Donor

An individual who supplies living tissue or material to be used in another body, such as a person who furnishes a kidney for renal transplant.

Double Coverage

Enrollment by a TRICARE beneficiary in another insurance, medical service, or health plan that duplicates all or part of a beneficiary’s TRICARE benefits.

Double Coverage Plan

The specific insurance, medical service, or health plan under which a TRICARE beneficiary has entitlement to medical benefits that duplicate TRICARE benefits in whole or in part. Double coverage plans do not include:

1. Medicaid.
2. Coverage specifically designed to supplement TRICARE benefits.
3. Entitlement to receive care from the Uniformed Services medical care facilities; or
4. Entitlement to receive care from Department of Veterans Affairs (DVA) medical care facilities; or
5. Entitlement to receive care from Indian Health Services medical care facilities; or
6. Services and items provided under Part C (Infants and Toddlers with Disabilities) of the Individuals With Disabilities Education Act (IDEA).

DSM III

A technical reference, **Diagnostic and Statistical Manual of Mental Disorders, Third Edition.**

DSM IV

A technical reference, **Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.**

Dual Compensation

Federal law (5 USC 5536) prohibits active duty members or civilian employees of the United States Government from receiving additional compensation from the Government above their normal pay and allowances. This prohibition applies to TRICARE cost-sharing of medical care provided by active duty members or civilian Government employees to TRICARE beneficiaries.

Edit Error (TEDs Only)

Errors found on TEDs (initial submissions, resubmissions, and adjustments/cancellation submissions) which result in nonacceptance of the records by TMA. These require correction of the error by the contractor and resubmission of the corrected TED to TMA for acceptance.

Electronic Media (HIPAA/Privacy Definition)

The mode of electronic transmission. It includes the Internet (wide-open), Extranet (using Internet technology to link a business with information only accessible to collaborating parties), leased lines, dial-up lines, private networks, and those transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk media.

Employment Records (HIPAA/Privacy Definition)

Records that include health information and that:

1. Are maintained by a component of the Department of Defense or other entity subject to the DoD Health Information Privacy Regulation;
2. Are about an individual who is (or seeks or sought to become) a member of the uniformed services, employee of the United States Government, employee of a Department of Defense contractor, or person with a comparable relationship to the Department of Defense; and
3. Are not maintained in connection with carrying out any covered function under the DoD Health Information Privacy Regulation.

Enrollment Fees

The amount required to be paid by some categories of MHS beneficiaries to enroll in and receive the benefits of TRICARE Prime or other special TRICARE programs.

Enrollment Plan

A plan established by the contractor to inform beneficiaries of the availability of the TRICARE Prime program, facilitate enrollment in the program, and maintain enrollment records. The plan must be approved by the government.

Enrollment Records

The official record of a beneficiary's enrollment in TRICARE Prime and maintained on the DEERS System.

Exclusion

Exclusion from participation as a provider or entity under TRICARE means that items, services, and/or supplies furnished will not be reimbursed under TRICARE. This term may be used interchangeably with "suspension."

Explanation Of Benefits (EOB)

The document prepared by insurance carriers, health care organizations, and TRICARE to inform beneficiaries of the actions taken with respect to a claim for health care coverage.

Federal Records Center (FRCs)

Centers established and maintained by the General Services Administration at locations throughout the United States for the storage, processing, and servicing of noncurrent records for Federal agencies.

Files Administration

The application of records management techniques to filing practices to maintain records easily and to retrieve them rapidly, to ensure their completeness, and to facilitate the disposition of noncurrent records.

Fiscal Year (FY)

The Federal Government's 12 month accounting period which currently runs from October 1 through September 30 of the following year.

Format (HIPAA/Privacy Definition)

The transaction data elements that provide or control the enveloping or hierarchical structure, or assist in identifying data content of, a transaction.

Formulary

A listing of pharmaceuticals and other authorized supplies to be dispensed with appropriate prescriber's order from a particular point of service. The formulary for any TRICARE contract will be managed by the DoD Pharmacy and Therapeutics (P&T) Committee with clinical guidance from the DoD Pharmacoeconomic Center (PEC). Applicable formulary information may be viewed on the TRICARE web site at: <http://www.tricare.osd.mil/pharmacy>.

Fragmented Billing

(See "Unbundled Billing")

Freedom Of Choice

The right to obtain medical care from any TRICARE-authorized source available, including TRICARE Prime, the DC system (MTF system), or obtain care from a provider not affiliated with the contractor and seek reimbursement under the terms and conditions of the TRICARE Standard Program (see definition). Beneficiaries who voluntarily enroll in TRICARE Prime must be informed of any restrictions on freedom of choice that may be applicable to enrollees as a result of enrollment. Except for any limitations on freedom of choice that are fully disclosed to the beneficiaries at the time of enrollment, freedom of choice provisions applicable to the TRICARE Standard Program shall be applicable to TRICARE Prime.

Freedom Of Information Act (FOIA)

A law enacted in 1967 as an amendment to the "Public Information" section of the Administrative Procedures Act, establishing provisions making information available to the public. TMA and contractors are subject to these provisions.

Freestanding

Not "institution-affiliated" or "institution-based."

Full Mobilization

When the President recommends and the Congress orders full mobilization. Full mobilization requires passage by the Congress of a public law or joint resolution declaring war and involves the mobilization of all Reserve Component (RC) units.

Gag Clause

A gag clause is any clause included in a professional provider's agreement or contract with a managed care organization (such as a PPO network or HMO network) or third party payer that directly or indirectly limits the ability of the health care professional provider to provide treatment information and options to their patients in particular limitations on advice regarding the patient's health status, medical care, and treatment options, the risks, benefits and consequences of treatment or non-treatment, or the opportunity for the individual to refuse treatment and to express preferences about future treatment options.

Good Faith Payments

Those payments made to civilian sources of medical care who provided medical care to persons purporting to be eligible beneficiaries but who are determined later to be ineligible for TRICARE benefits. (The ineligible person usually possesses an erroneous or illegal identification card.) To be considered for good faith payments, the civilian source of care must have exercised reasonable precautions in identifying a person claiming to be an eligible beneficiary.

Grievance

A written complaint on a non-appealable issue which deals primarily with a perceived failure of a network provider, the Health Care Finder (HCF), or contractor or subcontractor, to furnish the level or quality of care expected by a beneficiary.

Grievance Process

A contractor developed and managed system for resolving beneficiary grievances.

Group Health Plan (HIPAA/Privacy Definition)

An employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income and Security Act of 1974 (ERISA), 29 USC 1002(1)), including insured and self-insured plans, to the extent that the plan provides medical care (as defined in section 2791(a)(2) of the Public Health Service Act (PHS Act), 42 USC 300gg-91(a)(2)), including items and services paid for as medical care, to employees or their dependents directly or through insurance, reimbursement, or otherwise, that:

1. Has 50 or more participants (as defined in section 3(7) of ERISA, 29 USC 1002(7)); or
2. Is administered by an entity other than the employer that established and maintains the plan.

HCPCS (HIPAA/Privacy Definition)

The Transaction and Code Sets Regulation defines "HCPCS" as follows, "HCPCS stands for the Health Care Common Procedure Coding System."

Health Benefits Advisors (HBAs)

Those individuals located at Uniformed Services medical facilities (on occasion at other locations) and assigned the responsibility for providing TRICARE information, information concerning availability of care from the Uniformed Services direct medical care system, and generally assisting beneficiaries (or sponsors). The term also includes "Health Benefits Counselor."

Health Care (HIPAA/Privacy Definition)

Care, services, or supplies related to the health of an individual. Health care includes but is not limited to, preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and the sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

Health Care Clearinghouse (HIPAA/Privacy Definition)

A public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that does either of the following functions.

1. Processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.
2. Receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.

Health Care Finder (HCF)

The person who manages and performs the duties necessary to operate the HCF System.

Health Care Finder (HCF) System

A system or mechanism established by the contractor in each **Prime Service Area (PSA)** in the region to facilitate referrals and other customer service functions of beneficiaries to military and/or civilian health care services.

Health Care Provider (HCP)

1. An individual or institution licensed or otherwise authorized to practice medicine or deliver health care services, supplies, or equipment.
2. For purposes of the Transaction and Code Sets Regulation and the Privacy Regulation, a provider of medical or health services and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business.

Health Information (HIPAA/Privacy Definition)

Any information, whether oral or recorded in any form or medium, that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

Health Insurance Issuer (HIPAA/Privacy Definition)

An insurance company, insurance service, or insurance organization (including an HMO) that is licensed to engage in the business of insurance in a State and is subject to State Law that regulates insurance. Such term does not include a group health plan.

Health Maintenance Organization (HMO) (HIPAA/Privacy Definition)

A federally qualified HMO, an organization recognized as an HMO under State law, or a similar organization regulated for solvency under State law in the same manner and to the same extent as such an HMO.

Health Oversight Agency (HIPAA/Privacy Definition)

An agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is authorized by law to oversee the health care system (whether public or private) or government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which health information is relevant. The term "health oversight agency" includes any DoD Component authorized under applicable DoD Regulation to oversee the MHS, including with respect to matters of quality of care, risk management, program integrity, financial management, standards of conduct, or the effectiveness of the Military Health System (MHS) in carrying out its mission.

Health Plan (HIPAA/Privacy Definition)

Any DoD program that provides or pays the cost of health care. For full details, see the DoD Health Information Privacy Regulation.

HHS Regulation (HIPAA/Privacy Definition)

45 CFR Parts 160-164.

Hospital Day

An overnight stay at a hospital. Normally if the patient is discharged in less than 24 hours it would not be considered an inpatient stay; however, if the patient was admitted and assigned to a bed and the intent of the hospital was to keep the patient overnight, regardless of the actual Length-Of-Stay (LOS), the stay will be considered an inpatient stay and, therefore, a hospital day. For hospital stays exceeding 24 hours, the day of admission is considered a hospital day; the day of discharge is not.

ICD-9-CM

A technical reference, **International Classification of Diseases, 9th Edition, Clinical Modification**. It is a required reference and coding system for diagnoses in processing TRICARE claims for medical care.

Immediate Family

The spouse, natural parent, child and sibling, adopted child and adoptive parent, stepparent, stepchild, grandparent, grandchild, stepbrother and stepsister, father-in-law, mother-in-law of the beneficiary, or provider, as appropriate. For purposes of this definition only, to determine who may render services to a beneficiary, the step-relationship continues to exist even if the marriage upon which the relationship is based terminates through divorce or death of one of the parents.

Independent Laboratory

A freestanding laboratory approved for participation under Medicare and certified by the Center for Medicare and Medicaid Service (CMS).

Indirect Treatment Relationship (HIPAA/Privacy Definition)

A relationship between an individual and a HCP in which:

1. The health care provider delivers health care to the individual based on the orders of another health care provider; and
2. The health care provider typically provides services or products, or reports the diagnosis or results associated with the health care, directly to another health care provider, who provides the services or products or reports to the individual.

Individual (HIPAA/Privacy Definition)

The person who is the subject of PHI.

Individual Consideration (IC) Procedure

An individual consideration procedure is one that is not routinely provided, is unusual, variable, or new. These procedures will require additional information from the provider of care, including an adequate definition or description of the nature, extent and need for the procedure; and the time, effort, and necessary equipment required. Any complexities related to the service should also be identified.

Individually Identifiable Health Information (IIHI) (HIPAA/Privacy Definition)

Information that is a subset of health information, including demographic information collected from an individual, and:

1. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and
 - That identifies the individual; or
 - With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Intervention, Pharmacy

A change in therapy resulting from the prospective drug utilization review process and contact with the prescriber and/or the beneficiary because of allergy, clinically significant interactions, duplicative therapy, or other reasons.

Intervention Report, Pharmacy

A report of prescriptions not dispensed or changes in therapy as a result of contact with prescribers and/or beneficiaries because of allergies, clinically significant interactions, duplicative therapy, or other reasons. The intervention report shall also contain the resultant change in cost due to the intervention, if possible.

Initial Determination

A formal written decision (including an EOB) regarding a TRICARE claim, a request for benefit authorization, a request by a provider for approval as an authorized TRICARE provider, or a decision sanctioning a TRICARE provider. Rejection of a claim or a request for benefit or provider authorization for failure to comply with administrative requirements, including failure to submit reasonably requested information, is not an initial determination. Responses to general or specific inquiries regarding TRICARE benefits are not initial determinations.

Initial Payment

The first payment on a continuing claim, such as a long-term institutional claim.

Inpatient Care

Care provided to a patient who has been admitted to a hospital or other authorized institution for bed occupancy for purposes of receiving necessary medical care, with the reasonable expectation that the patient will remain in the institution at least 24 hours, and with the registration and assignment of an inpatient number or designation. Institutional care in connection with in and out (ambulatory) surgery is not included within the meaning of inpatient whether or not an inpatient number or designation is made by the hospital or other institution. If the patient has been received at the hospital, but death occurs before the actual admission occurs, an inpatient admission exists as if the patient had lived and had been formally admitted.

Inquiry

Requests for information or assistance made by or on behalf of a beneficiary, provider, the public, or the Government. Written inquiries may be made in any format (letter, memorandum, note attached to a claim, etc.). Allowable charge complaints, grievances, and appeals are excluded from this definition.

Institution-Affiliated

Related to a TRICARE authorized institutional provider through a shared governing body but operating under a separate and distinct license or accreditation.

Institution-Based

Related to a TRICARE authorized institutional provider through a shared governing body and operating under a common license and shared accreditation.

Institutional Provider

A HCP which meets the applicable requirements established by [32 CFR 199.6](#).

Internal Control Number (ICN)

The unique number assigned to a claim by the contractor to distinguish it in processing, payment, and filing procedures. It is the number affixed to the face of each claim received and will, at a minimum, include the Julian date of receipt and a five digit sequence number assigned by the contractor. Each TED must have a unique ICN. For records generated from claims, it will be the ICN of the claim from which it was generated. For TED which are not generated from claims, it will be a unique number assigned by the contractor which will include the Julian date of the record's creation and a five digit sequence number.

Investigational Drugs

New drugs or biological drugs, not yet available for prescribing to the general public but currently being used in a clinical investigation.

Laboratory And Pathological Services

Laboratory and pathological examinations (including machine diagnostic tests that produce hard-copy results) when necessary to, and rendered in connection with medical, obstetrical, or surgical diagnosis or treatment of an illness or injury, or in connection with well-baby care.

Law Enforcement Official (HIPAA/Privacy Definition)

An officer or employee of any agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, who is empowered by law to:

1. Investigate or conduct an official inquiry into a potential violation of law; or
2. Prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.

Legacy Identifier (HIPAA/Privacy Definition)

Any provider identifier besides the NPI and Federal Tax IDs. Legacy identifiers may include but not be limited to OSCAR, NSC, PINS, UPINS and other identifiers. A Federal Tax ID is not considered a legacy identifier for health care purposes as it's primary purpose is to support IRS 1099 reporting.

Limited Data Set (HIPAA/Privacy Definition)

PHI that excludes direct identifiers of the individual or of relatives, employers, or household members of the individual.

Machine-Readable Records/Archives

The records and archives whose informational content is usually in code and has been recorded on media, such as magnetic disks, drums, tapes, punched paper cards, or punched paper tapes, accompanied by finding aids known as software documentation. The coded information is retrievable only by machine.

Maintain Or Maintenance (HIPAA/Privacy Definition)

Activities necessary to support the use of a standard adopted by the Secretary (HHS), including technical corrections to an implementation specification, and enhancements, or expansion of a code set. This term excludes the activities related to the adoption of a new standard or implementation specification, or modification to an adopted standard or implementation specification.

Major Diagnostic Category (MDC)

A grouping of Diagnosis Related Groups (DRGs) aggregated on the basis of clinical similarity.

Managed Care Support Contractor (MCSC)

Regional contractors providing managed care support to the MHS. The MCSCs are responsible for assisting the TMA Regional Director(s) (RD(s)) and the MTF Commander(s) in operating an integrated health care delivery system, combining resources of the military's direct medical care system and the contractor's managed care support to provide health, medical and administrative support services to eligible beneficiaries.

Marketing

Communication about a product or service to encourage recipients of the communication to purchase or use the product or service. The DoD Health Information Privacy Regulation lists specific exclusions to this definition.

Maximum Allowable Prevailing Charge

The TRICARE state prevailing charges adjusted by the Medicare Economic Index (MEI) according to the methodology as set forth in [Chapter 10](#).

Maximum Defined Data Set

The required data elements for a particular standard based on a specific implementation specification.

Medicaid

The medical benefits program authorized under Title XIX of the Social Security Act as administered by state agencies in the various states.

Medical

The generally used term which pertains to the diagnosis and treatment of illness, injury, pregnancy, and mental disorders by trained and licensed or certified health professionals. For purposes of TRICARE, the term "medical" should be understood to 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 Necessity Determination

A review by the contractor, based on Government provided criteria, to determine if a nonformulary pharmaceutical agent should be dispensed with a formulary copay.

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.

Medication Error

A medication error occurs when a pharmacy dispenses to a beneficiary a medication that is not in compliance with what is prescribed by the provider (e.g., wrong medication, wrong strength, wrong quantity, wrong dose, wrong route of administration, outdated medications, wrong directions, wrong auxiliary labels, wrong patient information leaflets, or medication(s) labeled for or dispensed to the wrong patient).

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 MTF. The categories of 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 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 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.

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 DC 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 10 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 12 month base period.

National Provider Identifier (NPI)

The HIPAA Administrative Simplification: Standard Unique Health Identifier for HCPs; Final Rule (45 CFR 162), defines "National Provider Identifier" as a standard unique health identifier for HCPs. The NPI format consists of an all numeric identifier, 10 positions in length, with an International Standard Organization (ISO) standard check-digit in the 10th position (§162.406(a)). The NPI will not contain intelligence about the HCP.

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 NAS, 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](#).

Non-Availability Statement (NAS)

A statement issued by a commander (or designee) of a Uniformed Services Medical Treatment Facility (USMTF) 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 (ASD(HA)), be extended to other specific types of care. TRICARE Prime enrollees are exempt from NAS requirements, even under the Point-of-Service option. All other beneficiaries residing within the MTF's 40 mile catchment area require an NAS as specified.

Non-Claim Health Care Data

That data captured by the contractor to complete the required TED 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.

Non-Compliant, Pharmacy

Patient did not receive the medication for various reasons (e.g., did not pick up the prescription within the given 10 day grace period, pharmacy cancelled the prescription) and as a result the medication is returned to stock. A subsequent reversal is automatically sent to PDTS which will result in the removal of the prescription fill from the patient profile. A reversed or adjusted TED record is also submitted to TMA resulting in a financial credit to the Government.

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 (DoD) uniformed services (the Commissioned Corps of the U.S. Public Health Service (USPHS), the U.S. Coast Guard, and the Commissioned Corps of the National Oceanic and Atmospheric Administration (NOAA)).

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.

Organized Health Care Arrangement (HIPAA/Privacy Definition)

1. A clinically integrated care setting in which individuals typically receive health care from more than one health care provider;
2. An organized system of health care in which more than one covered entity participates, and in which the participating covered entities hold themselves out to the public as participating in a joint arrangement and participate in joint activities such as utilization review, quality assessment and improvement activities, or payment activities.
3. A group health plan and a health insurance issuer or HMO with respect to such group health plan, but only with respect to PHI created or received by such health insurance issuer or HMO that relates to individuals who are or who have been participants or beneficiaries in such group health plan;
4. A group health plan and one or more other group health plans each of which are maintained by the same plan sponsor; or
5. The group health plans described in paragraph 4 of this definition and health insurance issuers or HMOs with respect to such group health plans, but only with respect to PHI created or received by such health insurance issuers or HMOs that relates to individuals who are or have been participants or beneficiaries in any of such group health plans.

For full details refer to the DoD Health Information Privacy Regulation.

Other Health Insurance (OHI)

Primary health insurance coverage other than TRICARE (does not include supplemental insurance plans).

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.

Over-the-Counter (OTC) Medications

Medications that by law do not require a prescription. OTC items covered by the TRICARE Pharmacy (TPharm) benefit (see www.tricare.osd.mil/pharmacy for covered items) will be reimbursed by the TPharm contractor when purchased with or without a prescription, as long as the purchase was from a retail pharmacy. Covered OTC's purchased without a prescription from a medical supply house or venue other than a retail pharmacy are under the jurisdiction of the Managed Care Support Contractor (MCSC).

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.

Patient Profile, Pharmacy

A complete record for each beneficiary receiving prescriptions under the TRICARE program including: name, address, telephone number, date of birth, gender, patient identification number (sponsor's SSN and DEERS dependent suffix), DEERS ID, service sponsorship, status category, chronic medical conditions (diagnosis code), allergies and adverse drug experiences, past medication history, prescriptions dispensed, non receipt of prescriptions, status on interventions and prescription problems resolved, Prior Authorizations approved or denied, and any other information supplied by the beneficiary in the patient data form or updates.

Pending Claim, Correspondence, Or Appeal

The claim/correspondence/appeal case has been received but has not been processed to final disposition.

Performance Standard

Standards against which performance shall be measured for specific aspects of a TRICARE contract.

Pharmacoeconomic Center (PEC)

The DoD PEC's mission is to improve the clinical, economic, and humanistic outcomes of drug therapy in support of the readiness and managed care missions of the MHS. The PEC is comprised of pharmacists, physicians, and pharmacy technicians from each of the three services, as well as civilian pharmacists and support personnel.

Pharmacy and Therapeutics (P&T) Committee

A DoD Chartered committee with representatives from MTF providers and MTF pharmacists. The P&T Committee's primary role is establishing and maintaining the DoD Uniform Formulary for the purchased care system and the DC system (MTFs).

Pharmacy Data Transaction Service (PDTS)

A bi-directional data transaction service that provides a pharmaceutical data warehouse and electronically transmits encrypted prescription data using NCPDP standards to the pharmacy contractor. The PDTS provides the capability to perform Prospective Drug Utilization Review (ProDUR) and houses prior authorization/medical necessity history by integrating pharmacy data from all three points of service (DC, mail order, and retail pharmacies) with increased clinical screening and medication-related outcomes.

Pharmacy Operations Center (POC)

DoD organization responsible for Tier I and Tier II (systems and software) support of the PDTS project. The POC resolves ProDUR point of service (POS) conflicts between MTFs, the TPharm contractor; monitors quantity limits (which are cumulative between all three points of service); issues NCPDP provider numbers for DC pharmacies; and maintains "lock out" and "include" databases for closed class and mandatory use requirements contracts.

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. POS 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.

Prescriber

A physician or other individual professional provider of services specifically authorized to prescribe medications or supplies in accordance with all applicable federal and state laws.

Prescription

A legal order from an authorized prescriber to dispense pharmaceuticals or other authorized supplies.

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 TRM.

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 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.

Prior Authorization, Pharmacy

For certain drugs, DoD requires the contractor to obtain verification from the prescriber that the beneficiary meets certain criteria to receive the drug. Prior Authorization criteria, when developed by the DoD Pharmacy and Therapeutics Committee, will be provided by the Government to the contractor. In certain circumstances, the contractor will be responsible for developing prior authorization criteria, e.g., quantity limit overrides.

Priority Correspondence

Correspondence received by the contractor from the Office of the (ASD(HA)) (OASD(HA)), TMA, and Members of Congress, or any other correspondence designated for priority status by the contractor's management.

Privacy Act, 5 USC 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 (PTC) (Or Final Disposition)

1. Claims. Claims are PTC, 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:

- 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
- Payment, deductible application or denial action has been posted to ADP history.

2. Correspondence. Correspondence is PTC 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 PTC (resolved) when the final reply is provided by either telephone or letter. A final telephone reply means that the caller's inquiry has been fully responded to, there are no unanswered issues remaining, and no additional call-backs are necessary. If the contractor must take a subsequent action to correct a problem or address an issue raised during the telephone call, the telephone inquiry is considered resolved when the contractor identifies the need for the subsequent action, and so notifies the inquirer. For example, if a claim requires adjustment as a result of a telephone inquiry, the call is resolved when the contractor initiates the claim adjustment and the inquirer is so notified (i.e., it is not necessary to keep the call open until the actual processing of the claim adjustment occurs).

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.

Procuring Contracting Officer (PCO)

A government employee having authority vested by a PCO's Warrant to execute, administer, and terminate contracts and orders, and modifications thereto, which obligate Government funds and commit the Government to contractual terms and conditions.

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 Drug Utilization Review (ProDUR)

A process used to identify any potential medication problems that may occur, based on a patient's current prescription, applicable patient profile information, and medication history, prior to the point of dispensing. ProDUR is used to detect over-utilization, under-utilization, therapeutic duplication, drug-disease complications, drug interactions, incorrect dosages and duration of therapy.

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.

Protected Health Information (PHI) (HIPAA/Privacy Definition)

PHI that is:

1. Transmitted by electronic media;
2. Maintained in any medium described in the definition of electronic media; or
3. Transmitted or maintained in any other form or medium.

PHI excludes PHI in:

1. Education records covered by the Family Educational Right and Privacy Act, as amended, 20 USC 1232g;
2. Records described at 20 USC 1232g(a)(4)(B)(iv); and
3. Employment records held by a covered entity in its role as an employer."

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 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.

Psychotherapy Notes (HIPAA/Privacy Definition)

Notes recorded (in any medium) by a HCP who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual’s medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

Public Health Authority (HIPAA/Privacy Definition)

An agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate. The term “public health authority” includes any DoD Component authorized under applicable DoD regulation to carry out public health activities, including medical surveillance activities under DoD Directive 6490.2.

Quality Assurance (QA), Pharmacy

A process for ensuring that effective quality control measures are in place to ensure that pharmaceuticals are dispensed accurately and timely. Quality assurance functions may be performed by both the contractor and the government.

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.

Quality Control, Pharmacy

Processes and procedures employed by the contractor to ensure that pharmaceuticals are dispensed accurately and timely.

Quality Improvement

An approach to quality management that builds upon traditional quality assurance methods by emphasizing (1) the organization and systems (rather than individuals), (2) the need for objective data with which to analyze and improve processes, and (3) the ideal that systems and performance can always improve even when high standards appear to have been met.

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.

Records

All books, papers, maps, photographs, machine readable materials, or other documentary materials, regardless of physical form or characteristics, made or received by an agency of the United States Government under Federal law or in connection with the transaction of public business or appropriate for presentation by that agency or its legitimate successor as evidence of the organization, functions, policies, decisions, procedures, operations, or other activities of the Government.

Records Management

The area of general administrative management concerned with achieving economy and efficiency in the creation, use and maintenance, and disposition of records. Included in the fulfilling of archival requirements and ensuring effective documentation.

Referral

The process of the contractor directing an MHS beneficiary to a network or non-network provider. (See also Same Day and Seventy-Two Hour Referral)

Referral Management

Referral Management is the process by which PCM's determine if they need to refer a member either to a specialist or for services to be performed outside of the PCM's office (diagnostic tests, outpatient surgery, home health care, etc.). If a referral is necessary, the PCM also needs to decide to whom the referral is made, for how long, and for what services.

Region

A geographic area determined by the Government for civilian contracting of medical care and other services for TRICARE-eligible beneficiaries.

Regional Director (RD)

The individual responsible for supporting TRICARE contract administration in a specific region and directing the activities of the TRICARE Regional Office (TRO).

Regional Director's (RD's) Office

The responsible organizational entity and designated focal point for Tri-Services health services development and planning for a single, integrated health care network within an identified Health Service Region (HSR).

Regional Review Authority (RRA)

The entity performing PRO functions. The contractor performs the duties of the RRA.

Representative

Any person who has been appointed by a party to the initial determination as counsel or advisor and who is otherwise eligible to serve as the counsel or advisor of the party to the initial determination, particularly in connection with a hearing.

Required By Law (HIPAA/Privacy Definition)

A mandate contained in law that compels a covered entity to make a use or disclosure of **PHI** and that is enforceable in a court of law. Required by law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to HCPs participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits. Required by law includes any mandate contained in a DoD Regulation that requires a covered entity (or other person functioning under the authority of a covered entity) to make a use or disclosure and is enforceable in a court of law. The attribute of being enforceable in a court of law means that in a court or court-martial proceeding, a person required by the mandate to comply would be held to have a legal duty to comply or, in the case of noncompliance, to have had a legal duty to have complied. Required by law also includes any DoD regulation requiring the production of information necessary to establish eligibility for reimbursement or coverage under TRICARE.

Research (HIPAA/Privacy Definition)

A systematic investigation, including research, development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.

Residence

For purposes of TRICARE, "residence" is the dwelling place of the beneficiary for day-to-day living. A temporary living place during periods of temporary duty or during a period of confinement, such as a residential treatment center, does not constitute a residence. In the case of minor children, the residence of the custodial parent(s) or the legal guardian shall be deemed the residence of the child. In the case of incompetent adult beneficiaries, the residence of the legal guardian shall be deemed the residence of such beneficiary. Under split enrollment, when a dependent resides away from home while attending school, their residence shall be where they are domiciled.

Residual Claim

A claim for health care services rendered during the health care delivery period of one contract, but processed under a different (incoming) contract.

Resource Sharing Agreement (External)

Agreement between the contractor and individual MTF commanders to place an MTF provider in a civilian facility (external resource sharing).

Respite Care

Short-term care for a patient in order to provide rest and change for those who have been caring for the patient at home, usually the patient's family.

Resubmissions

A group of TED records submitted to TMA to correct those TED claims and adjustments which generated edit errors when originally processed by TMA. These groups of records will be identified by the batch number and resubmission in the TED Header Record.

Retention Period

The time period for particular records (normally a series) to be kept.

Retiree

A member or former member of a Uniformed Service who is entitled to retired, retainer, or equivalent pay based on duty in a Uniformed Service.

Retrospective Drug Utilization Review

Monitoring, which occurs after a medication is dispensed, for therapeutic appropriateness, over-utilization and under-utilization, therapeutic duplication, drug-disease contraindications, drug interactions, incorrect dosage or duration of therapy.

Retrospective Review

Evaluation of care already delivered to determine appropriateness of care and conformance to pre-established criteria for utilization. The purpose for this type of review may be to validate utilization decisions made during the review process and/or to validate payment made for care provided (by examining the actual record of treatment).

Returned Claim

A claim the contractor returns to the sender because there is missing information that is needed for processing, and the missing information cannot be obtained from in-house sources.

Reversed

Status of claim once reversal transaction is transmitted for the removal of the PAID claim from a patient's profile.

Routine Correspondence

Any correspondence which is not designated as Priority Correspondence.

Same Day Referral

A referral that must be processed, appointed, and patient seen within 24 hours as medically indicated. This includes STAT, 24 hours, ASAP, and Today referral request priorities from CHCS.

Sanction

A provider exclusion, suspension, or termination.

Secondary Payer

The plan or program whose medical benefits are payable in double coverage situations only after the primary payer has adjudicated the claim.

Secretary Of Health And Human Services (HHS) (HIPAA/Privacy Definition)

The Secretary of HHS or any other officer or employee of HHS to whom the relevant authority has been delegated.

Segment (HIPAA/Privacy Definition)

A group of related data elements in a transaction.

Service Point Of Contact (SPOC)

The Uniformed Services office or individual responsible for coordinating civilian health care for ADSMs who receive care under the Supplemental Health Care Program and the TRICARE Prime Remote Program. The SPOC reviews requests for specialty and inpatient care to determine impact on the ADSM's fitness for duty; determines whether the ADSM shall receive care related to fitness for duty at a medical MTF or with a civilian provider; initiates/coordinates medical evaluation boards; arranges transportation for hospitalized service members when necessary; and provides overall health care management for the ADSMs. The SPOC 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. SPOCs for the Army, Navy/Marines, and Air Force are assigned to the Military Medical Support Office (MMSO). [See "Military Medical Support Office (MMSO)."] See [Chapter 16, Addendum A](#), for information on contacting the SPOCs for all services.

Seventy-Two Hour Referral

A referral that must be processed, appointed, and patient seen within 72 hours as medically indicated.

Skilled Nursing Facility (SNF)

An institution (or a distinct part of an institution) that meets the criteria as set forth in [32 CFR 199.6](#).

Skilled Nursing Service

A service that can only be furnished by an R.N., or L.P.N. or L.V.N., and is required to be performed under the supervision of a physician to ensure the safety of the patient and achieve the medically desired result. Examples of skilled nursing services are intravenous or intramuscular injections, levin tube or gastrostomy feedings, or tracheotomy aspiration and insertion. Skilled nursing services are other than those services that provide primarily support for the essentials of daily living or that could be performed by an untrained adult with minimum instruction or supervision.

Special Checks

Checks issued outside the normal processing workflow for the purpose of expediting payment of a claim for benefits.

Special Inquiries

Freedom of Information Act requests; Privacy Act requests; information requests by the news media; surveys, audits, and requests by Government agencies (including DoD agencies and entities other than TMA) and Congressional Committees.

Specialty Care

Specialized medical services provided by a physician specialist.

Split-Billing

The process by which claims for beneficiaries who have more than one insurer can have their claims processed for payment with the submission of only one electronic claim (also referred to as coordination of benefits).

Split Enrollment

Refers to multiple family members enrolled in TRICARE Prime under different RDs/contractors, including Managed Care Support (MCS) contractors and Uniformed Services Family Health Plan (USFHP) designated providers.

Sponsor

An active duty member, retiree, or deceased active duty member or retiree, of a Uniformed Service upon whose status his or her family members' eligibility for TRICARE is based.

Spouse

A lawful wife or husband regardless of whether or not dependent upon the active duty member or retiree.

Stakeholders

Any party who has an interest in the success of the contract. Stakeholders include the DoD, the RDs, MTF Commanders, TMA, the MHS, and all employees thereof, contractors, elected officials, and MHS beneficiaries.

Standard Transaction (HIPAA/Privacy Definition)

A transaction that complies with the applicable standard adopted under this part.

Start Of Service

The date the incoming contractor officially begins delivery of health care services, processing claims, and/or delivery of other services in a production environment, as specified in the contract.

State (HIPAA/Privacy Definition)

1. For a health plan established or regulated by Federal law, State has the meaning set forth in the applicable section of the USC for such health plan.
2. For all other purposes, State means any of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, and Guam.

Student Status

A dependent of a member or former member of a Uniformed Service who has not passed his or her 23rd birthday, and is enrolled in a full-time course of study in an institution of higher learning.

Subcontractors

1. Includes, but is not limited to, enrolled program health benefits business entities at whatever level of the contract organization they exist. It does not include institutional or non-institutional providers of health care.
2. In determining whether a business entity is a network first tier subcontractor, consideration is given as to whether or not the entity providing the designated services acts as a broker of care; i.e., the entity itself obtains the medical coverage needed by in turn contracting with institutional and non-institutional providers. Implicit in the determination is size of the offered network; i.e., does this entity provide a large number of contracted providers for a large geographical area?
3. This definition does not exclude business entities that are not specifically addressed herein but whose legal status within the contract organization establishes them as subcontractors because that term may be otherwise defined in the FAR.

Subcontracts

The contractual assignment of elements of requirements to another organization or person for purposes of TRICARE. Unless otherwise specified in the contract, the term also includes purchase orders, with changes and/or modifications thereto.

Summary Health Information (HIPAA/Privacy Definition)

Information that may be **IIHI**, and:

1. That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and
2. From which the information has been deleted, except that the geographic information may be aggregated to the level of a five digit zip code.

Supplemental Care

Medical care received by ADSMs of the Uniformed Services and other designated patients pursuant to an MTF referral (MTF Referred Care). Supplemental Health Care also includes specific episodes of ADSM non-referred civilian care, both emergent and authorized non-emergent care (non-MTF Referred Care).

Supplemental Funds

Funds used to pay for supplemental care.

Supplemental Insurance

Health benefit plans that are specifically designed to supplement TRICARE Standard benefits. Unlike other health insurance (OHI) plans that are considered primary payers, TRICARE supplemental plans are always secondary payers on TRICARE claims. These plans are frequently available from military associations and other private organizations and firms.

Suspension Of Claims Processing

The temporary discontinuance of processing (to protect the Government's interests) of claims for care furnished by a specific provider (whether the claims are submitted by the provider or beneficiary) or claims submitted by or on behalf of a specific TRICARE beneficiary pending action by the Director, TMA, or a designee, in a case of suspected fraud or abuse. The action may include administrative remedies or any other DoD issuance (e.g., DoD issuances implementing the Program Fraud Civil Remedies Act), case development or investigation by TMA, or referral to the DoD-Inspector General (IG) or the Department of Justice (DOJ) for action within their cognizant jurisdictions.

Termination

Termination is the removal of a provider as an authorized TRICARE provider based on a finding that the provider does not meet the qualifications established by [32 CFR 199.6](#) to be an authorized TRICARE provider. This includes those categories of providers who have signed specific participation agreements.

Third Party Liability (TPL) Claims

TPL claims are claims in favor of the Government that arise when medical care is provided to an entitled beneficiary for treatment or injury or illness caused under circumstances creating tort liability legally requiring a third person to pay damages for that care. The Government pursues repayment for the care provided to the beneficiary under the provisions and authority of the Federal Medical Care Recovery Act (FMCRA) (42 USC paragraphs 2651-2653).

Third Party Liability (TPL) Recovery

The recovery by the Government of expenses incurred for medical care provided to an entitled beneficiary in the treatment of injuries or illness caused by a third party who is liable in tort for damages to the beneficiary. Such recoveries can be made from the liable third party directly or from a liability insurance policy (e.g., automobile liability policy or homeowners insurance) covering the liable third party. TPL recoveries are made under the authority of the FMCRA (42 USC paragraph 2651 et sec. Other potential sources of recovery in favor of the Government in TPL situations include, but are not limited to, no fault or uninsured motorist insurance, medical payments provisions of insurance policies, and workers compensation plans. Recoveries from such other sources are made under the authority of 10 USC paragraphs 10790, 1086(g), and 1095b.)

Third Party Payer

An entity that provides an insurance, medical service, or health plan by contract or agreement, including an automobile liability insurance or no fault insurance carrier and a workers compensation program or plan, and any other plan or program (e.g., homeowners insurance, etc.) that is designed to provide compensation or coverage for expenses incurred by a beneficiary for medical services or supplies.

Timely Filing

The filing of TRICARE claims within the prescribed time limits as set forth in [32 CFR 199.7](#).

Toll-Free Telephones

All telephone calls are considered toll-free for the purposes of measuring the standards contained in [Chapter 1, Section 3, paragraph 3.4](#), except for those telephone calls to a TRICARE Service Center (TSC).

Trading Partner Agreement (HIPAA/Privacy Definition)

An agreement related to the exchange of information in electronic transactions, whether the agreement is distinct or part of a larger agreement, between each party to the agreement. (For example, a trading partner agreement may specify, among other things, the duties and responsibilities of each party to the agreement in conducting a standard transaction.)

Transaction (HIPAA/Privacy Definition)

The transmission of information between two parties to carry out financial or administrative activities related to health care. It includes the following types of information transmissions:

1. Health care claims or equivalent encounter information.
2. Health care payment and remittance advice.
3. Coordination of benefits.
4. Health care claims status.

5. Enrollment and disenrollment in a health plan.
6. Eligibility for a health plan.
7. Health plan premium payments.
8. Referral certification and authorization.
9. First report of injury.
10. Health claims attachments.
11. Other transactions that may be prescribed by regulation.

Transfer Claims

A claim received by a contractor which is for services received and billed from another contractor's jurisdiction. TRICARE claims and attendant documentation must be referred to the appropriate contractor for processing. Notification must be sent to the claimant explaining the action taken, including the name and address of the correct contractor. Claims for active duty members which are sent to the appropriate Uniformed Service are not considered to be "transfer claims."

Transition

The process of changing contractors who serve a particular area or areas. Transition begins with the Notice of Award to the incoming contractor and is formally completed with the close out procedures of the outgoing contractor, several months after the start work date.

Transitional Patients Or Cases

Patients for whom active care is in progress on the date of a contractor's start work date. If the care being provided is for covered services, the contractor is financially responsible for the portion of care delivered on or after the contractor's start work date.

Treatment (HIPAA/Privacy Definition)

The provision, coordination, or management of health care and related services by one or more HCPs, including the coordination or management of health care by a HCP with a third party; consultation between HCPs relating to a patient; or the referral of a patient for health care from one HCP to another.

Treatment Encounter

The smallest meaningful unit of health care utilization: One provider rendering one service to one beneficiary.

Treatment Plan

A detailed description of the medical care being rendered or expected to be rendered a TRICARE beneficiary seeking approval for inpatient benefits for which pre authorization is required as set forth in [32 CFR 199.4](#). A treatment plan must include, at a minimum, a diagnosis (either ICD-9-CM or DSM-III); detailed reports of prior treatment, medical history, family history, social history, and physical examination; diagnostic test results; consultant's reports (if any); proposed treatment by type (such as surgical, medical, and psychiatric); a description of who is or will be providing treatment (by discipline or specialty); anticipated frequency, medications, and specific goals of treatment; type of inpatient facility required and why (including length of time the related inpatient stay will be required); and prognosis. If the treatment plan involves the transfer of a TRICARE patient from a hospital or another inpatient facility, medical records related to that inpatient stay also are required as a part of the treatment plan documentation.

Triage

A method of assessing the urgency of need for medical care using the patient's complaints and medical algorithms or other appropriate methods for analysis and then arranging for care. Medically qualified contractor personnel on 24 hour telephone coverage will perform the function.

TRICARE

The DoD's managed health care program for ADSMs, service families, retirees and their families, survivors, and other TRICARE-eligible beneficiaries. TRICARE is a blend of the military's DC system of hospitals and clinics and civilian providers. TRICARE offers three options: TRICARE Standard Plan, TRICARE Extra Plan, and TRICARE Prime Plan (see definitions).

TRICARE Beneficiary

An individual who has been determined to be eligible for TRICARE benefits, as set forth in [32 CFR 199.3](#).

TRICARE Contractor

An organization with which TMA has entered into a contract for delivery of and/or processing of payment for health care services through contracted providers and for processing of claims for health care received from non-network providers and for performance of related support activities.

TRICARE DRG-Based Payment System

A reimbursement system for hospitals which assigns prospectively-determined payment levels to each DRG based on the average cost of treating all TRICARE patients in a given DRG.

TRICARE Encounter Data (TED)

A data set of information required for all care received/delivered under the contract and provided by the contractor in a government-specified format and submitted to TMA via a telecommunication network. The information in the data set can be described in the following broad categories:

1. Beneficiary identification.
2. Provider identification.
3. Health information:
 - Place and type of service
 - Diagnosis and treatment-related data
 - Units of service (admissions, days, visits, etc.)
4. Related financial information.

TRICARE Encounter Data (TED) Record Transmittal Summary

A single record which identifies the submitting contractor and summarizes, for transmittal purposes, the number of records and the financial information contained within the associated "batch" of TED records.

TRICARE Extra

A PPO-like option, provided as part of the TRICARE program under [32 CFR 199.17](#), where MHS beneficiaries may choose to receive care in facilities of the uniformed services, or from special civilian network providers (with reduced cost-sharing), or from any other TRICARE-authorized provider (with standard cost-sharing).

TRICARE For Life (TFL)

Benefit for Medicare eligibles, based on age. TRICARE is secondary payor when service is a benefit of both Medicare and TRICARE.

TRICARE Management Activity (TMA)

The DoD organization responsible for managing the TRICARE contracts and day-to-day operations of the TRICARE program.

TRICARE Operations Manual (TOM) (6010.56-M)

The manual which provides instructions and requirements for claims processing and health care delivery under TRICARE.

TRICARE Policy Manual (TPM) (6010.57-M)

A TMA manual which provides the description of program benefits, adjudication guidance, policy interpretations, and decisions implementing the TRICARE Program.

TRICARE Plus

An enrollment option for TRICARE beneficiaries not enrolled in Prime. Beneficiaries are enrolled with a primary care coordinator (PCC) at a MTF. Enrollees are to receive primary care appointments within the TRICARE Prime access standards. TRICARE Plus 'enrollment' will be annotated in DEERS and CHCS. For care from civilian providers, TRICARE Standard/Extra rules will apply. For services payable by Medicare, Medicare rules will apply, with TRICARE as second payer for TRICARE covered services and supplies. Specialty care in the MTF will be on referrals from the primary care provider or on a self-referral basis. Enrollees are not guaranteed specialty care appointments within the TRICARE Prime access standards. There is no enrollment fee. MTFs may limit enrollment based on capability and capacity.

TRICARE Prime

An HMO-like option, provided as part of the TRICARE program under [32 CFR 199.17](#), where MHS beneficiaries elect to enroll in a voluntary enrollment program, which provides TRICARE Standard benefits and enhanced primary and preventive benefits with nominal beneficiary cost-sharing. TRICARE Prime requires beneficiaries to use a PCM located at either the MTF or from the contractor's network except when beneficiaries are exercising their freedom of choice under the Point of Service Option.

TRICARE Prime Remote Program (TPR)

The program designed to provide health care services to ADSMs assigned to remote locations in the United States and the District of Columbia.

TRICARE Prime Remote (TPR) Work Unit

A uniformed services work unit whose members are eligible to enroll in the TRICARE Prime Remote (TPR) Program as designated by the Military Services.

TRICARE Prime Service Area (PSA)

The geographic area where TRICARE Prime benefits are offered. **At a minimum, this includes areas around MTFs and Base Realignment and Closure (BRAC) sites.**

TRICARE Program

A DoD managed health care program operated under the authority of [32 CFR 199.17\(d\)](#).

TRICARE Quality Monitoring Contract (TQMC)

A national-level contractor responsible to DoD and TMA that performs second level reconsiderations for payment denials and focused retrospective quality of care reviews.

TRICARE Regulation

32 CFR 199. This regulation prescribes guidelines and policies for the administration of the TRICARE Program for the Army, Navy, Air Force, Marine Corps, Coast Guard, Commissioned Corps of the USPHS, and the Commissioned Corps of the NOAA. It includes the guidelines and policies for the administration of the TRICARE Program.

TRICARE Representative

A highly qualified service representative serving within a defined part of a contractor's region, providing information and assistance to providers, whether network or non-network, to Health Benefit Advisors (HBAs) in the service area and to congressional offices.

TRICARE Standard

A health care option, provided as part of the TRICARE program under [32 CFR 199.17](#), where MHS beneficiaries may choose to receive care in facilities of the uniformed services, or from any TRICARE authorized providers (with standard cost-sharing).

TRICARE Systems Manual (TSM) (7950.2-M)

A TMA manual which provides ADP instructions and requirements for contractors who use the TEDs system for reporting data to TMA.

Unbundled (Or Fragmented) Billing

A form of procedure code manipulation which involves a provider separately billing the component parts of a procedure instead of billing only the single procedure code which represents the entire comprehensive procedure.

Uniform Formulary

PL 106-65, DoD Authorization Act of Fiscal Year 2000, at section 701, mandated that DoD develop a uniform formulary to be applied across all points of service within the TRICARE system. Pharmaceuticals and other supplies authorized for dispensing will be in accordance with TRICARE policy and the Uniform Formulary. Recommendations for the design, structure and composition of the Uniform Formulary are developed by the DoD Pharmacy and Therapeutics (P&T) Committee, with comments by the Uniform Formulary Beneficiary Advisory Panel, and provided to the Executive Director, TMA for approval and implementation.

Uniform HMO Benefit

The health care benefit established by [32 CFR 199.18](#).

Uniformed Services

The Army, Navy, Air Force, Marine Corps, Coast Guard, Commissioned Corps of the USPHS, and the Commissioned Corps of the NOAA.

Uniformed Services Clinic (USC)

A MHS clinic that delivers primary care to ADSMs.

Uniformed Services Family Health Plan (USFHP)

A Government-contracted health plan that offers enrollment in TRICARE Prime to individuals who reside in the geographic service area of a USFHP designated provider who are eligible to receive care in medical MTFs (except ADSMs). This includes those individuals over age 65 who, except for their eligibility for Medicare benefits, would have been eligible for TRICARE benefits. Designated providers under the USFHP were previously known as "Uniformed Services Family Treatment Facilities" (USTFs) and are former USPHS hospitals. The service areas of the USFHP designate providers are listed at <http://www.usfhp.org> on the world wide web and under "USTF" in the Catchment Area Directory.

United States

"United States" means the 50 states and the District of Columbia.

United States Public Health Service (USPHS)

An agency within the U.S. Department of HHS which has a Commissioned Corps which are classified as members of the "Uniformed Services."

Unprocessable TRICARE Encounter Data (TED)

TED records transmitted by the contractor to TMA and received in such condition that the basic record identifier information is not readable on the TRICARE data system, i.e., header incorrect, electronic records garbled, etc.

Unproven Drugs, Devices, And Medical Treatments Or Procedures

Drugs, devices, medical treatments or procedures are considered unproven if:

1. FDA approval is required and has not been given;
2. If the device is a FDA Category A Investigational Device Exemption (IDE);
3. If there is no reliable evidence which documents that the treatment or procedure has been the subject of well-controlled studies of clinically meaningful endpoints which have determined its maximum tolerated dose, its toxicity, its safety, and its efficacy as compared with the standard means of treatment or diagnosis;
4. If the reliable evidence shows that the consensus among experts regarding the treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its safety, or its effectiveness as compared with the standard means of treatment or diagnosis.

For further clarification see [32 CFR 199.4\(g\)\(15\)](#).

Urgent Care

Medically necessary treatment that is required for illness or injury that would not result in further disability or death if not treated immediately. The illness or injury does require professional attention, and should be treated within 24 hours to avoid development of a situation in which further complications could result if treatment is not received.

Use (HIPAA/Privacy Definition)

The Privacy Regulation defines "Use" as "with respect to **IIHI**, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information."

Utilization Criteria

Specific conditions that must be met in order to provide appropriate treatment. DoD-approved criteria to use for screening medical/surgical care and for mental health care as outlined in [Chapter 7](#).

Utilization Management

A set of techniques used to manage health care costs by influencing patient care decision-making through case-by-case assessment of the appropriateness and medical necessity of care either prior to, during, or after provision of care. Utilization management also includes the systematic evaluation of individual and group utilization patterns to determine the effectiveness of the employed utilization management techniques and to develop modifications to the utilization management system designed to address aberrances identified through the evaluation.

Utilization Review

A process of case-by-case examination for consistency of the provider's request for specific treatment(s) (e.g., level of care, procedures, etc.) with preestablished criteria. Specific types of review include (but are not limited to) prospective review, concurrent review, and retrospective review. For the purposes of a TRICARE contract, utilization review will be mandatory for enumerated conditions and treatments in order to generate certification and authorization for care provided.

Veteran

A person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.

Note: Unless the veteran is eligible for "retired pay," "retirement pay," or "retainer pay," which refers to payments of a continuing nature and are payable at fixed intervals from the Government for military service neither the veteran nor his or her family members are eligible for benefits under TRICARE.

Widow Or Widower

A person who was a spouse at the time of death of the active duty member or retiree and who has not remarried.

Workday

A day on which full-time work is performed.

Worker's Compensation Benefits

Medical benefits available under any worker's compensation law (including the Federal Employees Compensation Act), occupational disease law, employers liability law, or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure.

Workforce (HIPAA/Privacy Definition)

The Privacy Regulation defines, "Workforce" as "employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity is under the direct control of such entity, whether or not they are paid by the covered entity."

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