



TRICARE  
MANAGEMENT ACTIVITY

**OD**

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE  
HEALTH AFFAIRS

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**CHANGE 108  
6010.56-M  
SEPTEMBER 19, 2013**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL  
FOR  
TRICARE OPERATIONS MANUAL (TOM), FEBRUARY 2008**

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

**CHANGE TITLE: ELIMINATION OF THE NON-AVAILABILITY STATEMENT (NAS) REQUIREMENT  
FOR NON-EMERGENCY INPATIENT MENTAL HEALTH CARE**

**CONREQ:** 16539

**PAGE CHANGE(S):** See page 2.

**SUMMARY OF CHANGE(S):** This change eliminates the requirement that states a Non-Availability Statement (NAS) is needed for non-emergency inpatient mental health care in order for a TRICARE Standard beneficiary's claim to be paid. Currently, NAS are required for non-emergency inpatient mental health care for TRICARE Standard beneficiaries who live within a military treatment facility catchment area.

**EFFECTIVE DATE:** March 28, 2013.

**IMPLEMENTATION DATE:** Upon direction of the Contracting Officer.

**This change is made in conjunction with Feb 2008 TPM, Change No. 99, Feb 2008 TRM, Change No. 89, and Feb 2008 TSM, Change No. 54.**

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**ATTACHMENT(S): 20 PAGES  
DISTRIBUTION: 6010.56-M**

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

**CHANGE 108**  
**6010.56-M**  
**SEPTEMBER 19, 2013**

**REMOVE PAGE(S)**

**CHAPTER 7**

Section 2, pages 1 and 2

**CHAPTER 8**

Section 3, pages 1 and 2

**CHAPTER 24**

Section 11, pages 3 through 6

**APPENDIX B**

pages 7 through 16, 35, and 36

**INSERT PAGE(S)**

Section 2, pages 1 and 2

Section 3, pages 1 and 2

Section 11, pages 3 through 6

pages 7 through 16, 35, and 36

## Preauthorizations

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### 1.0 GENERAL

Preauthorization review shall be performed for all care and procedures listed below. The contractor may propose additional authorization reviews. (See [Section 1](#) for additional guidance.) The admissions/procedures are subject to change over time based upon the Government's assessment of the efficacy of the review. The changes will include adding and/or removing admissions/procedures. When the beneficiary has other insurance that provides primary coverage, exception to the preauthorization requirements will apply as provided in the TRICARE Policy Manual (TPM), [Chapter 1, Section 7.1, paragraph 1.10](#). When the contractor is acting as a secondary payor any medically necessary reviews shall be performed on a retrospective basis.

#### THE FOLLOWING INPATIENT ADMISSIONS WILL BE PREAUTHORIZED:

Adjunctive Dental

Mental Health

Substance Abuse

Skilled Nursing Facility (SNF) care for dual eligible beneficiaries

**Note:** Effective for dates of service **June 1, 2010**, SNF care received in the U.S. and U.S. territories must be preauthorized for TRICARE dual eligible beneficiaries. The TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) contractor will preauthorize SNF care beginning on day 101, when TRICARE becomes primary payer. For those beneficiaries inpatient on the effective date, a preauthorization will be required August 1, 2010.

Organ and Stem Cell Transplants

#### THE FOLLOWING OUTPATIENT SERVICES WILL BE PREAUTHORIZED:

Adjunctive Dental

Mental Health Care after the **eighth** visit each fiscal year. Primary Care Manager (PCM) referral is not required; however, the Managed Care Support Contractor (MCSC) shall steer all beneficiaries who contact them to the Military Treatment Facility (MTF) or appropriate network provider. Additionally, the MCSC shall expound upon the benefits of using the MTF and network providers during all appropriate beneficiary and provider briefings.

**Note:** Active Duty Service Members (ADSMs) require preauthorization before receiving mental health services. The contractor shall comply with the provisions of [Chapters 16](#) and [17](#) when processing requests for service for active duty personnel.

#### THE FOLLOWING SERVICES WILL BE PREAUTHORIZED IN ANY SETTING:

Extended Care Health Option (ECHO) Services

Hospice

## 2.0 INPATIENT MENTAL HEALTH

Inpatient mental health requires preauthorization. In the event that inpatient mental health services were not preauthorized, the contractor shall obtain the necessary information and complete a retrospective review. Penalties for failing to obtain preauthorization apply (see [32 CFR 199.15](#)). Non-Availability Statement (NAS) requirements also apply to inpatient **behavioral** health admissions **if the admission occurred prior to March 28, 2013**.

## 3.0 EFFECTIVE AND EXPIRATION DATES

The preauthorization shall have an effective date and an expiration date. For organ and stem cell transplants, the preauthorization shall remain in effect as long as the beneficiary continues to meet the specific transplant criteria set forth in the TPM, or until the approved transplant occurs.

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## Claims Filing Deadline

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### 1.0 TIME LIMITATIONS ON FILING TRICARE CLAIMS

**1.1** All TRICARE claims shall be stamped with an Internal Control Number (ICN). The actual date of receipt shall be counted as day one. The ICN uniquely identifies each claim, includes the actual date received in the contractor's custody, and permits aging and counting of the claim for workload reporting purposes at specific system locations at any time during its processing. The contractor shall provide procedures to ensure the actual date of receipt is entered into the ICN and all required claims aging and inventory controls are applied for paperless claims.

**1.2** All claims for benefits must be filed with the appropriate TRICARE contractor No Later Than (NLT) one year after the date the services were provided or one year from the date of discharge for an inpatient admission for facility charges billed by the facility. Professional services billed by the facility must be submitted within one year from the date of service.

**Example:**

FOR SERVICE OR DISCHARGE	MUST BE RECEIVED BY THE CONTRACTOR
March 22, 2007	No later than March 22, 2008
December 31, 2007	No later than December 31, 2008

**1.3** Any written request for benefits, whether or not on a claim form, shall be accepted for determining if the "claim" was filed on a timely basis. However, when other than an approved claim form is first submitted, the claimant shall be notified that only an approved TRICARE claim form is acceptable for processing a claim for benefits. The contractor shall inform the claimant in writing that in order to be considered for benefits, an approved TRICARE claim form and any additional information (if required) must be submitted and received by the contractor NLT one year from the date of service or date of discharge, or 90 calendar days from the date they were notified by the contractor, whichever is later. The claimant should submit claims on either the Centers for Medicare and Medicaid Services (CMS) 1500 (08/2005), the CMS 1450 UB-04, or the Defense Department (DD) Form 2642 as appropriate.

### 2.0 EXCEPTIONS TO FILING DEADLINE

#### 2.1 Retroactive Determinations

**2.1.1** In order for an exception to be granted based on a retroactive determination, the retroactive determination must have been obtained/issued after the timely filing period elapsed. If a retroactive determination is obtained/issued within one year from the date of service/discharge, the one year timely filing period is still binding.

**2.1.2** Only the Uniformed Services or the Department of Veterans Affairs (DVA) may determine retroactive eligibility. For purposes of granting an exception, retroactive issuance of a Non-Availability Statement (NAS) **when applicable** shall be treated as retroactive eligibility. Once a retroactive eligibility determination is made, an exception to the claims filing deadline shall be granted. A copy of the retroactive eligibility decision must be provided. In any case where a retroactive "preauthorization" determination is made to cover such services as the Extended Care Health Option (ECHO), adjunctive dental care, surgical procedures requiring preauthorization, etc., the timely filing requirements shall be waived back to the effective date of the retroactive authorization. Claims which are past the filing deadline must; however, be filed not more than 180 calendar days after the date of issue of the retroactive determination.

## **2.2 Administrative Error**

**2.2.1** If an administrative error is alleged, the contractor shall grant an exception to the claims filing deadline only if there is a basis for belief that the claimant had been prevented from timely filing due to misrepresentation, mistake or other accountable action of an officer or employee of TRICARE Management Activity (TMA) (including TRICARE Overseas) or a contractor, performing functions under TRICARE and acting within the scope of that individual's authority.

**2.2.2** The necessary evidence shall include a statement from the claimant, regarding the nature and affect of the error, how he or she learned of the error, when it was corrected, and if the claim was filed previously, when it was filed, as well as one of the following:

- A written report based on agency records (TMA or contractor) describing how the error caused failure to file within the usual time limit, or
- Copies of an agency letter or written notice reflecting the error.

**Note:** The statement of the claimant is not essential if the other evidence establishes that his or her failure to file within the usual time limit resulted from administrative error, and that he or she filed a claim within 90 calendar days after he or she was notified of the error. There must be a clear and direct relationship between the administrative error and the late filing of the claim. If the evidence is in the contractor's own records, the claim file shall be annotated to that effect.

## **2.3 Inability To Communicate And Mental Incompetency**

**2.3.1** For purposes of granting an exception to the claims filing deadline, mental incompetency includes the inability to communicate even if the result of a physical disability. A physician's statement, which includes dates, diagnosis(es) and treatment, attesting to the beneficiary's mental incompetency shall accompany each claim submitted. Review each statement for reasonable likelihood that mental incompetency prevented the person from timely filing.

**2.3.2** If the failure to timely file was due to the beneficiary's mental incompetency and a legal guardian had not been appointed during the period of time in question, the contractor shall grant an exception to the claims filing deadline based on the required physician's statement. (See above.) If the charges were paid by someone else, i.e., spouse or parent, request evidence from the spouse or parent that the claim was paid and by whom. When the required evidence is received, make payment to the signer of the claim, with the check made out: "Pay to the order of (spouse's or parent's name) for the use and benefit of (beneficiary's name)."

### **3.2.2 Referral Assistance for Beneficiaries Enrolled or Residing in the 50 United States and the District of Columbia**

The TOP contractor shall provide referral assistance for TRICARE Prime/TPR enrollees who require urgent or emergent health care while traveling outside the 50 United States and the District of Columbia. These referrals will generally be initiated by the beneficiary, a host nation provider, or an overseas MTF provider. Emergency care never requires preauthorization; however, ADFMs enrolled to TRICARE Prime/TPR may receive urgent and emergency health care services in locations outside the 50 United States and the District of Columbia (to include emergency medical evacuation per [Section 7](#)) on a cashless, claimless basis if the care is coordinated in advance with the TOP contractor. The TOP contractor shall implement guarantee of payment or other business processes to ensure that ADFMs enrolled to TRICARE Prime/TPR may receive urgent or emergency medical services on a cashless, claimless basis upon beneficiary request.

### **3.2.3 Authorizations**

**3.2.3.1** The TOP HCF will authorize care for TPR enrollees; for ADSMs who are on TAD/TDY, in an authorized leave status, or deployed, deployed on liberty in a remote overseas location, and for TRICARE Prime/TPR enrollees who require urgent or emergent health care while traveling outside the 50 United States and the District of Columbia. The contractor shall also ensure that MTF-issued authorizations are entered into all applicable contractor systems. Non-emergent specialty health care received from a host nation provider must be authorized if benefits are to be paid as TOP Prime/TPR.

**3.2.3.2** Care subject to a PCM referral/authorization/Non-Availability Statement (NAS) may receive a clinical review and authorization by the HCF or other designee.

**3.2.4** If an ADFM TOP Prime/TOP Prime Remote enrollee receives care that was not authorized, the care may be covered under the TOP Point of Service (POS) option, with POS deductibles and cost-shares. POS provisions also apply to TRICARE Prime/TPR enrollees who receive non-emergency care outside the 50 United States and the District of Columbia without obtaining prior authorization from the TOP contractor. The care must also be otherwise coverable under TRICARE or the claim shall be denied.

**3.2.5** ADSM care that was not referred and authorized may be denied unless it is retroactively authorized by the appropriate service or TAO personnel. POS does not apply to ADSMs.

## **4.0 CUSTOMER SERVICE RESPONSIBILITIES**

TOP customer support shall be provided to TOP RD and TAO staffs, TOP host nation providers, TOP beneficiaries, designated Point of Contacts (POCs), TOP MTF staffs including Health Benefit Advisors (HBAs)/Beneficiary Counseling and Assistance Coordinators (BCACs)/Debt Collection Assistance Officers (DCAOs), stateside TRICARE Regional Offices (TROs), stateside Managed Care Support Contractors (MCSCs), stateside TRICARE beneficiaries traveling overseas, claims processing contractors, and TMA. TOP contractor customer support service shall include the following:

**4.1** The TOP contractor shall secure at a minimum one dedicated post office box for the receipt of all claims and correspondence from foreign locations per overseas region.

## TRICARE Operations Manual 6010.56-M, February 1, 2008

### Chapter 24, Section 11

#### Beneficiary Education And Support Division (BE&SD)

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**4.2** The TOP contractor shall identify a specific individual and an alternate to assist the TOP RD, TAO Directors, TMA, BCACs and stateside claims processing contractors with the resolution of TOP issues. Issues which cannot be successfully resolved shall be referred to the TOP Contracting Officer's Representative (COR).

**4.3** The TOP contractor shall identify a specific individual and an alternate to assist DCAOs with the resolution of TOP beneficiary debt collection issues.

**4.4** The TOP contractor shall be responsible for establishing and operating a dedicated TRICARE overseas claims/correspondence processing department with a dedicated staff. This department and staff shall be under the direction of a supervisor, who shall function as the contractor's POC for TRICARE overseas claims and related operational and support services. The contractor's department for TRICARE overseas claims shall include at a minimum the following functions/requirements:

**4.4.1** The TOP contractor shall provide toll-free telephone service for claims assistance to TOP beneficiaries and providers seven days a week, 365 days a year, between the hours of 2:00 AM and 7:00 PM CST. Toll-free services must be available from any stateside or overseas location.

**4.4.2** The TOP contractor shall have the ability to translate claims submitted in a foreign language and write in German, Italian, Japanese, Korean, Tagalog (Filipino) and Spanish, or shall have the ability to obtain such translation or writing.

**4.4.3** The TOP contractor shall provide on-line read only access to their claims processing system to the TOP RD, each TOP TAO Director, and the TMA technical representative for TOP claims.

**4.4.4** The TOP contractor shall provide a secure, user-friendly internet portal for receipt of customer claims status inquiries and access to claims status information (to include the ability to view and print Explanation of Benefits (EOBs)).

**4.4.5** The TOP contractor is required to provide, upon TMA or TAO Director request, documentation of claims for auditing purposes.

**4.5** The TOP contractor is required to assist traveling TOP beneficiaries to ensure beneficiary access/receipt of urgent or emergent care in the 50 United States and the District of Columbia. The contractor shall also assist beneficiaries residing or enrolled in the United States or the District of Columbia who require urgent or emergent care while traveling overseas. ADFMs who are enrolled to TRICARE Prime or TPR may receive emergency medical services in locations outside the 50 United States and the District of Columbia (to include emergency medical evacuation) on a cashless, claimless basis if the care is coordinated in advance with the TOP contractor.

**4.6** The contractor shall refer beneficiary, provider, HBAs, and congressional inquiries not related to claims status to TMA Chief, BE&SD.

## **5.0 BENEFICIARY SERVICES**

**5.1** The TOP contractor shall achieve the highest level of beneficiary satisfaction possible in the overseas environment. This shall be accomplished by developing qualified host nation provider networks (complemented by non-network host nation providers as necessary), ensuring timely

access to host nation care, providing TOP information/education/training to beneficiaries and host nation providers, and processing claims in a timely, accurate manner.

**5.2** In addition to the beneficiary education requirements outlined in [Chapter 11, Sections 1 and 2](#), the TOP contractor may be required to conduct beneficiary education/enrollment activities for arriving/deploying units in accordance with the enrollment protocols established in the Memorandum of Understanding (MOU) between the TOP contractor and the MTFs.

**5.3** In addition to the requirements outlined in [Chapter 11, Section 2](#), all beneficiary satisfaction activities (including beneficiary surveys conducted in accordance with [Chapter 11, Section 2](#)) shall be coordinated with the three TAOs to achieve a coordinated, uniform approach to Department of Defense (DoD) customer services overseas.

**5.4** The TOP contractor shall maintain up-to-date lists of host nation network providers, and shall make this information available at all TOP TSCs and via web-based access. Web-based network provider listings shall include information regarding authorization requirements that are applicable to TOP enrollees.

**5.5** The TOP contractor's beneficiary education plan shall address their process for educating TOP beneficiaries regarding care received in the 50 United States and the District of Columbia. At a minimum, this process shall include information regarding referrals/authorizations while stateside, TOP POS policy, and the recommended process for accessing care while stateside. TOP beneficiaries traveling stateside shall be encouraged to utilize MTF care whenever possible. If MTF care is not available, beneficiaries should be encouraged to seek care from a network provider before obtaining care from a non-network provider.

**5.6** The requirement for a quarterly three-day TRICARE training course, as outlined in [Chapter 11, Section 2, paragraph 1.1](#), is superseded for the TOP contractor by a requirement for a total of nine three-day TRICARE training courses per contract option period (two per option period within the TRICARE Eurasia-Africa area; two within the TRICARE Pacific area; two within the TRICARE Latin America/Canada (TLAC) area; and three additional courses that may occur in any stateside or overseas location at the direction of the Contracting Officer (CO)).

**Note:** Only the frequency requirements of [Chapter 11, Section 2, paragraph 1.1](#) are superseded; all other requirements of the referenced paragraph apply to the TOP contractor.

**5.7** The requirement for mailing TRICARE handbooks, as outlined in [Chapter 11, Section 1, paragraph 4.1](#), is superseded for the TOP contractor by a requirement for "on-demand" processes for distributing TRICARE handbooks upon beneficiary request (including, at a minimum, web-based requests, telephone requests, and on-site requests at a TSC).

## **6.0 PROVIDER SERVICES**

**6.1** The TOP contractor shall ensure that all host nation network providers and their support staff have sufficient understanding of the applicable TRICARE program requirements, policies, and procedures to allow them to carry out the requirements of this contract in an efficient and effective manner that promotes beneficiary satisfaction.

**6.2** The TOP contractor shall have the responsibility for developing and delivering TRICARE Program information to host nation providers. The contractor shall determine the requirements for printed products and will develop and deliver these products after obtaining approval from the government. The information in these products will generally be determined by the contractor based on their understanding of the needs of their network providers; however, the government may mandate the inclusion of certain topics or information.

**6.3** Provider education materials shall include information regarding claims processing procedures, claims submission deadlines, and normal claims processing time lines.

**6.4** The government shall ensure provider satisfaction with contractor-provided information by conducting random satisfaction surveys of select network providers.

## **7.0 GRIEVANCES AND GRIEVANCE PROCESSING**

The TOP contractor shall process all grievances related to contractor personnel or contractor actions. The contractor shall also process all grievances related to network or non-network host nation providers or institutions, with a copy provided to the TMA COR and the appropriate TAO.

- END -

## **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 on 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 health care from the Military Treatment Facility (MTF).

### **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 (CSA)**

An agreement, executed by a contract action under a Managed Care Support (MCS) contract, that is/was undertaken at the behest of an MTF Commander and which requires a contractor to provide needed clinical personnel at an MTF.

### **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 IIHI 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 of 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).

## **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.

### **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.