



DEFENSE  
HEALTH AGENCY

**HPOS**

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**CHANGE 145  
6010.56-M  
JULY 1, 2015**

**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: CONSOLIDATED CHANGE 15-001**

**CONREQ: 17326**

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

**SUMMARY OF CHANGE(S): See page 3.**

**EFFECTIVE DATE: August 3, 2015.**

**IMPLEMENTATION DATE: August 3, 2015.**

**This change is made in conjunction with Feb 2008 TPM, Change No. 137, and Feb 2008 TSM, Change No. 74.**

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**ATTACHMENT(S): 107 PAGES  
DISTRIBUTION: 6010.56-M**

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

**CHANGE 145  
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**REMOVE PAGE(S)**

**CHAPTER 1**

Section 7, pages 1 - 14

**CHAPTER 6**

Section 1, pages 1, 2, 5 - 20

**CHAPTER 8**

Section 1, pages 1 - 3

Section 5, pages 7 and 8

**CHAPTER 22**

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**APPENDIX A**

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**APPENDIX B**

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## **SUMMARY OF CHANGES**

### **CHAPTER 1**

1. Section 7. This change removes the requirement to mail a TRICARE Handbook at the start of health care delivery. TRICARE handbooks are to be provided upon request.

### **CHAPTER 6**

2. Section 1. This change provides how Universal TRICARE Beneficiary Cards are now being provided to beneficiaries, how providers are to confirm eligibility for TRICARE benefits, and adds recurring electronic payments to the Quarterly Payment Fee Options.

### **CHAPTER 8**

3. Section 1. This change defines the deemed enrollment period for Newborn Claims.
4. Section 5. This change defines Urgent and Routine Referrals and Military Treatment Facility response times.

### **CHAPTER 22**

5. Section 1. This change removes Right of First Refusal requirement reviews from the TRICARE Reserve Select health plan.
6. Section 2. This change removes Right of First Refusal requirement reviews from the TRICARE Retired Reserve health plan.

### **APPENDIX A**

7. Adds new acronyms.

### **APPENDIX B**

8. This change corrects grammatical errors.



## Transitions

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### 1.0 CONTRACT PHASE-IN

#### 1.1 Start-Up Plan

This comprehensive plan shall be submitted electronically, in Microsoft® Project files, as described in Exhibit B, Contract Data Requirements Lists (CDRL), of the contract.

#### 1.2 Transition Specifications Meeting

The incoming contractor shall attend a two to four day meeting with the outgoing contractor and **Defense Health Agency (DHA)** within 15 calendar days following contract award. This meeting is for the purpose of developing a schedule for phase-in and phase-out activities. **DHA** will notify the contractor as to the exact date of the meeting. Contractor representatives attending this meeting shall have the experience, expertise, and authority to provide approvals and establish project commitments on behalf of their organization.

#### 1.3 Interface Meetings

Within 30 calendar days from contract award, the incoming contractor shall arrange meetings with Government and external agencies to establish all systems interfaces necessary to meet the requirements of this contract. **DHA** representatives shall be included in these meetings and all plans developed shall be submitted to the **DHA** Procuring Contracting Officer (PCO) and the Contracting Officer's Representative (COR) within 10 calendar days after the meeting.

### 2.0 START-UP REQUIREMENTS

#### 2.1 Systems Development

Approximately 60 calendar days prior to the initiation of health care delivery, the non-claims processing systems and the telecommunications interconnections between these systems shall be reviewed by the **DHA** or its designees, to include a demonstration by the contractor of the system(s) capabilities, to determine whether the systems satisfy the requirements of TRICARE as otherwise provided in the contract. This includes the telecommunications links with **DHA** and Defense Enrollment Eligibility Reporting System (DEERS). The review will also confirm that the hardware, software, and communications links required for operating the automated TRICARE Duplicate Claims System (DCS) have been installed and are ready for **DHA** installation of the DCS application software (see [Chapter 9](#)). The contractor shall effect any modifications required by **DHA** prior to the initiation of services.

## **2.2 Execution Of Agreements With Contract Providers**

**2.2.1** All contract provider agreements shall be executed, and loaded to the contractor's system, 60 calendar days prior to the start date of TRICARE Prime in the Prime Service Area (PSA) or at such other time as is mutually agreed between the contractor and DHA.

**2.2.2** The contractor shall begin reporting on network adequacy on a monthly basis during the transition.

## **2.3 Provider Certification**

The outgoing contractor shall transfer the provider certification documentation to the incoming contractor. The incoming contractor shall limit certification actions to new providers and shall verify a provider's credentials once, upon application to become a certified provider.

## **2.4 Execution Of Memoranda Of Understanding (MOU)**

### **2.4.1 MOU With Military Treatment Facility (MTF) Commanders**

No Later Than (NLT) 30 days following contract award, the outgoing contractor shall provide the incoming contractor the most recent version of all MTF MOUs in place at that time for the purpose of ensuring continuity of services to the MTFs and continuity of care for TRICARE beneficiaries. Sixty calendar days prior to the start of health care delivery, the contractor shall have executed an MOU with all MTF Commanders in the region. The MOU shall include, but not be limited to, MTF Optimization, Customer Service, Education and Health Care Finder (HCF) functions, Government-furnished services, surveillance and reporting, use of facilities, Medical Management, and TRICARE Service Center (TSC) locations (TRICARE Overseas Program (TOP) MOUs only). The contractor shall provide two copies of each executed MOU to the PCO and the COR within 10 calendar days following the execution of the MOU.

### **2.4.2 MOU with DHA Beneficiary Education and Support Division (BE&SD)**

The contractor shall meet with the DHA BE&SD within 60 calendar days after health care contract award to develop a MOU, including deliverables and schedules. The MOU shall be executed within 30 days of the MOU meeting with the BE&SD. The contractor shall provide copies of the executed MOU to the PCO and the COR within 10 calendar days following the execution of the MOU.

## **2.5 Phase-In of TRICARE Prime Enrollment**

The contractor shall begin the enrollment process for the TRICARE Prime Program NLT 60 calendar days prior to the scheduled start of health care delivery, with actual enrollment processing to begin 40 days prior to the start of health care delivery, subject to DHA approval of systems under the contract.

### **2.5.1 Enrollment Actions During 45 Day Transition Period**

**2.5.1.1** For enrollments in the region with an effective date prior to the start of health care delivery (e.g., active duty (AD) enrollment, mid-month enrollment; transfer-in), the incoming

contractor must effect an enrollment to begin on the start of health care delivery once notified by the outgoing contractor of the new enrollment. (Defense Manpower Data Center (DMDC) may run a report at the end of the transition period that reflects new additions.)

**2.5.1.2** When a current enrollment in the region requires deletion with an effective date prior to the start of health care delivery (e.g., transfers out; disenrollments for failure to pay fees; cancellations, etc.), when requested by the outgoing contractor, the incoming contractor must cancel the future enrollment segment and notify the outgoing contractor when this action has been completed.

**2.5.1.3** For all other enrollment actions with an effective date prior to start of health care delivery (e.g., PCM changes; Defense Medical Information System Identification Code (DMIS-ID) changes; enrollment begin date changes; etc.), when requested by the outgoing contractor, the incoming contractor must cancel the future enrollment segment and notify the outgoing contractor when this action has been completed. When notified by the outgoing contractor that their change has been effected, the incoming contractor must reinstate the future enrollment segment.

**2.5.1.4** Once health care delivery begins, all enrollment actions will be accomplished by the incoming contractor. If the outgoing contractor requires a retroactive change, they must submit their request to the incoming contractor who will perform the change and notify the outgoing contractor when it is complete.

**2.5.2** In addition to other contractually required enrollment reports, the contractor, shall submit the Enrollment Plan Implementation Report on progress made in implementing **DHA** approved enrollment plan.

## **2.6 Transfer Of Enrollment Files**

**2.6.1** The incoming contractor shall obtain enrollment policy information from DEERS through an initial enrollment load file. DMDC will provide the incoming contractor with an incremental enrollment load file for each contract transition. The incoming contractor shall process each enrollment load file within 24 hours or less from receipt of the file.

**Note:** Each contract transition shall require a three-day freeze of enrollment and claim processing. This freeze will occur beginning the first weekend that precedes the 60 day window prior to the start of health care delivery. The actual calendar dates will be determined during the transition meeting.

**2.6.2** The incoming contractor shall send enrollment renewal notices for all enrollees whose current enrollment period expires on or after the start of health care delivery. The incoming contractor shall send billing statements where the enrollment fee payment would be due on or after the start of health care delivery. The incoming contractor shall start sending billing notices and process renewals 45 days prior to the start of health care.

**2.6.3** Outstanding enrollment record discrepancies and issues reported to the DEERS Support Office (DSO) by the outgoing contractor will be transferred to the incoming contractor for reconciliation. Records will be reconciled in accordance with TRICARE Systems Manual (TSM), [Chapter 3, Section 1.5](#).

## **2.7 Enrollment Fees**

**2.7.1** The incoming contractor shall obtain the cumulative total of enrollment fees and paid-through dates for the policies from the outgoing contractors with the enrollment transition information. The contractor who collects the enrollment fee will retain the enrollment fee based on the start date of the enrollment. The incoming contractor shall resolve any discrepancies of cumulative enrollment fees and paid-through dates with the outgoing contractor within 90 days of start of health care on policies inherited during the transition. The incoming contractor shall send the corrected fee information to DEERS using the Fee/Catastrophic Cap and Deductible (CCD) Web Research application or the batch fee interface outlined in the TSM, [Chapter 3](#).

**2.7.2** The incoming contractor will obtain information from the outgoing contractor on fees that are being paid monthly (i.e., by allotment or Electronic Funds Transfer (EFT) and transition these monthly payment types in the least disruptive manner for the beneficiary.

**2.7.3** The incoming contractor shall coordinate the transition of allotment data, through [DHA](#) Purchased Care Systems Integration Branch (PCSIB) and/or the applicable [DHA](#) Program Office, with the Defense Finance and Accounting Service (DFAS), the Public Health System (PHS) and the U.S. Coast Guard (USCG) during the transition-in period of the contract (see the TSM, [Chapter 1, Section 1.1](#)).

## **2.8 Phase-In Requirements Related to the HCF Function**

The hiring and training of call center HCF function staff shall be completed prior to the start of health care delivery for TRICARE Prime in each PSA. The provider/beneficiary community shall be advised of the procedures for obtaining HCF assistance prior to the start of health care delivery.

## **2.9 Phase-In Requirements of the TSCs (TRICARE Overseas Contract Only)**

**2.9.1** The incoming contractor will utilize the existing TSCs. The outgoing contractor shall allow reasonable access to the incoming contractor throughout the transition period to become familiar with the communication lines, equipment and office layout.

**2.9.2** The final schedule for access to and occupancy of the TSCs will be determined at the Transition Specifications Meeting. The approved schedule must allow the outgoing contractor to fulfill all contract requirements through the last day of health care delivery, and must provide the incoming contractor sufficient access to the TSC to prepare for delivery of all required functions on the first day of their contract.

### **2.9.3 Acquisition of Resources**

All Managed Care Support Contractor (MCSC) Customer Service, Education and HCF Field Representatives and overseas TSC representatives shall be fully trained and available for all duties no less than 40 calendar days prior to initiation of health care services.

## 2.10 Claims Processing System and Operations

During the period between the date of award and the start of health care delivery, the incoming contractor shall, pursuant to an implementation schedule approved by DHA, meet the following requirements:

### 2.10.1 Contractor File Conversions and Testing

The incoming contractor shall perform initial conversion and testing of all Automated Data Processing (ADP) files (e.g., provider files, pricing files, and beneficiary history) NLT 30 calendar days following receipt of the files from the outgoing contractor(s). Integration testing will be conducted to validate the contractor's internal interfaces to each of the TRICARE Military Health Systems (MHSs). 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 45 days prior to the start of healthcare delivery.

DHA 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 DHA 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.

### 2.10.2 Receipt of Outgoing Contractor's Weekly Shipment of History Updates and Dual Operations

**2.10.2.1** Beginning with the 120th calendar day prior to the start of health care delivery and continuing for 180 calendar days after the start of health care delivery, the incoming contractor shall convert the weekly shipments of the beneficiary history updates from the outgoing contractor(s) within two working days following receipt. These files shall be validated by the incoming contractor before use. Tests for claims and duplicate claims shall be performed within two workdays following conversion. Following the start of health care delivery, these files shall be loaded to history and used for claims processing.

**2.10.2.2** During the 180 calendar days after the start of health care delivery when both the incoming and outgoing contractors are processing claims, both contractors shall maintain close interface on history update exchanges and provider file information. 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. The incoming contractor shall assume total responsibility for the maintenance of the TRICARE Encounter Provider Record (TEPRV) beginning with the start of health care delivery. The incoming contractor will coordinate and cooperate with the outgoing contractor to ensure that the outgoing contractor can continue to process claims accurately; conversely, the outgoing contractor has responsibility to notify the incoming contractor of any changes in provider status that they become aware of through their operations.

### **2.10.3 Phase-In Requirements Related To Transitional Cases**

In notifying beneficiaries of the transition to another contractor, both the incoming and outgoing contractors shall include instructions on how the beneficiary may obtain assistance with transitional care. If the outgoing contractor succeeds itself, costs related to each contract will be kept separate for purposes of contract accountability.

#### **2.10.3.1 Non-Network Inpatient Transitional Cases**

These are beneficiaries who are inpatients (occupying an inpatient bed) at 0001 hours on the first day of any health care contract period in which the incoming contractor begins health care delivery. In the case of **Diagnosis** Related Group (DRG) reimbursement, the outgoing contractor shall pay through the first month of health care delivery or the date of discharge, whichever occurs first. If the facility is reimbursed on a per diem basis, the outgoing contractor is responsible for payment of all the institutional charges accrued prior to 0001 hours on the first day of health care delivery, under the incoming contractor. The incoming contractor thereafter is responsible for payment.

#### **2.10.3.2 Non-Network Outpatient/Professional Transitional Cases**

These are cases, such as obstetric care, that are billed and payable under "Global" billing provisions of Current Procedural Terminology, 4th edition (CPT-4), HCFA Common Procedure Coding System (HCPCS), or local coding in use at the time of contract transition, and where an Episode Of Care (EOC) shall have commenced during the period of health care delivery of the outgoing contractor and continues, uninterrupted, after the start of health care delivery by the incoming contractor. Outpatient/professional services related to transitional cases are the responsibility of the outgoing contractor for services delivered prior to 0001 hours on the first day of health care delivery and of the incoming contractor thereafter.

#### **2.10.3.3 Network Inpatient Care During Contract Transition**

The status of network provider changes (provider's network agreement with the outgoing contractor is terminated resulting in the provider's loss of network status) with the start of health care delivery of the new contract. As a result, claims for inpatient care shall be reimbursed in accordance with [paragraph 2.10.3.1](#) for non-network transitional cases. Beneficiary copay is based on the date of admission; therefore, Prime beneficiaries who are inpatients as described in [paragraph 2.10.3.1](#), shall continue to be subject to Prime network copayments and shall not be subject to Point Of Service (POS) copayments.

#### **2.10.3.4 Home Health Care (HHC) During Contract Transition**

HHC, for a 60-day episode of care, initiated during the outgoing contractor's health care delivery period and extending, uninterrupted, into the health care delivery period of the incoming contractor are considered to be transitional cases. Reimbursement for both the Request for Anticipated Payment (RAP) and the final claim shall be the responsibility of the outgoing contractor for the entire 60-day episodes covering the transition period from the outgoing to the incoming contractor.

#### **2.10.4 Prior Authorizations and Referrals**

The incoming contractor shall honor outstanding prior authorizations and referrals issued by the outgoing contractor, covering care through 60 days after the start of health care delivery under the incoming contract, in accordance with the outgoing contractors existing practices and protocols, within the scope of the TRICARE program and applicable regulations or 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 DHA 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, DHA 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 TOP contractor. One hundred twenty days following the end of any 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 DHA 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 DHA 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 be prepared to mail the appropriate TRICARE Handbook to beneficiaries requesting a copy. The beneficiary shall first be encouraged to read or download a copy of the handbook from the <http://www.tricare.mil> web site.

### **3.0 CONTRACT PHASE-OUT**

#### **3.1 Transition Specifications Meeting**

The outgoing contractor shall attend a meeting with representatives of the incoming contractor and DHA at the DHA office in Aurora, Colorado, within 15 calendar days following contract award. This meeting is for the purpose of developing a schedule of phase-out/phase-in activities. DHA will notify the contractor as to the exact date of the meeting. The outgoing contractor shall provide a proposed phase-out plan at the Transition Specifications Meeting.

### 3.2 Data

The outgoing contractor shall provide to DHA (or, at the option of DHA, to a successor contractor) such information as DHA shall require to facilitate transitions from the contractor's operations to operations under any successor contract. All files shall be provided in a non-proprietary format and the contractor shall include such file specifications and documentation as may be necessary for interpretation of these files. Such information may include, but is not limited to, the following:

- The data contained in the contractor's enrollment information system.
- The data contained in the contractor's claims processing systems.
- Information about the management of the contract that is not considered, under applicable Federal law, to be proprietary to the contractor.

### 3.3 Phase-Out of the Contractor's Claims Processing Operations

Upon notice of award to another contractor, and during the procurement process leading to a contract award, the contractor shall undertake the following phase-out activities regarding services as an outgoing contractor.

#### 3.3.1 Transfer of Electronic File Specifications

The outgoing contractor shall transfer to the incoming contractor by express mail or similar overnight delivery service, NLT three calendar days following award announcement, electronic copies of the record layouts with specifications, formats, and definitions of fields, and data elements, access keys and sort orders, for the following:

- The TRICARE Encounter Provider Files (TEPRVs).
- The TRICARE Encounter Pricing Files (TEPRCs).
- The Enrolled Beneficiary and PCM Assignment Files.
- Mental Health Provider Files - The outgoing contractor must assure that the incoming contractor has been given accurate provider payment information on all mental health providers paid under the TRICARE inpatient mental health per diem payment system. This should include provider name; tax identification number; address including zip code; high or low volume status; if high volume, provide the date the provider became high volume; and the current per diem rate along with the two prior year's per diem amounts. The providers under the per diem payment system must be designated by Medicare, or meets exemption criteria, as exempt from the inpatient mental health unit, the unit would be identified as the provider under the TRICARE inpatient mental health per diem payment system.

### **3.3.2 Transfer Of ADP Files (Electronic)**

The outgoing contractor shall prepare in non-proprietary electronic format and transfer to the incoming contractor or **DHA**, by the 15th calendar day following the Transition Specifications Meeting unless, otherwise negotiated by the incoming and outgoing contractors, all specified ADP files, such as the Provider and Pricing files, in accordance with specifications in the official transition schedule and will continue to participate in preparation and testing of these files until they are fully readable by the incoming contractor or **DHA**.

### **3.3.3 Outgoing Contractor Weekly Shipment Of History Updates**

The outgoing contractor shall transfer to the incoming contractor, in electronic format, all beneficiary history and deductible transactions (occurring from the date of preparation for shipment of the initial transfer of such history files and every week thereafter) beginning the 120th calendar day prior to the start of health care delivery (until such a time that all processing is completed by the outgoing contractor) in accordance with the specifications in the official transition schedule.

### **3.3.4 Transfer Of Non-ADP Files**

The outgoing contractor shall transfer to the incoming contractor all non-ADP files (e.g., authorization files, clinic billing authorizations, and tapes/CDs, which identify PSAs, Congressional and **DHA** completed correspondence files, appeals files, TRICARE medical utilization, and administration files) in accordance with the specifications in the official transition schedule and [Chapter 2](#). The hard copies of the Beneficiary History Files are to be transferred to the incoming contractor or Federal Records Center (FRC) as required by [Chapter 2](#). The contractor shall provide samples and descriptions of these files to the incoming contractor at the Transition Specification Meeting.

### **3.3.5 EOB Record Data Retention And Transmittal**

If the contractor elects to retain the EOB data on a computer record, it must, in the event of a transition to another contractor, provide either a full set of electronic records covering the current and two prior years, or, at the PCO's discretion, provide the data and necessary programs to reproduce the EOB in acceptable form and transfer such data and programs to the successor contractor or to **DHA**. **DHA** shall be the final authority in determining the form and/or acceptability of the data.

### **3.3.6 Outgoing Contractor Weekly Status Reporting**

Until all inventories have been processed, the outgoing contractor shall submit a weekly status report of inventories and phase-out activities to **DHA** beginning the 20th calendar day following the Specifications Meeting until otherwise notified by the PCO to discontinue. This shall be done in accordance with specifications of the official transition schedule.

### **3.3.7 Prior Authorizations and Referrals**

The outgoing contractor shall provide all prior authorizations and referrals that cover care spanning the start of health care delivery under the new contract or care that could potentially

begin in the incoming contractor's health care delivery period. The outgoing and incoming contractor shall mutually agree to the date and schedule for transfer of this information.

### **3.3.8 Case Management and Disease Management Files**

NLT 60 days prior to the start of health care delivery under the new contract, the outgoing contractor shall provide the incoming contractor with all files pertaining to beneficiaries covered under a Case Management or Disease Management program. Electronic files shall be provided under a non-proprietary format. The outgoing contractor shall cooperate with the incoming contractor to ensure seamless continuity of care and services for all such beneficiaries.

### **3.3.9 MTF MOUs**

NLT 30 days following contract award, the outgoing contractor shall provide the incoming contractor the most recent version of all MTF MOUs in place at that time for the purpose of ensuring continuity of services to MTFs and continuity of care for TRICARE beneficiaries.

### **3.3.10 Program Integrity Files**

NLT 30 days prior to the start of health care delivery under the new contract, the outgoing contractor shall provide the incoming contractor with all active Program Integrity case files that have been forwarded to **DHA** Program Integrity Office (PI). The outgoing contractor shall also provide weekly updates of Program Integrity case file, including new cases initiated through the end of the contract delivery period.

### **3.3.11 Provider Certification File**

NLT 30 days after contract award and on a monthly basis until the start of health care delivery, the outgoing contractor shall provide the incoming contractor with copies of all provider certification files.

## **3.4 Final Processing Of Outgoing Contractor**

The outgoing contractor shall:

- Process all claims and adjustments for care rendered prior to the start of health care delivery of the new contract that are received through the 120th day following cessation of the outgoing contractor's health care delivery. Processing of these claims shall be completed within 180 calendar days following the start of the incoming contractor's health care delivery. All claims shall meet the same standards as outlined in the current outgoing contract. Any residual claim received after 120 days shall be forwarded to the incoming contractor within 24 hours of receipt.
- Be liable, after the termination of services under this contract, for any payments to subcontractors of the contractor arising from events that took place during the period of this contract.
- Refer to [paragraph 2.10.3](#), for transitional case requirements.

- Process all correspondence, allowable charge complaints, and incoming telephonic inquiries which pertain to claims or services processed or delivered under this contract within the time frames established for response by the standards of the contract.
- Complete all appeal and grievance cases that pertain to claims or services processed or delivered under this contract within the time frames established for response by the standards of the contract.

#### **3.4.1 Correction of Edit Rejects**

The outgoing contractor shall retain sufficient resources to ensure correction (and reprocessing through **DHA**) of all TED record edit errors NLT 210 calendar days following the start of the incoming contractor's health care delivery.

#### **3.4.2 Phase-Out of the Automated TRICARE DCS**

The outgoing contractor shall phase-out the use of the automated TRICARE DCS in accordance with [Chapter 9](#) and transition plan requirements.

#### **3.4.3 Phase-Out Of The Contractor's Provider Network, TSCs (TRICARE Overseas Contract Only), And MTF Agreements**

**3.4.3.1** Upon notice of award to another contractor, the outgoing contractor shall provide full cooperation and support to the incoming contractor, to allow an orderly transition, without interruption, of all functions relating to the MTF interface and the establishment of a provider network by the incoming contractor. This shall include, but is not limited to, data relating to on-site service centers, resource sharing agreements, equipment, telephones and all other functions having an impact on the MTFs.

**3.4.3.2** Within 15 calendar days of the Transitions Specifications Meeting the outgoing contractor shall draft and submit a revised plan for transition of the MTF interfaces. Resolution of differences identified through the coordination process must be accomplished in collaboration with the Transition Monitor appointed by **DHA** and according to the guidelines in the transition schedule.

**3.4.3.3** The outgoing contractor shall ensure a HCF function continues through the last date of health care delivery under the current contract, unless otherwise negotiated with the incoming contractor during the Transition Specifications Meeting. The outgoing contractor shall also vacate the TSCs (TRICARE overseas contract only) on the 40th calendar day prior to the start of the health care delivery and establish a centralized HCF function.

**3.4.3.4** The outgoing contractor shall continue to issue prior authorizations for care for which it is financially responsible. However, authorization-related information shall be shared between the incoming and the outgoing contractors to preclude requiring a provider or beneficiary to duplicate the paperwork and other effort related to establishing prior authorizations. The outgoing contractor may issue prior authorizations as late as midnight on the day prior to the end of its health care delivery for inpatient stays that will continue as transitional cases. The two contractors shall interface on the clinical issues of a case where both contractors will, or can reasonably expect to have periods of liability for the same EOC.

**3.4.3.5** The outgoing contractor shall maintain toll-free lines and web-based customer service capabilities, accessible to the public during the first 90 calendar days of dual operations in order to properly respond to inquiries related to claims processed for services incurred during the period of their respective liability. Beneficiary inquiry lines will continue to be staffed as defined in the contract. In general, the outgoing contractor shall maintain adequate toll-free line coverage to ensure that the blockage rate does not exceed the blockage rate on the contractor's most critical private or other government business access line.

### **3.5 Phase-Out of Enrollment Activities**

**3.5.1** Prior to the start of health care delivery under the successor contract, for all enrollment renewals or payments in which the new enrollment period or period covered by the premium payment will begin under the new contract, the outgoing contractor shall amend renewal notices and billing statements (or include a stuffer/insert) to advise the enrollee to direct any enrollment-related correspondence and enrollment fee payments to the successor contractor.

**3.5.2** Prior to the start of health care delivery under the successor contract, the Government will provide the outgoing contractor with the software for the DOES version to be used during transition. The software version should be loaded and used for the phase-out of enrollment activities.

### **3.5.3 Enrollment Actions During 45 Day Transition Period**

**3.5.3.1** For new enrollments in the region with an effective date prior to the start of health care delivery (e.g., AD enrollment, mid-month enrollment; and transfer-in), the outgoing contractor must effect an enrollment action with an end date of the current contract period (i.e., one day prior to the start of health care delivery under the incoming contract). Any enrollment fees due for an effective date that is prior to the start of health care delivery will be retained by the outgoing contractor. Once the enrollment is effected, the outgoing contractor will notify the incoming contractor of the new enrollment.

**3.5.3.2** When a current enrollment in the region requires deletion with an effective date prior to the start of health care delivery (e.g., transfers out; disenrollments for failure to pay fees; cancellations, etc.), the outgoing contractor must request the incoming contractor to cancel the future enrollment segment that was included on the Gold File. Once notified by the incoming contractor that the segment has been cancelled, the outgoing contractor completes the appropriate disenrollment action.

**3.5.3.3** For all other enrollment actions with an effective date prior to start of health care delivery (e.g., PCM changes; DMIS-ID changes; and enrollment begin date changes), the outgoing contractor must request the incoming contractor cancel the future enrollment segment. Once notified that the cancellation has been completed, the outgoing contractor will make the necessary change. Upon completion of the change, the outgoing contractor must notify the incoming contractor so that the future enrollment segment can be restored.

**3.5.3.4** The outgoing contractor should complete all pending enrollment actions prior to the DEERS freeze to transition enrollment. Any enrollment action not completed by the outgoing contractor prior to the freeze (and after the Gold File is created) will have to be accomplished following the above procedures.

**3.5.3.5** Once health care delivery begins, all enrollment actions will be accomplished by the incoming contractor. If the outgoing contractor requires a retroactive change, they must submit their request to the incoming contractor who will perform the change and notify the outgoing contractor when it is complete.

**3.5.4** Any enrollment-related correspondence and/or enrollment fee payments subsequently received by the outgoing contractor shall be forwarded to the incoming contractor within three working days of receipt.

**3.5.5** The outgoing contractor shall terminate marketing and enrollment activity 40 calendar days prior to the start of the incoming contractor's health care delivery. Any enrollment requests or applications received after the 40th calendar day shall be transferred to the incoming contractor by overnight delivery at the outgoing contractor's expense.

**3.5.6** Throughout the transition period, the outgoing and incoming contractors shall coordinate enrollment files no less than weekly to ensure that new enrollments and enrollment renewals are accurately and timely reflected in the incoming contractor's enrollment files and in DEERS.

### **3.6 Cost Accounting**

If the outgoing contractor succeeds itself, costs related to each contract shall be kept separate for purposes of contract accountability, according to the above guidelines.

### **3.7 Records Disposition**

The outgoing contractor shall comply with the provisions of [Chapter 2](#), in final disposition of all files and documentation. The contractor shall include a records disposition plan as part of the phase-out plan submitted to [DHA](#) at the Transition Specifications Meeting.

### **3.8 Provide Information**

The contractor shall, upon receipt of a written request from [DHA](#), provide to potential offerors such items and data as required by [DHA](#). This shall include non-proprietary information, such as record formats and specifications, field descriptions and data elements, claims and correspondence volumes, etc.

- END -

## Enrollment Processing

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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** For paper enrollment requests, the contractor shall use the TRICARE Prime Enrollment, Disenrollment, and Primary Care Manager (PCM) Change Form (one combined form), Department of Defense (DD) Form 2876. The contractor shall ensure the aforementioned form is 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 forms at a site(s) 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. The contractors shall encourage the beneficiaries to use the Beneficiary Web Enrollment (BWE) system to enroll. The overseas contractor shall also collect applications at their TRICARE Service Centers (TSCs).

**1.1.2** Enrollment requests must be initiated by the sponsor, spouse, other legal guardian of the beneficiary, or an eligible beneficiary 18 or older. An official enrollment request includes those with (1) an original signature, (2) an electronic signature offered by and collected by the contractor, (3) a verbal consent provided via telephone and documented in the contractor's call notes, or (4) a self attestation by the beneficiary when using the BWE system. A signature from an ADSM is never required to complete Prime enrollment as enrollment in Prime is mandatory per the TRICARE Policy Manual (TPM), [Chapter 10, Section 2.1, paragraph 1.1](#).

**1.1.3** The contractor shall also accept and process TRICARE Prime enrollment requests via the 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 TPM, [Chapter 10, Section 3.1](#).

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

### Chapter 6, Section 1

#### Enrollment Processing

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**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 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 request (see [paragraph 1.1.2](#)) contains neither a residential address nor a mailing address, the contractor shall attempt to develop for a residential address. If it is determined the beneficiary does not have an established residential address or that the beneficiary's mailing address differs from the residential address, the contractor shall also develop the enrollment request 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 enrollment request 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 **send a notification** directly to the enrollee at the residential mailing address specified in the enrollment request (see [paragraph 1.1.2](#)) **or via e-mail advising them how to obtain a copy of their Universal TRICARE Beneficiary Card**. 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](#).) **If the notification is made via a mailed postcard**, the return address will be that of the appropriate MCSC. In the case of receiving a returned **postcard**, the MCSC shall develop a process to fulfill the delivery to the enrollee.

**1.8** An enrollee must present a Uniformed Services **identification** card to a provider to demonstrate eligibility for TRICARE benefits. **A beneficiary may also present their Universal TRICARE Beneficiary Card, although it is not required.**

**3.7** PCM change requests submitted via any means other than BWE application by beneficiaries enrolled to the civilian network must be processed by the MCSC within three working days of receipt, with an effective date no later than (NLT) the third working day.

**3.8** PCM change requests submitted to the MCSC via the BWE application by beneficiaries will be processed within six calendar days of receiving the requests, and the effective date will be the sixth calendar day after the request was submitted or the date requested by the beneficiary if over six days but less than 91 days.

## **4.0 ENROLLMENT PERIOD**

### **4.1 Effective Date of Enrollment**

The contractor shall support continuous open enrollment for all beneficiaries. Enrollment may occur any time during the contract period; however, all new enrollment periods shall coincide with the fiscal year. The contractor shall align any enrollment established based on an enrollment year period to the fiscal year upon the first renewal of the enrollment period.

**4.1.1** The effective date of enrollment for ADSMs shall be the date the contractor receives the signed enrollment application. A signed enrollment application includes those with (1) an original signature, (2) an electronic signature offered by and collected by the contractor, or (3) the self attestation by the beneficiary when using the BWE system.

**4.1.2** All other enrollment periods shall begin on the first day of the month following the month in which the enrollment application and any required enrollment fee payment are received by the contractor. If an application and fee are received after the 20th day of the month, enrollment will be on the first day of the second month after the month in which the contractor received the application. (This recurring principle is referred to as the 20th of the month rule.)

**4.1.3** Enrollees who transfer enrollment continue with the same enrollment period. The enrollment transfer, however, is effective the date the gaining contractor receives a signed enrollment application or transfer application. See TPM, [Chapter 10, Sections 2.1 and 5.1](#) for information on Transitional Assistance Management Program (TAMP) and other changes in status. An ADSM or ADFM signature is not required to make enrollment changes when using the Enrollment Portability process outlined in [Chapter 6, Section 2, paragraph 1.4](#).

### **4.2 Enrollment Expiration**

**4.2.1** NLT 30 calendar days before the expiration date of an enrollment, the contractor shall send the appropriate individual (sponsor, custodial parent, retiree, retiree family member, survivor or eligible former spouse, etc.) a written notification of the pending expiration and renewal of the TRICARE Prime enrollment and a bill for the enrollment fee, if applicable (since ADSMs must be enrolled but their family members need not be, there is no action required if an ADSM does not have enrolled family members). The bill shall offer all available payment options and methods. The contractor shall issue a delinquency notice to the appropriate individual 15 calendar days after the expiration date of the enrollment.

**4.2.2** The contractor shall automatically renew enrollments, including those for ADSMs, upon expiration unless the enrollee declines renewal, is no longer eligible for Prime enrollment, or fails to

pay any required enrollment fee on a timely basis, including a 30 calendar day grace period beginning the first day following the last day of the enrollment period.

**4.2.3** If the enrollee requests disenrollment during this grace period, the contractor shall disenroll the beneficiary effective retroactive to the enrollment period expiration date.

**4.2.4** If an enrollee does not respond to the re-enrollment notification and fails to make an enrollment fee payment by the end of the grace period, the contractor is to assume that the enrollee has declined re-enrollment. The contractor shall disenroll the beneficiary retroactive to the enrollment expiration date.

**4.2.5** ADSMs may not decline reenrollment nor may they request disenrollment.

**4.2.6** DMDC sends written notification to the beneficiary of the disenrollment and the reason for the disenrollment within five business days of the disenrollment transaction.

### **4.3 Disenrollment**

**4.3.1** Disenrollment requests must be initiated by the sponsor, spouse, other legal guardian of the beneficiary, or an eligible beneficiary 18 or older. An official disenrollment request includes those with (1) an original signature, (2) an electronic signature offered by and collected by the contractor, (3) a verbal consent provided via telephone and documented in the contractor's call notes, or (4) a self-attestation by the beneficiary when using the BWE system. (A sponsor cannot be disenrolled per [paragraph 4.2.5](#).)

**4.3.2** The contractor shall automatically disenroll beneficiaries when the appropriate enrollment fee payment is not received by the 30th calendar day following the enrollment period expiration date or the due date for the installment payment. The contractor shall set the disenrollment effective date retroactive to the annual renewal date or the payment due date, whichever applies. An appropriate enrollment fee payment includes the appropriate form of payment for the period the fee is intended to cover (i.e., monthly, quarterly, or annually).

**4.3.3** Prior to processing a disenrollment for "non-payment of fees," the MCSC or Uniformed Services Family Health Plan (USFHP) provider must reconcile their fee payment system against the fee totals in DEERS. Once the contractor confirms that the payment amounts match, the disenrollment may be entered in DOES.

**4.3.4** The disenrolled beneficiary will be responsible for the deductible and cost-shares applicable under TRICARE Extra or Standard for any health care received during the 30 day grace period. In addition, the beneficiary shall be responsible for the cost of any services received during the 30 day grace period that may have been covered under TRICARE Prime but are not a benefit under TRICARE Extra or Standard, e.g., preventive care.

**4.3.5** The contractor may suspend claims processing during the grace period to avoid the need to recoup overpayments.

**4.3.6** See the TPM, [Chapter 10, Sections 2.1](#) and [3.1](#) for additional information on disenrollment.

## 4.4 Enrollment Lockout

**4.4.1** The contractor shall “lockout” or deny re-enrollment for a period of 12 months from the effective date of disenrollment for the following beneficiaries:

- Retirees and/or their family members who voluntarily disenroll prior to their annual enrollment renewal date;
- ADFMs (E-5 and above) who change their enrollment status (i.e., from enrolled to disenrolled twice in a given year) for any reason during the enrollment year (October 1 to September 30) (refer to this chapter and TPM, [Chapter 10, Sections 2.1 and 3.1](#); and
- Any beneficiary disenrolled for failure to pay required enrollment fees during a period of enrollment.

**Note:** The 12 month lockout provision does not apply to ADFMs whose sponsor’s pay grade is E-1 through E-4.

**4.4.2** Beneficiaries who decline re-enrollment during their annual renewal period are not subject to the 12 month enrollment lockout. At the end of an annual enrollment period, if the beneficiary declines to continue their enrollment and subsequently requests re-enrollment the contractor shall process the request as a “new” enrollment. (If an enrollee did not respond to a re-enrollment notification and failed to make an enrollment fee payment by the end of the grace period, the contractor is to assume that the enrollee declined re-enrollment.)

**4.4.3** The contractor shall not grant waivers to the 12 month lockout provision. TRICARE Regional Office (TRO) Directors may grant waivers to the lockout provisions in extraordinary circumstances.

## 5.0 ENROLLMENT FEES

### 5.1 General

The contractor shall collect enrollment fee payments from TRICARE Prime enrollees as appropriate and shall report those fees, including any overpayments that are not refunded to the enrollee, to DEERS. (See the TSM, [Chapter 3](#).) The Prime enrollee may select one of the following three payment fee options (i.e., annual, quarterly, or monthly). In the event that there are insufficient funds to process a premium payment, the contractor may assess the account holder a fee of up to 20 U.S. dollars (\$20.00). The contractor shall provide commercial payment methods for Prime enrollment fees that best meet the needs of beneficiaries while conforming to the following ([paragraphs 5.1.1 through 5.1.3.7](#)):

#### 5.1.1 Annual Payment Fee Option

An annual installment is collected in one lump sum. For initial enrollments, the contractor shall prorate the fee from the enrollment date to September 30. The contractor shall accept payment of the annual enrollment fee only by credit card (e.g., Visa/MasterCard). See [paragraph 4.3.2](#) for disenrollment information if the appropriate enrollment fee payment is not received.

### 5.1.2 Quarterly Payment Fee Option

Quarterly installments are equal to one-fourth (1/4) of the total annual fee amount. For initial enrollments, the contractor shall prorate the quarterly fee to cover the period until the next fiscal year quarter. (Fiscal quarters begin on January 1, April 1, July 1, and October 1.) The contractor shall collect quarterly fees thereafter. The contractor shall accept payment of the quarterly enrollment fee only by credit card (e.g., Visa/MasterCard) or **Electronic Funds Transfer (EFTs) from the enrollee's designated financial institution. Payments may be made on a recurring basis.** See [paragraph 4.3.2](#) for disenrollment information if the appropriate enrollment fee payment is not received.

### 5.1.3 Monthly Payment Fee Option

Monthly installments are equal to one-twelfth (1/12) of the total annual fee amount. Monthly enrollment fees must be paid-through an automated, recurring electronic payment either in the form of an allotment from retirement pay or through Electronic Funds Transfer (EFTs) from the enrollee's designated financial institution (which may include a recurring credit or debit card charge). These are the only acceptable payment methods for the monthly payment option.

**5.1.3.1** Enrollees who elect the monthly fee payment option must pay the first quarterly installment (i.e., the first three months) at the time the enrollment application is submitted to allow time for the allotment or EFT to be established. The contractor shall accept payment of the first quarterly installment by personal check, cashier's check, traveler's check, money order, or credit card (e.g., Visa/MasterCard).

**5.1.3.2** The contractor shall initiate monthly allotments and EFTs and is responsible for obtaining and verifying the information necessary to do so.

**5.1.3.3** The contractor shall direct bill the beneficiary only when a problem occurs in initially setting up the allotment or EFT.

**5.1.3.4** When an administrative issue arises that stops or prevents an automated monthly payment from being received by the contractor (e.g., incorrect or transposed number provided by the beneficiary, credit card expired, bank account closed, etc.), the contractor shall grant the enrollee 30 days to provide information for a new automated monthly payment method or the option to pay quarterly or annually. The contractor may accept payment by check during this 30 day period in order to preserve the beneficiary's Prime enrollment status.

**5.1.3.5** Allotments from retired pay will be coordinated through the contractor with the Defense Finance and Accounting Service (DFAS), U.S. Coast Guard (USCG), or Public Health Service (PHS), as appropriate (see the TSM, [Chapter 1, Section 1.1, paragraph 11.10](#) for Payroll Allotment Interface Requirements). The contractor shall process all allotment requests submitted by beneficiaries.

**5.1.3.6** The contractor shall also research all requests that have been rejected or not processed by DFAS, USCG, or PHS. If the contractor's research results in the positive application of the allotment action, the contractor shall resubmit the allotment request.

**5.1.3.7** Within five business days, the contractor will notify the beneficiary of rejected allotment requests and issue an invoice to the beneficiary for any outstanding enrollment fees due. The contractor will respond to all beneficiary inquiries regarding allotments.

## **5.2 Member Category**

The sponsor's member category on the effective date of the initial enrollment, as displayed in DOES, shall determine the requirement for an enrollment fee.

## **5.3 Unremarried Former Spouses (URFSs) and Children Residing with Them**

**5.3.1** URFSs became sponsors in their own right as of October 1, 2003. As such, they are enrolled under their own SSNs and pay an individual enrollment fee. URFS may not "sponsor" other family members and their fees may not be factored into any family fees associated with the former spouse/sponsor.

**5.3.2** Children residing with the URFS and whose eligibility for benefits is based on the ex-spouse/former sponsor are identified under the ex-spouse/former sponsor's SSN on DEERS. Likewise, they are enrolled under the ex-spouse/former sponsor and fees for these children shall be combined with other fees paid under the ex-spouse/former sponsor.

**Example:** A contractor would collect the individual enrollment fee for an URFS's enrollment under the URFS's own SSN. The contractor would also collect a family enrollment fee for any two or more eligible family members enrolled under the SSN of the ex-spouse/former sponsor. These enrollees might include the sponsor, any current spouse, and all eligible children, including those living with the URFS.

## **5.4 TRICARE Prime Fee Waiver**

Each Prime enrolled beneficiary regardless of age, who maintains enrollment in Medicare Part B, is entitled to a waiver of an amount equivalent to the individual TRICARE Prime enrollment fee. Hence, individual enrollments for such beneficiaries will have the enrollment fee waived. A family enrollment in TRICARE Prime, where one family member maintains enrollment in Medicare Part B, shall have one-half of the family enrollment fee waived; the remaining half must be paid. For a family enrollment where two or more family members maintain enrollment in Medicare Part B, the family enrollment fee is waived regardless of the number of family members who are enrolled in addition to those entitled to Medicare Part B.

## **5.5 Survivors of Active Duty Deceased Sponsors and Medically Retired Uniformed Services Members and their Dependents**

Effective Fiscal Year (FY) 2012, beneficiaries who are (1) survivors of active duty deceased sponsors, or (2) medically retired Uniformed Services members and their dependents, shall have their Prime enrollment fees frozen at the rate in effect when classified and enrolled in a fee paying Prime plan. (This does not include TRICARE Young Adult (TYA) plans). Beneficiaries in these two categories who were enrolled in FY 2011 will continue paying the FY 2011 rate. The beneficiaries who become eligible in either category and enroll during FY 2012, or in any future fiscal year, shall have their fee frozen at the rate in effect at the time of enrollment in Prime. The fee for these beneficiaries shall remain frozen as long as at least one family member remains enrolled in Prime.

The fee for the dependent(s) of a medically retired Uniformed Services member shall not change if the dependent(s) is later re-classified a survivor.

## 5.6 Mid-Month Enrollees

The contractor shall collect any applicable enrollment fee from mid-month enrollees at the time of enrollment. However, there will be no enrollment fee collected for the days between the effective enrollment date and the determined enrollment date.

**5.6.1** The effective enrollment date shall be the actual start date of the enrollment.

**5.6.2** The determined enrollment date shall be established using the 20th of the month rule, as it is for initial enrollments.

**Example:** If the retirement date is May 27, the effective enrollment date will be May 27 and the determined enrollment date will be July 1. Fees will be charged for the period from July 1 forward; no fees will be assessed for the period from May 27 through June 30. Effective with enrollment fees that are to be applied to periods on or after October 1, 2012, DEERS will calculate the paid-through dates based on DEERS data and the enrollment fee amount collected and entered into DEERS by the contractor. Reference the TPM, [Chapter 10, Section 3.1](#).

## 5.7 Overpayment Of Enrollment Fees

### 5.7.1 Prior To October 1, 2012

If enrollment fees are overpaid at any point during an enrollment year, the contractor may credit the overpayment to any outstanding payments due. Such credits shall be reported on DEERS. If the overpayment of enrollment fees is not applied to outstanding payments due, the contractor shall refund any overpayments of \$1 or more to the enrollee. When TRICARE Prime enrollment changes from a family to an individual prior to annual renewal, the unused portion of the enrollment fee shall be prorated on a monthly basis and shall be applied toward a new enrollment period.

### 5.7.2 On Or After October 1, 2012

Effective with enrollment fees that are to be applied for coverage on or after October 1, 2012, the contractor shall update DEERS with the fee amount collected and DEERS will calculate the paid-through date and notify the contractor. DEERS will only extend the paid-through date to cover the current enrollment year, plus two future fiscal years. DEERS will store amounts that cannot cover one month's fees or amounts that extend the paid-through date beyond two fiscal years in the future as a credit. Additionally, funds applied that would move the paid-through date beyond the policy end date will be stored as a credit. (The exception is when Prime policies end mid-month; DEERS will set a paid-through date to the end of that month.) Also, if there is a 100% fee waiver with an end date that exceeds more than two fiscal years beyond the current enrollment year, the paid period can extend beyond the two fiscal years and any fee amounts sent to DEERS will be applied as a credit. The contractor shall refund any credit of \$1 or more on a current enrollment that extends beyond two fiscal years. The contractor shall update DEERS with any fee amount refunded within 30 calendar days. The contractor shall include an explanation for the premium refund.

**5.8** The following reports will be provided to the contractor by DEERS to assist with identifying and correcting enrollment fee discrepancies. The contractor shall correct all accounts identified as discrepant. The contractor who is responsible for a beneficiary's current enrollment is responsible for resolving any over/under payments. For split enrollments, the reports will use the billing hierarchy to determine the responsible contractor.

**5.8.1 Monthly Under Report (Prior To October 1, 2012)**

Enrollment fees are considered delinquent and will show up on the Monthly Under Report when the paid-through date associated with a policy is greater than 60 days in the past. The Under Report will be provided on the first of each month. The contractor is required to analyze and correct all reported delinquencies within 30 days of the report's availability. The corrections may include synchronizing the fee data between the contractor's system and DEERS, correcting data discrepancies, and potentially terminating enrollments for failure to pay fees.

**5.8.2 Monthly Over Report (Prior To October 1, 2012)**

The Monthly Over Report will identify those policies where the paid amount is over the amount owed. Amount owed is based on the enrollment begin date, the paid-through date, any existing fee waivers, and DEERS data used to determine payment tiers (if applicable) and/or freezes of enrollment fees (premium override periods). The Over Report will be provided before the 10th business day of each month. The contractor is required to analyze and correct all reported accounts within 30 days of the report's availability. The contractor is responsible for correcting any data inaccuracies within the enrollment fee reporting system to include the refunding of any enrollment fees in excess of what is due if necessary.

**5.8.3 Quarterly Under Report (Prior To October 1, 2012)**

The Quarterly Under Report will identify all terminated policies since the inception of the contract that have an associated paid-through date prior to the termination date. The Quarterly Report will be provided on the first day of the first month of the fiscal quarter (i.e., October 1, January 1, April 1, and July 1). The contractor shall correct all data discrepancies within 60 days of the report's availability.

**5.8.4 Monthly Reports (On or After October 1, 2012)**

**5.8.4.1** DEERS will provide the following reports on a monthly basis:

- Current policies that are two months past due (paid period end date more than two months in the past)
- Any policies where the paid period end date exceeds the policy end date
- Policies where the paid period end date meets the policy end date but a credit exists
- Terminated policies where the paid period end date does not meet the policy end date

**5.8.4.2** These reports will be provided before the 10th business day of each month. The contractor is required to analyze and correct all report accounts within 30 days of the report's availability. The contractor is responsible for correcting any data inaccuracies within the enrollment fee reporting system to include the refunding of any enrollment fees in excess of what is due if necessary. For enrollment fee payments effective on or after October 1, 2012, the contractor shall update DEERS with any fee amount refunded within 30 calendar days.

## **6.0 ENROLLMENT OF FAMILY MEMBERS OF E-1 THROUGH E-4**

**6.1** When family members of E-1 through E-4 reside in a Prime Service Area (PSA) of an MTF offering TRICARE Prime, the family members will be encouraged to enroll in TRICARE Prime. Upon enrollment, they will choose or be assigned a PCM located in the MTF. Such family members may, however, specifically decline such enrollment without adverse consequences. The choice of whether to enroll in TRICARE Prime, or to decline enrollment is completely voluntary. Family members of E-1 through E-4 who decline enrollment or who enroll in Prime and subsequently disenroll may re-enroll at any time. The completion of an enrollment application is a prerequisite for enrollment of such family members.

**6.2** Enrollment processing and allowance of civilian PCM assignments will be in accordance with the Memorandum of Understanding between the contractor and the MTF.

**6.3** The primary means of identification and subsequent referral for enrollment will occur during in-processing. Non-enrolled E-4 and below families may also be referred to the MCSC's call center, Commanders, First Sergeants/Sergeants Major, supervisors, Family Support Centers, and others. Beneficiaries at overseas locations may also be referred to their local TSC.

**6.4** MCSC representatives at their call center and those giving beneficiary education briefings will provide enrollment information and support the family member in making an enrollment decision (i.e., to enroll in TRICARE Prime or to decline enrollment). The education of such potential enrollees shall specifically address the advantages of TRICARE Prime enrollment, including guaranteed access, the support of a PCM, etc. The contractor shall reinforce that enrollment is at no cost for family members of E-1 through E-4 and will give them the opportunity to select or be assigned an MTF PCM, to select a civilian PCM if permitted by applicable MOU, or to decline enrollment in TRICARE Prime.

**6.5** The contractor shall also discuss the potential effective date of the enrollment, explaining that the actual effective date will depend upon the date the enrollment application is received, consistent with current TRICARE rules (i.e., the "20th of the month" rule). The effective date of enrollment shall be determined by the date the enrollment application is received by the MCSC. These enrollments and enrollment refusals should not be tracked, nor the enrollees identified differently than enrollments initiated through any other process, such as the MCSC's own marketing efforts.

**6.6** Enrollment may be terminated at any time upon request of the enrollee, sponsor or other party as appropriate under existing enrollment/disenrollment procedures. Beneficiaries in this group may re-enroll at any time without restriction or penalty. However, such re-enrollments are subject to the 20th of the month rule.

**6.7** Contractors are not required to screen TRICARE claims to determine whether it may be for treatment of a non-enrolled ADFM of E-1 through E-4 living in a PSA. Rather, they are to support the prompt and informed enrollment of such individuals when they have been identified by DoD in the course of such a person's interaction with the military health care system or personnel community and have been referred to the contractor for enrollment.

## **7.0 TRICARE ELIGIBILITY CHANGES/REFUNDS OF FEES**

**7.1** Refer to the TPM, [Chapter 10, Section 3.1](#), for information on changes in eligibility.

**7.2** The contractor shall allow a TRICARE-eligible beneficiary who has less than 12 months of eligibility remaining to enroll in TRICARE Prime until such time as the enrollee loses his/her TRICARE eligibility. The beneficiary shall have the choice of paying the entire enrollment fee or paying the fees on a more frequent basis (e.g., monthly or quarterly). If the enrollee chooses to pay by installments, the contractor shall collect only those installments required to cover the period of eligibility. For enrollment fee payments effective on or after October 1, 2012, DEERS will calculate the paid-through date based on the enrollment fee amount collected and entered into DEERS by the contractor, which in this circumstance, should cover the period of the beneficiary's eligibility. The contractor shall refund any overpayment of \$1 or more that DEERS does not use to extend the paid-through date to the policy end date (or the last day of the month in which a Prime policy ends). The contractor shall include an explanation to the beneficiary for the fee refund. The contractor shall update DEERS with any fee amount refunded within 30 calendar days.

**7.3** Contractors shall refund the unused portion of the TRICARE Prime enrollment fee to retired TRICARE Prime enrollees and their families who have been recalled to active duty. The contractor shall include an explanation to the beneficiary for the fee refund. Contractors shall calculate the refund using monthly prorating, and shall report such refunds to DEERS within 30 calendar days. If the reactivated member's family chooses continued enrollment in TRICARE Prime, the family shall begin a new enrollment period and shall be offered the opportunity to keep its PCM, if possible. Any enrollment/fiscal year catastrophic cap accumulations shall be applied to the new enrollment period.

**7.4** The contractor shall refund enrollment fees for deceased enrollees upon receiving a written request from the remaining enrollee or the executor of the decedent's estate. The contractor shall include an explanation to the beneficiary for the fee refund. The enrollee's request must include a copy of the death certificate. Refunds shall be prorated on a monthly basis and apply both to individual plans where the sole enrollee is deceased and to the conversion of a family enrollment to an individual plan upon the death of one or more family members. For individual enrollments, the contractor shall refund remaining enrollment fees to the executor of the estate. For family enrollments that convert to individual plans, the contractor shall either credit the excess fees to the individual plan or refund them either to the remaining enrollee or to the executor of the decedent's estate, as appropriate. Enrollment fees for family enrollments of three or more members are not affected by the death of only one enrollee and no refunds shall be issued. The contractor shall update DEERS with any amount refunded within 30 calendar days.

**7.5** The contractors shall refund the unused portion of the TRICARE Prime enrollment fee to TRICARE Prime enrollees who become eligible for Medicare Part A based upon disability, End Stage Renal Disease (ESRD) or upon attaining age 65, provided the beneficiary has Medicare Part B coverage.

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**7.5.1** The contractor shall issue refunds to these beneficiaries upon receiving (1) a written request from the beneficiary (that includes a copy of their Medicare card) and either confirming their Part B enrollment in DEERS or in a previous Policy Notification Transaction (PNT), or (2) upon receipt of an unsolicited PNT noting a beneficiary's fee waiver update based on the Part B enrollment. DEERS generates a PNT when the Centers for Medicare and Medicaid Services (CMS) sends DEERS data indicating a Part B enrollment or disenrollment. Refunds are required for all payments that extend beyond the date the enrollee has Medicare Part B coverage, as calculated by DEERS. The contractor shall update DEERS with any amount refunded within 30 calendar days. The contractor shall include an explanation to the beneficiary for the fee refund. Effective October 1, 2012, if the fee waiver is a 100% waiver of the Prime enrollment fee, the contractor shall send a refund to the beneficiary. If the fee waiver is a 50% waiver of the Prime enrollment fee, DEERS will automatically calculate the overpayment and extend the paid through date for the policy, as appropriate; therefore, a refund may not be required unless a credit remains when the policy is paid in full.

**7.5.2** For Prime enrollees who become Medicare eligible and who maintain Medicare Part B coverage, refunds are required for overpayments occurring on and after the start of health care delivery of all MCS contracts. The contractor shall utilize the PNTs received indicating a fee waiver based on Medicare to substantiate any claim of overpayment.

**7.5.3** Medicare eligible ADFMs age 65 and over are not required to have Medicare Part B to remain enrolled in TRICARE Prime. To maintain TRICARE coverage upon the sponsor's retirement, they must enroll in Medicare Part B during Medicare's Special Enrollment Period prior to their sponsor's retirement date. (The Special Enrollment Period is available anytime the sponsor is on active duty or within the first eight months of the sponsor's retirement. If they enroll in Part B after their sponsor's retirement date, they will have a break in TRICARE coverage.)

**7.5.4** Medicare eligibles age 65 and over who are not entitled to premium-free Medicare Part A are not required to have Medicare Part B to remain enrolled in TRICARE Prime. Because they may become eligible for premium-free Medicare Part A at a later date, under their or their spouse's SSN, they should enroll in Medicare Part B when first eligible at age 65 to avoid the Medicare surcharge for late enrollment.

**7.6** The contractor shall include full and complete information about the effects of changes in eligibility and rank in beneficiary education materials and briefings.

## **8.0 WOUNDED, ILL, AND INJURED (WII) ENROLLMENT CLASSIFICATION**

The WII program provides a continuum of integrated care from the point of injury to the return to duty or transition to active citizenship for the Active Component (AC) or the Reserve Component (RC) service members who have been activated for more than 30 days. These AC/RC service members, referred to as ADSMs, have been injured or become ill while on active duty and will remain in an active duty status while receiving medical care or undergoing physical disability processing. WII programs vary in name according to Service. The Service shall determine member eligibility for enrollment into a WII program, as well as whether or not to utilize these enrollments.

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To better manage this population, a secondary enrollment classification of HCDP Plan Coverage Codes, WII 415 and WII 416 were developed. The primary rules apply to the WII HCDP codes:

- ADSMs must be enrolled to a TRICARE Prime program prior to, or at the same time, as being enrolled into a WII 415 or WII 416 program.
- A member cannot be enrolled in WII 415 and WII 416 programs at the same time.
- WII 415 and WII 416 enrollments will terminate at the end of the member's active duty eligibility, when members transfer enrollment to another MTF, change of a plan code, or at the direction of the Service-specific WII entity.
- Any claims processed for WII 415/416 enrollees shall follow the rules associated with the primary HCDP Plan Coverage Code, such as TRICARE Prime, TRICARE Prime Remote (TPR), TRICARE Overseas Program (TOP) Prime, or TOP Prime Remote. All claims will process and pay under Supplemental Health Care Program (SHCP) rules. DEERS will not produce specific enrollment cards or letters for WII 415/416 enrollment.

WII 415/416 TRICARE Encounter Data (TED) records shall be coded with the WII 415/416 HCDP Plan Coverage Code; however, the Enrollment/Health Plan Code data element on the TED record shall reflect the appropriate value for the primary HCDP Plan Coverage Code. For example, a TED record for a WII 416 enrollee with primary enrollment to TPR would reflect the HCDP Plan Coverage Code of "416" but the Enrollment/Health Plan Code would be coded "W TPR Active Duty Service Member".

#### **8.1 WII 415 - Wounded, Ill, And Injured (e.g., Warrior Transition/MEDHOLD Unit (WTU))**

**8.1.1** Service defined eligible ADSMs assigned to a WII 415 Program such as a MEDHOLD or WTU shall be enrolled to TRICARE Prime or TOP Prime prior to, or at the same time, as being enrolled into the WII 415. Members cannot be enrolled to the WII 415 without a concurrent TRICARE Prime or TOP Prime enrollment. Service appointed WII case managers as determined by the Services, will coordinate with the MTF to facilitate TRICARE Prime PCM assignments for WII 415 members. The contractor shall then assign a PCM in accordance with the MTF MOU and in coordination with the WII case manager. WII 415 enrollment will not run in conjunction with TAMP and members enrolled in TPR, or TOP Prime Remote are not eligible to enroll in the WII 415.

**8.1.2** The Service-specific WII entity will stamp the front page of the DD Form 2876, enrollment application form, with WII 415 for new enrollments that begin after the DEERS implementation date. The enrollment form will then be sent to the appropriate contractor who shall perform the enrollment in the DOES and include the following information:

- WII 415 HCDP Plan Coverage Code
- WII 415 Enrollment Start Date (Contractors may change the DOES defaulted start date, which may or may not coincide with the Prime Enrollment Start Date. The start date can be changed up to 289 days in the past or 90 days into the future.)

**8.1.3** WII 415 enrollments will be in conjunction with an MTF enrollment only, not to civilian network PCMs under TPR enrollment rules. DEERS will end WII 415 enrollments upon loss of member's active duty eligibility. WII 415 program enrollments will not be portable across programs or regions. The TOP contractor will enter WII 415 enrollments through DOES for outside the 50 United States and the District of Columbia.

**8.1.4** The contractors shall accomplish the following functions based on receipt of notification from the Service-specific WII program entities:

- Enrollment
- Disenrollment
- Cancel enrollment
- Cancel disenrollment
- Address update
- Contractors can request unsolicited PNTs resend
- Modify begin date
- Modify end date

**8.1.5** Service WII entities will provide contractors with a list by name and SSN of those ADSMs currently assigned to their WII program at the time the program is implemented by DEERS. The contractors shall enter these ADSMs into DOES as enrolled in WII 415 with a start date of the date of implementation, unless another date, up to 289 days in the past, is provided by the WII entity.

## **8.2 WII 416 - Wounded, Ill, And Injured - Community-Based (e.g., Community-Based Health Care Organization (CBHCO))**

**8.2.1** Service defined eligible ADSMs may be assigned to a WII 416 Program such as the Army's CBHCO and receive required medical care near the member's home. The service member shall be enrolled to TRICARE Prime, TPR, TOP Prime, or TOP Prime Remote prior to or at the same time as being enrolled into WII 416. Members cannot be enrolled to the WII 416 program without a concurrent Prime, TPR, TOP Prime, or TOP Prime Remote enrollment. Service appointed case managers will coordinate with the contractor or MTF to facilitate TRICARE Prime or TPR PCM assignments for eligible beneficiaries. The contractor shall then assign a PCM based on the MTF MOU and in coordination with the WII entity (e.g., CBHCO). WII 416 enrollments will not run in conjunction with TAMP.

**8.2.2** The Service-specific WII Program will stamp the front page of the DD Form 2876, enrollment application form, with WII 416 for all new enrollments. The begin date will be the date the contractors receive the signed enrollment form. A signed enrollment application includes those with (1) an original signature, (2) an electronic signature offered by and collected by the contractor, or (3) the self attestation by the beneficiary when using the BWE system. The enrollment form will then be sent to the appropriate contractor who shall perform the enrollment in the DOES and include the following information:

- WII 416 HCDP Plan Coverage Code
- WII 416 Enrollment Start Date (Date received by the contractor or the date indicated by the Service-specific WII Program which can be up to 289 days in the past, or 90 days in the future.)

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An ADSM or ADFM signature is not required to make enrollment changes when using the Enrollment Portability process outlined in [Chapter 6, Section 2, paragraph 1.4](#).

**8.2.3** WII 416 enrollments can be in conjunction with an MTF, TPR, TOP Prime, or TOP Prime Remote enrollment. DEERS will end WII 416 enrollments upon loss of member's active duty eligibility. WII 416 program enrollments will not be portable across programs or regions.

**8.2.4** The contractors shall accomplish the following functions based on receipt of notification from Service-specific WII program entities:

- Enrollment
- Disenrollment
- Cancel enrollment
- Cancel disenrollment
- Address update
- Contractors can request PNT resend
- Modify begin date
- Modify end date

**8.2.5** Service-specific WII entities will provide contractors with a list by name and SSN of those ADSMs currently participating in their WII program at the time the program is implemented by DMDC. The contractors shall enter these ADSMs into DOES as enrolled to WII 416 with a start date as the date of implementation, unless another date up to 289 days in the past is provided by the Service-specific WII program entities.

## **9.0 TRICARE POLICY FOR ACCESS TO CARE (ATC) AND PRIME SERVICE AREA (PSA) STANDARDS**

**9.1** Non-active duty beneficiaries in the Continental United States (CONUS) and Hawaii who reside more than 30 minutes travel time from their desired PCM must waive primary and specialty drive-time ATC standards. (Due to the unique health care delivery challenges in Alaska, the requirement to request a waiver for the drive-time access standard does not apply to beneficiaries in Alaska.) Before effecting an enrollment or portability transfer request, contractors shall ensure that a beneficiary has waived travel time ATC standards either by signing Section V of the DD Form 2876 enrollment application (this includes an electronic signature offered by and collected by the contractor), by providing verbal consent via telephone communication (which is documented in the contractor call notes), or by requesting enrollment through the BWE service (for both civilian and MTF PCMs). An approved waiver for a beneficiary residing less than 100 miles from their PCM will remain in effect until the beneficiary changes residence.

**9.2** Contractors must estimate the travel time or distance between a beneficiary's residence to a PCM (either a civilian PCM or an MTF) using at least one web-based mapping program. The choice of the mapping program(s) is at the discretion of the contractor, but the contractor must use a consistent process to determine the driving distance for each enrollee applicant who may reside more than 30 minutes travel time from their PCM. The time or distance shall be computed between the enrollee's residence and the physical location of the PCM (including MTFs). It is not acceptable to use a geographic substitute, such as a geographic centroid.

**9.3** Contractors (in conjunction with MTFs for MTF enrollees) are responsible for beneficiary drive-time waiver education and must ensure that beneficiaries who choose to waive these standards have a complete understanding of the rules associated with their enrollment and the travel time standards they are forfeiting. This includes educating beneficiaries who waive their ATC travel standards of the following:

- They should expect to travel more than 30 minutes for access to primary care (including urgent care) and possibly more than one hour for access to specialty care services.
- They will be held responsible for POS charges for care they seek that has not been referred by their PCM (or for MTF enrollees, by another MTF provider).
- They should consider whether any delay in accessing their enrollment site might aggravate their health status or delay receiving timely medical treatment.

**9.4** Enrollment shall only be effected for beneficiaries who reside in the Region. If at any point during the enrollment period the contractor determines or is advised that a beneficiary's residential address is outside the Region, the contractor shall inform the beneficiary of the discrepant address situation. This notification shall occur when the discrepant information is known to the contractor (i.e., not wait until the end of the enrollment period). When there is a discrepant address situation, the contractor shall confirm with the beneficiary the correct address. If the beneficiary confirms that a DEERS-recorded address is incorrect, the contractor shall request the beneficiary update DEERS with correct information (and assist as appropriate). If the contractor determines that the beneficiary resides outside the Region in which they are enrolled, the contractor shall inform the beneficiary no later than two months prior to expiration of the current enrollment period that enrollment will not be renewed to a Region in which they do not reside. The contractor shall provide information necessary for the beneficiary to contact the contractor for the region in which they do reside to request enrollment in that region.

## **9.5 MTF Enrollees**

**9.5.1** Non-active duty beneficiaries must reside within 30 minutes travel time from an MTF to which they desire to enroll. If a beneficiary desiring enrollment resides more than 30 minutes (but less than 100 miles) from the MTF, they may be enrolled so long as they waive primary and specialty ATC standards and the MTF Commander (or designee) approves the enrollment. (If the MOU includes zip codes or drive-time distances for which the MTF is willing to accept enrollments that are beyond a 30 minute drive, this constitutes approval. If not addressed in the MOU, the contractor shall submit each request to the MTF Commander (or designee) in a method that is outlined in the MOU.) The TRICARE Regional Office (TRO) Director may approve waiver requests from beneficiaries who desire to enroll to an MTF and who reside 100 miles or more from the MTF. In these cases, the MTF Commander must also be agreeable to the enrollment and have sufficient capacity and capability.

**9.5.2** The contractor shall process all requests for enrollment to an MTF in accordance with the MOU between the MTF and the contractor. Enrollment guidelines in MOUs may include:

**9.5.2.1** Zip codes and/or distances for which the MTF Commander is mandating enrollment to the MTF. These mandatory MTF enrollment areas must be within access standards (i.e., a 30 minute

drive-time of the MTF) and can apply to all eligible beneficiaries or can be based on beneficiary category priorities for MTF access.

**Note:** Non-active duty TRICARE Prime applicants who reside more than 30 minutes travel time from an MTF must be afforded the opportunity to enroll with a civilian PCM if they live in a PSA.

**9.5.2.2** Zip codes and/or distances for which the MTF Commander is willing to accept enrollment. This can include both areas within a 30 minute or less drive-time and over a 30 minute drive but within 100 miles. Any enrollment for a beneficiary with a drive of more than 30 minutes requires a signed waiver of access standards. If an enrollee applicant resides within a zip code previously determined to lie entirely within 30 minutes travel time from the MTF, the contractor need not compute the travel time for that applicant.

**9.5.2.3** Whether or not the MTF Commander will consider a request for enrollment for 100 miles or greater. In determining whether or not the MTF Commander will consider a request for enrollment beyond 100 miles, the MTF Commander may use zip codes to designate those areas the MTF Commander will consider requests or will not consider requests.

**9.5.3** The contractor shall notify the MTF Commander (or designee) when a beneficiary residing 100 miles or more from the MTF, but in the same Region, requests a new enrollment or portability transfer to the MTF. Such notification is not necessary if the MOU has already established that the MTF Commander will not accept enrollment of beneficiaries who reside 100 miles or more from the MTF. The contractor shall make this notification by any mutually agreeable method specified in the MOU. The contractor shall not make the MTF enrollment effective unless notified by the MTF to do so.

**9.5.3.1** The MTF Commander will notify the TRO Director of their desire to enroll a beneficiary who resides 100 miles or greater from the MTF and request approval for the enrollment. The TRO Director will make a determination on whether or not to approve or deny the request and notify the MTF Commander of their decision by a mutually agreeable method. The MTF Commander is responsible for notifying the contractor of all approved enrollment requests for beneficiaries who reside 100 miles or greater from the MTF. The contractor shall notify the beneficiary of the final decision.

**9.5.3.2** Approved waivers for beneficiaries residing 100 miles or more from the MTF shall remain in effect until the beneficiary changes residence or unless the MTF Commander determines that they will no longer allow these enrollments. Even if a beneficiary has previously waived travel time standards, any MTF Commander may revise the MOU (following the MOU revision process) to state that enrollment of some or all current enrollees who reside 100 or more miles from the MTF are not to be renewed at the end of the enrollment period. The contractor shall inform such beneficiaries no later than two months prior to expiration of the current enrollment period that they are no longer qualified for renewal of enrollment to the MTF. Prior to notification, the contractor shall obtain the rationale for the change from the MTF to include in the notice to the beneficiary. The proposed notice shall be reviewed and concurred on by the TRO prior to being sent to the impacted beneficiaries. (The TRO will coordinate notices with the Defense Health Agency (DHA) Beneficiary Education and Support Division (BE&SD) prior to approval.)

**9.5.4** At any time during the enrollment period, if the contractor determines there is no signed travel time waiver on file for a current MTF enrollee who resides more than 30 minutes from the

MTF, the contractor shall, at the next annual TRICARE Prime renewal point, require the beneficiary to waive the primary and specialty care ATC standards before the enrollment will be renewed. (This includes monitoring address changes received by the contractor from all sources.) The contractor shall notify the beneficiary of this waiver requirement no later than two months before expiration of the annual enrollment period. The language for all beneficiary notices shall be reviewed and concurred on by the TRO prior to being sent to beneficiaries. (The TRO will coordinate notices with DHA BE&SD prior to approval.)

- Any notice to a beneficiary that is requesting they sign a waiver of access standards, denying their enrollment, or advising them they are not eligible for re-enrollment to an MTF, shall include information on any alternative options for enrollment. The notice must also advise the beneficiary of the option to participate in TRICARE Standard, Extra, or the USFHP where available.

**9.5.5** For each approved enrollment to an MTF where the beneficiary has waived access standards, the contractor shall retain the enrollment request in a searchable electronic file until 24 months after the beneficiary is no longer enrolled to the MTF. The contractor shall provide the retained file to a successor contractor at the end of the final option period.

**9.5.6** When an enrollment request requires MTF Commander or TRO Director approval, any contractual requirements relating to processing timeliness for enrollment requests will begin when the contractor has obtained direction from the MTF Commander or TRO Director regarding waiver approval or disapproval.

## **9.6 Civilian Enrollees**

**9.6.1** Within a PSA, the civilian network must have the capability and capacity to allow beneficiaries who reside in the PSA to enroll to a PCM within access standards. If a beneficiary who resides in the PSA requests enrollment to a specific PCM who is located more than a 30 minute drive from the beneficiary's residence, the contractor may allow the enrollment so long as the beneficiary waives travel time access standards. (Also, see [Chapter 5, Section 1](#).)

**9.6.2** For new enrollments (including portability transfers), the contractor is not required to establish a network with the capability and capacity to grant enrollment to beneficiaries who reside outside a PSA. Requests for new enrollments to the civilian network from beneficiaries residing outside a PSA will be granted provided there is sufficient unused network capacity and capability to accommodate the enrollment and that the PSA civilian network PCM to be assigned is located less than 100 miles from the beneficiary's residence. Beneficiaries who reside outside the PSA and enroll in TRICARE Prime must waive their primary and specialty care travel time access standards. (The network shall have the capability and capacity to allow beneficiaries enrolled in TRICARE Prime, residing outside of PSAs, with a civilian network PCM prior to the beginning of Option Period One of the applicable regional Managed Care Support (MCS) contract to enroll to a PSA PCM provided the beneficiary resides less than 100 miles from an available network PCM in the PSA and waives both primary and specialty care travel time standards.)

**9.6.3** Beneficiaries who reside outside the PSA and are 100 miles or greater from an available civilian network PCM in the PSA shall not be allowed to enroll in TRICARE Prime.

- END -

## General

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### 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 **Defense Health Agency (DHA)**. (Refer to the TRICARE Reimbursement Manual (TRM), [Chapter 1, Section 20](#).)

## 2.3 Participating Provider - Agency Agreement With A Third Party

**2.3.1** 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 **DHA** Office of General Counsel (OGC), through the Contracting Officer (CO), for resolution.

**2.3.2** On a monthly basis, **DHA's** Office of Program Integrity (PI) provides each contractor with an updated data file of excluded third party billing agents. Based on this file, the contractor shall not accept any claims from excluded third party billing agents. Any claim received from an excluded third party billing agent shall be returned to the provider, instructing the provider that the submission of a valid claim cannot be done through a sanctioned entity, and to resubmit the claim directly, or through an approved third party billing agent. The contractor shall inform the provider that the third party billing agent has been excluded by Health and Human Services (HHS)/Centers for Medicare and Medicaid Services (CMS) and that no claims will be accepted from the third party billing agent until it has been reinstated. The contractor shall also provide notification to the third party billing agent that no claims will be accepted from it until it has been reinstated by HHS/CMS.

## 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 latest mandated version of the following claim forms for TRICARE benefits: the DoD Document (DD) Form 2642, the CMS 1500 Claim Form, 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 HIPAA-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 Claim Form 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 [DHA](#) 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 automated system within five workdays of actual receipt. For both hardcopy and Electronic Media Claim (EMC), the ICN shall contain the Julian date indicating the actual date of receipt. The Julian date of receipt shall remain the same even if additional ICNs are required to process the claim. If a claim is returned, the date of the receipt of the resubmission shall be entered as the new date of receipt. All claims not processed to completion and supporting documentation shall be retrievable by beneficiary name, sponsor's Social Security Number (SSN), Defense Enrollment Eligibility Reporting System (DEERS) family ID, or ICN within 15 calendar days following receipt.

#### 5.0 NEWBORN CLAIMS

5.1 Claims for newborns can be processed without eligibility on DEERS as long as:

- The newborn date of birth is within 365 days of the contractor's eligibility query; and
- The sponsor is/was eligible for TRICARE for the dates of care on the newborn claim.

5.2 Newborns are deemed enrolled in Prime as of the day of birth if the uniform service member sponsor is showing as eligible in DEERS (enrolled or non-enrolled), or the non-active duty sponsor or another family member is enrolled in Prime. This deemed enrollment period will continue for 60 calendar days from the newborn's date of birth or **to the effective date of enrollment**, whichever is earlier. If the newborn is not formally enrolled during the 60-day period, the newborn will revert to a non-enrolled status on the 61st day. Claims for care during the deemed enrollment period will be processed with Prime copayments, according to sponsor's status in DEERS. No referrals are required and Point of Service (POS) provisions do not apply during the deemed enrollment period. See the TRICARE Policy Manual (TPM), [Chapter 10, Section 3.1](#). For additional information on newborns under the TRICARE Retired Reserve (TRR) and TRICARE Reserve Select (TRS) programs, see [Chapter 22, Sections 2 and 1](#) respectively.

- END -



**6.1.3** The contractor shall screen the information provided and return, by fax or other electronic means acceptable to the MTF and the MCSC, incomplete requests within one business day. The return of a referral to the MTF is considered processed to completion. One business day is defined as the work day following the day of transmission at the close of business at the location of the receiving entity. A business day is Monday through Friday, excluding federal holidays.

**6.1.4** The contractor shall verify that the services are a TRICARE benefit through appropriate medical review and screening to ensure that the service requested is reimbursable through TRICARE. The contractor's medical review shall be in accordance with the contractor's best business practices. This process does not alter the TRICARE Operations Manual (TOM), TRICARE Policy Manual (TPM), or TRICARE Systems Manual (TSM) provisions covering active duty personnel or TRICARE For Life (TFL) beneficiaries.

**6.1.5** The MCSC shall advise the patient, referring MTF, and receiving provider of all approved referrals. The MTF single Point Of Contact (POC) shall be advised via fax or other electronic means acceptable to the MTF and the MCSC. (The MTF single POC may be an individual or a single office with more than one telephone number.) The notice to the beneficiary shall contain the unique identifier and information necessary to support obtaining ordered services or an appointment with the referred to provider within the access standards. The notice shall also provide the beneficiary with instructions on how to change their provider, if desired. If the MCSC is made aware the beneficiary changed the provider listed on the referral, the MCSC will make appropriate modifications to MTF issued referral (to revise the provider the beneficiary was referred to by the MTF). The revised referral shall contain the same level of data as the initial MTF referral. The revised referral will be issued to the current provider, with a copy to the MTF. For same day, 24-hour, and 72-hour referrals no beneficiary notification shall be issued. The MCSC shall notify the provider to whom the beneficiary is being referred of the approved services, to include clinical information furnished by the referring provider.

**6.1.6** If services are denied, the MCSC shall notify the patient and shall advise the patient of their right to appeal consistent with the TOM. The MCSC shall also notify the referring single MTF POC by fax of the initial denial.

**6.1.7** For services beyond the initial authorization, the MCSC shall use its best practices in determining the extent of additional services to authorize. The MCSC shall not request a referral from the MTF but shall provide the MTF, through the MTF's single POC, a copy of the authorization and clinical information that served as the basis for the new authorization.

## **6.2 Referrals From The Contractor To The MTF**

Referrals subject to the ROFR provision from the civilian sector shall be processed **as follows:**

**6.2.1** The **MCSC** shall fax, or send via other electronic means acceptable to the MTF and MCSC, the referral to the single MTF POC. The request shall contain the minimum data set described in [paragraph 6.1](#) (with the exception of the UIN) plus the civilian provider's fax number, telephone number, and mailing address. This data set shall be provided to the MTF in plain text with or without diagnosis or procedure codes. This transmission will generally take place within one business day. A business day is Monday through Friday, excluding Federal holidays.

**6.2.1.1** Referrals to the MTF shall be classified as follows:

**6.2.1.1.1** Urgent referrals are those that must be accepted or declined by the MTF within 90 minutes. If the MTF fails to respond within that time period, the referral is considered a passive denial and the patient is directed to the network by the MCSC.

**6.2.1.1.2** Routine referrals are those that must be accepted or declined by the MTF within two business days. If the MTF fails to respond within that time period, the referral is considered a passive denial and the patient is directed to the network by the MCSC.

**6.2.2** The MTF will respond via fax or other electronic means acceptable to the MTF and the MCSC as defined in [paragraph 6.2.1](#), to the single POC provided in the MOU by the MCSC. When no response is received from the MTF **within the time frames specified** above, the MCSC shall process the referral request as if the MTF declined to see the patient. The MCSC shall provide each MTF with a report of the number of referrals forwarded based on the ROFR provision.

**6.2.3** ROFR requests will be forwarded for Prime beneficiaries if the MTF has indicated the desire to receive referral request based on specialty or selective diagnosis code or procedure codes, and/or enrollment category. ROFR requests shall be provided prior to the MCSCs medical necessity and covered benefit review to afford the MTF the opportunity to see the patient prior to any decision.

**6.2.4** In instances where the MTF elects to accept the patient, the MTF will advise the MCSC as defined in [paragraph 6.2.1](#). The MCSC will notify the beneficiary of the MTF's acceptance and provide instructions for contacting the MTF to obtain an appointment.

**7.0 EXIGENT CASES REQUIRING IMMEDIATE COORDINATION WITH REGIONAL OFFICE**

In cases involving serious medical conditions or other instances where time is of the essence, the contractor shall initiate an expedited review and suspend case processing if the care does not satisfy TRICARE benefit criteria. The contractor shall notify the TRICARE Regional Office (TRO) as soon as possible of its findings and forward the entire case file to the TRO for review. The case shall remain suspended until the TRO notifies the contractor of the DHA's determination. The types of cases that may require immediate TRO coordination include, but are not limited to, the following:

- Life-threatening illness
- Rare disease
- Treatment of cancer patients
- Treatment of very ill children
- Organ transplant

- END -

## TRICARE Reserve Select (TRS)

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### 1.0 GENERAL

TRICARE Reserve Select (TRS) is a premium-based TRICARE health plan available for purchase by qualified members of the Reserve Components (RCs) and qualified survivors that offers health coverage for RC members and their eligible family members. The RCs will validate members' and survivors' qualifications to purchase TRS coverage and will identify qualified members/survivors in the Defense Enrollment Eligibility Reporting System (DEERS).

### 1.1 Benefits/Scope Of Care

The TRS health plan delivers the TRICARE Standard benefit to all covered individuals. TRICARE Standard and TRICARE Extra cost-shares, deductibles and catastrophic caps applicable to Active Duty Family Members (ADFMs) shall apply to all individuals (including RC members themselves) covered under TRS. TRS members, their covered family members, and TRS survivors are eligible for Direct Care (DC) in a Military Treatment Facility (MTF), including MTF pharmacies with the same access priority as ADFMs not enrolled in TRICARE Prime. The contractor shall review and modify MTF Memoranda of Understanding (MOU) as necessary to reflect MTF requirements for accommodating and ensuring that TRS members, family members and survivors are provided the same level of service as ADFMs under TRICARE Standard/Extra.

### 1.2 Specific Programs Not Available Under TRS

Specific programs not available under TRS include those listed below:

- TRICARE Reserve and National Guard Family Member Benefits program that established the authority to waive the annual TRICARE Standard (or Extra) deductible for RC family members who became eligible for TRICARE as a result of their sponsor's activation in support of a contingency operation as specified in TRICARE Policy Manual (TPM), [Chapter 10, Section 8.1](#).
- Extended Care Health Option (ECHO)
- TRICARE Prime Programs including the Uniformed Services Family Health Plan (USFHP)
- Supplemental Health Care Program (SHCP) funds, except for civilian care referred by Military Health System (MHS) Facilities as specified in [Chapter 17](#) to the same extent that SHCP covers civilian care for MHS beneficiaries who are not Active Duty Service Members (ADSMs).
- Special Supplemental Food Program

## **2.0 TRS PREMIUMS**

TRS offers two types of coverage: TRS member-only coverage and TRS member and family coverage. Each year the government will determine premium rates payable monthly by the member/survivor for each type of coverage. The government will provide the premium rates to the contractor No Later Than (NLT) 60 calendar days prior to the effective date. TRS premium rates are specified in [Addendum A, Figure 22.A-2](#). Unless otherwise specified, the premium rates will be in effect for a full calendar year. A surviving family member who qualifies to purchase (or continue) TRS coverage as described in [paragraph 3.2](#) shall pay the member-only rate if there is only one covered survivor and the member and family rate if there are two or more survivors to be covered.

## **3.0 QUALIFYING TO PURCHASE TRS COVERAGE**

The RCs will validate member's and survivor's qualifications to purchase TRS coverage and will identify qualified members/survivors in DEERS. The contractor shall rely solely upon DEERS to identify members who have been qualified to purchase TRS coverage. The contractor shall refer RC members/survivors to their respective RC for issues concerning qualifying to purchase TRS coverage. To qualify for TRS a RC member must be in the Selected Reserve throughout the period of coverage. The qualifications unique to TRS are listed below for contractor information purposes only.

### **3.1 Member Purchase**

A member of the RC of the Armed Forces qualifies to purchase TRS coverage if the member meets both the following conditions:

- Member of the Selected Reserve of the Ready Reserve;
- Not enrolled in, or eligible to enroll in, a health benefits plan under 5 United States Code (USC) Chapter 89, the Federal Employees Health Benefit Program (FEHBP).

### **3.2 Survivor Coverage Under TRS**

If a member of the Selected Reserves dies while in a period of TRS coverage, the family member(s) may purchase new or continue existing TRS coverage for up to six months beyond the date of the member's death. If a member of the Selected Reserve is not covered by TRS on the date of his or her death, his or her surviving dependents do not qualify for TRS survivor coverage at any time. For survivor qualification, there is no exclusionary criterion involving a health benefits plan under 5 USC Chapter 89, the FEHBP.

## **4.0 COVERAGE-RELATED PROCEDURES**

The contractor shall process coverage-related transactions through the Defense Online Enrollment System (DOES) (TRICARE Systems Manual (TSM), [Chapter 3, Section 1.4, paragraph 1.2.2](#)). Premium-related transactions shall be reported through the enrollment fee payment interface (see the TSM, [Chapter 3, Section 1.4, paragraph 1.2.8.1](#)). The contractor shall perform all premium and billing functions in accordance with [paragraph 5.0](#) and its subordinate paragraphs. The TRICARE Overseas Program (TOP) contractor shall perform these services for TRS members/survivors residing outside of the 50 United States or the District of Columbia. See the TSM, [Chapter](#)

[2, Addendum L](#) for a full list of TRS Health Care Delivery Plan (HCDP) Coverage Code Values. The TRICARE South Region contractor shall perform these services for TRS members or survivors residing outside the 50 United States or the District of Columbia until such time specified in the transition schedule to the new overseas contractor.

#### **4.1 Purchasing Coverage**

To purchase TRS coverage, qualified RC members and qualified survivors must complete the prescribed form using the appropriate online web application and submit it, along with an initial payment in the amount of the first two months of premium, within deadlines specified in the following paragraphs. The initial payment may be made with a personal check, cashier's check, money order, or credit/debit card (i.e., Visa/MasterCard). No handwritten TRS requests are to be accepted by the contractor. The contractor shall collect completed TRS requests submitted by mail, at overseas TRICARE Service Centers (TSCs), and by other means determined by the contractor. If a lockout is in place, the contractor may accept and process requests up to 45 days before the end of the 12 month lockout period for new coverage to begin after the 12 month lockout period ends. The contractor shall not process new coverage transactions into DOES unless the initial payment received is the correct amount 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 or qualified survivor may purchase TRS coverage with an effective date immediately following the termination of coverage under another TRICARE program. The TRS request required by [paragraph 4.1](#) must be either received by the MCSC/TOP contractor or postmarked NLT 30 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 military personnel officials with Real-Time Automated Personnel Identification System (RAPIDS) access to appropriately update DEERS. Second, the TRS request form identifying the QLE, required by [paragraph 4.1](#) must be either received by the MCSC/TOP contractor 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, survivor; or
- Last family member/survivor becomes ineligible (e.g., child ages out).

### 4.1.3 Open Enrollment

A qualified member or qualified survivor may purchase TRS coverage throughout the year. If the request and premium payment required by [paragraph 4.1](#) are received **by the MCSC/TOP contractor** 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 eligible family members may purchase (or continue) TRS coverage for up to six months beyond the date of the member's death. Except for automatic transfers specified in [paragraph 4.1.4.1](#), effective dates and deadlines specified in [paragraphs 4.1.1](#), [4.1.2](#), and [4.1.3](#) apply. 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 with an effective date of the day after the date of death 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 suspend coverage, if so desired, by completing a TRS request form via the appropriate online web application or in a written letter to the appropriate Managed Care Support Contractor (MCSC). The DMDC generated survivor letter will include instructions on how to obtain a DoD Self-Service Logon (DS Logon) to access the TRS Web Portal or the option to suspend coverage via a written letter.

**4.1.4.2** If TRS member-only coverage was in effect on the date of the member's death, DEERS will terminate coverage with an effective date coinciding with 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 **by the MCSC/TOP contractor** 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, TRS members, which include TRS-covered survivors, may request the following types of changes.

### 4.2.1 Type of Coverage Changes

A TRS member/survivor 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 5.4](#) for premium adjustments resulting from changes in coverage.

new child's health care.

**6.3** Premium payments made for TRS coverage shall not be applied to the fiscal year deductible or catastrophic cap limit.

**6.4** Non-Availability Statement (NAS) requirements shall apply to TRS members, family members, and survivors in the same manner as for ADFMs under TRICARE Standard/Extra.

**6.5** Medicare is the primary payer for TRICARE beneficiaries who are eligible for Medicare. Claims under the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) will be adjudicated under the rules set forth in the TRICARE Reimbursement Manual (TRM), [Chapter 4, Section 4](#). The Managed Care Support Contractors (MCSCs) shall follow procedures established in [Chapter 8, Section 2](#), regarding claims jurisdiction for dual eligibles.

**6.6** If the contractor receives a PNT notifying them of a retroactive TRS disenrollment the contractor shall initiate recoupment of claims paid, if appropriate, as specified in [Chapter 10](#).

**6.7** If at any time the contractor discovers that the Selected Reserve member may be eligible for or enrolled in the FEHBP, the contractor shall report the discovery to the appropriate TRICARE RD, or their designee, or TAO Director NLT one business day after discovery. As applicable, the contractor shall follow [paragraph 4.4.1](#) and its subordinate paragraphs for loss of TRS qualification.

## **7.0 BENEFICIARY EDUCATION AND SUPPORT DIVISION (BE&SD)**

In addition to BE&SD functions specified throughout this chapter, the contractor shall perform BE&SD functions to the same extent as they do for TRICARE Standard and TRICARE Extra.

### **7.1 Customer Education**

**7.1.1** Information materials (i.e., public notices, flyers, informational brochures, etc.) will be developed and printed centrally by Department of Defense (DoD), [Defense Health Agency \(DHA\)](#), Office of BE&SD. The contractor shall distribute all documents associated with the TRS Program to the same extent and through the same means as TRICARE Standard materials are distributed. Copies of the TRICARE handbook and other information materials may be ordered through the usual [DHA](#) BE&SD ordering process.

**7.1.2** Upon start of coverage under TRS the contractor shall mail one copy of the TRICARE handbook to each first time TRS member's or survivor's household. The TRS member's or survivor's servicing contractor shall send additional handbooks upon request.

### **7.2 Customer Service**

The contractor shall provide all customer service support in a manner equivalent to that provided TRICARE Standard beneficiaries. When the contractor receives an inquiry involving TRS qualifications, the contractor shall refer the individual to the appropriate RC.

## **8.0 PAYMENTS FOR CONTRACTOR SERVICES RENDERED**

### **8.1 Claims Reporting**

The contractor shall report TRS program claims according to [Chapter 3](#). The contractor shall process payments on a non-financially underwritten basis for the health care costs incurred for each TRS claim processed to completion according to the provisions of [Chapter 3](#).

### **8.2 Fiduciary Responsibilities**

**8.2.1** The contractor shall act as a fiduciary for all funds acquired from TRS premium collections, which are government property. The contractor shall develop strict funds control processes for its collection, retention and transfer of premium funds to the government. All premium collections received by the contractor shall be maintained in accordance with these procedures.

**8.2.2** Either a separate non-interest bearing account shall be established for the collection and disbursement of TRS premiums or the account used for TRICARE Retired Reserve (TRR) premium collections, when established, shall be used for TRS premiums as well. The contractor shall deposit premium collections to the established account within one business day of receipt.

**8.2.3** The contractor shall wire-transfer the premium collections and net of refund payments monthly to a specified government account as directed by the DHA Contract Resource Management (CRM) Finance and Accounting Office (F&AO). The government will provide the contractor with information for this government account. The contractor shall notify the DHA CRM F&AO, by e-mail, within one business day of the deposit specifying, the date and amount of the deposit, as well as its purpose (i.e., TRS premiums). Premiums for TRS and TRR, when established, may be sent as a single wire as long as CRM is notified of the amounts of each type of premium. Collections for delinquency cases that have been transferred to DHA Office of General Counsel - Appeals, Hearings & Claims Collection Division (OGC-AC) shall be wire-transferred separately. The contractor shall notify DHA CRM F&AO and DHA OGC-AC by e-mail within one business day of the day of deposit, specifying the sponsor name, sponsor Social Security Number (SSN) (last four digits), payment amount, payment date, date case was transferred to DHA OGC-AC and the date and amount of the deposit.

**8.2.4** The contractor shall maintain a system for tracking and reporting premium billings, collections, and starts of coverage. The system is subject to government review and approval.

## **9.0 DELINQUENT PREMIUMS**

**9.1** The contractor shall no longer collect delinquent premiums with two exceptions:

- Contractors shall continue to collect delinquent premiums in cases in which TRS members and/or family members have entered into installment payment agreements.
- Contractors shall continue to collect delinquent premiums in cases in which TRS members and/or family members received health care services during the grace period.

## TRICARE Retired Reserve (TRR)

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### 1.0 GENERAL

TRICARE Retired Reserve (TRR) is a premium-based TRICARE health plan available for purchase by qualified members of the Retired Reserve and qualified survivors that offers health coverage for Retired Reserve members and their eligible family members. The Reserve Components (RCs) will validate members' and survivors' qualifications to purchase TRR coverage and will identify qualified members/survivors in the Defense Enrollment Eligibility Reporting System (DEERS).

### 1.1 Benefits/Scope Of Care

The TRR health plan delivers the TRICARE Standard/Extra benefit to all covered individuals. TRICARE Standard and TRICARE Extra cost-shares, deductibles and catastrophic caps applicable to retirees and their eligible family members shall apply to all individuals (including Retired Reserve members themselves) covered under TRR. TRR members, their covered family members, and TRR survivors are eligible for direct care in a Military Treatment Facility (MTF), including MTF pharmacies with the same access priority as retirees, their family members and survivors who are not enrolled in TRICARE Prime. The contractor shall review and modify MTF Memorandums of Understanding (MOUs) as necessary to reflect MTF requirements for accommodating and ensuring that TRR members, family members and survivors are provided the same level of service as retirees and their eligible family members under TRICARE Standard/Extra.

### 1.2 Specific Programs Not Available Under TRR

Specific programs not available under TRR include those listed below:

- TRICARE Prime Programs including the Uniformed Services Family Health Plan (USFHP)
- Supplemental Health Care Program (SHCP) funds, except for civilian care referred by Military Health System (MHS) Facilities as specified in [Chapter 17](#) to the same extent that SHCP covers civilian care for MHS beneficiaries who are not ADSMs
- Extended Care Health Option (ECHO)

### 2.0 TRR PREMIUMS

TRR offers two types of coverage: TRR member-only coverage and TRR member-and-family coverage. Each year the government will determine premium rates payable monthly by the member for each type of coverage. The government will provide the premium rates to the contractor no later than (NLT) 60 calendar days prior to the effective date. TRR premium rates are specified in [Addendum A, Figure 22.A-3](#). Unless otherwise specified, the premium rates will be in

effect for a full calendar year effective the first day of January. A surviving family member who qualifies to purchase (or continue) TRR coverage, as described in [paragraph 3.2](#) shall pay the member-only rate if there is only one covered survivor and the member-and-family rate if there are two or more survivors to be covered.

### **3.0 QUALIFYING TO PURCHASE TRR COVERAGE**

The RCs will validate member's and survivor's qualifications to purchase TRR coverage and will identify qualified members/survivors in DEERS. The contractor shall rely solely upon DEERS to identify members/survivors who have been qualified to purchase TRR coverage. The contractor shall refer Retired Reserve members/survivors to their respective RC for issues concerning qualifying to purchase TRR coverage. The qualifications unique to TRR are listed below for contractor information purposes only.

#### **3.1 Retired Member Purchase**

A member qualifies to purchase TRR coverage if the member meets both of the following conditions:

- is a member of the Retired Reserve of a RC of the armed forces who is qualified for a non-regular retirement under 10 USC Chapter 1223, but is not age 60; and
- is not enrolled, or eligible to enroll, in a health benefits plan under 5 USC Chapter 89, the Federal Employees Health Benefit Program (FEHBP).

#### **3.2 Survivor Coverage Under TRR**

If the qualified member of the Retired Reserve dies while in a period of TRR coverage, the immediate family member(s) of such member shall remain qualified to purchase new or continue existing TRR coverage until the date on which the deceased member of the Retired Reserve would have attained age 60. For survivor qualification, there is no exclusionary criterion involving a health benefits plan under 5 USC Chapter 89, the FEHBP. If a member of the Retired Reserve is not covered by TRR on the date of his or her death, his or her surviving dependents do not qualify for TRR survivor coverage at anytime.

### **4.0 COVERAGE-RELATED PROCEDURES**

The contractor shall process coverage-related transactions through the Defense Online Enrollment System (DOES) (TRICARE Systems Manual (TSM) [Chapter 3, Section 1.4, paragraph 1.2.8.1](#)). Premium-related transactions shall be reported through the enrollment fee payment interface (see the TSM [Chapter 3, Section 1.4, paragraph 1.2.8.1](#)). The contractor shall perform all premium and billing functions in accordance with [paragraph 5.0](#) and its subordinate paragraphs. The TRICARE Overseas Program (TOP) contractor shall perform these services for TRR members/survivors residing outside of the 50 United States or the District of Columbia. See the TSM [Chapter 2, Addendum L](#) for a full list of TRR Health Care Delivery Program (HCDP) Coverage Code Values.

**6.2** The contractor shall pend all claims for health care provided to a newborn/new child of a TRR member until the member completes the process specified in [paragraph 4.2.3.1](#). If the contractor becomes aware that a TRR member has an unregistered newborn/new child, the contractor shall notify the TRR member of the requirement to register the new child in DEERS and submit a request form for the newborn/new child NLT 60 days after birth/custody. When the member completes the process specified in [paragraph 4.2.3.1](#), the contractor shall process any claims associated with the child's health care. If the member fails to complete the process as specified in [paragraph 4.2.3.1](#), the contractor shall deny any claims associated with the child's health care.

**6.3** Premium payments made for TRR coverage shall not be applied to the fiscal year deductible or catastrophic cap limit.

**6.4** Non-Availability Statement (NAS) requirements shall apply to TRR members, family members, and survivors in the same manner as for retirees under TRICARE Standard/Extra.

**6.5** If a Retired Reserve member purchases TRR coverage during the same calendar year that the member had a TRICARE Reserve Select (TRS) plan in effect, the catastrophic cap, deductibles and cost shares shall not be recalculated.

**6.6** Medicare is the primary payer for TRICARE beneficiaries who are entitled to Medicare. Claims under the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) will be adjudicated under the rules set forth in the TRICARE Reimbursement Manual (TRM), [Chapter 4, Section 4](#). The MCSCs shall follow procedures established in [Chapter 8, Section 2](#) regarding claims jurisdiction for dual-eligibles.

**6.7** If the contractor receives a PNT notifying them of a retroactive TRR disenrollment the contractor shall initiate recoupment of claims paid if appropriate as specified in [Chapter 10](#).

**6.8** If at anytime the contractor discovers that the Retired Reserve member may be eligible for or enrolled in the FEHBP, the contractor shall report the discovery to the appropriate TRICARE RD or their designee or TAO Director NLT one business day after discovery. As applicable, the contractor shall follow [paragraph 4.4.1](#) and its subordinate paragraphs for loss of TRR qualification. If any other actions are to be taken by the contractor as a result of this discovery, the TRICARE RD or their designee or TAO Director will send instructions to the contractor.

## **7.0 BENEFICIARY EDUCATION AND SUPPORT DIVISION (BE&SD)**

In addition to BE&SD functions specified throughout this chapter, the contractor shall perform BE&SD functions to the same extent as they do for TRICARE Standard and TRICARE Extra.

### **7.1 Customer Education**

**7.1.1** Materials (i.e., public notices, flyers, informational brochures, web site etc.) will be developed and distributed centrally by Department of Defense (DoD), [Defense Health Agency \(DHA\)](#), Office of BE&SD. The contractor shall distribute all informational materials associated with the TRR program to the same extent and through the same means as TRICARE Standard materials are distributed. Copies of the TRICARE handbook and other information materials may be obtained through the usual [DHA](#) BE&SD process.

**7.1.2** Upon start of coverage under TRR each contractor shall mail one copy of the TRICARE handbook to each first time TRR member's or survivor's household. The TRR member's or survivor's servicing contractor shall send additional handbooks upon request.

## **7.2 Customer Service**

The contractor shall provide all customer service support in a manner equivalent to that provided TRICARE Standard beneficiaries. When the contractor receives an inquiry involving TRR qualifications, the contractor shall refer the individual to the appropriate RC.

## **8.0 ANALYSIS AND REPORTING**

TRR workload shall be included, but not separately identified, in all reports.

## **9.0 PAYMENTS FOR CONTRACTOR SERVICES RENDERED**

### **9.1 Claims Reporting**

The contractor shall report TRR program claims according to [Chapter 3](#). The contractor shall process payments on a non-financially underwritten basis for the health care costs incurred for each TRR claim processed to completion according to the provisions of [Chapter 3](#).

### **9.2 Fiduciary Responsibilities**

**9.2.1** The contractor shall act as a fiduciary for all funds acquired from TRR premium collections, which are government property. The contractor shall develop strict funds control processes for its collection, retention and transfer of premium funds to the government. All premium collections received by the contractor shall be maintained in accordance with these procedures.

**9.2.2** Either a separate non-interest bearing account shall be established for the collection and disbursement of TRR premiums or the account used for TRS premium collections shall be used for TRR premiums as well. The contractor shall deposit premium collections to the established account within one business day of receipt.

**9.2.3** The contractor shall wire-transfer the premium collections, net of refund payments, monthly to a specified government account as directed by the **DHA** Contract Resource Management (CRM) Finance and Accounting Office (F&AO). The government will provide the contractor with information for this government account. The contractor shall notify the **DHA** CRM F&AO, by e-mail, within one business day of the deposit, specifying the date and amount of the deposit as well as its purpose (i.e. TRR premiums). Premiums for TRS and TRR may be sent as a single wire as long as CRM is notified of the amounts of each type of premium. Collections for delinquency cases that have been transferred to **DHA** Office of General Counsel-Appeals, Hearings & Claims collection Division (OGC-AC) shall be wire-transferred separately. The contractor shall notify **DHA** CRM F&AO and **DHA** OGC-AC by e-mail within one business day of the day of deposit, specifying the sponsor name, sponsor Social Security Number (SSN) (last four digits), payment amount, payment date, date case was transferred to **DHA** OGC-AC and the date and amount of the deposit.

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

### Appendix A

#### Acronyms And Abbreviations

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DTF	Dental Treatment Facility
DTM	Directive-Type Memorandum
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 Versatile Disc (formerly Digital Video Disc)
DVD-R	Digital Versatile Disc-Recordable
DWR	DSO Web Request
Dx	Diagnosis
DXA	Dual Energy X-Ray Absorptiometry
E-ID	Early Identification
E-NAS	Electronic Non-Availability Statement
e-QIP	Electronic Questionnaires for Investigations Processing
E&M	Evaluation & Management
E2R	Enrollment Eligibility Reconciliation
EACH	Essential Access Community Hospital
EAL	Common Criteria Evaluation Assurance Level
EAP	Employee-Assistance Program Ethandamine phosphate
EBC	Enrollment Based Capitation
ECA	External Certification Authority
ECAS	European Cardiac Arrhythmia Society
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
<b>EFD</b>	<b>Energy Flux Density</b>
EFM	Electronic Fetal Monitoring
EFMP	Exceptional Family Member Program
EFP	Environmental Failure Protection
eFRC	Electronic Federal Records Center
EFT	Electronic Funds Transfer Environmental Failure Testing

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#### Acronyms And Abbreviations

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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
EHRA	European Heart Rhythm Association
EIA	Educational Interventions for Autism Spectrum Disorders
EID	Early Identification Enrollment Information for Dental
EIDS	Executive Information and Decision Support
EIIP	External Insulin Infusion Pump
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
eMSM	Enhanced Multi-Service Market
EMTALA	Emergency Medical Treatment & Active Labor Act
ENTNAC	Entrance National Agency Check
EOB	Explanation of Benefits
EOBs	Explanations of Benefits
EOC	Episode of Care
EOE	Evoked Otoacoustic Emission
EOG	Electro-oculogram
EOMB	Explanation of Medicare Benefits
EOP	Explanation of Payment
ePHI	electronic Protected Health Information
EPO	Erythropoietin Exclusive Provider Organization
EPR	EIA Program Report
EPROM	Erasable Programmable Read-Only Memory
ER	Emergency Room
ERA	Electronic Remittance Advice
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

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ETIN	Electronic Transmitter Identification Number
EWPS	Enterprise Wide Provider System
EWRAS	Enterprise Wide Referral and Authorization System
F&AO	Finance and Accounting Office(r)
FAI	Femoroacetabular Impingement
FAP	Familial Adenomatous Polyposis
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 <sub>1</sub>	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
FL	Form Locator
FMCRA	Federal Medical Care Recovery Act
FMRI	Functional Magnetic Resonance Imaging
FOBT	Fecal Occult Blood Testing
FOC	Full Operational Capability
FOIA	Freedom of Information Act
FOUO	For Official Use Only
FPO	Fleet Post Office
FQHC	Federally Qualified Health Center
FR	Federal Register Frozen Records
FRC	Federal Records Center
FSH	Follicle Stimulating Hormone
FSO	Facility Security Officer
FTC	Federal Trade Commission
FTE	Full Time Equivalent
FTP	File Transfer Protocol

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FX	Foreign Exchange (lines)
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GAO	General Accounting Office
GAF	Geographic Adjustment Factor
GDC	Guglielmi Detachable Coil
GFE	Government Furnished Equipment
GHP	Group Health Plan
GHz	Gigahertz
GIFT	Gamete Intrafallopian Transfer
GIQD	Government Inquiry of DEERS
GP	General Practitioner
GPCI	Geographic Practice Cost Index
GTMCPA	General Temporary Military Contingency Payment Adjustment
H/E	Health and Environment
HAC	Health Administration Center Hospital Acquired Condition
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
HCM	Hypertrophic Cardiomyopathy
HCO	Healthcare Operations Division
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
HDE	Humanitarian Device Exemption
HDGC	Hereditary Diffuse Gastric Cancer
HDL	Hardware Description Language
HDR	High Dose Radiation
HEAR	Health Enrollment Assessment Review
HEDIS	Health Plan Employer Data and Information Set

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<b>HE ESWT</b>	<b>High Energy Extracorporeal Shock Wave Therapy</b>
HepB-Hib	Hepatitis B and Hemophilus influenza B
HH	Home Health
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
HIAA	Health Insurance Association of America
HIC	Health Insurance Carrier
HICN	Health Insurance Claim Number
HINN	Hospital-Issued Notice Of Noncoverage
HINT	Hearing in Noise Test
HIPAA	Health Insurance Portability and Accountability Act (of 1996)
HIPEC	Hyperthermic Intraperitoneal Chemotherapy
HIPPS	Health Insurance Prospective Payment System
HIQH	Health Insurance Query for Health Agency
HITECH	Health Information Technology for Economic and Clinical Health
HIV	Human Immunodeficiency Virus
HL7	Health Level 7
HLA	Human Leukocyte Antigen
HMAC	Hash-Based Message Authentication Code
HMO	Health Maintenance Organization
HNPCC	Hereditary Non-Polyposis Colorectal Cancer
HOPD	Hospital Outpatient Department
HPA&E	Health Program Analysis & Evaluation
HPSA	Health Professional Shortage Area
HPV	Human Papilloma Virus
HRA	Health Reimbursement Arrangement
HRG	Health Resource Group
HRS	Heart Rhythm Society
HRT	Heidelberg Retina Tomograph Hormone Replacement Therapy
HSCRC	Health Services Cost Review Commission
HSWL	Health, Safety and Work-Life
HTML	HyperText Markup Language
HTTP	HyperText Transfer (Transport) Protocol
HTTPS	Hypertext Transfer (Transport) Protocol Secure
HUAM	Home Uterine Activity Monitoring
HUD	Humanitarian Use Device

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HUS	Hemolytic Uremic Syndrome
HVPT	Hyperventilation Provocation Test
IA	Information Assurance
IATO	Interim Approval to Operate
IAVA	Information Assurance Vulnerability Alert
IAVB	Information Assurance Vulnerability Bulletin
IAVM	Information Assurance Vulnerability Management
IAW	In accordance with
IBD	Inflammatory Bowel Disease
IC	Individual Consideration Integrated Circuit
ICASS	International Cooperative Administrative Support Services
ICD	Implantable Cardioverter Defibrillator
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification
ICD-10-PCS	International Classification of Diseases, 10th Revision, Procedure Coding System
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
IDB	Intradiscal Biacuplasty
IDD	Internal or Intervertebral Disc Decompression
IDE	Investigational Device Exemption Investigational Device
IDEA	Individuals with Disabilities Education Act
IDES	Integrated Disability Evaluation System
IDET	Intradiscal Electrothermal Therapy
IDME	Indirect Medical Education
IdP	Identity Protection
IDTA	Intradiscal Thermal Annuloplasty
IE	Interface Engine Internet Explorer
IEA	Intradiscal Electrothermal Annuloplasty
IEP	Individualized Educational Program
IFC	Interim Final Rule with comment
IFR	Interim Final Rule
IFSP	Individualized Family Service Plan
IG	Implementation Guidance
IgA	Immunoglobulin A
IGCE	Independent Government Cost Estimate

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IHC	Immunohistochemistry
IHI	Institute for Healthcare Improvement
IHS	Indian Health Service
IIHI	Individually Identifiable Health Information
IIP	Implantable Infusion Pump
IM	Information Management Instant Message/Messaging Intramuscular
IMRT	Intensity Modulated Radiation Therapy
IND	Investigational New Drugs
INR	International Normalized Ratio Intramuscular International Normalized Ratio
INS	Immigration and Naturalization Service
IOC	Initial Operational Capability
IOD	Interface Operational Description
IOLs	Intraocular Lenses
IOM	Internet Only Manual
IOP	Intraocular Pressure
IORT	Intra-Operative Radiation Therapy
IP	Inpatient
IPC	Information Processing Center (outdated term, see SMC)
IPHC	Intraperitoneal Hyperthermic Chemotherapy
IPN	Intraperitoneal Nutrition
IPP	In-Person Proofing
IPPS	Inpatient Prospective Payment System
IPS	Individual Pricing Summary
IPSEC	Secure Internet Protocol
IQ	Intelligence Quotient
IQM	Internal Quality Management
IRB	Institutional Review Board
IRF	Inpatient Rehabilitation Facility
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

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IVD	In Vitro Diagnostic Ischemic Vascular Disease
IVF	In Vitro Fertilization
JC	Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations (JCAHO))
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCIH	Joint Committee on Infant Hearing
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
LCD	Local Coverage Determination
LCF	Long-term Care Facility
LCIS	Lobular Carcinoma In Situ
LDL	Low Density Lipoprotein
LDLT	Living Donor Liver Transplantation
LDR	Low Dose Rate
LDT	Laboratory Developed Test
<b>LE ESWT</b>	<b>Low Energy Extracorporeal Shock Wave Therapy</b>
LGS	Lennox-Gastaut Syndrome
LH	Luteinizing Hormone
LIS	Low Income Subsidy
LLLT	Low Level Laser Therapy
LNT	Lexical Neighborhood Test
LOC	Letter of Consent
LOD	Letter of Denial/Revocation Line of Duty
LOI	Letter of Intent
LOS	Length-of-Stay
LOT	Life Orientation Test
LPN	Licensed Practical Nurse
LSIL	Low-grade Squamous Intraepithelial Lesion
LSN	Location Storage Number

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LTC	Long-Term Care
LUPA	Low Utilization Payment Adjustment
LV	Left Ventricle [Ventricular]
LVEF	Left Ventricular Ejection Fraction
LVN	Licensed Vocational Nurse
LVRS	Lung Volume Reduction Surgery
LVSD	Left Ventricular Systolic Dysfunction
MAC	Maximum Allowable Charge Maximum Allowable Cost
MAC III	Mission Assurance Category III
MAID	Maximum Allowable Inpatient Day
MAP	MYH-Associated Polyposis
MB&RB	Medical Benefits and Reimbursement Branch
MBI	Molecular Breast Imaging
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 Multiple Daily Injection
MDR	MHS Data Repository
MDS	Minimum Data Set
MEB	Medical Evaluation Board
MEC	Marketing and Education Committee
MEI	Medicare Economic Index
MEPS	Military Entrance Processing Station
MEPRS	Medical Expense Performance Reporting System
MESA	Microsurgical Epididymal Sperm Aspiration
MET	Microcurrent Electrical Therapy
MFCC	Marriage and Family Counseling Center
MGCRB	Medicare Geographic Classification Review Board
MGIB	Montgomery GI Bill
MH	Mental Health
MHCC	Maryland Health Care Commission
MHO	Medical Holdover
MHS	Military Health System
MHSO	Managing Health Services Organization
MHSS	Military Health Services System
MI	Myocardial Infarction
MI&L	Manpower, Installations, and Logistics

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MIA	Missing In Action
MIAP	Multi-Host Internet Access Portal
MIDCAB	Minimally Invasive Direct Coronary Artery Bypass
mild®	Minimally Invasive Lumbar Decompression
MIRE	Monochromatic Infrared Energy
MLNT	Multisyllabic Lexical Neighborhood Test
MMA	Medicare Modernization Act
MMEA	Medicare and Medicaid Extenders Act (of 2010)
MMP	Medical Management Program
MMPCMHP	Maryland Multi-Payer Patient-Centered Medical Home Program
MMPP	Maryland Multi-Payer Patient
MMR	Mismatch Repair
MMWR	Morbidity and Mortality Weekly Report
MNR	Medical Necessity Report
MOA	Memorandum of Agreement
MOH	Medal Of Honor
MOMS	Management of Myelomeningocele Study
MOP	Mail Order Pharmacy
MOU	Memorandum of Understanding
MPC	Medical Payments Coverage
MPI	Master Patient Index
MR	Magnetic Resonance Medical Review Mentally Retarded
MRA	Magnetic Resonance Angiography
MRHFP	Medicare Rural Hospital Flexibility Program
MRI	Magnetic Resonance Imaging
MRPU	Medical Retention Processing Unit
MRS	Magnetic Resonance Spectroscopy
MS	Microsoft® Multiple Sclerosis
MSA	Metropolitan Statistical Area
MSC	Military Sealift Command
MSI	Microsatellite Instability
MSIE	Microsoft® Internet Explorer
MSP	Medicare Secondary Payer
MSS	Medical Social Services
MST	Mountain Standard Time
MSUD	Maple Syrup Urine Disease
MSW	Masters of Social Work Medical Social Worker
MT	Mountain Time
MTF	Military Treatment Facility

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MUE	Medically Unlikely Edits
MV	Multivisceral (transplant)
MVS	Multiple Virtual Storage
MWR	Morale, Welfare, and Recreation
MYH	mutY homolog
N/A	Not Applicable
N/D	No Default
NAC	National Agency Check
NACHA	National Automated Clearing House Association
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	Naval Air Station
	Non-Availability Statement
NATO	North Atlantic Treaty Organization
NAVMED	Naval Medical (Form)
NBCC	National Board of Certified Counselors
NCCI	National Correct Coding Initiatives
NCCN	National Comprehensive Cancer Network
NCD	National Coverage Determination
NCE	National Counselor Examination
NCF	National Conversion Factor
NCI	National Cancer Institute
NCMHCE	National Clinical Mental Health Counselor Examination
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
NF	Nursing Facility
NG	National Guard
NGPL	No Government Pay List
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
NII	Networks and Information Integration

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NIPRNET	Nonsecure Internet Protocol Router Network
NIS	Naval Investigative Service
NISPOM	National Industrial Security Program Operating Manual
NIST	National Institute of Standards and Technology
NLDA	Nursery and Labor/Delivery Adjustment
NLT	No Later Than
NMA	Non-Medical Attendant
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
NPWT	Negative Pressure Wound Therapy
NQF	National Quality Forum
NRC	Nuclear Regulatory Commission
NRS	Non-Routine [Medical] Supply
NSDSMEP	National Standards for Diabetes Self-Management Education Programs
NSF	Non-Sufficient Funds
NTIS	National Technical Information Service
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claims Committee
O/ATIC	Operations/Advanced Technology Integration Center
OA	Office of Administration
OAE	Otoacoustic Emissions
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
OCMO	Office of the Chief Medical Officer

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OCONUS	Outside of the Continental United States
OCR	Office for Civil Rights Optical Character Recognition
OCSP	Organizational Corporate Services Provider
OCT	Optical Coherence Tomograph
OD	Optical Disk
OF	Optional Form
OGC	Office of General Counsel
OGC-AC	Office of General Counsel-Appeals, Hearings & Claims Collection Division
OGP	Other Government Program
OHI	Other Health Insurance
OHS	Office of Homeland Security
OIG	Office of Inspector General
<b>OLT</b>	<b>Orthotopic Liver Transplantation</b>
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
OR	Operating Room
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
OTCD	Ornithine Transcarbamylase Deficiency
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&CL	Privacy & Civil Liberties [Office]
P&T	Pharmacy And Therapeutics (Committee)
PA	Physician Assistant
PACAB	Port Access Coronary Artery Bypass
PACO <sub>2</sub>	Partial Pressure of Carbon Dioxide
PAO <sub>2</sub>	Partial Pressure of Oxygen
PAK	Pancreas After Kidney (transplant)
PAP	Papanicolaou
PAS	Privacy Act Statement
PAT	Performance Assessment Tracking
PATH Intl	Professional Association of Therapeutic Horsemanship International

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PatID	Patient Identifier
PAVM	Pulmonary Arteriovenous Malformation
PBM	Pharmacy Benefit Manager
PBT	Proton Beam Therapy
PC	Peritoneal Carcinomatosis Personal Computer Professional Component
PCA	Patient Controlled Analgesia
PCDIS	Purchased Care Detail Information System
PCI	Percutaneous Coronary Intervention
PCM	Primary Care Manager
PCMBN	PCM By Name
PCMH	Patient-Centered Medical Home
PCMRA	PCM Research Application
PCMRS	PCM Panel Reassignment (Application) PCM Reassignment System
PCO	Procurement (Procuring) Contracting Officer
PCP	Primary Care Physician Primary Care Provider
PCS	Pelvic Congestion Syndrome Permanent Change of Station
PCSIB	Purchased Care Systems Integration Branch
PD	Passport Division
PDA	Patent Ductus Arteriosus Personal Digital Assistant
PDD	Percutaneous (or Plasma) Disc Decompression
PDDBI	Pervasive Developmental Disorders Behavior Inventory
PDDNOS	Pervasive Developmental Disorder Not Otherwise Specified
PDF	Portable Document Format
PDI	Potentially Disqualifying Information
PDQ	Physicians's Data Query
PDR	Person Data Repository
PDS	Person Demographics Service
PDTS	Pharmacy Data Transaction System
PDX	Principal Diagnosis
PE	Physical Examination
PEC	Pharmacoeconomic Center
PEP	Partial Episode Payment
PEPR	Patient Encounter Processing and Reporting
PERMS	Provider Education and Relations Management System
PESA	Percutaneous Epididymal Sperm Aspiration
PET	Positron Emission Tomography
PFCRA	Program Fraud Civil Remedies Act

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PFP	Partnership For Peace
PFPWD	Program for Persons with Disabilities
PGD	Preimplantation Genetic Diagnosis
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
PII	Personally Identifiable Information
PIN	Personnel Identification Number
PIP	Personal Injury Protection Personnel Identity Protection
PIRFT	Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)
PIT	PCM Information Transfer
PIV	Personal Identity Verification
PK	Public Key
PKE	Public Key Enabling
PKI	Public Key Infrastructure
PKU	Phenylketonuria
PLS	Preschool Language Scales
PM-DRG	Pediatric Modified-Diagnosis Related Group
PMPM	Per Member Per Month
PMR	Percutaneous Myocardial Laser Revascularization
PNET	Primitive Neuroectodermal Tumors
PNT	Policy Notification Transaction
POA	Power of Attorney Present On Admission
POA&M	Plan of Action and Milestones
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
PPACA	Patient Protection and Affordable Care Act
PPC-PCMH	Physician Practice Connections Patient-Centered Medical Home
PPD	Per Patient Day

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PPN	Preferred Provider Network
PPO	Preferred Provider Organization
PPP	Purchasing Power Parity
PPS	Prospective Payment System Ports, Protocols and Services
PPSM	Ports, Protocols, and Service Management
PPV	Pneumococcal Polysaccharide Vaccine
PQI	Potential Quality Indicator Potential Quality Issue
PR	Periodic Reinvestigation
PRC	Program Review Committee
PRFA	Percutaneous Radiofrequency Ablation
PRG	Peer Review Group
PRO	Peer Review Organization
ProDUR	Prospective Drug Utilization Review
PROM	Programmable Read-Only Memory
PRP	Personnel Reliability Program
PRPP	Pharmacy Redesign Pilot Project
PSA	Prime Service Area Physician Scarcity Area
PSAB	Personnel Security Appeals Board
PSCT	Peripheral Stem Cell Transplantation
PSD	Personnel Security Division
PSF	Provider Specific File
PSG	Polysomnography
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
PTNS	Posterior Tibial Nerve Stimulation
PTSD	Post-Traumatic Stress Disorder
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	Radiofrequency Annuloplasty Remittance Advice
RADDP	Remote Active Duty Dental Program
RAM	Random Access Memory
RAP	Request for Anticipated Payment
RAPIDS	Real-Time Automated Personnel Identification System
RARC	Remittance Advice Remark Code
RBT	Registered Behavior Technician
RC	Reserve Component
RCC	Recurring Credit/Debit Charge Renal Cell Carcinoma
RCCPDS	Reserve Component Common Personnel Data System
RCN	Recoupment Case Number Refund Control Number
RCS	Report Control Symbol
RD	Regional Director Registered Dietitian
RDBMS	Relational Database Management System
RDDDB	Reportable Disease Database
REM	Rapid Eye Movement
RF	Radiofrequency
RFA	Radiofrequency Ablation
RFI	Request For Information
RFP	Request For Proposal
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RhoGAM	RRho (D) Immune Globulin
RIA	Radioimmunoassay
RM	Records Management
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
ROMF	Record Object Metadata File

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ROT	Read-Only Table
ROTC	Reserved Officer Training Corps
ROVER	RHHI OASIS Verification
RPM	Record Processing Mode
RRA	Regional Review Authority
RRS	Records Retention Schedule
RTC	Residential Treatment Center
rTMS	Repetitive Transcranial Magnetic Stimulation
RUG	Resource Utilization Group
RV	Residual Volume Right Ventricle [Ventricular]
RVU	Relative Value Unit
SAAR	System Authorization Access Request
SAD	Seasonal Affective Disorder
SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier
SAFE	Sexual Assault Forensic Examination
SAMHSA	Substance Abuse and Mental Health Services Administration
SAO	Security Assistant Organizations
SAP	Special Access Program
SAPR	Sexual Assault Prevention and Response
SAS	Sensory Afferent Stimulation Specified Authorization Staff (formerly Service Point of Contact (SPOC))
SAT	Service Assist Team
SAVR	Surgical Aortic Valve Replacement
SBCC	Service Branch Classification Code
SBI	Special Background Investigation
SCA	Service Contract Act
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	Stem 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
SFTP	Secure File Transfer Protocol
SGDs	Speech Generating Devices
SHCP	Supplemental Health Care Program

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### Appendix A

#### Acronyms And Abbreviations

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SI	Sensitive Information Small Intestine (transplant) Special Indicator (code) Status Indicator
SIDS	Sudden Infant Death Syndrome
SIF	Source Input Format
SII	Special Investigative Inquiry
SI/L	Small Intestine-Live (transplant)
SIOP-ESI	Single Integrated Operational plan-Extremely Sensitive Information
SIP	System Identification Profile
SIRT	Selective Internal Radiation Therapy
SIT	Standard Insurance Table
SLP	Speech-Language Pathology
SMC	System Management Center
SMHC	Supervised Mental Health Counselor
SN	Skilled Nursing
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 System of Records
SORN	System of Records Notice
SPA	Simple Power Analysis
SPC	Special Processing Code
SPECT	Single Photon Emission Computed Tomography
SPK	Simultaneous Pancreas Kidney (transplant)
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
SSDI	Social Security Disability Insurance
SSL	Secure Socket Layer
SSM	Site Security Manager
SSN	Social Security Number
SSO	Short-Stay Outlier
ST	Speech Therapy

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STF	Specialized Treatment Facility
STS	Specialized Treatment Services
STSF	Specialized Treatment Service Facility
SUBID	Sub-Identifier
SUDRF	Substance Use Disorder Rehabilitation Facility
SVO	SIT Validation Office
SVP	State Vaccine Program State Vaccine Program entity
SVT	Supraventricular Tachycardia
SWLS	Satisfaction With Life Scale
T-3	TRICARE Third Generation
TAD	Temporary Additional Duty
TAFIM	Technical Architecture Framework for Information Management
TAH	Total Artificial Heart
TAMP	Transitional Assistance Management Program
TAO	TRICARE Alaska Office TRICARE Area Office
TAR	Total Ankle Replacement
TARO	TRICARE Alaska Regional Office
TAVR	Transcatheter Aortic Valve Replacement
TB	Tuberculosis
TBD	To Be Determined
TBE	Tick Borne Encephalitis
TBI	Traumatic Brain Injury
TC	Technical Component
TCMHC	TRICARE Certified Mental Health Counselor
TCP/IP	Transmission Control Protocol/Internet Protocol
TCSRC	Transitional Care for Service-Related Conditions
TDD	Targeted Disc Decompression
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Program/Plan
TDR	Total Disc Replacement
TDRL	Temporary Disability Retired List
TDY	Temporary Duty
TED	TRICARE Encounter Data
TEE	Transesophageal Echocardiograph [Echocardiography]
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

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#### Acronyms And Abbreviations

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TFL	TRICARE For Life
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
TIP	Thermal Intradiscal Procedure
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
TMCPA	Temporary Military Contingency Payment Adjustment
TMH	Telemental Health
TMI&S	Technology Management Integration & Standards
TMOP	TRICARE Mail Order Pharmacy
TMR	Transmyocardial Revascularization
TMS	Transcranial Magnetic Stimulation
TN	Termination Notice
TNEX	TRICARE Next Generation (MHS Systems)
TNP	Topical Negative Pressure
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
TOPO	TRICARE Overseas Program Office
TP	Treatment Plan
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

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TPRADFM	TRICARE Prime Remote Active Duty Family Member
TPRADSM	TRICARE Prime Remote Active Duty Service Member
TPRC	TRICARE Puerto Rico Contract(or)
TPSA	Transitional Prime Service Area
TQMC	TRICARE Quality Monitoring Contractor
TRDP	TRICARE Retiree Dental Program
TRI	TED Record Indicator
TRIAP	TRICARE Assistance Program
TRIP	Temporary Records Information Portal
TRM	August 2002 TRICARE Reimbursement Manual 6010.55-M February 2008 TRICARE Reimbursement Manual 6010.58-M
TRO	TRICARE Regional Office
TRO-N	TRICARE Regional Office-North
TRO-S	TRICARE Regional Office-South
TRO-W	TRICARE Regional Office-West
TRPB	TRICARE Retail Pharmacy Benefits
TRR	TRICARE Retired Reserve
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
TTOP	TRICARE Transitional Outpatient Payment
TTPA	Temporary Transitional Payment Adjustment
TTY	Teletypewriter
TUNA	Transurethral Needle Ablation
TYA	TRICARE Young Adult
UAE	Uterine Artery Embolization
UARS	Upper Airway Resistance Syndrome
UB	Uniform Bill
UBO	Uniform Business Office
UCBT	Umbilical Cord Blood Stem Cell Transplantation
UCC	Uniform Commercial Code Urgent Care Center
UCSF	University of California San Francisco

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UIC	Unit Identification Code
UIN	Unit Identifier Number
UM	Utilization Management
UMO	Utilization Management Organization
UMP	User Maintenance Portal
UPIN	Unique Physician Identification Number
UPPP	Uvulopalatopharyngoplasty
URFS	Unremarried Former Spouse
URL	Universal Resource Locator
US	Ultrasound United States
US-CERT	United States-Computer Emergency Readiness Team
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(r)
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
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	Veterans Affairs (hospital) Veterans Administration
VAC	Vacuum-Assisted Closure
VAD	Ventricular Assist Device
VAMC	VA Medical Center
VATS	Video-Assisted Thorascopic Surgery
VAX-D	Vertebral Axial Decompression
VD	Venereal Disease

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Acronyms And Abbreviations

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VO	Verifying Office (Official)
VPN	Virtual Private Network
VPOC	Verification Point of Contact
VRDX	Reason Visit Diagnosis
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
WebDOES	Web DEERS Online Enrollment System (application)
WEDI	Workgroup for Electronic Data Interchange
WHS	Washington Headquarters Services
WIC	Women, Infants, and Children (Program)
WII	Wounded, Ill, and Injured
WLAN	Wireless Local Area Network
WORM	Write Once Read Many
WRAMC	Walter Reed Army Medical Center
WTC	World Trade Center
WTRR	Wire Transfer Reconciliation Report
WTU	Warrior Transition Unit
WWW	World Wide Web
X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome
XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer
2D	Two Dimensional
3D	Three Dimensional

- END -

## **Adjustment**

A correction to the information in the TRICARE Encounter Data records (TEDs) and/or Beneficiary History Files (Hard Copy Files and Automated Beneficiary History and Deductible Files) related to a claim previously Processed To Completion (PTC). Adjustments include any recoupments, additional payment(s), all cancellations (total or partial), and corrections to statistical data, whether or not the changes result in changes to the financial data.

### **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 **Defense Health Agency (DHA)** 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 **DHA**-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 **DHA** and processed by the contractor. The contractor's output is compared to predetermined results prepared or approved by **DHA** 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 **DHA** 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 **DHA**)
- 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 result 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.

### **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 DHA 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 DHA 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 **DHA**, of a contractor’s level of compliance with the terms and conditions of the contract. Usually, an operational audit performed by **DHA** 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 **DHA** 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.

**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 **DHA**. These require correction of the error by the contractor and resubmission of the corrected TED to **DHA** 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.

## Enrollment Transfer

A transfer of TRICARE Prime enrollment from one location or contractor to another:

- 1. Out-Of-Contract Enrollment Transfer.** An enrollment transfer between contractors, to include the Continental United States (CONUS) to CONUS, CONUS to Outside of the Continental United States (OCONUS), and OCONUS to CONUS. The term "contractors" also includes Designated Providers (DPs) under the Uniformed Services Family Health Plan (USFHP).
- 2. Within-Contract Enrollment Transfer.** An enrollment transfer within a TRICARE region, which involves a change of address and possibly a change of Primary Care Managers (PCMs), but not a change of contractors.

## Entity

An entity includes a corporation, trust, partnership, sole proprietorship or other kind of business enterprise that is or may be eligible to receive reimbursement either directly or indirectly from TRICARE, as established by 32 CFR 199.2(b).

## 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.

## Extraordinary Physical Or Psychological Condition (Respite Care Definition)

A complex physical or psychological clinical condition of such severity which results in the active duty beneficiary being homebound.

## 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. DHA 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.

### **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 its 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 **DHA** 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](#).

### **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, **DHA**, 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 **DHA**-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 **DHA** and the contractor. For example, the establishment of eligibility is a Uniformed Service responsibility and if the service has not established that eligibility, neither **DHA** 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 **DHA** 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.

### **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, **DHA**, 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 Caregiver (Respite Care Definition)**

An individual who provides services to a beneficiary to support ADL and specific services essential to the safe management of the beneficiary's condition.

**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)), **DHA**, 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.

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 primary caregivers who have been caring for the patient at home. Although this is usually the patient's family, it may be a relative or friend who assists the member with their ADL. Respite care consists of providing skilled and non-skilled services to a beneficiary such that in the absence of the primary caregiver, management of the beneficiary's qualifying condition and safety are provided. Respite care services are provided exclusively to the ADSM beneficiary.

**1. Qualifying Condition For Receipt Of Respite Benefits.** For the purposes of receiving respite benefits, a qualifying condition is defined as a serious injury or illness resulting in, or based on the clinical assessment of the member's provider or case management team that will result in a physical disability, or an extraordinary physical or psychological condition.

**2. Limitations On Respite Benefits:**

- Respite care is available for the member of the uniformed services with a qualifying condition. Respite care is available if an ADSM's plan of care includes frequent interventions by the primary caregiver(s). (The term "frequent" means "more than two interventions during the eight-hour period per day that the primary caregiver would normally be sleeping.")

- The services performed by the primary caregiver are those that can be performed safely and effectively by the average non-medical person without direct supervision of a health care provider after the primary caregiver has been trained by appropriate medical personnel.
- Respite care services are limited to a maximum of eight hours per calendar day, five days per calendar week.

### **Resubmissions**

A group of TED records submitted to **DHA** to correct those TED claims and adjustments which generated edit errors when originally processed by **DHA**. 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 DHA) 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 MCSCs and USFHP DPs.

### **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, DHA, 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 U.S. 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 IHI, 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, **DHA**, 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 **DHA**, 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.

### **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 preauthorization is required as set forth in [32 CFR 199.4](#). A treatment plan must include, at a minimum, a diagnosis (either ICD-9-CM, ICD-10-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.

**Note:** \*The edition of the **International Classification of Diseases, Clinical Modification**, reference to be used is determined by the date of service for outpatient services or date of discharge for inpatient services of the care provided. Diagnoses coding for dates of service for outpatient services or date of discharge for inpatient services before **the mandated date, as directed by HHS, for ICD-10 implementation**, should be consistent with ICD-9-CM. Diagnoses coding for dates of service for outpatient services or date of discharge for inpatient services on or after **the mandated date, as directed by HHS, for ICD-10 implementation** should be consistent with ICD-10-CM.

### **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 **DHA** 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 **DHA** 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)**

TFL pays secondary to Medicare for TRICARE beneficiaries who are entitled to Medicare Part A and enrolled in Medicare Part B, regardless of their age or place of residence. In addition, TFL covers a beneficiary in the same manner as a Standard beneficiary for any benefits covered by TRICARE but not covered by Medicare, imposing the Standard cost-share amounts for the service.

### **TRICARE Management Activity (TMA)/Defense Health Agency (DHA)**

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 **DHA** 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 [DHA](#) 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 [DHA](#) manual which provides ADP instructions and requirements for contractors who use the TEDs system for reporting data to [DHA](#).

### **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, **DHA** 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 DP 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. DPs 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 **DHA** 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.