



DEFENSE
HEALTH AGENCY

HPOB

**OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS
16401 EAST CENTRETECH PARKWAY
AURORA, CO 80011-9066**

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**LOZOYA.JOSE
.L.1231416397**

Digitally signed by
LOZOYA.JOSE.L.1231416397
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ou=DoD, ou=PKI, ou=DHA,
cn=LOZOYA.JOSE.L.1231416397
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**John L. Arendale
Section Chief, Health Plan
Operations Branch (HPOB)
Defense Health Agency (DHA)**

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SUMMARY OF CHANGES

CHAPTER 1

1. Section 3:
 - a. Added language regarding referral processing accuracy standards.
 - b. Changed references to from TRICARE Management Activity (TMA) to Defense Health Agency (DHA).

CHAPTER 7

2. Section 1:
 - a. Updated the title of Section 1.
 - b. Added a definition of medical management.
 - c. Added language pointing the contractors to a Contract Data Requirement List (CDRL) for content of the Medical Management/Utilization Management Program Plan.
 - d. Added a process for approval of the Utilization Management Plan.
 - e. Clarified language regarding physician peer reviews.
 - f. Clarified language regarding concurrent reviews.
 - g. Added language pointing the contractors to a CDRL for quarterly focused review reports.
3. Section 4:
 - a. Updated language pointing the contractors to CDRLs.
 - b. Removed language regarding the review of the Clinical Quality Management Program plan (included the language in the CDRL).
 - c. Clarified language regarding the Clinical Quality Management Program Annual Report.
 - d. Changed references to DPPO to Clinical Support Division (CSD).
 - e. Clarified language for DHA participation in committee(s).
 - f. Added language to Clinical Quality Management Program functional requirements.
 - g. Added a performance standard for processing potential quality issues and points contractor to CDRL for reporting.
 - h. Clarified language for a quality intervention and points contractor to CDRL for reporting.
 - i. Updated the definition for a sentinel event to reflect the most current Joint Commission definition.

SUMMARY OF CHANGES (Continued)

CHAPTER 7 (Continued)

3. Section 4 (Continued):
 - j. Added language regarding peer review.
 - k. Added language and points contractor to CDRL for reporting Agency for Healthcare Research and Quality Patient Safety Indicators.
 - l. Added language regarding the Centers for Medicare and Medicaid Hospital Compare web site and points contractor to CDRL for reporting.

CHAPTER 24

4. Section 7. Correction from TOM Change 167 (Consolidated 15-003), published January 19, 2016.

TRICARE Processing Standards

1.0 TIMELINESS AND QUALITY STANDARDS OF PERFORMANCE

Contractors are charged with providing or arranging for delivery of quality, timely health care services and have the responsibility for providing the timely and accurate processing of all claims received into their custody, whether for network or non-network care. In addition, the contractor must provide courteous, accurate, and timely response to all inquiries from beneficiaries, providers, **Defense Health Agency (DHA)**, and other legitimately interested parties. **DHA** has established standards of performance which will be monitored by **DHA** and other government agencies to measure contractor performance. Minimum performance standards are listed below.

1.1 Preauthorizations/Authorizations

The contractor shall issue determinations on at least:

- Ninety percent (90%) of all requests for preauthorization/authorization within two working days following receipt of the request and all required information.
- One hundred percent (100%) of such requests within five working days following receipt of the request and all required information.

1.2 Referrals/Network Adequacy

1.2.1 Following the date of receipt of a request for a referral, the contractor shall issue a referral authorization or denial on at least:

- Ninety percent (90%) of all requests within two workdays
- One hundred percent (100%) of all requests within three workdays

1.2.2 A minimum of 96% of referrals for Prime enrollees who reside in TRICARE Prime Service Areas (PSAs) and Prime enrollees who reside outside PSAs and have waived the travel-time access standards shall be to the Military Treatment Facility (MTF) or a civilian network provider. All referrals, except the following, will be included to determine compliance with the standard: (1) referrals that are unknown to the contractor before the visit (specifically Emergency Room (ER) visits, retroactively authorized referrals), (2) self referrals and referrals of beneficiaries who use Other Health Insurance (OHI) as first payor, (3) MTF directed referrals to non-network providers when network providers are available, and (4) the eight mental health self-referrals. All other referrals are included without exception.

1.2.3 In addition to the referral timeliness standards identified in paragraph 1.2.1, the contractor shall achieve and continuously maintain a referral processing accuracy percentage of

95%. A referral shall be considered to be processed accurately when all three of the following actions are performed correctly:

- Consideration of Right of First Refusal (ROFR) rules on referrals from the private sector in CONUS;
- Verification of beneficiary eligibility in Defense Enrollment Eligibility Reporting System (DEERS); and
- Issuance of an authorization to an appropriate provider/facility based on the referral.

Referrals which do not result in an authorization (e.g., a referral which is returned to the civilian provider or to the MTF for missing information) shall not be considered in calculating referral processing accuracy.

The details for content and submission of the timeliness standards for preauthorization/authorizations, referrals and referral accuracy are contained in the contract, DD Form 1423, Contract Data Requirements List (CDRL).

1.3 Network Adequacy

In Option Period One, the following percent of claims for Prime enrollees region-wide (excluding TPR enrollees) will be for care rendered by a network provider. This includes all claims for Prime enrollees except emergency room claims, Point of Service (POS) claims, or claims with OHI.

- North Region: 86%
- South Region: 86%
- West Region: 72%

This percent for the number of claims from network providers will increase 1% each option period.

1.4 Electronic Claims Submittal

The following percentage of all claims shall be submitted electronically after the specified percentage of claims has been excluded. For the North Region, 30% of paper claims will be excluded each option year from the total number of paper claims processed. For the South Region, 25% of paper claims will be excluded each option year from the total number of paper claims processed. For the West Region, 28% of paper claims will be excluded each option year from the total number of paper claims processed.

OPTION YEAR	NORTH	SOUTH	WEST
1	74%	78%	83%
2	77%	81%	84%
3	79%	83%	85%
4	80%	84%	86%
5	81%	85%	87%

1.5 Claims Processing Timeliness

Unless otherwise specified, the standards below apply to all claims.

1.5.1 Retained Claims

- Ninety-eight (98%) of retained claims and adjustment claims shall be processed to completion within 30 calendar days from the date of receipt.

A "Retained Claim" is defined as any claim retained (held in the contractor's possession) for any reason. Contractors shall retain all claims that contain sufficient information to allow processing to completion and all claims for which missing information may be developed from in-house sources, including DEERS and contractor operated or maintained electronic, paper, or film files.

Note: Nothing in this definition prohibits a contractor from retaining a claim for external development.

1.5.2 Retained and Excluded Claims

One hundred percent (100%) of all claims (both retained and excluded, including adjustments), shall be processed to completion within 90 calendar days unless the Government specifically directs the contractor to continue pending a claim or group of claims.

"Excluded Claims" are defined as:

- Claims retained at the discretion of the contractor for the external development of information necessary to process the claim to completion;
- Claims requiring development for possible third-party liability;
- Claims requiring intervention by another Prime contractor; and
- Claims requiring government intervention (i.e., claims held for CHAMPUS Maximum Allowable Charge (CMAC) updates, claims held pending the issuance of a policy change, etc.).

1.6 Claims Processing Cycle

The contractor shall generate an initial submission claims processing cycle and transmit related TRICARE Encounter Data (TED) and required documents to **DHA** not less than three times every seven calendar days. The contractor shall have an updated beneficiary processed claims history and deductible file available and accessible within one workday following each processing cycle. The contractor shall ensure only one processed claims history and deductible file is maintained for each beneficiary.

1.7 Claims Processing Accuracy

1.7.1 Claim Payment Errors

The absolute value of the payment errors shall not exceed 2% of the total billed charges for the first two option periods. In all remaining option periods, the absolute value of the payment errors shall not exceed 1.75% of the total billed charges.

1.7.2 Claim Occurrence Errors

The TED occurrence error rate shall not exceed 3% for all types of TEDs.

1.8 TEDs - Timeliness

- One hundred percent (100%) of initial submission vouchers/batches shall be transmitted to **DHA** within five calendar days of the date of the batch/voucher create date.
- Eighty-five percent (85%) of all unprocessable vouchers/batches, including but not limited to, out-of-balance conditions and invalid header record information shall be corrected by the contractor and returned for receipt at **DHA** within 20 calendar days of the date the invalid data was transmitted to the contractor by **DHA**.
- One hundred percent (100%) of unprocessable vouchers/batches shall be corrected and returned for receipt at **DHA** within 30 calendar days of the date the invalid data was transmitted to the contractor by **DHA**.
- Ninety-nine and one-half percent (99.5%) of all vouchers/batches having TEDs (initial submissions, resubmissions, and adjustment/cancellation submissions) failing the edit system shall be corrected and resubmitted to **DHA** within 30 calendar days after the errors and rejected TEDs were transmitted to the contractor by **DHA**. The resubmission data shall contain all TEDs rejected on the voucher/batch in question.
- One hundred percent (100%) of all remaining vouchers/batches having TEDs failing the edit system shall be corrected and resubmitted to **DHA** within 45 calendar days after the errors and rejected TEDs were transmitted to the contractor by **DHA**. The resubmission data shall contain all TEDs rejected in the voucher/batch.

1.9 TEDs - Accuracy

1.9.1 Following the start of health care delivery, the contractor shall have the following percentages of TEDs (initial submissions, resubmissions and adjustment/cancellation submissions) passing the **DHA** edit system at the following time lines:

- One through three months - 80%
- Four through six months - 85%
- Seven through nine months - 90%
- Ten through 11 months - 95%
- Twelve through 23 months - 96%
- Month 24 through contract close - 97%

1.9.2 Vouchers/Batches

Three months following the start work date of the contract, the contractor shall have no more than 2% of the vouchers/batches being unprocessable due to, but not limited to, such problems as:

- Out-of-balance;
- Invalid header conditions;
- Invalid record type;
- Invalid contractor number;
- Invalid voucher/batch identifier;
- Invalid voucher/batch date;
- Invalid sequence number;
- Invalid resubmission number;
- Invalid period begin date;
- Invalid period end date;
- Invalid total number of records; and
- Invalid total amount paid.

2.0 MANAGEMENT

2.1 Filing

The contractor shall file all hard copy, microform copies and digital/optical disk imaging of claims/adjustment claims, with attached documentation by Internal Control Number (ICN) by state or contract number within five calendar days after they are processed to completion. The claim and all supporting documents shall be maintained in hard copy, microcopy, or digital image or optical disk. Provisions shall be made for appropriate retention and disposition of files in accordance with the Federal Records Act and [DHA](#) instructions (see [Chapter 2](#)).

2.2 Availability Of Information

Information required for appropriate responses to inquiries, including but not limited to claim files, appeals files, previous correspondence, and check files shall be retrievable and forwarded within five workdays following a request for the information.

3.0 BENEFICIARY AND PROVIDER SERVICES (BPS)

For all processing standards, the actual date of receipt shall be counted as the first day. The date the reply is mailed shall be counted as the processed to completion date. The standards with which the contractor shall comply include:

3.1 Routine Written Inquiries

All routine written inquiries shall be stamped with the actual date of receipt within three workdays of receipt in the contractor's custody. The contractor shall provide final responses to routine written inquiries as follows:

- Eighty-five percent (85%) within 15 calendar days of receipt;

- Ninety-seven percent (97%) within 30 calendar days of receipt; and
- One hundred percent (100%) within 45 calendar days of receipt.

3.2 Priority Written Inquiries (Congressional, ASD(HA), And DHA)

All priority written inquiries shall be stamped with the actual date of receipt within three workdays of receipt in the contractor's custody. The contractor shall provide final responses to priority written inquiries as follows:

- Eighty-five percent (85%) within 10 calendar days of receipt;
- One hundred percent (100%) within 30 calendar days of receipt.

3.3 Walk-In Inquiries (TRICARE Overseas Contract Only)

- Ninety-five percent (95%) of walk-in inquiries shall be acknowledged and be assisted by a service representative within 15 minutes of entering the reception area.
- Ninety-nine percent (99%) of walk-in inquiries shall be acknowledged and assisted by a service representative within 20 minutes of entering the reception area.

3.4 Telephone Inquiries

The following required levels of service shall be available at all times - daily, weekly, monthly, etc. Averages are not acceptable.

- Blockage rates shall never exceed 5%. Never is defined as at any time during any day.
- Ninety-five percent (95%) of all telephones shall be answered within two rings by a Automated Response Unit (ARU). The caller shall have only two choices: transfer to an ARU (e.g., automated claims inquiry, recorded messages where to submit claims or correspondence, etc.) or to an individual.
- If transferred to an ARU, 100% of all telephone calls shall be acknowledged within 20 seconds.
- If transferred to an individual, 90% of all calls shall be answered by an individual (not an answering machine) within 30 seconds.
- Total "on hold" time for 95% of all calls shall not exceed 30 seconds during the entire telephone call.
- Eighty-five percent (85%) of all inquiries shall be fully and completely answered during the initial telephone call. (Applies to all calls transferred to an individual.)
- Ninety-nine and one-half percent (99.5%) of all inquiries not fully and completely answered initially shall be fully and completely answered within 10 business days.

4.0 APPEALS

4.1 Expedited Preadmission/Preprocedure Reconsiderations

One hundred percent (100%) of requests for expedited preadmission/preprocedure reconsiderations processed to completion within three working days of the date of receipt by the contractor of the reconsideration request (unless the reconsideration is rescheduled at the written request of the appealing party). Expedited preadmission/preprocedure requests are those requests filed by the beneficiary within three calendar days after the beneficiary receipt of the initial denial determination.

4.2 Nonexpedited Medical Necessity Reconsiderations

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

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

4.3 Nonexpedited Factual Reconsiderations

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

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

4.4 Determinations Reversed by the Appeals Process

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

5.0 GRIEVANCES

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

6.0 POTENTIAL DUPLICATE CLAIM RESOLUTION

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

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

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

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

- END -

Chapter 7

Utilization And Quality Management

Section/Addendum	Subject/Addendum Title
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|---|--|
| 1 | Medical Management/Utilization Management (MM/UM) |
| 2 | Preauthorizations |
| 3 | Contractor Relationship With The Military Health System (MHS) TRICARE Quality Monitoring Contractor (TQMC)
Figure 7.3-1 Box Inventory Document (Sample)
Figure 7.3-2 Routine E-Mail (Sample) |
| 4 | Clinical Quality Management Program (CQMP) |
| A | An Important Message From TRICARE |
| B | Hospital Issued Notices Of Noncoverage |
| C | Hospital Adjustments |

Medical Management/Utilization Management (MM/UM)

1.0 MEDICAL MANAGEMENT/UTILIZATION MANAGEMENT (MM/UM) PROGRAM PLAN

The Defense Health Agency (DHA) defines MM as an integrated managed care model that promotes UM, Case Management (CM), and chronic care/Disease Management (DM) programs as a hybrid approach to managing patient care. MM integrates evidence-based and outcome-oriented programs into the MM processes.

1.1 These requirements are applicable to utilization and quality review of all health care services delivered to beneficiaries living within the region, to all beneficiaries receiving care in the Region regardless of their place of residence, and to all providers delivering care within the region. Additional requirements for enrollees (such as authorizations for specialty care) and network providers (such as qualifications to be network providers) are further identified in [Chapter 5](#). All providers shall be subject to the same review standards and criteria. The contractor shall be considered a multi-function Peer Review Organization (PRO) under this contract.

1.2 The contractor shall fully describe in a written MM/UM Plan all processes, procedures, criteria, staff and staff qualifications, and information and data collection activities and requirements the contractor shall use in conducting MM/UM activities. **The details for content and submission of this plan are contained in the contract, DD Form 1423, Contract Data Requirements List (CDRL).**

1.2.1 The appropriate TRICARE Regional Office/TRICARE Overseas Program Office (TRO/TOPO) shall review the plan and make recommendations for revision if necessary within 45 calendar days or provide written approval through the Contracting Officer (CO). In the absence of Clinical Quality Management (CQM) staff in the Designated Provider Program Office (DPPO), the Clinical Support Division (CSD) of the DHA will review the plans submitted by the Designated Provider (DP) programs and provide recommendations for revision or written acceptance within 45 days.

1.2.2 The contractor shall provide a revised plan addressing the recommendations within 15 business days to the appropriate reviewing office, which will provide written approval of the plan through the appropriate CO within 45 calendar days if there are no recommendations or upon receipt of a revised plan which addresses the recommendations.

2.0 NOTIFICATION OF REVIEW REQUIREMENTS

The contractor is responsible for education and training to providers and beneficiaries on the requirements of the UM programs. The contractor shall describe fully the process for notification in a timely manner (but not less than 30 calendar days prior to commencement of review) of all providers, both network and non-network, of all review requirements such as preauthorization, concurrent review, retrospective review (including the fiscal penalties for failing to obtain review authorizations), review criteria to be used, and requirements for CM.

3.0 REVIEWER QUALIFICATIONS AND PARTICIPATION

3.1 Peer Review By Physicians

3.1.1 Except as provided in paragraph 3.1.2, each person who makes an initial **or reconsideration** denial determination **or standard of care determination** about services furnished or proposed to be furnished by a licensed doctor of medicine or osteopathy or by a doctor of dentistry must be respectively another licensed doctor of medicine **in a like specialty**, or osteopathy **in a like specialty**, or of dentistry with an active clinical practice in the PRO area, if the initial, **reconsideration, or standard of care** determination is based on lack of medical necessity or other reason relative to reasonableness, necessity, or appropriateness.

3.1.2 If a PRO determines that peers are not available, **then a nationally accredited external independent review organization shall be used** to make **the** denial determinations.

3.2 Peer Review By Health Care Practitioners Other Than Physicians

Health care practitioners other than physicians may review services **and/or make standard of care determinations for services** furnished by other practitioners in the same professional field **and specialty**.

3.3 Diagnosis Related Group (DRG) Validation Review

Decisions about procedural and diagnostic information must be made by physicians. Technical coding issues must be reviewed by individuals with training and experience in International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) coding (for outpatient services with dates of service or inpatient services with dates of discharge provided before the mandated date, as directed by Health and Human Services (HHS), for International Classification of Diseases, 10th Revision (ICD-10) implementation) and in ICD-10-CM coding (for outpatient services with dates of service or inpatient services with dates of discharge provided on or after the mandated date, as directed by HHS, for ICD-10 implementation, or International Classification of Diseases, 10th Revision, Procedure Coding System (ICD-10-PCS) for inpatient services with dates of discharge provided on or after the mandated date, as directed by HHS, for ICD-10 implementation).

3.4 Persons Excluded From Review

3.4.1 A person may not review health care services or make initial denial determinations or changes as a result of DRG validations if he or she, or a member of his or her family:

- Participated in developing or executing the beneficiary's treatment plan;
- Is a member of the beneficiary's family; or
- Is a governing body member, officer, partner, 5% or more owner, or managing employee in the health care facility where the services were or are to be furnished.

3.4.2 A member of a reviewer's family is a spouse (other than a spouse who is legally separated under a decree of divorce or separate maintenance), child (including a legally adopted child), grandchild, parent, or grandparent.

3.5 Administrative Requirements

Each review shall be dated and include the signature, legibly printed name, clinical specialty, and credentials of the reviewer. Each reviewer shall include rationale for his or her decision (i.e., a complete statement of the evidence and the reasons for the decision).

4.0 WRITTEN AGREEMENTS WITH INSTITUTIONAL PROVIDERS

The contractor shall establish written agreements with each institutional provider over which the contractor has review authority. These agreements shall be in place before the start of services. Agreements must specify that:

- Institutional providers will cooperate with the contractor in the assumption and conduct of review activities.
- Institutional providers will allocate adequate space for the conduct of on site review.
- Institutional providers will photocopy and deliver to the contractor all required information within 30 calendar days of a request for off-site review.
- Institutional providers will provide all beneficiaries, in writing, their rights and responsibilities (e.g., "An Important Message from TRICARE" ([Addendum A](#)), "Hospital Issued Notice of Noncoverage" ([Addendum B](#))).
- Institutional providers will inform the contractor within three working days if they issue a notice that the beneficiary no longer requires inpatient care.
- Institutional providers will assure that each case subject to preadmission/preprocedure review has been reviewed and approved by the contractor.
- Institutional providers will agree, when they fail to obtain certification as required, they will accept full financial liability for any admission subject to preadmission review that was not reviewed and is subsequently found to be medically unnecessary or provided at an inappropriate level ([32 CFR 199.15\(g\)](#)).
- The contractor shall reimburse the provider for the costs of photocopying and postage using the same reimbursement as Medicare.
- The contractor shall provide detailed information on the review process and criteria used, including financial liability incurred by failing to obtain preauthorization.

5.0 BENEFIT POLICY DECISIONS

TRICARE Versus Local Policy. TRICARE policies have precedence over any local or internal policy of the contractor or the medical community of the region. However, the contractor shall

notify DHA promptly of any conflicts between TRICARE policy and local policy. Variations from policy which expand, reduce, or adjust benefit coverage shall be referred to DHA for approval before being implemented.

6.0 CONCURRENT REVIEW REQUIREMENTS

The contractor shall conduct concurrent review for continuation of inpatient mental health services within 72 hours of notification of emergency admissions (see 32 CFR 199.4(a)(12)(iv) and (b)(6)(iv)), and authorize, as appropriate, additional days.

7.0 RETROSPECTIVE REVIEWS RELATED TO DRG VALIDATION

7.1 The contractor shall conduct quarterly focused reviews of a 1% sample of medical records to assure that reimbursed services are supported by documentation in the patient's medical record. This review must determine if the diagnostic and procedural information and discharge status of the patient as reported by the hospital matches the attending physician's description of care and services documented in the patient's record. In order to accomplish this, the contractor shall conduct the following review activities:

7.2 Review of claim adjustments submitted by hospitals which result in the assignment of a higher weighted DRG (see Addendum C).

7.3 Review for physician certification as to the major diagnosis and procedures and the physician's acknowledgment of a penalty statement on file.

7.4 When the claim is submitted, the hospital must have on file a signed and dated acknowledgment from the attending physician that the physician has received the following notice:

"Notice to Physicians: TRICARE payment to hospitals is based in part on each patient's principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient's attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws."

7.5 The acknowledgment must be completed by the physician either before or at the time that the physician is granted admitting privileges at the hospital, or before, or at the time the physician admits his or her first patient. Existing acknowledgments signed by physicians already on staff remain in effect as long as the physician has admitting privileges at the hospital.

7.6 Outlier Review

Claims that qualify for additional payment as a cost-outlier shall be subject to review to ensure that the costs were medically necessary and appropriate and met all other requirements for payment. In addition, claims that qualify as short-stay outliers shall be reviewed to ensure that the admission was medically necessary and appropriate and that the discharge was not premature.

7.7 Procedures Regarding Certain Services Not Covered By The DRG-Based Payment System

In implementing the quality and utilization review for services not covered by the DRG-based payment system, the requirements of this section shall pertain, with the exception that ICD-9-CM (for dates of discharge before the mandated date, as directed by HHS, for ICD-10 implementation) and Current Procedural Terminology, 4th Edition (CPT-4) codes will provide the basis for determining whether diagnostic and procedural information is correct and matches information contained in the medical records. The ICD-10-CM and ICD-10-PCS codes will be used to provide basis of correct information for dates of discharge beginning on or after the mandated date, as directed by HHS, for ICD-10 implementation.

8.0 RETROSPECTIVE REVIEW REQUIREMENTS FOR OTHER THAN DRG VALIDATION

The contractor shall conduct and report quarterly focused reviews of a statistically valid sample or 30 records, whichever is greater of medical records to determine the medical necessity and quality of care provided, validate the review determinations made by review staff, and determine if the diagnostic and procedural information and/or discharge status of the patient as reported on the hospital and/or professional provider's claim matches the attending physician's description of care and services documented in the medical record. The specific types of records to be sampled shall be determined separately by each Regional Director (RD) who will provide the contractor with the sampling criteria (DRG, diagnosis, procedure, Length-Of-Stay (LOS), provider, incident or occurrence as reported on claim forms) and the time frame from which the sample is to be drawn 60 calendar days prior to each quarter. For all cases selected for retrospective review, the following review activities shall occur:

8.1 Admission Review

The medical record must indicate that inpatient hospital care was medically necessary and provided at the appropriate level of care.

8.2 Invasive Procedure Review

The performance of unnecessary procedures may represent a quality and/or utilization problem. In addition, the presence of codes of procedures often affects DRG classification. Therefore, for every case under review, the medical record must support the medical necessity of the procedure performed. For this purpose, invasive procedures are defined as all surgical and any other procedures which affect DRG assignment.

8.3 Discharge Review

Records shall be reviewed using appropriate criteria for questionable discharges or other potential quality problems.

8.4 Mental Health Review

The contractor shall review all mental health claims in accordance with the provisions in [32 CFR 199.4\(a\)\(11\)](#) and [\(a\)\(12\)](#).

8.5 The details for content and submission of all quarterly focused review reports are contained in the contract, DD Form 1423, CDRL.

9.0 REVIEW RESULTS

9.1 Actions As A Result Of Retrospective Review Related To Individual Claims

If it is determined, based upon information obtained during reviews, that a hospital has misrepresented admission, discharge, or billing information, or is found to have quality of care defects, or has taken an action that results in the unnecessary admission of an individual entitled to benefits, unnecessary multiple admission of an individual, or other inappropriate medical or other practices with respect to beneficiaries or billing for services furnished to beneficiaries, the contractor shall, as appropriate:

- Deny payment for or recoup (in whole or in part) any amount claimed or paid for the inpatient hospital and professional services related to such determination;
- Require the hospital to take other corrective action necessary to prevent or correct the inappropriate practice;
- Advise the provider and beneficiary of appeal rights, as required by [Chapter 12, Section 4, paragraph 2.0](#).

9.2 Findings Related To A Pattern Of Inappropriate Practices

The contractor shall notify **DHA** of the hospital and practice involved in all cases where a pattern of inappropriate admissions and/or billing practices, that have the effect of circumventing the TRICARE DRG-based payment system, is identified.

9.3 Revision Of Coding Relating To DRG Validation

The contractor shall ensure the application of the following provisions in connection with the DRG validation process.

- If the diagnostic and procedural information attested to by the attending physician is found to be inconsistent with the hospital's coding or DRG assignment, the hospital's coding on the TRICARE claim shall be appropriately changed and payments recalculated on the basis of the appropriate DRG assignment.
- If the information attested to by the physician as stipulated in [paragraph 7.3](#) is found not to be correct, the contractor shall change the coding and assign the appropriate DRG on the basis of the changed coding in accordance with the paragraph above.

9.4 Notice Of Changes As A Result Of A DRG Validation

The contractor shall notify the provider of changes to procedural and diagnostic information that result in a change of DRG assignment within 30 calendar days of the contractor's decision. The

notice must be understandable, written in English and shall contain:

- The corrected DRG assignment;
- The reason for the change resulting from the DRG validation;
- A statement addressing who is liable for payment of denied services (e.g., a beneficiary will be liable if the change in DRG assignment results in noncoverage of a furnished service);
- A statement informing each party (or his or her representative) of the right to request a review of a change resulting from DRG validation in accordance with the provisions in [paragraph 9.5](#);
- The locations for filing a request for review and the time period within which a request must be filed; and
- A statement concerning the duties and functions of the multi-function PRO.

9.5 Review Of DRG Coding Change

9.5.1 A provider dissatisfied with a change to the diagnostic or procedural coding information made by the contractor as a result of DRG validation is entitled to a review of that change if the change caused an assignment of a different DRG and resulted in a lower payment. A beneficiary may obtain a review of the contractor's DRG coding change only if that change results in noncoverage of a furnished service (see 42 CFR 478.15(a)(2)).

9.5.2 The contractor shall issue written notification of the results of the DRG validation review within 60 calendar days of receipt of the request for review. In the notification, the contractor shall summarize the issue under review and discuss the additional information relevant to such issue. The notification shall state the contractor's decision and fully state the reasons that were the basis for the decision with clear and complete rationale. The notification shall include a statement that the decision is final and no further reviews are available.

10.0 PREPAYMENT REVIEW

10.1 The contractor shall establish procedures and conduct prepayment utilization review to address those cases involving diagnoses requiring prospective review, where such review was not obtained, to focus on program exclusions and limitations and to assist in the detection of and/or control of fraud and abuse. The contractor shall not be excused from claims processing cycle time standards because of this requirement.

10.2 The contractor shall perform prepayment review of all cases involving diagnoses requiring preauthorization where review was not obtained. No otherwise covered care shall be denied solely on the basis that authorization was not requested in advance, except for care provided by a network provider.

10.3 The contractor shall perform prepayment review of all DRG claim adjustments submitted by a provider which result in higher weighted DRGs.

11.0 CM

CM shall not be accomplished for beneficiaries eligible for Medicare Part A and Enrolled in Medicare Part B unless it is specifically contracted for inside an individual MTF or if the individual is part of the Individual Case Management Program for Persons with Extraordinary Conditions (ICMP-PEC).

12.0 CONFIDENTIALITY APPLICABLE TO ALL UM ACTIVITIES, INCLUDING RECOMMENDATIONS AND FINDINGS

12.1 The contractor shall develop and implement procedures, processes, and policies that meet the confidentiality and disclosure requirements set forth in Title 10, United States Code (USC), Chapter 55, Section 1102; the Social Security Act, Section 1160, and implementing regulations at 42 CFR 476, the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) Reorganization Act (42 USC 290dd-2), the Privacy Act (5 USC 552a), 32 CFR 199.15(j) and (l). Additionally, the contractor shall display the following message on all quality assurance documents:

“Quality Assurance document under 10 USC 1102. Copies of this document, enclosures thereto, and information therefrom will not be further released under penalties of law. Unauthorized disclosure carries a possible \$3,000 fine.”

12.2 Release of Information - If an inquiry is made by the beneficiary, including an eligible family member (child) regardless of age, the reply should be addressed to the beneficiary, not the beneficiary’s parent or guardian. The only exceptions are when a parent writes on behalf of a minor child or a guardian writes on behalf of a physically or mentally incompetent beneficiary. The contractor must not provide information to parents/guardians of minors or incompetents when the services are related to the following diagnoses:

- Abortion
- Alcoholism
- Substance Abuse
- Venereal Disease
- Acquired Immune Deficiency Syndrome (AIDS)

12.3 The term “minor” means any person who has not attained the age of 18 years. Generally, the parent of a minor beneficiary and the legally appointed guardian of an incompetent beneficiary shall be presumed to have been appointed the representative without specific designation by the beneficiary. Therefore, for beneficiaries who are under the age of 18 years or who are incompetent, a notice issued to the parent or guardian, under established TRICARE procedures, constitutes notice to the beneficiary.

12.4 If a beneficiary has been legally declared an emancipated minor, they are to be considered as an adult. If the beneficiary is under 18 years of age and is (or was) a spouse of an Active Duty Service Member (ADSM) or retiree, they are considered to be an emancipated minor.

13.0 DOCUMENTATION

The contractor shall develop and implement a program for providing beneficiaries and providers with the written results of all review activities affecting benefit determinations. All

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notifications to beneficiaries and providers shall be completed and mailed within the time limits established for the completion of reviews in this section. Notifications of denials shall include: patient's name, sponsor's name and last four digits of their Social Security Number (SSN), the clinical rationale for denial of payment for specific services (form letters are unacceptable as the clinical rationale shall provide a complete explanation, referencing any and all appropriate documentation, for the cause of the denial), all applicable appeal and grievance procedures, and the name and telephone number of an individual from whom additional information may be obtained.

- END -

Clinical Quality Management Program (CQMP)

The Managed Care Support Contractors (MCSCs), Designated Providers (DPs), and the TRICARE Overseas Program (TOP) contractor (from this point forward to be referred to as the contractor) shall operate a CQMP which results in demonstrable quality improvement in the quality of health care provided beneficiaries, and in the process and services delivered by the contractor. The CQMP is defined as the integrated processes, both clinical and administrative, that provide the framework for the contractor to objectively define and measure the quality of care received by beneficiaries. This CQMP shall demonstrate how the contractor's goals and objectives, leadership, structure, and operational components are designed to achieve the efficient and effective provision of timely access to high quality health care. As part of the CQMP, the contractor shall develop a CQMP Plan with goals and objectives followed by a CQMP Annual Report (AR) describing the results of the quality activities performed during each program year.

1.0 CQMP PLAN

The contractor shall develop a written CQMP Plan which is defined as a detailed description of the purpose, methods, proposed goals and objectives designed to meet the intent of the program. The contractor shall fully describe in a written CQMP Plan the structural and functional components of the program. Details for content and submission of this plan are contained in the contract, DD Form 1423, Contract Data Requirements List (CDRL).

2.0 CLINICAL QUALITY MANAGEMENT PROGRAM ANNUAL REPORT (CQMP AR)

Details for content and submission of this report are contained in the contract, DD Form 1423, CDRL. The TRICARE Regional Offices (TROs), TRICARE Overseas Program Office (TOPO), and Clinical Support Division (CSD) will provide relevant comments to the contractors based on review of the annual CQMP report. The report will be reviewed in conjunction with the annual plan for the particular period of performance. Recommendations for revision or acceptance of the annual report shall be provided in a written format through the appropriate Contracting Officer (CO) to the contractor within 45 calendar days of receipt of the annual program report.

3.0 COMMON TERMS AND DEFINITIONS

3.1 Quality Improvement Initiative (QII)

The purpose of a QII is to improve processes internal to the organization and may include improvements in clinical administrative processes, program related issues or new methods in accomplishing outcomes of the program such as cycle time, effectiveness, efficiency, reporting tools, related processes between departments affecting desired outcomes, etc. Common tools for improvements in processes may include various methods that include core elements such as baseline data, interventions/actions, re-measurement, monitoring and follow-up. Process improvements shall be appropriately documented to demonstrate purpose of improvement,

baseline measure(s), actions/interventions, re-measurement(s) and outcomes.

3.2 Quality Improvement Projects (QIPs)

A QIP is a set of related activities designed to achieve measurable improvement in processes and outcomes of care. Improvements are achieved through interventions that target health care providers, practitioners, plans, and/or beneficiaries. QIPs may address administrative processes, beneficiary health, error reduction or safety improvement, beneficiary functional status, beneficiary or provider satisfaction, program related issues or to serve as a valid proxy for high-volume or high-risk issues. They may result after being identified from a Clinical Quality Study (CQS) as an opportunity for improvement. QIPs should be structured with appropriate elements such as clearly defined sample sizes and inclusions/exclusion criteria. They shall be appropriately operationalized, meaning appropriate scientific methodology and rigor should be applied such as using written research questions and statistically significant analysis as applicable. Lastly, QIPs shall be appropriately documented by including the following common elements of a QIP:

- Description and purpose of topic.
- Description of the population.
- Rationale for selection of the QIP baseline data.
- Description of data collection.
- Goals and time frames.
- Action plan/interventions.
- Periodic re-measurements and outcomes.

3.3 CQS

An assessment conducted of a patient care problem for the purpose of improving patient care through peer analysis, intervention, resolution of the problem, and follow-up. A CQS should be appropriately operationalized, meaning appropriate scientific methodology and rigor should be applied such as using written research questions and statistical significant analysis as applicable. Typically these do not require evidence-based interventions, multiple measurement cycles, or sophisticated statistical analysis. Common elements of CQS:

- Description of CQS and purpose of topic.
- Rationale for the selection of the CQS.
- Define the study question.
- Description of methodology used.
- Select the indicators/measures.
- Description of data collection.
- Description of the population and sampling techniques (if applicable).
- Report of findings to include a definition of the study, description of data collection, statement of hypothesis, analytic methods and population employed, data analysis and

interpretation.

- Plan for follow-up of the CQS to include interventions and measurements as applicable.

3.4 Potential Quality Issue (PQI)

A clinical or system variance warranting further review and investigation for determination of the presence of an actual Quality Issue (QI).

3.5 Quality Issue (QI)

A verified deviation from acceptable standards of practice or standards of care as a result of some process, individual, or institutional component of the health care system.

4.0 CQMP STRUCTURAL AND FUNCTIONAL REQUIREMENTS

4.1 The contractor shall allow the respective and appropriate clinical staff from the TRO/TRICARE Area Office (TAO), TOPO, Medical Director for the Regional Director (RD), and CSD (acting on behalf of the Designated Provider Program Office (DPPO)) active participation in their CQMP and non-voting membership in their region level Quality Management Committees, peer review committees both medical-surgical and behavioral health, and Credentialing Committees. The contractor shall develop and implement written policies and procedures to identify PQIs, steps to resolve identified problems, suggest interventions to resolve problems, and provide ongoing monitoring of all components of the contractor's operations and the care and treatment of TRICARE beneficiaries.

4.2 Using the most current National Quality Forum (NQF) Serious Reportable Events (SREs), Centers for Medicare and Medicaid Services (CMS) Hospital Acquired Conditions (HACs), Agency for Healthcare Research and Quality (AHRQ) Patient Safety Indicators (PSIs), and any other Defense Health Agency (DHA) required indicator/event (see DD Form 1423, CDRL), the contractor shall identify, track, trend, and report interventions to resolve the PQIs and QIs. Additionally, the contractor shall report potential SREs to the TRO/TAO or CSD within two business days from when the contractor becomes aware of the event. At a minimum, the report shall include the beneficiary's name, last four digits of sponsor's Social Security Number (SSN) or Department of Defense (DoD) identification number, beneficiary Date Of Birth (DOB), enrollment status (Prime or Standard), beneficiary type (Active Duty (AD), AD dependent, retiree, retiree family member), Primary Care Manager (PCM) (name of civilian PCM or Military Treatment Facility (MTF)), a synopsis of the event, location of the event (to include provider name, address, city and state or country, if applicable), provider status, and any contractor actions taken to date. The contractor shall report, by a secure means, closure of the reported SRE within two business days to include closure date, outcome of review (to include the determination of whether a QI occurred, and if so, the severity level) and summary of actions taken. Details for content and submission of SREs are contained in the contract, DD Form 1423, CDRL.

5.0 PATIENT SAFETY OR QI IDENTIFICATION

The contractor shall apply medical judgment, evidence based medicine, best medical practice and follow the TRICARE criteria as set forth in paragraphs 4.1 and 4.2 for the identification, evaluation and reporting of all PQIs and confirmed QIs. The contractor shall assess every medical

record reviewed for any purpose and any care managed/observed/monitored on an ongoing basis for PQIs. **The contractor shall process to completion 95% of all PQIs within 90 calendar days from date of identification and 99% within 180 calendar days of identification. For reporting of PQIs and QIs, see DD Form 1423, CDRL, CQM Monthly Quality Intervention Reporting.**

5.1 Quality Intervention

The contractor shall implement appropriate quality interventions using evidence based medicine/guidelines and best medical practices to reduce the number of QIs and improve patient safety. When the contractor confirms a QI **or determines there is deviation in the standard of practice or care**, the determination shall include assignment of an appropriate severity level and/or sentinel event, and describe the actions taken to resolve the quality problem. **Details for content and submission of a Clinical Quality Management Intervention Report are contained in the contract, DD Form 1423, CDRL.**

5.2 Definitions

5.2.1 PQI

A **PQI is a clinical or system variance**, warranting further review and investigation for determination of the presence of an **actual QI**.

5.2.2 No QI

Following investigation there is **NO QI finding**.

5.2.3 QI

A **QI is a verified deviation, as determined by a qualified reviewer**, from acceptable standard of practice or standard of care as a result of some process, individual, or institutional component of the health care system.

- **Severity Level 1.** QI is present with minimal potential for significant adverse effects on the patient.
- **Severity Level 2.** QI is present with the potential for significant adverse effects on the patient.
- **Severity Level 3.** QI is present with significant adverse effects on the patient.
- **Severity Level 4.** **QI is present** with the most severe adverse effect and warrants exhaustive review.
- **Sentinel Event.** A sentinel event is **defined by the TRICARE program utilizing the most current definition as published by the Joint Commission.**

5.3 PQI Jurisdiction

The contractor with geographic jurisdiction has the ability to have meaningful “quality interventions,” and has the best opportunity to demonstrate improved quality by providers within its jurisdiction. Thus, consistent with the TRICARE Operations Manual (TOM) requirements, cross-region PQI issues are handled as follows: The contractor who receives and/or identifies a PQI shall conduct an initial clinical assessment based upon the information on hand and if a PQI exists, forward the case and all supporting information to the contractor with the geographic jurisdiction for the case review, investigation, and intervention(s).

5.4 Peer Review

All claims submitted for health services are subject to review for quality of care and appropriate utilization. In all cases, peer review activities under the Quality and Utilization Review Peer Review Organization (PRO) program (32 CFR 199.15) are carried out by physicians and other qualified health care professionals. The PRO program is concerned primarily with medical judgments regarding the quality and appropriateness of health care services. Issues regarding such matters as benefit limitations are similar but, if not determined on the basis of medical judgments, are governed by Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) rules and procedures other than those provided in this section. (See, for example, 32 CFR 199.7 regarding claims submission, review and payment.) Based on this purpose, a major attribute of the PRO program is that medical judgments are made by (directly or pursuant to guidelines and subject to direct review) reviewers who are peers of the health care providers providing the services under review. Broadly, the program of quality and utilization review has as its objective to review the quality, completeness, and adequacy of care provided, as well as its necessity, appropriateness and reasonableness. (Refer to Section 1, paragraph 3.0 for peer reviewer qualifications and participation.)

5.4.1 All QIs, regardless of the source, shall be reviewed and confirmed by a peer review committee composed, at a minimum, of qualified peer reviewers to determine deviations from standards of care, severity levels, recommending interventions to include Corrective Action Plans (CAPs), reporting to licensure boards, and follow-up monitoring through resolution. All standard of care determinations shall be approved by the peer review committee(s).

5.4.2 The CQMP shall describe the peer review committee(s) composition, quorum of voting members to conduct peer review and frequency of the meetings.

5.4.3 The peer review committee shall assure all identified issues are tracked, trended, patterns identified, reported to the committee and appropriately addressed until resolution is achieved.

5.5 The Medical Directors of the TROs, TAOs, RD, TOPO and CSD (acting on behalf of the DPPO), acting as Government representatives and as the Contracting Officer's Technical Expert, may perform the following functions:

5.5.1 When the Government identifies a patient safety issue where TRICARE beneficiaries are or could be at risk, the TRO/TAO/TOPO/CSD/RD Medical Directors may request the contractor to take the necessary steps to safeguard the safety of TRICARE beneficiaries.

5.5.2 When the Government identifies clinical quality concerns regarding the care rendered to a TRICARE beneficiary or group of beneficiaries, the TRO/TAO/TOPO/CSD/RD Medical Directors may request the contractor to conduct a clinical quality review and case investigation and report their findings to the Government.

6.0 AHRQ PSIs

The contractor shall utilize the current PSI software, provider level, available from the AHRQ, to evaluate the safety of care delivered in the network. The software is designed for use with administrative data sets and will not require manual chart abstraction. The contractor shall run the appropriate data for all of the PSIs and use the analysis of the results to identify PQIs and patient safety issues for individual providers, groups or facilities. Analysis will also be used to provide focus for specific patient safety interventions and/or study activity that will be implemented at the direction of the contractor. The contractor shall report their findings, interventions and outcomes on 100% of the cases that meet the AHRQ PSI criteria on semi-annual and annual reports to the Government. The details for content and submission are contained in the contract, DD Form 1423, CDRL.

7.0 HOSPITAL COMPARE

The contractor shall utilize the CMS Hospital Compare web site (measures, readmission, mortality and other reported data) to evaluate and analyze institutional performance for each network facility in the respective region and provide a report of the analysis. The results of the analysis are to be used for identification of facility or specific patient safety performance improvement, network credentialing activities and/or study activity that will be implemented at the direction of the contractor and included in the report. The details for content and submission are contained in the contract, DD Form 1423, CDRL.

- END -

Ambulance/Aeromedical Evacuation Services

1.0 GENERAL

All TRICARE requirements regarding ambulance/aeromedical evacuation services shall apply to the TRICARE Overseas Program (TOP) unless specifically **changed**, waived, or superseded by the provisions of this section; **the TRICARE Policy Manual (TPM), Chapter 12**; or the TRICARE contract for health care support services outside the 50 United States and the District of Columbia (hereinafter referred to as the "TOP contract"). See **32 CFR 199.4** and the TPM, **Chapter 8, Section 1.1** for additional instruction.

2.0 CONTRACTOR RESPONSIBILITIES

2.1 The TOP contractor shall arrange for medically necessary ambulance/aeromedical evacuation services for TRICARE Overseas Program (TOP) Prime/TOP Prime Remote enrollees, Active Duty Service Members (ADSMs) who are deployed, in a temporary duty status, or in an authorized leave status in an overseas location, and all Prime enrolled Active Duty Family Members (ADFMs) (regardless of enrollment location) who require ambulance/aeromedical evacuation services while traveling outside of the 50 United States and the District of Columbia (including ADFMs enrolled in TOP Prime, TOP Prime Remote, TRICARE Prime, or TRICARE Prime Remote (**TPR**) for ADFMs) according to the processes identified in the TOP contract.

2.1.1 When arranging for ambulance/aeromedical evacuation for the beneficiaries identified in **paragraph 2.1**, the contractor shall establish medical necessity, identify the most appropriate method of evacuation, schedule the evacuation with the most appropriate resource, authorize the services, arrange for medical records to accompany the patient, and coordinate the transfer with the receiving institution or provider.

2.1.2 For ADSM emergency medical evacuations (including ADSMs who are on temporary duty, in an authorized leave status, or deployed/deployed on liberty), the TOP contractor shall ensure that the ADSM's unit is aware of the medical evacuation. The TRICARE Area Office (TAO) shall be contacted for assistance if the member's unit information cannot be determined by the contractor.

2.1.3 Except for normal TRICARE cost-shares, these beneficiaries shall not be responsible for any up-front payments for emergency ambulance service (to include aeromedical evacuation, when medically necessary and appropriate). The contractor shall establish business processes (e.g., Guarantee of Payment to host nation ambulance provider) to ensure that these beneficiaries are not subjected to up-front payments in excess of normal TRICARE cost-shares.

Note: "Medical necessity" is defined in **32 CFR 199.2**.

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2.2 Upon request, the TOP contractor shall facilitate medically necessary ambulance/aeromedical evacuation services for all TRICARE-eligible beneficiaries not identified in [paragraph 2.1](#) (regardless of enrollment location or residence) according to the processes identified in the TOP contract. When facilitating ambulance/aeromedical evacuation for these beneficiaries, the contractor shall identify ambulance/aeromedical evacuation resources that service the patient's location; however, the contractor is not required to schedule the evacuation, coordinate with the receiving institution or provider, obtain medical records, or establish business processes (e.g., Guarantee of Payment) to limit up-front payments for these beneficiaries.

2.3 Since medical evacuations may involve transfers between TRICARE regions, the TOP contractor shall establish processes for coordinating medical evacuations with the stateside Managed Care Support Contractors (MCSCs). The TOP contractor shall also work cooperatively with the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) contractor to provide customer service support, and to facilitate the medically necessary evacuation of TRICARE dual-eligible beneficiaries back to the United States.

2.4 The TOP contractor shall ensure that ambulance/aeromedical evacuation services can be accomplished in an expeditious manner that is appropriate and responsive to the beneficiary's medical condition. The contractor may establish a dedicated unit for responding to such requests, or may augment existing service units. Contractor staff must be available for ambulance/aeromedical evacuation assistance 24 hours per day, seven days per week, 365 days per year. Ambulance/aeromedical evacuation telephone assistance must be available without toll charges to the beneficiary, regardless of their location.

2.5 The TOP contractor shall maximize the use of military medical transport services before considering other options. If military medical transport services are not available (or if services cannot be provided in a timely manner that is appropriate for the patient's medical condition), the contractor shall attempt to arrange services through the most economical commercial resource that is capable of providing appropriate services within the required time frame. Private, chartered evacuation services will only be used as a last resort when all other options have been exhausted. The contractor shall document their rationale and selection process for any commercial and/or private, chartered evacuation services. If multiple resources are identified that are capable of providing the needed services, the contractor shall select the resource that represents the best value to the government. Upon request, the contractor shall provide Defense Health Agency (DHA) with documentation supporting their rationale and selection process.

2.6 Upon transfer to a facility for stabilization and care, the TOP contractor shall coordinate with the appropriate MTF (for TOP Prime enrollees) or TAO (for TOP Prime Remote enrollees) to advise of the patient's transfer and to provide further assistance as appropriate.

2.7 The TOP contractor shall comply with the provisions of TPM, [Chapter 8, Section 1.1](#), except that the TOP contractor shall utilize the coding requirements identified for ambulance charges but is not required to develop claims for diagnosis or transfer information for ambulance services received overseas. The TOP contractor shall utilize the diagnosis if provided, or may use available in-house methods such as claims history when processing the claim. If a diagnosis is not provided and there are no claim attachments or other claims for the Episode of Care (EOC) from which a diagnosis can be determined, the claim shall be processed using an unlisted diagnosis.

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Appendix A

Acronyms And Abbreviations

CAD	Coronary Artery Disease
CAF	Central Adjudication Facility
CAH	Critical Access Hospital
CAMBHC	Comprehensive Accreditation Manual for Behavioral Health Care
CAP	Competitive Acquisition Program
CAP/DME	Capital and Direct Medical Education
CAPD	Continuous Ambulatory Peritoneal Dialysis
CAPP	Controlled Access Protection Profile
CAQH	Council for Affordable Quality Health
CARC	Claim Adjustment Reason Code
CAS	Carotid Artery Stenosis
CAT	Computerized Axial Tomography
CB	Consolidated Billing
CBC	Cypher Block Chaining
CBE	Clinical Breast Examination
CBHCO	Community-Based Health Care Organizations
CBL	Commercial Bill of Lading
CBP	Competitive Bidding Program
CBSA	Core Based Statistical Area
CC	Common Criteria Convenience Clinic Criminal Control (Act)
CC&D	Catastrophic Cap and Deductible
CCCT	Clomiphene Citrate Challenge Test
CCD	Corporate Credit or Debit
CCDD	Catastrophic Cap and Deductible Data
CCEP	Comprehensive Clinical Evaluation Program
CCN	Case Control Number
CCPD	Continuous Cycling Peritoneal Dialysis
CCR	Cost-To-Charge Ratio
CCSW	Certified Clinical Social Worker
CCTP	Custodial Care Transitional Policy
CD	Compact Disc
CDC	Centers for Disease Control and Prevention
CDCF	Central Deductible and Catastrophic Cap File
CDD	Childhood Disintegrative Disorder
CDH	Congenital Diaphragmatic Hernia
CD-I	Compact Disc - Interactive
CDR	Clinical Data Repository
CDRL	Contract Data Requirements List
CD-ROM	Compact Disc - Read Only Memory
CDT	Current Dental Terminology

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Appendix A

Acronyms And Abbreviations

CEA	Carotid Endarterectomy
CEIS	Corporate Executive Information System
CEO	Chief Executive Officer
CEOB	CHAMPUS Explanation of Benefits
CES	Cranial Electrotherapy Stimulation
CF	Conversion Factor Cystic Fibrosis
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CFRD	Cystic Fibrosis-Related Diabetes
CFS	Chronic Fatigue Syndrome
CGMS	Continuous Glucose Monitoring System
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHAMPVA	Civilian Health and Medical Program of the Department of Veteran Affairs
CHBC	Criminal History Background Check
CHBR	Criminal History Background Review
CHC	Civilian Health Care
CHCBP	Continued Health Care Benefits Program
CHCS	Composite Health Care System
CHEA	Council on Higher Education Accreditation
CHKT	Combined Heart-Kidney Transplant
CHOP	Children's Hospital of Philadelphia
CI	Counterintelligence
CIA	Central Intelligence Agency
CID	Central Institute for the Deaf
CIF	Central Issuing Facility Common Intermediate Format
CIO	Chief Information Officer
CIPA	Classified Information Procedures Act
CJCSM	Chairman of the Joint Chiefs of Staff Manual
CL	Confidentiality Level (Classified, Public, Sensitive)
CLIA	Clinical Laboratory Improvement Amendment
CLIN	Contract Line Item Number
CLKT	Combined Liver-Kidney Transplant
CLL	Chronic Lymphocytic Leukemia
CM	Case Management
CMAC	CHAMPUS Maximum Allowable Charge
CMHC	Community Mental Health Center
CML	Chronic Myelogenous Leukemia
CMN	Certificate(s) of Medical Necessity
CMO	Chief Medical Officer
CMP	Civil Money Penalty

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Appendix A

Acronyms And Abbreviations

CMR	Cardiovascular Magnetic Resonance
CMS	Centers for Medicare and Medicaid Services
CMVP	Cryptographic Module Validation Program
CNM	Certified Nurse Midwife
CNS	Central Nervous System Clinical Nurse Specialist
CO	Contracting Officer
COB	Close of Business Coordination of Benefits
COBC	Coordination of Benefits Contractor
COBRA	Consolidated Omnibus Budget Reconciliation Act
COCO	Contractor Owned-Contractor Operated
COE	Common Operating Environment
CONUS	Continental United States
COO	Chief Operating Officer
COOP	Continuity of Operations Plan
COPA	Council on Postsecondary Accreditation
COPD	Chronic Obstructive Pulmonary Disease
COR	Contracting Officer's Representative
CORE	Committee on Operating Rules for Information Exchange
CORF	Comprehensive Outpatient Rehabilitation Facility
CORPA	Commission on Recognition of Postsecondary Accreditation
COTS	Commercial-off-the-shelf
CP	Cerebral Palsy
CPA	Certified Public Accountant
CPE	Contract Performance Evaluation
CPI	Consumer Price Index
CPI-U	Consumer Price Index - Urban (Wage Earner)
CPNS	Certified Psychiatric Nurse Specialists
CPR	CAC PIN Reset
CPT	Chest Physiotherapy Current Procedural Terminology
CPT-4	Current Procedural Terminology, 4th Edition
CQM	Clinical Quality Management
CQMP	Clinical Quality Management Program
CQMP AR	Clinical Quality Management Program Annual Report
CQS	Clinical Quality Studies
CRM	Contract Resource Management (Directorate)
CRNA	Certified Registered Nurse Anesthetist
CRP	Canalith Repositioning Procedure
CRS	Cytoreductive Surgery
CRSC	Combat-Related Special Compensation
CRT	Computer Remote Terminal

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Appendix A

Acronyms And Abbreviations

CSA	Clinical Support Agreement
CSE	Communications Security Establishment (of the Government of Canada)
CSP	Corporate Service Provider Critical Security Parameter
CST	Central Standard Time
CSU	Channel Sending Unit
CSV	Comma-Separated Value
CSW	Clinical Social Worker
CT	Central Time Computerized Tomography
CTA	Composite Tissue Allotransplantation Computerized Tomography Angiography
CTC	Computed Tomographic Colonography
CTCL	Cutaneous T-Cell Lymphoma
CTEP	Cancer Therapy Evaluation Program
CTLN1	Citrullinemia Type 1
CTX	Corporate Trade Exchange
CUI	Controlled Unclassified Information
CUC	Chronic Ulcerative Colitis
CVAC	CHAMPVA Center
CVS	Contractor Verification System
CY	Calendar Year
DAA	Designated Approving Authority
DAO	Defense Attache Offices
DBA	Doing Business As
DBN	DoD Benefits Number
DC	Direct Care
DCAA	Defense Contract Audit Agency
DCAO	Debt Collection Assistance Officer
DCID	Director of Central Intelligence Directive
DCII	Defense Clearance and Investigation Index
DCIS	Defense Criminal Investigative Service Ductal Carcinoma In Situ
DCN	Document Control Number
DCP	Data Collection Period
DCPE	Disability Compensation and Pension Examination
DCR	Developed Character Reference
DCS	Duplicate Claims System
DCSI	Defense Central Security Index
DCWS	DEERS Claims Web Service
DD (Form)	Department of Defense (Form)
DDAS	DCII Disclosure Accounting System
DDD	Degenerative Disc Disease

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Appendix A

Acronyms And Abbreviations

DDP	Dependent Dental Plan
DDS	DEERS Dependent Suffix
DE	Durable Equipment
DECC	Defense Enterprise Computing Center
DED	Dedicated Emergency Department
DEERS	Defense Enrollment Eligibility Reporting System
DELM	Digital Epiluminescence Microscopy
DENC	Detailed Explanation of Non-Concurrence
DepSecDef	Deputy Secretary of Defense
DES	Data Encryption Standard Disability Evaluation System
DFAS	Defense Finance and Accounting Service
DG	Diagnostic Group
DGH	Denver General Hospital
DHA	Defense Health Agency
DHA-GL	Defense Health Agency-Great Lakes (formerly Military Medical Support Office (MMSO))
DHHS	Department of Health and Human Services
DHP	Defense Health Program
DHS	Department of Homeland Security
DIA	Defense Intelligence Agency
DIACAP	DoD Information Assurance Certification And Accreditation Process
DII	Defense Information Infrastructure
DIS	Defense Investigative Service
DISA	Defense Information System Agency
DISCO	Defense Industrial Security Clearance Office
DISN	Defense Information Systems Network
DISP	Defense Industrial Security Program
DITSCAP	DoD Information Technology Security Certification and Accreditation Process
DLAR	Defense Logistics Agency Regulation
DLE	Dialyzable Leukocyte Extract
DLI	Donor Lymphocyte Infusion
DM	Disease Management
DMDC	Defense Manpower Data Center
DME	Durable Medical Equipment
DMEPOS	Durable medical equipment, prosthetics, orthotics, and supplies
DMI	DMDC Medical Interface
DMIS	Defense Medical Information System
DMIS-ID	Defense Medical Information System Identification (Code)
DMLSS	Defense Medical Logistics Support System
DMR	Direct Member Reimbursement
DMZ	Demilitarized Zone

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DNA	Deoxyribonucleic Acid
DNA-HLA	Deoxyribonucleic Acid - Human Leucocyte Antigen
DNACI	DoD National Agency Check Plus Written Inquiries
DO	Doctor of Osteopathy Operations Directorate
DOB	Date of Birth
DOC	Dynamic Orthotic Cranioplasty (Band)
DoD	Department of Defense
DoD AI	Department of Defense Administrative Instruction
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DoDIG	Department of Defense Inspector General
DoDM	Department of Defense Manual
DoD P&T	Department of Defense Pharmacy and Therapeutics (Committee)
DOE	Department of Energy
DOEBA	Date of Earliest Billing Action
DOES	DEERS Online Enrollment System
DOHA	Defense Office of Hearings and Appeals
DOJ	Department of Justice
DOLBA	Date of Latest Billing Action
DOS	Date Of Service
DP	Designated Provider
DPA	Differential Power Analysis
DPCLO	Defense Privacy and Civil Liberties Office
DPI	Designated Providers Integrator
DPO	DEERS Program Office
DPPO	Designated Provider Program Office
DRA	Deficit Reduction Act
DREZ	Dorsal Root Entry Zone
DRG	Diagnosis Related Group
DRPO	DEERS RAPIDS Program Office
DRS	Decompression Reduction Stabilization
DSA	Data Sharing Agreement
DSAA	Data Sharing Agreement Application Defense Security Assistance Agency
DSC	DMDC Support Center
DSCC	Data and Study Coordinating Center
DS Logon	DoD Self-Service Logon
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSM-III	Diagnostic and Statistical Manual of Mental Disorders, Third Edition
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DSMC	Data and Safety Monitoring Committee

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DSMO	Designated Standards Maintenance Organization
DSMT	Diabetes Self-Management Training
DSO	DMDC Support Office
DSPOC	Dental Service Point of Contact
DSU	Data Sending Unit
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
EFD	Energy Flux Density

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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
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

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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
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 ₁	Forced Expiratory Volume
FFM	Foreign Force Member
FHL	Familial Hemophagocytic Lymphohistiocytosis
FI	Fiscal Intermediary
FIPS	Federal Information Processing Standards (or System)
FIPS PUB	FIPS Publication
FISH	Fluorescence In Situ Hybridization
FISMA	Federal Information Security Management Act
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

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FRC	Federal Records Center
FSH	Follicle Stimulating Hormone
FSO	Facility Security Officer
FTC	Federal Trade Commission
FTE	Full Time Equivalent
FTP	File Transfer Protocol
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

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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
HE ESWT	High Energy Extracorporeal Shock Wave Therapy
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
HIT	Health Information Technology
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

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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
HUS	Hemolytic Uremic Syndrome
HVPT	Hyperventilation Provocation Test
I&OD	Infrastructure & Operations Division
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

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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
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

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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
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 ⁷
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
LE ESWT	Low Energy Extracorporeal Shock Wave Therapy
LGS	Lennox-Gastaut Syndrome
LH	Luteinizing Hormone
LIS	Low Income Subsidy
LLLT	Low Level Laser Therapy
LNT	Lexical Neighborhood Test
LOC	Letter of Consent

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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
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

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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
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
MM	Medical Management
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

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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
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
NACL	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

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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
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)

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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
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
OLT	Orthotopic Liver Transplantation
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

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PACAB	Port Access Coronary Artery Bypass
PACO ₂	Partial Pressure of Carbon Dioxide
PAO ₂	Partial Pressure of Oxygen
PAK	Pancreas After Kidney (transplant)
PAP	Papanicolaou
PAS	Privacy Act Statement
PAT	Performance Assessment Tracking
PATH Intl	Professional Association of Therapeutic Horsemanship International
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

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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
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

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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
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

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PTK	Phototherapeutic Keratectomy
PTNS	Posterior Tibial Nerve Stimulation
PTSD	Post-Traumatic Stress Disorder
PVCs	Premature Ventricular Contractions
QA	Quality Assurance
QABA	Qualified Applied Behavior Analysis
QASP	Qualified Autism Services Practitioner
QC	Quality Control
QI	Quality Improvement Quality Issue
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
RHA	Records Holding Area
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary

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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
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

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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
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
SME	Subject Matter Expert
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
SP	Special Publication
SPA	Simple Power Analysis
SPC	Special Processing Code
SPECT	Single Photon Emission Computed Tomography
SPK	Simultaneous Pancreas Kidney (transplant)
SPR	SECRET Periodic Reinvestigation

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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
STF	Specialized Treatment Facility
STS	Specialized Treatment Services
STSF	Specialized Treatment Service Facility
SUBID	Sub-Identifier
SUD	Substance Use Disorder
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

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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
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

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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
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

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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
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)
USCYBERCOM	United States Cyber Command
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

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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
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
WDR	Written Determination Report
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

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