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**CHANGE TITLE:** BREACH RESPONSE CHANGES

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

**SUMMARY OF CHANGE(S):** This change updates the TRICARE Operations Manual to reflect new guidance from the Department of Homeland Security and Defense Privacy and Civil Liberties Division.

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

**CHANGE 180  
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**REMOVE PAGE(S)**

**CHAPTER 1**

Section 5, pages 3 through 14

**APPENDIX B**

pages 7 through 61

**INSERT PAGE(S)**

Section 5, pages 3 through 16

pages 7 through 62

**1.5** See [paragraph 2.1](#), for definitions of the following terms: breach, possible breach, confirmed breach, HIPAA breach, cybersecurity incident.

## **2.0 PRIVACY ACT AND RELATED REQUIREMENTS**

Under the Privacy Act, contractors must assure that PII about beneficiaries collected in TRICARE records is limited to that which is legally authorized and necessary, and is maintained in a manner which assures its confidentiality. **When confidentiality is not assured, a privacy breach may have occurred, which triggers requirements under the Privacy Act. When the PII is in electronic form, additional requirements under the Federal Information Security Modernization Act of 2014 (FISMA) apply. When the PII includes PHI, requirements under the HIPAA Privacy, Breach, and Security Rules apply. The procedures in [paragraphs 2.1](#) and [2.2](#) take into account Privacy Act, FISMA, and HIPAA requirements. With respect to electronic PII and security compliance, the contractor must follow applicable FISMA and DoD cybersecurity requirements, including information security compliance under the National Institute of Standards and Technology (NIST) program as stated in the TRICARE Systems Manual (TSM), [Chapter 1, Section 1.1](#). These requirements are concerned with not only confidentiality but also integrity and availability of PII.**

### **2.1 Breach Response - Definition and General Requirements**

**2.1.1** A breach, as defined in DoDD 5400.11 (2014), is a loss of control, **compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, or any similar term referring to situations where persons other than authorized users and for an other than authorized purpose have access or potential access to PII/PHI, whether in paper or electronic form. Breaches are classified as either possible or confirmed (see the following two definitions) and as either cyber or non-cyber (i.e., involving either electronic PII/PHI or paper/oral PII/PHI).**

**2.1.2** A “possible breach” is an incident where the possibility of unauthorized access is suspected (or should be suspected) and has not been ruled out. For example, if a laptop containing PII/PHI is lost, and the contractor does not initially know whether or not the PII/PHI was encrypted, then the incident must initially be classified as a possible breach, because it is impossible to rule out the possibility of unauthorized access to the PII/PHI. In contrast, that possibility can be ruled out immediately, and a possible breach has not occurred, when misdirected postal mail is returned unopened in its original packaging. However, if the intended recipient informs the contractor that an expected package has not been received, then a possible breach exists until and unless the unopened package is returned to the contractor. In determining whether unauthorized access should be suspected, the contractor shall consider at least the following factors:

- How the event was discovered;
- Did the information stay within the covered entity's control;
- Was the information actually accessed/viewed; and
- Ability to ensure containment (e.g., recovered, destroyed, or deleted).

**2.1.3** A confirmed breach is an incident in which it is known that unauthorized access could occur. For example, if a laptop containing PII/PHI is lost and the contractor knows that the PII/PHI is unencrypted, then the contractor should classify and report the incident as a confirmed breach, because unauthorized access could occur due to the lack of encryption (the contractor knows this even without knowing whether or not unauthorized access to the PII/PHI has actually occurred). If the laptop is subsequently recovered and forensic investigation reveals that files containing PII/PHI

were never accessed, then the possibility of unauthorized access can be ruled out, and the contractor should re-classify the incident as a non-breach incident.

**2.1.4** A HIPAA Breach is an incident that satisfies the definition of a breach in 45 CFR 164.402 (HIPAA Breach Rule).

**2.1.5** A cybersecurity incident is a violation or imminent threat of violation of computer security policies, acceptable use policies, or standard security practices, with respect to electronic PII/PHI. A cybersecurity incident may or may not involve a breach of PII/PHI. For example, a malware infection would be a possible breach if it could cause unauthorized access to PII/PHI. However, if the malware only affects data integrity or availability (not confidentiality), then a non-breach cybersecurity incident has occurred.

**2.1.6** The contractor shall follow the procedures below upon discovery of a possible breach or cybersecurity incident. These procedures focus on the first two steps (breach identification and reporting) of a comprehensive breach response program, but also require addressing the remaining steps: containment, mitigation (which includes individual notification), eradication, recovery, and follow-up. The contractor shall establish internal processes for carrying out the procedures set forth below. These processes shall assign responsibility for investigating, classifying, reporting and otherwise responding to breaches and cybersecurity incidents. The contractor should consult with the DHA Privacy Office where guidance is needed, such as when the contractor is uncertain whether a discovered breach is the contractor's responsibility (e.g., if the contractor discovers a breach not caused by the contractor), or how the contractor is to classify an incident (breach vs. non-breach, confirmed vs. possible). Under no circumstances will a contractor delay reporting a confirmed or possible breach to the DHA Privacy Office beyond the 24-hour deadline (see [paragraph 2.2.5](#)) while waiting for the DHA Privacy Office guidance or while investigating the incident.

**2.1.7** In the event of a cybersecurity incident not involving a PII/PHI breach, the contractor shall follow applicable DoD cybersecurity and NIST requirements. If at any point a contractor finds that a cybersecurity incident involves a confirmed or possible PII/PHI breach, the contractor shall immediately initiate the reporting procedures set forth below. The contractor shall also continue to follow any required cybersecurity incident response procedures and other applicable DoD cybersecurity requirements.

**2.1.8** Contractors shall require subcontractors who discover a possible breach or cybersecurity incident to initiate the incident response requirements herein by reporting the incident to the contractor immediately after discovery. The time of that report to the contractor shall trigger the contractor's DHA Privacy Office reporting deadline (24 hours) under [paragraph 2.2.5](#). If a cybersecurity incident is involved, the contractor's deadline for US-CERT reporting (one hour) runs from the time the incident is confirmed, under [paragraph 2.2.1](#). The contractor shall require the subcontractor to cooperate as necessary to meet these deadlines, maintain records, and otherwise enable the contractor to complete the breach response requirements herein. Alternatively, the contractor and subcontractor may agree that the subcontractor shall report directly to US-CERT and the DHA Privacy Office, and that the subcontractor shall be responsible for completing the response process, provided that such agreement requires the subcontractor to inform the contractor of the incident and the subsequent response actions.

**2.1.9** Contractors shall maintain records of all breach and cybersecurity incident investigations, regardless of the outcome. Investigations identifying unauthorized disclosures must be logged for HIPAA and Privacy Act disclosure accounting purposes, whether or not individual notification is required under the HIPAA Breach Rule.

**2.1.10** Contractors, when acting as HIPAA-covered entities (rather than as business associates), are not subject to the breach response requirements of this Manual. However, such contractors are subject to both the HIPAA Breach Rule (applicable to them in their capacity as covered entities) and DoD cybersecurity requirements (applicable to them in their capacity as DoD contractors).

## **2.2 Breach Response - Specific Reporting and Individual Notification Requirements**

**2.2.1** Immediately upon discovery of a possible or confirmed breach or cybersecurity incident, the contractor shall initiate an investigation. If the incident involves electronic PII/PHI, and if the investigation finds a confirmed breach or cybersecurity incident, the contractor shall report it within one hour of confirmation, to the United States-Computer Emergency Readiness Team (US-CERT) Incident Reporting System at <https://forms.us-cert.gov/report/>, as required by the Department of Homeland Security (DHS).

**Note:** DHS no longer requires US-CERT reporting of non-cyber breaches or unconfirmed electronic breaches. However, DHS permits US-CERT reporting of unconfirmed cyber-related incidents on a voluntary basis. Thus, if a contractor is uncertain whether a possible cyber-related incident should be treated as confirmed and thus reportable, the contractor may voluntarily report the incident.

**2.2.2** Before submission to US-CERT, the contractor shall save a copy of the on-line report. After submitting the report, the contractor shall record the US-CERT incident reporting number, which shall be included in the initial report to the DHA Privacy Office as described in paragraphs 2.2.5 through 2.2.7.

**Note:** Regardless of whether or not an incident is confirmed, the contractor must also investigate whether or not the incident impacts data integrity or availability of PII/PHI. If such impact is confirmed, then the incident is reportable to US-CERT. For guidance on investigating the impact on data integrity and availability, refer to DoD cybersecurity and NIST guidance.

**2.2.3** The contractor shall provide any updates to the initial US-CERT report by e-mail to [soc@us-cert.gov](mailto:soc@us-cert.gov), with the Reporting Number in the subject line. The contractor shall provide a copy of the initial or updated US-CERT report to the DHA Privacy Office if requested. Contractor questions about US-CERT reporting shall be directed to the DHA Privacy Office, not the US-CERT office.

**2.2.4** In conjunction with its initial investigation, the contractor shall immediately take steps to minimize any impact from the occurrence and proceed with further investigation of any relevant details such as root causes, vulnerabilities exploited, or actions needed (such as containment, mitigation, eradication, recovery and follow-up).

**2.2.5** In addition to US-CERT reporting, the contractor shall report to the DHA Privacy Office by submitting the form specified below within 24 hours of discovery of a breach (possible or confirmed), unless the breach falls within a category that the Privacy Office has determined to be

not reportable. This 24 hour period runs from the time of discovery, unlike the one hour US-CERT reporting period, which runs from the time a cybersecurity incident is confirmed. Thus, depending on the time period needed to confirm, the report to the DHA Privacy Office may be due either before or after the US-CERT report.

**2.2.6** The breach report form required within the 24 hour deadline shall be sent by e-mail to: [dha.ncr.pcl.mbx.dha-privacy-officer@mail.mil](mailto:dha.ncr.pcl.mbx.dha-privacy-officer@mail.mil). Encryption is not required, because reports and notices shall not contain PII/PHI. If electronic mail is not available, telephone notification is also acceptable, but all notifications and reports delivered telephonically must be confirmed in writing as soon as technically feasible.

**2.2.7** Contractors shall prepare the breach reports required within the 24 hour deadline by completing the Breach Reporting DD Form 2959 (Breach of PII Report), available at the Breach Response link on the DHA Privacy Office web site, <http://www.health.mil/Military-Health-Topics/Privacy-and-Civil-Liberties/Breaches-of-PII-and-PHI>. For non-cyber incidents without a US-CERT number, the contractor shall assign an internal tracking number and include that number in Box 1.e of the DD Form 2959. The contractor shall coordinate with the Privacy Office for subsequent action such as beneficiary notification, and mitigation. The corresponding Contract Data Requirements List (CDRL) provides guidance on completing and updating the Breach Reporting Form DD 2959. The contractor must promptly update the DD Form 2959 as new information becomes available.

**2.2.8** If the DHA Privacy Office determines that beneficiary notification is required, the contractor shall provide written notification to beneficiaries affected by the breach as soon as possible, but no later than 10 working days after the breach is discovered and the identities of the beneficiaries are ascertained. The 10 day period begins when the contractor is able to determine the identities (including addresses) of the beneficiaries whose records were impacted.

**2.2.9** The contractor's proposed notification to be issued to the affected beneficiaries shall be submitted to the DHA Privacy Office for approval. The notification to the beneficiaries, at a minimum, shall include the following:

- Specific data elements
- Basic facts and circumstances
- Recommended precautions the beneficiary can take
- Federal Trade Commission (FTC) identity theft hotline information
- Any mitigation support services offered such as credit monitoring

**2.2.10** Contractors shall ensure that envelopes containing written notifications to affected beneficiaries are clearly labeled to alert the recipient to the importance of its contents, e.g., "Data Breach Information Enclosed," and that the envelope is marked with the identity of the contractor and/or subcontractor organization that suffered the breach.

**2.2.11** If notification cannot be accomplished within 10 working days, the contractor shall notify the DHA Privacy Office to determine needed follow-up actions.

**2.2.12** If media notice is required, the contractor will submit a proposed notice and suggested media outlets for the DHA Privacy Office review (which will include coordination with the DHA Communications Division) and approval.

**2.2.13** The contractor shall, at no cost to the government, bear any costs associated with a breach of PII/PHI that the contractor has caused or is otherwise responsible for addressing.

### **2.3 System of Records (SOR) Maintained or Operated by Contractors**

**2.3.1** Contractor activity is typically associated with the SOR described in System of Records Notice (SORN) EDTMA 04 - Medical/Dental Claim History Files (note that physical location of records in this SOR may be decentralized). However, some contractor records may instead be associated with the following SORs:

- EDTMA 01 - Health Benefits Authorization Files;
- EDTMA 02 - Medical/Dental Care and Claims Inquiry Files;
- EDHA 06 - Designated Provider Managed Care System Records, formerly known as UTF Managed Care System;
- EDHA 07 - Military Health Information System; and
- EDHA 08 - Health Affairs Survey and Study Data Base.

Except for "routine use" disclosures and other authorized disclosures as provided in DoD 5400.11-R, C4.1.1.3 and C4.2, no record contained in a SOR operated and maintained by the contractor for the Government shall be disclosed to any person or to any agency outside DoD without prior written consent or request of the beneficiary to whom the record pertains.

**2.3.2** The Privacy Act permits use of PII throughout the Military Health System (MHS) for legitimate mission purposes, including when TRICARE contractors have a need for the records in performance of their duties. TRICARE contractors should be aware that TRICARE Beneficiary Counseling and Assistance Coordinators (BCACs), Debt Collection Assistance Officers (DCAOs), Health Benefit Advisors (HBAs), and Uniformed Services Claims Officers (USCOs) are employees of the DoD authorized to receive information from TRICARE records if they have a need for the information in the performance of their duties. A TRICARE BCAC, DCAO, HBA, USCO, or other authorized DHA/MHS representative who is assisting a beneficiary may receive TRICARE information pertaining to that beneficiary, provided that identity and authority of such representative is verified (e.g., through the Customer Service Community Directory). The restriction on disclosure of only that information directly releasable to the beneficiary also applies to the BCAC, DCAO, HBA, USCO, or other representative.

**2.3.3** Following proper SORN publication and Government confirmation of contractor authority to operate the applicable system(s), the contractor shall coordinate through the DHA Privacy Office, regarding any needed updates. The contractor shall promptly advise the DHA Privacy Office of changes in SORs or their use that may require a change in the applicable SORN, whether EDTMA 04 or otherwise.

### **2.4 Confidentiality Of Medical/Dental Claim History Files**

Certain categories of PII/PHI (such as SSN or Date of Birth (DOB) data, or PHI relating to mental health, sexually transmitted disease, etc.) are sensitive. Except as otherwise permitted in this

paragraph or as permitted by law, the contractor shall not release such sensitive PII/PHI to a third party unless the beneficiary who is the subject of the PII/PHI has specifically consented to disclosure of such sensitive information in accordance with applicable consent/authorization requirements (under Privacy Act, HIPAA, or Substance Abuse and Mental Health Services Administration (SAMHSA) rules). However, if the contractor is uncertain whether disclosure without consent is warranted (for example, on the basis of a HIPAA Privacy Rule exception), the contractor shall consult with DHA Privacy Office or DHA Office of General Counsel (OGC). In determining what PHI is sensitive, the contractor may take into account the Explanation of Benefits (EOB) issuance exceptions in [Chapter 8, Section 8](#), the contractor's own internal guidelines, and/or the contractor's case-by-case determinations.

## 2.5 Collecting Information

**2.5.1** The Privacy Act requires personal information to be collected, to the greatest extent practicable, directly from the subject beneficiary when the information may result in adverse determinations about the beneficiary's rights, benefits, or privileges under federal programs. The collection of information from third parties shall be minimized except where there is a need to obtain the information directly from a third party, such as a need to verify information provided by the subject beneficiary.

**2.5.2** Whenever PII is solicited and collected (by paper, electronic, or verbal means) from a beneficiary for a SOR, a **Privacy Act Statement (PAS)** shall be provided. The PAS informs the beneficiary of the authority for soliciting and collecting PII, the principal purposes for which that PII will be used, where that PII may be disclosed outside of DoD, whether furnishing that information is voluntary or mandatory, and the effects on the beneficiary of choosing not to provide all or part of that requested PII. The PAS must be conspicuously posted before the point of collection. On paper forms this usually means placing the PAS at the beginning of the form, immediately following the title, before the first official heading/selection, or immediately prior to the first collection field. On electronic forms, this means placing the PAS so that the beneficiary sees it before providing information. A PAS may not be displayed via a hyper-link or pop-up that the beneficiary could bypass. When information is collected by telephone, a brief oral explanation of the Privacy Act shall be given to the beneficiary. The following text illustrates acceptable language for an oral PAS, showing the mandatory portion of the PAS with example language in **bold** (this is only illustrative; modify as needed):

This information is being collected to: **Process your request to change your provider.**

Providing this information is: **Voluntary. However, failure to provide all requested information may result in a delay or denial of your request to change your provider.**

This information may be disclosed for routine uses consistent with why it was collected.

This information is being collected under the authority of: **10 U.S.C. Chapter 55; 32 CFR Part 199; and E.O. 9397 (SSN), as amended.**

**To hear this again please tell me / press 1 [If answer is "yes," repeat script.]**

**If you do not want it repeated, please tell me / press 2 [If answer is "yes," continue with script.]**

**If you would like to hear a full list of routine uses which may be made of your information, and the complete legal authorities for collecting this information, please tell me / press 9 now.**

**Note:** The last few lines may change depending on whether the PAS is being provided by a human or automated system and on how that system would operate. The point is to actively ask whether the beneficiary (1) would like the PAS to be repeated and (2) would like to hear the routine uses and authority titles.

**2.5.3** Claims received by the contractor which do not indicate that the claimant received a PAS shall, nevertheless, be processed for payment. However, if additional information concerning a claim is required, the request to the beneficiary must include the appropriate PAS language.

## **2.6 Access To Contractor Records Under The Privacy Act**

**2.6.1** The contractor must develop and describe procedures by which a beneficiary is permitted access to records pertaining to him or her under the Privacy Act. If the request is under HIPAA, refer to [Chapter 19, Section 3](#). (If the request specifies neither HIPAA nor the Privacy Act, the contractor shall apply its judgment as to whether the Privacy Act or HIPAA is more applicable.) Upon request, a beneficiary must be informed whether or not the Medical/Dental Claim History Files contain a record pertaining to him or her. And, if the beneficiary so desires, he or she shall be permitted to review such record and to be accompanied for the purpose of reviewing the record by a person of his or her choice. Further, a beneficiary is permitted to obtain a copy of such record in a form which is comprehensible to him or her.

**2.6.2** The contractor shall not require the beneficiary to provide a reason or justification before granting beneficiary access to a record containing his/her PII. However, the requester shall be required to provide such information as is necessary to determine where and how to look for the records. The beneficiary shall also be required to provide reasonable identity verification, in accordance with 45 CFR 164.514(h), before access is granted. Since most records in the Medical/Dental Claim History Files relate to medical information, a beneficiary may be required to submit a written request for access to the file. This allows the contractor time to review the medical information in accordance with the following procedures to determine if direct access by the beneficiary to the medical information would have an adverse effect on the beneficiary.

**2.6.3** Neither the Privacy Act nor the HIPAA Privacy Rule distinguish between custodial and non-custodial parents in cases involving separation or divorce. A minor's PII/PHI may be released to either parent, unless the contractor is informed of divorce or legal separation or a court order or other documentation potentially affecting parental authority with respect to the minor's health care. In that situation, the contractor shall review the documentation to verify which parent has authority with respect to the minor's health care and whether disclosure of the minor's PHI to either parent is restricted.

**2.6.4** Disclosure shall be made only to the minor if the minor consents to care and parental consent is not required under law, or the minor and parent have agreed that the minor may have a confidential relationship with the provider of the care about which disclosure is requested. If the

minor obtains care at the direction of a court or guardian or other court appointee, then disclosures shall be made to the court or appointee. In addition, a minor's PII/PHI need not be disclosed to a parent if the contractor reasonably believes, in the exercise of professional judgment, that disclosure would not be in the minor's best interest, for example, due to risk of abuse or neglect by the parent or other risk of endangerment to the minor, or where the minor has signed a claim related to sensitive matters such as abortion, substance abuse or sexually transmitted disease. If the records relate to alcohol or drug abuse treatment, then see the SAMHSA Regulations provisions below. Questions regarding custodial parent issues shall be addressed to the DHA OGC.

**2.6.5** Requests for information or records must be acknowledged (if not responded to) within 10 working days from the date of receipt. A beneficiary's request for access to records pertaining to him or her shall receive concurrent consideration both under the Privacy Act and the Freedom of Information Act (FOIA), if appropriate. The contractor may consult the DHA FOIA Service Center if needed. The requested information must be furnished within 20 working days unless good cause exists to delay furnishing the record, in which case the beneficiary shall, within the 20 working days, be informed in writing of the reason for delay and when it is anticipated that the information will be furnished. If the contractor does not agree to access as requested, the contractor shall forward the request to DHA, ATTENTION OGC, within 10 working days of receipt of the request.

## **2.7 Corrections To Records**

**2.7.1** Beneficiaries' requests for corrections of records should be in writing and contain, at a minimum, sufficient identifying information to enable location of the record, a description of the items to be amended and the reason amendment is being requested. Requests for amendments must be acknowledged within 10 working days from the date of receipt, as provided in DoD 5400.11-R, C3.1.10 and C3.3.7.1. If it is determined that the patient's request is under HIPAA, refer to [Chapter 19, Section 3](#).

**2.7.2** TRICARE contractors shall implement procedures for reviewing records at the request of individuals concerned and develop and implement procedures for making corrections, if appropriate. Whenever practicable, contractors shall complete the review and advise the beneficiary of the decision to amend the record within 10 working days of receipt of the request. Otherwise, a written acknowledgment of receipt of a request for amendment must be provided within 10 working days after receipt, with notification of a decision to amend the record furnished within 30 working days of receipt of the request. The final amendment and notification must in any event be accomplished within 30 days after the request.

**2.7.3** If a contractor agrees with allowing any portion of the beneficiary's request to amend a record, it shall amend the record accordingly. The contractor must make reasonable efforts to inform previous recipients of the uncorrected record identified by the beneficiary or by a disclosure accounting as required below. Informing previous recipients must include providing them the amended text.

**2.7.4** If the TRICARE contractor does not agree to amend the record as requested, the beneficiary shall not be advised of the decision. Rather the beneficiary's request for amending the record, together with a copy of the record and the contractor's written explanation of the reason(s) for not amending the record, shall be sent to DHA, ATTENTION: OGC, within 10 working days of receipt of the request. Written acknowledgment of receipt of the request for amendment shall be provided to the beneficiary.

## 2.8 Accounting For Disclosures

**2.8.1** The Privacy Act requires an accurate accounting for disclosures of PII to third parties outside the DoD that are not disclosures under the FOIA or disclosures to DoD personnel for use in official duties. Such accounting requires tracking:

- The name and address of the person and, if appropriate, the agency to whom the disclosure is made.
- The date, nature, and purpose of each disclosure.
- For disclosures requiring consent, the consent of the beneficiary to whom the record pertains.

**2.8.2** The contractor must keep a record of each disclosure or be able to reconstruct from its system the required accounting information when needed. Accounting records must be retained for at least five years after the last disclosure, to assure compliance with HIPAA as well as the Privacy Act. If the PII to which the accounting request applies includes PHI, then the contractor must apply the disclosure accounting requirements of the HIPAA Privacy Rule and DoD 6025.18-R, C13 in such a manner that both the Privacy Act and the HIPAA Privacy Rule are satisfied. See the provisions on HIPAA accounting in [Chapter 19, Section 3](#) and TSM, [Chapter 1, Section 1.1](#).

## 2.9 Safeguards

Contractors must implement administrative and physical safeguards to protect Medical/Dental Claim History Files from unauthorized or unintentional access, disclosure, modification, or destruction. All persons whose official duties require access to or processing and maintenance of personal information shall be advised of the proper safeguarding and use of such information. In addition, all employees should be aware of their responsibilities under the Privacy Act.

## 2.10 General Correspondence

In responding to general correspondence, the reply should be sent to the beneficiary regardless of who made the inquiry. If a spouse or other family member makes an inquiry concerning a beneficiary's claim, etc., the inquiry shall not be returned to the spouse or family member unanswered. Rather, a reply should be addressed to the beneficiary with an explanation that under the Privacy Act the reply could not be made to the spouse or family member who made the inquiry. Also, if an inquiry is made by the beneficiary, including an eligible family member regardless of age, the reply shall be addressed to the beneficiary, not the beneficiary's spouse (service member) or parent. The only exceptions are when a parent writes on behalf of a minor child (under 18 years of age) or when a guardian writes on behalf of a physically or mentally incompetent beneficiary. However, in responding to a parent of a minor or guardian of an incompetent, the procedures outlined under Access to Contractor Records ([paragraph 2.6](#)) shall be followed in responding to a request by parent of a minor or guardian of an incompetent for disclosure of sensitive information (e.g., abortion, alcohol and substance abuse, venereal disease, etc.) or information which, if released, would have an adverse effect on the beneficiary. When a reply is made to the beneficiary, the reply should be fully responsive to the inquiry whether or not the query was originally made by the beneficiary. Copies of the response shall NOT be sent to any family member, spouse or other person who may have made the inquiry.

## 2.11 Release Of Information To Members Of Congress

**2.11.1** In accordance with the DoD policy of making maximum information concerning its operations and activities available to both Government officials and to the public in general, DHA and TRICARE contractors will answer constituent's letters to members of Congress as fully as possible.

**2.11.2** Information requested by members of the Congress for the constituents shall be handled in the same manner as if the beneficiary had written directly to DHA or the TRICARE contractor. If it develops that the information cannot be released, the Member of the Congress requesting the information shall be advised promptly of that fact and of the reasons for the determination.

**2.11.3** An established routine use of the Medical/Dental Claim History Files is providing information from a beneficiary's records to a Congressional office in response to the beneficiary's request to the Congressional office. However, special rules apply in certain situations, as summarized below. Consult the [DHA Privacy Office](#) if necessary.

**2.11.3.1** If the PII to be disclosed includes PHI, the HIPAA Privacy Rule applies, which requires that the beneficiary authorize disclosure by signing a HIPAA-compliant authorization form such as DD Form 2870. Pending receipt of a signed authorization form, any response disclosing PHI shall be issued directly to the beneficiary and not to the Congressional office (which shall be notified that the response has been sent to the beneficiary). Refer to [Chapter 19, Section 3](#).

**2.11.3.2** In those cases in which PHI is not requested and the Congressional inquiry indicates that the request is being made on behalf of a person other than the beneficiary whose record is to be disclosed (e.g., a spouse or family member), the contractor shall advise the Congressional office that written consent of the beneficiary is required, unless the person has legal authority to act for the beneficiary (e.g., authority as a parent of a minor or as a guardian). Absent written consent, the response shall generally be sent directly to the beneficiary (the Congressional office must be notified of this action).

**2.11.3.3** A record of a beneficiary which would not be releasable directly to the beneficiary (e.g., a medical record which would have an adverse effect on the beneficiary) cannot be released directly to the Congressional office making the inquiry on behalf of the beneficiary. Instead, the Congressional office shall be advised of the procedure for release of such record. Of course, in those cases where a contractor can respond to a Congressional request for assistance on behalf of a beneficiary, without disclosing PII/PHI which would fall under the Privacy Act, the contractor shall comply.

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

## 2.12 Appeals

Guidance for handling general correspondence also applies to appeal cases, except that a designated "representative" (as defined in [32 CFR 199.10\(a\)\(2\)\(ii\)](#)), may be communicated with on the same basis as the beneficiary. However, unless the representative is the parent of a minor or the

legally appointed representative of an incompetent beneficiary, a written statement from the beneficiary appointing the representative is required. (See [Chapter 12, Section 2](#), for requirements.)

### **3.0 FREEDOM OF INFORMATION ACT (FOIA)**

#### **3.1 Policy of DoD**

The FOIA was enacted to reach a workable balance between the right of the public to know and the need of the Government to keep appropriate information confidential. The policy of the DoD is to make available to the public the maximum amount of information concerning its operations and activities, while withholding information as required by the nine FOIA exemptions.

#### **3.2 Responding to Requests For Release Of Information**

All requests for information under FOIA shall be immediately forwarded to the CO for appropriate action. Thereafter, the contractor shall provide records responsive to the request no later than 10 working days after receiving the request, and shall cooperate with the CO (and the FOIA Service Center if it deals with the requestor directly) as the request is processed. Wherever feasible, the contractor shall provide such records electronically. FOIA responses, including interim replies, by contractors to such requestors are not authorized. If requestor specifically seeks information under HIPAA, see [Chapter 19, Section 3](#).

### **4.0 FEDERAL REGULATIONS ON THE CONFIDENTIALITY OF ALCOHOL AND DRUG ABUSE PATIENT RECORDS**

The HHS SAMHSA has issued special rules on substance abuse information. For information regarding identity, diagnosis, prognosis or treatment of any beneficiary in connection with a substance abuse or alcoholism program, consent must generally be obtained before information can be released. See SAMHSA Regulations at 42 CFR Part 2, including the model consent form. Disclosure without beneficiary consent, however, may be made in certain circumstances (such as emergencies and approved research or other health care operational activities) described in 42 CFR Part 2 Subpart D. Before releasing health information based on a SAMHSA consent, HIPAA authorization requirements, where needed, must also be satisfied.

- The consent requirement and other SAMHSA rules apply in any civil, criminal, administrative or legislative proceeding. For information from SAMHSA regarding treatment programs, contact:

Telephone: (877) 726-4727

<http://www.healthfinder.gov/FindServices/>

- The contractor shall establish and maintain procedures and controls to assure compliance with SAMHSA requirements, including the following provisions.

#### **4.1 Consent for Minor, Incompetent or Deceased Beneficiaries**

**4.1.1** The SAMHSA rule applicable to minors, 42 CFR 2.14, relies on State laws to define minors and requirements for informed consent by minors and parents. If no age of majority is specified in the applicable State law, the age of 18 years shall be considered the age of majority. A beneficiary

who has been legally declared an emancipated minor shall be considered as an adult. A beneficiary who is under 18 years of age and is or was a spouse of an Active Duty Service Member (ADSM) or retiree shall also be considered an emancipated minor. In cases involving unemancipated minor beneficiaries and separated or divorced parents, it may be necessary to review any applicable court order, applicable state law and 42 CFR 2.14 to determine the privacy rights of a minor receiving alcohol and substance abuse prevention and treatment services.

**4.1.2** For beneficiaries, other than minors, judged to be incompetent, the consent to collection of information may be given by the guardian or other person authorized under state law to act on the patient's behalf.

**4.1.3** When consent is required for collection or disclosure of records of a deceased beneficiary, consent may be obtained from an executor, administrator, or other personal representative of the deceased beneficiary's estate. If such a representative has not been appointed, the spouse, or if none, other family member involved with the deceased beneficiary's care or payment for care may give consent.

## **4.2 Disclosure to Beneficiary or Family Members or Others**

Disclosure of alcohol and substance abuse information to the beneficiary shall be determined in accordance with the procedures set forth in "Access to Contractor Records Under the Privacy Act" ([paragraph 2.6](#)). When consent is given, disclosure may be made to family members or any person with whom the beneficiary has a close personal relationship and who is involved in the beneficiary's care unless, in the judgment of the person responsible for the beneficiary's treatment, the disclosure would be harmful to the beneficiary.

## **4.3 Prohibition On Redisclosure**

Whenever a written disclosure is made, with proper written consent, the disclosure shall be accompanied by a written statement as follows:

**Note:** "Prohibition on redisclosure: This information has been disclosed to you from records protected by Federal Law. Federal Regulations (42 CFR Part 2) prohibit you from making any further disclosure of this information except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information, if held by another party, is not sufficient for this purpose. Federal regulations state that any person who violates any provision of this law shall be fined not more than \$500 in the case of a first offense and not more than \$5,000 in the case of each subsequent offense." This statement shall either appear on correspondence transmitting the documents or be stamped on the first page of the documents disclosed.

## **4.4 Other Disclosures**

Requests for disclosures in situations not specified above shall be made only with the written approval of OGC or the DHA Privacy Office.

## **5.0 CYBERSECURITY**

Contractors are responsible for [satisfying DoD's National Institute of Standards and Technology \(NIST\)-based cybersecurity requirements as described in the TSM, Chapter 1, Section 1.1, paragraph 3.4.](#)

## **6.0 HIPAA**

See [Chapter 19, Section 3](#), and the TSM, [Chapter 1, Section 1.1, paragraph 4.0](#).

## **7.0 FEDERAL NON-DISCRIMINATION LAWS**

**7.1** Title VI of the Civil Rights Act of 1964 provides that no person shall, on the grounds of race, color or national origin, be excluded from participation under any program or activity receiving federal financial assistance. In addition, Section 1557 of the Patient Protection and Affordable Care Act (ACA) prohibits discrimination on the ground of race, color, national origin, sex, age, or disability under any health program or activity administered by an Executive agency. These federal laws apply to TRICARE and DHA, including the managed care support and ancillary services provided under TRICARE/DHA contracts. Hospitals, Skilled Nursing Facilities (SNFs), Residential Treatment Centers (RTCs), and special treatment facilities determined to be authorized providers under TRICARE are subject to the provisions of Title VI and Section 1557.

**7.2** Investigating complaints of noncompliance is a function of the DHA. Any discrimination complaints involving Title VI or ACA Section 1557 that are received by contractors shall be sent to DHA OGC, 16401 East Centretch Parkway, Aurora, Colorado 80011-9066.

**7.3** Contractors must comply with Section 504 of the Rehabilitation Act of 1973 as amended regarding qualified handicapped individuals. Any discrimination complaints involving Section 504 that are received by contractors shall be forwarded to DHA OGC within two working days of receipt.

## **8.0 WORKFORCE TRAINING**

**8.1** Workforce training is required in accordance with federally mandated statutory requirements for the following programs:

- Privacy Act (including DoD breach response)
- HIPAA Privacy, Security, Breach, and Enforcement Rules

**8.2** Training and communication(s) related to privacy, security, and breach must be job specific and commensurate with a workforce member's responsibilities. Training is required for system testing as well as ordinary system access if testing would involve PII/PHI access. Using the training modules developed by the contractor, each new member of the workforce shall be trained before having access to PHI and in any event within 30 work days of starting work.

**8.3** At a minimum, workforce training shall include the following:

### **8.3.1 Orientation Training**

Orientation training provides personnel with a basic understanding of Privacy Act and

HIPAA requirements, as applicable to the trainee's job performance. The training shall be provided to all personnel responsible for functions involving access to PII/PHI, and shall be a prerequisite to accessing such information.

### **8.3.2 Role-Based Training**

Where a job category requires access to PII/PHI, the contractor shall ensure that role based training is available where needed to enhance general orientation training.

### **8.3.3 Management Training**

Management training provides managers and decision-makers information that shall be taken into account when making management decisions affecting compliance with Privacy Act and HIPAA requirements. Personnel responsible for these management decisions should receive management training on privacy compliance when they first enter management positions.

## **8.4 Records Managers**

Training on PII/PHI breach response requirements will be included in the DHA Annual Records Management (RM) Training for contractor RM personnel under [Chapter 2, Section 1, paragraph 3.1.3](#). Electronic and hard copies of the RM breach training slide deck will be provided to contractors for use in developing their own training modules for non-RM personnel. In addition, records managers must receive Privacy Act SOR training in conjunction with their RM training.

## **8.5 Refresher Training and Retraining**

Contractors shall ensure employees and managers are continually aware of their responsibilities through the completion of annual refresher training. Refresher training demonstrates the importance of privacy requirements, and ensures that the workforce continues to understand current requirements. Retraining must be provided to inform workforce members whose functions are affected by changes in applicable rules, policies and procedures. Refresher training and retraining must be completed within 30 work days of when assigned.

## **8.6 Documentation**

Contractors shall maintain electronic records or other documentation of the completion of all training by each contractor, subcontractor and/or workforce member. Documentation shall include a signature or electronic signature or other satisfactory evidence for each trainee, verifying completion and date of the training and understanding of its pertinence to his or her position. Records of the completion of training shall be provided to the DHA Privacy Office if requested. These records are subject to review by government officials during audits, reviews and inspections.

- END -

## **Benefit**

The TRICARE benefit consists of those services, payment amounts, cost-shares and copayments authorized by Public Law (PL) 89-614, 32 CFR 199 and the TRICARE Policy Manual (TPM).

## **Best Value Health Care**

The delivery of high quality clinical and other related services in the most economical manner for the MHS that optimizes the Direct Care (DC) system while delivering the highest level of customer service.

## **Breach**

A breach, as defined in Department of Defense Directive (DoDD) 5400.11 (2014), is a loss of control, compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, or any similar term referring to situations where persons other than authorized users and for an other than authorized purpose have access or potential access to Personally Identifiable Information (PII)/ Protected Health Information (PHI), whether in paper or electronic form. Breaches are classified as either possible or confirmed (see the definitions of **Possible Breach** and **Confirmed Breach**) and as either cyber or non-cyber (i.e., involving either electronic PII/PHI or paper/oral PII/PHI).

## **Business Associate (HIPAA/Privacy Definition)**

1. A person who on behalf of a covered entity or of an organized health care arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs, or assists in the performance of a function or activity involving the use or disclosure of Individually Identifiable Health Information (IIHI) or provides services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of IIHI from such covered entity or arrangement, or from another business associate of such covered entity or arrangement to the person.
2. A covered entity participating in an organized health care arrangement that performs a function or activity for or on behalf of such organized health care arrangement, or that provides a service to or for such organized health care arrangement, does not, simply through the performance of such function or activity or the provision of such service, become a business associate of other covered entities participating in such organized health care arrangement.
3. A covered entity may be a business associate of another covered entity.

For a full definition, refer to the Final Rule on Standards for Privacy of IIHI.

## **Capability Of A Provider**

The scope of services the provider is both capable of performing and willing to perform under a TRICARE contract. For example, a neurologist who only performs sleep studies may not be considered to have capability to perform as a general neurology specialist.

### **Capacity Of A Provider**

The amount of time or number of services a provider is able to perform in conjunction with a TRICARE contract. For example, a primary care physician whose practice is full has no available capacity for services.

### **Capped Rate**

The maximum per diem or all-inclusive rate that TRICARE will allow for care.

### **Care Coordination**

A comprehensive method of client assessment designed to identify client vulnerability, needs identification, and client goals which result in the development plan of action to produce an outcome that is desirable for the client. The goal is to provide client advocacy, a system for coordinating client services, and providing a systematic approach for evaluation of the effectiveness of the client's Life Plan.

### **Case Management**

A collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services to meet an individual's health care needs using resources available to provide quality and cost-effective outcomes, which includes assisting in coordinating case management patients from one location to another. Case management is not restricted to catastrophic illnesses and injuries.

### **Catastrophic Cap**

The National Defense Authorization Act for Fiscal Years 1988 and 1989 (PL 100-180) amended Title 10, USC, and established catastrophic loss protection for TRICARE beneficiary families on a government fiscal year basis. The law placed fiscal year limits or catastrophic caps on beneficiary liabilities for deductibles and cost-shares under the TRICARE Basic Program. Specific guidance may be found in the TRM, [Chapter 2, Section 2](#).

### **Catchment Areas**

Geographic areas determined by the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) that are defined by a set of five digit zip codes, usually within an approximate 40 mile radius of military inpatient treatment facility.

### **Certification and Accreditation (C&A) Process**

The C&A process ensures that the trust requirement is met for information systems and networks. Certification is the determination of the appropriate level of protection required for information systems/networks. Certification also includes a comprehensive evaluation of the technical and non-technical security features and countermeasures required for each system/network. Accreditation is the formal approval by the Government to operate the contractor's IS/networks in a particular security mode using a prescribed set of safeguards at an acceptable level of risk. In addition, accreditation allows IS/networks to operate within the given operational environment with stated

interconnections; and with appropriate level-of-protection for the specified period. The C&A requirements apply to all DoD ISs/networks and Contractor ISs/networks that access, manage, store, or manipulate electronic IS data. Specific guidance may be found in the TRICARE Systems Manual (TSM), [Chapter 1](#).

### **Certification For Care**

The determination that the provider's request for care (level of care, procedure, etc.) is consistent with preestablished criteria. (Note: This is NOT synonymous with authorization for care).

### **Certified Provider**

A hospital or institutional provider, physician, or other individual professional provider of services or supplies specifically authorized by [32 CFR 199.6](#). Certified providers have been verified by DHA or a designated contractor to meet the standards of [32 CFR 199.6](#), and have been approved to provide services to TRICARE beneficiaries and receive Government payment for services rendered to TRICARE beneficiaries.

### **CHAMPUS Maximum Allowable Charge (CMAC)**

CMAC is a nationally determined allowable charge level that is adjusted by locality indices and is equal to or greater than the Medicare Fee Scheduled amount.

### **CHAMPVA**

The Civilian Health and Medical Program of the Veterans Administration. This is a program of medical care for spouses and dependent children of disabled or deceased disabled veterans who meet the eligibility requirements of the DVA.

### **CHAMPVA Center (CVAC)**

The component within the Department of Veterans Affairs (DVA), Health Administration Center (HAC) which processes all CHAMPVA claims.

### **Change Order**

A written directive from the DHA Procuring Contracting Officer (PCO) to the contractor directing changes within the general scope of the contract, as authorized by the "changes clause" at FAR 52.243-1, Changes--Fixed Price.

### **Christian Science Nurse**

An individual who has been accredited as a Christian Science Nurse by the Department of Care of the First Church of Christ, Scientist, Boston, Massachusetts, and listed (or eligible to be listed) in the Christian Science Journal at the time the service is provided. The duties of Christian Science nurses are spiritual and are nonmedical and nontechnical nursing care performed under the direction of an accredited Christian Science practitioner. There are two levels of Christian Science nurse accreditation:

**1. Graduate Christian Science Nurse.** This accreditation is granted by the Department of Care of the First Church of Christ, Scientist, Boston, Massachusetts, after completion of a three year course of instruction and study.

**2. Practical Christian Science Nurse.** This accreditation is granted by the Department of Care of the First Church of Christ, Scientist, Boston, Massachusetts, after completion of a one year course of instruction and study.

### **Christian Science Practitioner**

An individual who has been accredited as a Christian Science Practitioner for the First Church of Christ, Scientist, Boston, Massachusetts, and listed (or eligible to be listed) in the Christian Science Journal at the time the service is provided. An individual who attains this accreditation has demonstrated results of his or her healing through faith and prayer rather than by medical treatment. Instruction is executed by an accredited Christian Science teacher and is continuous.

### **Christian Science Sanatorium**

A sanatorium either operated by the First Church of Christ, Scientist, or listed and certified by the First Church of Christ, Scientist, Boston, Massachusetts.

### **Claim**

**1.** Any request for payment for health care services rendered which is received from a beneficiary, a beneficiary's representative, or a network or non-network provider by a contractor on any TRICARE-approved claim form or approved electronic medium. If two or more forms for the same beneficiary are submitted together, they shall constitute one claim unless they qualify for separate processing under the claims splitting rules. (It is recognized that services may be provided in situations in which no claims, as defined here, are generated. This does not relieve the contractor from collecting the data necessary to fulfill the requirements of the TED for all care provided under the contract.)

**2.** Any request for reimbursement of a dispensed pharmaceutical agent or diabetic supply item. For electronic media claims, one prescription equals one claim. For paper claims, reimbursement for multiple prescriptions may be requested on a single paper claim.

### **Claim File**

The collected records submitted with or developed in the course of processing a single claim. It includes the approved TRICARE claim form and may include attached bills, medical records, record of telephone development, copies of correspondence sent and received in connection with the claim, the EOB, and record of adjustments to the claim. It may also include the record of appeals and appeal actions. The claim file may be in microcopy, hard copy, or in a combination of media.

### **Claim Form**

A fixed arrangement of captioned spaces designed for entering and extracting prescribed information, including ADP system forms.

### **Claims Cycle Time**

That period of time, recorded in calendar days, from the receipt of a claim into the possession/ custody of the contractor to the completion of all processing steps (See "Processed to Completion (or Final Disposition)" in this Appendix, and TSM, [Chapter 2, Section 2.4](#), "Date TED Record Processed to Completion").

### **Claims Payment Data**

The record of information contained on or derived from the processing of a claim or encounter.

### **Clinical Support Agreement (CSA)**

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

### **Code Set (HIPAA/Privacy Definition)**

Any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes. A code set includes the codes and descriptors of the codes.

### **Code Set Maintaining Organization (HIPAA/Privacy Definition)**

An organization that creates and maintains the code sets adopted by the Secretary (HHS) for use in the transactions for which standards are adopted.

### **Combined Daily Charge (HIPAA/Privacy Definition)**

A billing procedure by an inpatient facility that uses an inclusive flat rate covering all professional and ancillary charges without any itemization.

### **Concurrent Review/Continued Stay Review**

Evaluation of a patient's continued need for treatment and the appropriateness of current and proposed treatment, as well as the setting in which the treatment is being rendered or proposed. Concurrent review applies to all levels of care (including outpatient care).

### **Confidentiality Requirements**

The procedures and controls that assure the confidentiality of medical information in compliance with the Freedom of Information Act, the Comprehensive Alcohol Abuse and Alcoholism Prevention and Rehabilitation Act, and the Privacy Act.

### **Confirmed Breach**

An incident in which it is known that unauthorized access could occur. For example, if a laptop containing PII/PHI is lost and the contractor knows that the PII/PHI is unencrypted, then the

contractor should classify and report the incident as a confirmed breach, because unauthorized access could occur due to the lack of encryption (the contractor knows this even without knowing whether or not unauthorized access to the PII/PHI has actually occurred). If the laptop is subsequently recovered and forensic investigation reveals that files containing PII/PHI were never accessed, then the possibility of unauthorized access can be ruled out, and the contractor should re-classify the incident as a non-breach incident.

### **Conflict Of Interest**

Includes any situation where an active duty member (including a reserve member while on active duty) or civilian employee of the United States Government, through an official federal position, has the apparent or actual opportunity to exert, directly or indirectly, any influence on the referral of MHS beneficiaries to himself or herself or others with some potential for personal gain or appearance of impropriety. Individuals under contract to a Uniformed Service may be involved in a conflict of interest situation through the contract position.

### **Consulting Physician Or Dentist**

A physician or dentist, other than the attending physician, who performs a consultation.

### **Continued Health Care Benefit Program (CHCBP)**

The CHCBP provides temporary continued health care benefits for certain former beneficiaries of the Military Health System (MHS). Coverage under the CHCBP is purchased on a premium basis.

### **Continuum of Care**

All patient care services provided from "pre-conception to grave" across all types of settings. Requires integrating processes to maintain ongoing communication and documentation flow between the DC system and network.

### **Contract Performance Evaluation (CPE)**

The review by DHA, of a contractor's level of compliance with the terms and conditions of the contract. Usually, an operational audit performed by DHA staff focuses on timeliness, accuracy, and responsiveness of the contractor in performing all aspects of the work required by the contract.

### **Contract Physician**

A physician who has made contractual arrangements with a contractor to provide care or services to TRICARE beneficiaries. A contract physician is a network provider who participates on all TRICARE claims.

### **Contracting Officer's Representative (COR)**

A government representative, appointed in writing by the contracting officer, who represents the contracting officer in technical matters.

### **Contractor**

An organization with which DHA has entered into a contract for delivery of and/or processing of payment for health care services, performance of related support activities such as pharmacy services, quality monitoring or customer service.

### **Control Of Claims**

The ability to identify individually, locate, and count all claims in the custody of the contractor by location, including those that may be being developed by physical return of a copy of the claim, and age including total age in-house and age in a specific location.

### **Controlled Substances**

Those medications which are included in one of the schedules of the Controlled Substances Act of 1970 and as amended.

### **Coordination Of Benefits (COB)**

A system to require collection of other health insurance benefits before making any TRICARE benefit payment, except for Medicaid, in compliance with requirements specified in 32 CFR 199 and the TRM.

### **Copayment**

See the definition for "cost-share."

### **Cost Effective Provider Network Areas**

Areas in which provider networks can be developed where the discounts received from providers and the effects of Utilization Management activities are greater than or equal to the administrative costs associated with maintaining the Provider Network and accomplishing all additional marketing, education, enrollment, and related administrative activities.

### **Cost-Share**

The amount a beneficiary must pay for covered inpatient and outpatient services (other than the deductible, the annual TRICARE Prime enrollment fee, the balance billing amount, or disallowed amounts) as set forth in [32 CFR 199.4](#), [199.5](#), and [199.17](#). Active Duty Service Members (ADSMs) have no financial liability for the authorized health care services they receive. They do not pay cost-shares, deductibles, enrollment fees, or balance billed amounts. The contractor shall reimburse the full amount that a provider can collect, including any amount over CMAC up to the balance billing limit. Under TRICARE, cost-shares are expressed as either coinsurance or copayment. See the TRM, [Chapter 2](#), for additional information.

### **Correctional Institution (HIPAA/Privacy Definition)**

Any penal or correctional facility, jail, reformatory, detention center, work farm, halfway house, or residential community program center operated by, or under contract to, the United States, a State,

a territory, a political subdivision of a State or territory, or an Indian tribe, for the confinement or rehabilitation of persons charged with or convicted of a criminal offense or other persons held in lawful custody. Other persons held in lawful custody includes juvenile offenders adjudicated delinquent, aliens detained awaiting deportation, persons committed to mental institutions through the criminal justice system, witnesses, or others awaiting charges or trial. The term "correctional institution" includes military confinement facilities, but does not include internment facilities for enemy prisoners of war, retained personnel, civilian detainees and other detainees provided under the provisions of DoDD 2310.1 (reference (b)).

#### **Covered Entity (HIPAA/Privacy Definition)**

A health plan, health care clearinghouse or health care provider who transmits any health information in electronic form in connection with a transaction. In the case of a health plan administered by the Department of Defense, the covered entity is the DoD Component (or subcomponent) that functions as the administrator of the health plan.

For details refer to the Transaction and Code Sets Regulation and the Standards for Privacy of IIHI Regulation.

#### **Covered Functions (HIPAA/Privacy Definition)**

Those functions of a covered entity the performance of which makes the entity a health plan or health care provider.

#### **Credentialing**

The process by which providers are allowed to participate in the network. This includes a review of the provider's training, educational degrees, licensure, practice history, etc.

#### **Credentials Package**

Credentials packages are required for all clinical personnel supplied by the contractor who will be working in an MTF. Similar packages may be required for non-clinical personnel. The credentials package shall contain the following information.

1. All documents, verified per regulation/directive/instruction/policy, which are needed in order for the individual to provide the proposed services at the involved facility. This will include licensure from the jurisdiction in which the individual will be practicing and a National Practitioner Data Bank (NPDB) query as specified by the facility.
2. Credentials files for all personnel required by law to have a Criminal History Background Check (CHBC) will contain documentation showing that the required CHBC has been completed prior to awarding of privileges or the delivery of services.
  - If a CHBC has been initiated, but not completed, the MTF commander has the authority to allow awarding of privileges and initiation of services if delivered under clinical supervision.

- The mechanism for accomplishing the CHBC may vary between MTFs and should be determined during phase-in/transition and be agreed to by the MTF Commander.
- Regardless of the mechanism for initiating and completing a CHBC, the cost shall be borne by the contractor.

**3.** TRICARE Provider ID number when provider is of a type which is recognized by TRICARE. Medicare Provider ID number when provider is of a type recognized by Medicare.

**4.** Evidence of compliance (or scheduled compliance) with the MTF specific requirements including all local Employee Health Program (EHP), Federal Occupational Safety Act and Health Act (OSHA), and Bloodborne Pathogens Program (BBP) requirements.

### **Controlled Unclassified Information (CUI)**

Information that requires safeguarding or dissemination controls pursuant to and consistent with applicable law, regulations, and Government-wide policies.

### **Custodial Care Prior To December 28, 2001**

Care rendered to a patient:

- 1.** Who is disabled mentally or physically and such disability is expected to continue and be prolonged, and
- 2.** Who requires a protected, monitored, or controlled environment whether in an institution of in the home, and
- 3.** Who requires assistance to support the essentials of daily living, and
- 4.** Who is not under active and specific medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored, or controlled environment.

A custodial care determination is not precluded by the fact that a patient is under the care of a supervising or attending physician and that services are being ordered and prescribed to support and generally maintain the patient's condition, or provide for the patient's comfort, or ensure the manageability of the patient. Further, a custodial care determination is not precluded because the ordered and prescribed services and supplies are being provided by an RN, LPN, or LVN.

**Note:** The determination of custodial care in no way implies that the care being rendered is not required by the patient; it only means that it is the kind of care that is not covered under TRICARE. A program of physical and mental rehabilitation which is designed to reduce a disability is not custodial care as long as the objective of the program is a reduced level of care.

### **Custodial Care After December 28, 2001**

The treatment or services, regardless of who recommends such treatment or services or where such treatment or services are provided, that can be rendered safely and reasonably by a person who is not medically skilled or is or are designed mainly to help the patient with the activities of daily living.

### **Cycle Time**

The elapsed time, as expressed in calendar days (including any part of the first and last days counted as two days), from the date a claim, piece of correspondence, grievance, or appeal case was received by a contractor through the date PTC. (See claims cycle time for added detail.)

### **Cybersecurity Incident**

A cybersecurity incident is a violation or imminent threat of violation of computer security policies, acceptable use policies, or standard security practices, with respect to electronic PII/PHI. A cybersecurity incident may or may not involve a breach of PII/PHI. For example, a malware infection would be a possible breach if it could cause unauthorized access to PII/PHI. However, if the malware only affects data integrity or availability (not confidentiality), then a non-breach cybersecurity incident has occurred.

### **Data**

Any information collected, derived, or created as a result of operations as a TRICARE contractor. All data is the property of the Government regardless of where it is maintained/stored.

### **Data Aggregation (HIPAA/Privacy Definition)**

The combining of PHI by a business associate with the PHI received by the business associate in its capacity as a business associate of another covered entity, to permit data analyses that relate to the health care operations of the respective covered entities.

### **Data Condition (HIPAA/Privacy Definition)**

The circumstances under which a covered entity must use a particular data element or segment.

### **Data Content (HIPAA/Privacy Definition)**

The data elements and code sets inherent to a transaction, and not related to the format of the transaction. Data elements that are related to the format are not data content.

### **Data Element (HIPAA/Privacy Definition)**

The smallest named unit of information in a transaction.

### **Data Repository**

A single point of electronic storage, established and maintained by the contractor, that enables the Government to electronically access all data maintained by the contractor relative to a TRICARE contract. This includes all claims/encounter data, provider data, authorization, enrollment, and derived data collected in relation to a TRICARE contract.

### **Data Set (HIPAA/Privacy Definition)**

A semantically meaningful unit of information exchanged between two parties to a transaction.

### **Date Of Determination (Appeals)**

The date of completion appearing on the reconsideration determination, formal review determination, or hearing final decision.

### **Days**

Calendar days unless otherwise indicated.

### **Days Supply**

The number of days that the dispensed quantity of drug should last, based on directions for use with a limit as the First Data Bank recommended maximum daily dose (unless specifically altered by DoD).

### **Deductible**

The statutory requirement for payment by the beneficiary of an initial specified dollar amount of the TRICARE-determined allowable costs or charges for covered outpatient services or supplies provided in any one fiscal year.

**Example 1:** Under TRICARE Standard and TRICARE Extra, the deductible is \$50 (for family members of sponsors in pay grade E-4 and below) or \$150.00 (for family members of sponsors in pay grades above E-4, and retirees and their family members) For a family, the aggregate payment of \$100 (for family members of sponsors in pay grade E-4 and below) or \$300.00 (for family members of sponsors in pay grades above E-4, and retirees and their family members) by two or more beneficiaries will satisfy the deductible requirement.

**Example 2:** For TRICARE Prime enrollees, under the Point-of-Service option, the deductible is \$300 for individuals, \$600 for a family.

### **Defense Enrollment Eligibility Reporting System (DEERS)**

The computer-based enrollment/eligibility system for verifying entitlement to health care services. See the 32 CFR 199 definition and the TSM, for specific information concerning DEERS.

**De-Identified Data (HIPAA/Privacy Definition)**

Health information that has been rendered not IIHI by removal of identifiers of the individual or of relatives, employers, or household members of the individual, such as names, geographic subdivisions smaller than a State, all elements of dates (except year) for dates directly related to an individual, telephone numbers, Social Security Numbers, etc. For full details refer to the DoD Health Information Privacy Regulation.

**Demonstration**

A study or test project with respect to alternative methods of payment for health and medical services, cost-sharing by eligible beneficiaries, methods of encouraging efficient and economical delivery of care, innovative approaches to delivery and financing services and prepayment for services provided to a defined population. Following completion and evaluation of the test project, it may or may not become part of the program.

**Descriptor (HIPAA/Privacy Definition)**

The text defining a code.

**Designated Record Set (HIPAA/Privacy Definition)**

A group of records maintained by or for a covered entity that is:

1. The medical records and billing records about individuals maintained by or for a covered health care provider;
2. The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or
3. Used, in whole or in part, by or for the covered entity to make decisions about individuals.

For purposes of this definition, the term record means any item, collection, or grouping of information that includes PHI and is maintained, collected, used, or disseminated by or for a covered entity.

**Designated Standard Maintenance Organization (DSMO) (HIPAA/Privacy Definition)**

An organization designated by the Secretary (HHS) under §162.910(a) of the Transaction and Code Sets Regulation.

**Diagnosis Related Groups (DRGs)**

A categorization of hospital patients into clinically coherent groups based on their consumption of resources. Patients are assigned to the groups based on their principal diagnosis (the reason for admission, determined after study), secondary diagnoses, procedures performed, and the patient's age, sex, and discharge status. A reimbursement system using DRGs assigns payment levels to each DRG based on the average cost of treating all patients in a given DRG.

**Direct Data Entry (HIPAA/Privacy Definition)**

The direct entry of data (for example, using dumb terminals or web browsers) that is immediately transmitted into a health plan's computer.

**Direct Treatment Relationship (HIPAA/Privacy Definition)**

A treatment relationship between an individual and a health care provider that is not an indirect treatment relationship as defined under the DoD Health Information Privacy Regulation.

**Discharge Planning**

The development of an individualized discharge plan for the patient prior to leaving an institution for home, with the aim of improving patient outcomes, reducing the chance of unplanned readmission to an institution, and containing costs.

**Disclosure (HIPAA/Privacy Definition)**

The release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

**DoD Information**

Information that is provided by the DoD to a non-DoD entity, or that is collected, developed, received, transmitted, used, or stored by a non-DoD entity in support of an official DoD activity, where that information has not been cleared for public release.

**Domiciliary Care**

Care provided to a patient in an institution or home-like environment because (1) providing support for the activities for daily living in the home is not available or is unsuitable; or (2) members of the patient's family are unwilling to provide the care.

**Note:** The terms "domiciliary" and "custodial care" represent separate concepts and are not interchangeable. Custodial care and domiciliary care are not covered under the TRICARE Prime, Extra, or Standard programs or the Extended Care Health Option (ECHO).

**Donor**

An individual who supplies living tissue or material to be used in another body, such as a person who furnishes a kidney for renal transplant.

**Double Coverage**

Enrollment by a TRICARE beneficiary in another insurance, medical service, or health plan that duplicates all or part of a beneficiary's TRICARE benefits.

### **Double Coverage Plan**

The specific insurance, medical service, or health plan under which a TRICARE beneficiary has entitlement to medical benefits that duplicate TRICARE benefits in whole or in part. Double coverage plans do not include:

1. Medicaid.
2. Coverage specifically designed to supplement TRICARE benefits.
3. Entitlement to receive care from the Uniformed Services medical care facilities; or
4. Entitlement to receive care from Department of Veterans Affairs (DVA) medical care facilities; or
5. Entitlement to receive care from Indian Health Services medical care facilities; or
6. Services and items provided under Part C (Infants and Toddlers with Disabilities) of the Individuals With Disabilities Education Act (IDEA).

### **DSM III**

A technical reference, **Diagnostic and Statistical Manual of Mental Disorders, Third Edition.**

### **DSM IV**

A technical reference, **Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.**

### **Dual Compensation**

Federal law (5 USC 5536) prohibits active duty members or civilian employees of the United States Government from receiving additional compensation from the Government above their normal pay and allowances. This prohibition applies to TRICARE cost-sharing of medical care provided by active duty members or civilian Government employees to TRICARE beneficiaries.

### **Edit Error (TEDs Only)**

Errors found on TEDs (initial submissions, resubmissions, and adjustments/cancellation submissions) which result in nonacceptance of the records by DHA. These require correction of the error by the contractor and resubmission of the corrected TED to DHA for acceptance.

### **Electronic Media (HIPAA/Privacy Definition)**

The mode of electronic transmission. It includes the Internet (wide-open), Extranet (using Internet technology to link a business with information only accessible to collaborating parties), leased lines, dial-up lines, private networks, and those transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk media.

### **Employment Records (HIPAA/Privacy Definition)**

Records that include health information and that:

- 1.** Are maintained by a component of the Department of Defense or other entity subject to the DoD Health Information Privacy Regulation;
- 2.** Are about an individual who is (or seeks or sought to become) a member of the uniformed services, employee of the United States Government, employee of a Department of Defense contractor, or person with a comparable relationship to the Department of Defense; and
- 3.** Are not maintained in connection with carrying out any covered function under the DoD Health Information Privacy Regulation.

### **Enrollment Fees**

The amount required to be paid by some categories of MHS beneficiaries to enroll in and receive the benefits of TRICARE Prime or other special TRICARE programs.

### **Enrollment Plan**

A plan established by the contractor to inform beneficiaries of the availability of the TRICARE Prime program, facilitate enrollment in the program, and maintain enrollment records. The plan must be approved by the government.

### **Enrollment Records**

The official record of a beneficiary's enrollment in TRICARE Prime and maintained on the DEERS System.

### **Enrollment Transfer**

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

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

### **Entity**

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

### **Exclusion**

Exclusion from participation as a provider or entity under TRICARE means that items, services, and/or supplies furnished will not be reimbursed under TRICARE. This term may be used interchangeably with "suspension."

### **Explanation Of Benefits (EOB)**

The document prepared by insurance carriers, health care organizations, and TRICARE to inform beneficiaries of the actions taken with respect to a claim for health care coverage.

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

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

### **Federal Records Center (FRCs)**

Centers established and maintained by the General Services Administration at locations throughout the United States for the storage, processing, and servicing of noncurrent records for Federal agencies.

### **Files Administration**

The application of records management techniques to filing practices to maintain records easily and to retrieve them rapidly, to ensure their completeness, and to facilitate the disposition of noncurrent records.

### **Fiscal Year (FY)**

The Federal Government's 12 month accounting period which currently runs from October 1 through September 30 of the following year.

### **Format (HIPAA/Privacy Definition)**

The transaction data elements that provide or control the enveloping or hierarchical structure, or assist in identifying data content of, a transaction.

### **Formulary**

A listing of pharmaceuticals and other authorized supplies to be dispensed with appropriate prescriber's order from a particular point of service. The formulary for any TRICARE contract will be managed by the DoD Pharmacy and Therapeutics (P&T) Committee with clinical guidance from the DoD Pharmacoeconomic Center (PEC). Applicable formulary information may be viewed on the TRICARE web site at: <http://www.tricare.osd.mil/pharmacy>.

### **Fragmented Billing**

(See "Unbundled Billing")

### **Freedom Of Choice**

The right to obtain medical care from any TRICARE-authorized source available, including TRICARE Prime, the DC system (MTF system), or obtain care from a provider not affiliated with the contractor and seek reimbursement under the terms and conditions of the TRICARE Standard Program (see definition). Beneficiaries who voluntarily enroll in TRICARE Prime must be informed of any restrictions on freedom of choice that may be applicable to enrollees as a result of enrollment. Except for any limitations on freedom of choice that are fully disclosed to the beneficiaries at the time of enrollment, freedom of choice provisions applicable to the TRICARE Standard Program shall be applicable to TRICARE Prime.

### **Freedom Of Information Act (FOIA)**

A law enacted in 1967 as an amendment to the "Public Information" section of the Administrative Procedures Act, establishing provisions making information available to the public. DHA and contractors are subject to these provisions.

### **Freestanding**

Not "institution-affiliated" or "institution-based."

### **Full Mobilization**

When the President recommends and the Congress orders full mobilization. Full mobilization requires passage by the Congress of a public law or joint resolution declaring war and involves the mobilization of all Reserve Component (RC) units.

### **Gag Clause**

A gag clause is any clause included in a professional provider's agreement or contract with a managed care organization (such as a PPO network or HMO network) or third party payer that directly or indirectly limits the ability of the health care professional provider to provide treatment information and options to their patients in particular limitations on advice regarding the patient's health status, medical care, and treatment options, the risks, benefits and consequences of treatment or non-treatment, or the opportunity for the individual to refuse treatment and to express preferences about future treatment options.

### **Good Faith Payments**

Those payments made to civilian sources of medical care who provided medical care to persons purporting to be eligible beneficiaries but who are determined later to be ineligible for TRICARE benefits. (The ineligible person usually possesses an erroneous or illegal identification card.) To be considered for good faith payments, the civilian source of care must have exercised reasonable precautions in identifying a person claiming to be an eligible beneficiary.

### **Grievance**

A written complaint on a non-appealable issue which deals primarily with a perceived failure of a network provider, the Health Care Finder (HCF), or contractor or subcontractor, to furnish the level or quality of care expected by a beneficiary.

### **Grievance Process**

A contractor developed and managed system for resolving beneficiary grievances.

### **Group Health Plan (HIPAA/Privacy Definition)**

An employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income and Security Act of 1974 (ERISA), 29 USC 1002(1)), including insured and self-insured plans, to the extent that the plan provides medical care (as defined in section 2791(a)(2) of the Public Health Service Act (PHS Act), 42 USC 300gg-91(a)(2)), including items and services paid for as medical care, to employees or their dependents directly or through insurance, reimbursement, or otherwise, that:

1. Has 50 or more participants (as defined in section 3(7) of ERISA, 29 USC 1002(7)); or
2. Is administered by an entity other than the employer that established and maintains the plan.

### **HCPCS (HIPAA/Privacy Definition)**

The Transaction and Code Sets Regulation defines "HCPCS" as follows, "HCPCS stands for the Health Care Common Procedure Coding System."

### **Health Benefits Advisors (HBAs)**

Those individuals located at Uniformed Services medical facilities (on occasion at other locations) and assigned the responsibility for providing TRICARE information, information concerning availability of care from the Uniformed Services direct medical care system, and generally assisting beneficiaries (or sponsors). The term also includes "Health Benefits Counselor."

### **Health Care (HIPAA/Privacy Definition)**

Care, services, or supplies related to the health of an individual. Health care includes but is not limited to, preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and the sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

### **Health Care Clearinghouse (HIPAA/Privacy Definition)**

A public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that does either of the following functions.

1. Processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.
2. Receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity.

**Health Care Finder (HCF)**

The person who manages and performs the duties necessary to operate the HCF System.

**Health Care Finder (HCF) System**

A system or mechanism established by the contractor in each Prime Service Area (PSA) in the region to facilitate referrals and other customer service functions of beneficiaries to military and/or civilian health care services.

**Health Care Provider (HCP)**

1. An individual or institution licensed or otherwise authorized to practice medicine or deliver health care services, supplies, or equipment.
2. For purposes of the Transaction and Code Sets Regulation and the Privacy Regulation, a provider of medical or health services and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business.

**Health Information (HIPAA/Privacy Definition)**

Any information, whether oral or recorded in any form or medium, that is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

**Health Insurance Issuer (HIPAA/Privacy Definition)**

An insurance company, insurance service, or insurance organization (including an HMO) that is licensed to engage in the business of insurance in a State and is subject to State Law that regulates insurance. Such term does not include a group health plan.

**Health Maintenance Organization (HMO) (HIPAA/Privacy Definition)**

A federally qualified HMO, an organization recognized as an HMO under State law, or a similar organization regulated for solvency under State law in the same manner and to the same extent as such an HMO.

### **Health Oversight Agency (HIPAA/Privacy Definition)**

An agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is authorized by law to oversee the health care system (whether public or private) or government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which health information is relevant. The term "health oversight agency" includes any DoD Component authorized under applicable DoD Regulation to oversee the MHS, including with respect to matters of quality of care, risk management, program integrity, financial management, standards of conduct, or the effectiveness of the Military Health System (MHS) in carrying out its mission.

### **Health Plan (HIPAA/Privacy Definition)**

Any DoD program that provides or pays the cost of health care. For full details, see the DoD Health Information Privacy Regulation.

### **HHS Regulation (HIPAA/Privacy Definition)**

45 CFR Parts 160-164.

### **HIPAA Breach**

An incident that satisfies the definition of a breach in 45 CFR 164.402 (HIPAA Breach Rule).

### **Homebound (Respite Care Definition)**

A beneficiary's condition is such that there exists a normal inability to leave home and, consequently, leaving home would require considerable and taxing effort. Any absence of an individual from the home attributable to the need to receive health care treatment--including regular absences for the purpose of participating in rehabilitative, therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a state, or accredited to furnish adult day-care services in the state shall not disqualify an individual from being considered to be confined to home. Any other absence of an individual from the home shall not disqualify an individual if the absence is infrequent or of relatively short duration. Any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. Also, absences from the home for non-medical purposes, such as an occasional trip to the barber, a walk around the block or a drive, would not necessarily negate the beneficiary's homebound status if the absences are undertaken on an infrequent basis and are of relatively short duration. Absences, whether regular or infrequent, from the beneficiary's primary home for the purpose of attending an educational program in a public or private school that is licensed and/or certified by a state, shall not negate the beneficiary's homebound status.

### **Hospital Day**

An overnight stay at a hospital. Normally if the patient is discharged in less than 24 hours it would not be considered an inpatient stay; however, if the patient was admitted and assigned to a bed and the intent of the hospital was to keep the patient overnight, regardless of the actual Length-Of-Stay (LOS), the stay will be considered an inpatient stay and, therefore, a hospital day. For hospital stays exceeding 24 hours, the day of admission is considered a hospital day; the day of discharge is not.

### **ICD-9-CM**

A technical reference, **International Classification of Diseases, 9th Edition, Clinical Modification**. Volumes 1 and 2 are a required reference and coding system for diagnoses and Volume 3 is required as a coding system for procedures in processing TRICARE claims for medical care with dates of service for outpatient services or dates of discharge for inpatient services before the mandated date, as directed by HHS, for ICD-10 implementation.

### **ICD-10-CM**

A technical reference, **International Classification of Diseases, 10th Edition, Clinical Modification**. It is a required reference and coding system for diagnoses in processing TRICARE claims for medical care with dates of service for outpatient services or dates of discharge for inpatient services on or after the mandated date, as directed by HHS, for ICD-10 implementation.

### **ICD-10-PCS**

A technical reference, **International Classification of Diseases, 10th Edition, Procedure Coding System**. It is a required reference and coding system for procedures in processing TRICARE claims for medical care with dates of discharge for inpatient services on or after the mandated date, as directed by HHS, for ICD-10 implementation.

### **Immediate Family**

The spouse, natural parent, child and sibling, adopted child and adoptive parent, stepparent, stepchild, grandparent, grandchild, stepbrother and stepsister, father-in-law, mother-in-law of the beneficiary, or provider, as appropriate. For purposes of this definition only, to determine who may render services to a beneficiary, the step-relationship continues to exist even if the marriage upon which the relationship is based terminates through divorce or death of one of the parents.

### **Independent Laboratory**

A freestanding laboratory approved for participation under Medicare and certified by the Center for Medicare and Medicaid Service (CMS).

### **Indirect Treatment Relationship (HIPAA/Privacy Definition)**

A relationship between an individual and a HCP in which:

1. The health care provider delivers health care to the individual based on the orders of another health care provider; and
2. The health care provider typically provides services or products, or reports the diagnosis or results associated with the health care, directly to another health care provider, who provides the services or products or reports to the individual.

### **Individual (HIPAA/Privacy Definition)**

The person who is the subject of PHI.

### **Individual Consideration (IC) Procedure**

An individual consideration procedure is one that is not routinely provided, is unusual, variable, or new. These procedures will require additional information from the provider of care, including an adequate definition or description of the nature, extent and need for the procedure; and the time, effort, and necessary equipment required. Any complexities related to the service should also be identified.

### **Individually Identifiable Health Information (IIHI) (HIPAA/Privacy Definition)**

Information that is a subset of health information, including demographic information collected from an individual, and:

1. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and
2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and
  - That identifies the individual; or
  - With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

### **Intervention, Pharmacy**

A change in therapy resulting from the prospective drug utilization review process and contact with the prescriber and/or the beneficiary because of allergy, clinically significant interactions, duplicative therapy, or other reasons.

### **Intervention Report, Pharmacy**

A report of prescriptions not dispensed or changes in therapy as a result of contact with prescribers and/or beneficiaries because of allergies, clinically significant interactions, duplicative therapy, or other reasons. The intervention report shall also contain the resultant change in cost due to the intervention, if possible.

### **Initial Determination**

A formal written decision (including an EOB) regarding a TRICARE claim, a request for benefit authorization, a request by a provider for approval as an authorized TRICARE provider, or a decision sanctioning a TRICARE provider. Rejection of a claim or a request for benefit or provider authorization for failure to comply with administrative requirements, including failure to submit reasonably requested information, is not an initial determination. Responses to general or specific inquiries regarding TRICARE benefits are not initial determinations.

### **Initial Payment**

The first payment on a continuing claim, such as a long-term institutional claim.

### **Inpatient Care**

Care provided to a patient who has been admitted to a hospital or other authorized institution for bed occupancy for purposes of receiving necessary medical care, with the reasonable expectation that the patient will remain in the institution at least 24 hours, and with the registration and assignment of an inpatient number or designation. Institutional care in connection with in and out (ambulatory) surgery is not included within the meaning of inpatient whether or not an inpatient number or designation is made by the hospital or other institution. If the patient has been received at the hospital, but death occurs before the actual admission occurs, an inpatient admission exists as if the patient had lived and had been formally admitted.

### **Inquiry**

Requests for information or assistance made by or on behalf of a beneficiary, provider, the public, or the Government. Written inquiries may be made in any format (letter, memorandum, note attached to a claim, etc.). Allowable charge complaints, grievances, and appeals are excluded from this definition.

### **Institution-Affiliated**

Related to a TRICARE authorized institutional provider through a shared governing body but operating under a separate and distinct license or accreditation.

### **Institution-Based**

Related to a TRICARE authorized institutional provider through a shared governing body and operating under a common license and shared accreditation.

### **Institutional Provider**

A HCP which meets the applicable requirements established by [32 CFR 199.6](#).

### **Internal Control Number (ICN)**

The unique number assigned to a claim by the contractor to distinguish it in processing, payment, and filing procedures. It is the number affixed to the face of each claim received and will, at a minimum, include the Julian date of receipt and a five digit sequence number assigned by the contractor. Each TED must have a unique ICN. For records generated from claims, it will be the ICN of the claim from which it was generated. For TED which are not generated from claims, it will be a unique number assigned by the contractor which will include the Julian date of the record's creation and a five digit sequence number.

### **Investigational Drugs**

New drugs or biological drugs, not yet available for prescribing to the general public but currently being used in a clinical investigation.

### **Laboratory And Pathological Services**

Laboratory and pathological examinations (including machine diagnostic tests that produce hard-copy results) when necessary to, and rendered in connection with medical, obstetrical, or surgical diagnosis or treatment of an illness or injury, or in connection with well-baby care.

### **Law Enforcement Official (HIPAA/Privacy Definition)**

An officer or employee of any agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, who is empowered by law to:

1. Investigate or conduct an official inquiry into a potential violation of law; or
2. Prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.

### **Legacy Identifier (HIPAA/Privacy Definition)**

Any provider identifier besides the NPI and Federal Tax IDs. Legacy identifiers may include but not be limited to OSCAR, NSC, PINS, UPINS and other identifiers. A Federal Tax ID is not considered a legacy identifier for health care purposes as its primary purpose is to support IRS 1099 reporting.

### **Limited Data Set (HIPAA/Privacy Definition)**

PHI that excludes direct identifiers of the individual or of relatives, employers, or household members of the individual.

### **Machine-Readable Records/Archives**

The records and archives whose informational content is usually in code and has been recorded on media, such as magnetic disks, drums, tapes, punched paper cards, or punched paper tapes, accompanied by finding aids known as software documentation. The coded information is retrievable only by machine.

### **Maintain Or Maintenance (HIPAA/Privacy Definition)**

Activities necessary to support the use of a standard adopted by the Secretary (HHS), including technical corrections to an implementation specification, and enhancements, or expansion of a code set. This term excludes the activities related to the adoption of a new standard or implementation specification, or modification to an adopted standard or implementation specification.

### **Major Diagnostic Category (MDC)**

A grouping of Diagnosis Related Groups (DRGs) aggregated on the basis of clinical similarity.

### **Managed Care Support Contractor (MCSC)**

Regional contractors providing managed care support to the MHS. The MCSCs are responsible for assisting the DHA Regional Director(s) (RD(s)) and the MTF Commander(s) in operating an integrated health care delivery system, combining resources of the military's direct medical care system and the contractor's managed care support to provide health, medical and administrative support services to eligible beneficiaries.

### **Marketing**

Communication about a product or service to encourage recipients of the communication to purchase or use the product or service. The DoD Health Information Privacy Regulation lists specific exclusions to this definition.

### **Maximum Allowable Prevailing Charge**

The TRICARE state prevailing charges adjusted by the Medicare Economic Index (MEI) according to the methodology as set forth in [Chapter 10](#).

### **Maximum Defined Data Set**

The required data elements for a particular standard based on a specific implementation specification.

### **Medicaid**

The medical benefits program authorized under Title XIX of the Social Security Act as administered by state agencies in the various states.

## **Medical**

The generally used term which pertains to the diagnosis and treatment of illness, injury, pregnancy, and mental disorders by trained and licensed or certified health professionals. For purposes of TRICARE, the term "medical" should be understood to include "medical, psychological, surgical, and obstetrical," unless it is specifically stated that a more restrictive meaning is intended.

### **Medical Claims History File**

Refer to Beneficiary History File.

### **Medical Necessity**

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

### **Medical Necessity Determination**

A review by the contractor, based on Government provided criteria, to determine if a nonformulary pharmaceutical agent should be dispensed with a formulary copay.

### **Medical Supplies And Dressings (Consumables)**

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

### **Medical Management**

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

### **Medicare**

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

### **Medicare Economic Index (MEI)**

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

### **Medication Error**

A medication error occurs when a pharmacy dispenses to a beneficiary a medication that is not in compliance with what is prescribed by the provider (e.g., wrong medication, wrong strength, wrong quantity, wrong dose, wrong route of administration, outdated medications, wrong directions, wrong auxiliary labels, wrong patient information leaflets, or medication(s) labeled for or dispensed to the wrong patient).

### **Mental Health Therapeutic Absence**

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

### **Microcopy**

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

### **Microfiche**

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

### **Microfilm**

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

### **Microform**

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

### **Military Health System (MHS) Beneficiary**

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

### **Military Medical Support Office (MMSO)**

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

### **Military Treatment Facility (MTF)**

A military hospital or clinic.

### **Military Treatment Facility (MTF) Optimization**

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

### **Military Treatment Facility (MTF)-Referred Care**

When MTF patients require medical care that is not available at the MTF, the MTF will refer the patient to civilian medical care, and the contractor shall process the claim ensuring that discounts, cost-shares, copayments and/or deductibles are applied when appropriate.

### **Mobilization Plan - TRICARE**

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

### **Monthly Pro-Rating**

The process for determining the amount of the enrollment fee to be credited to a new enrollment period. For example, if a beneficiary pays their annual enrollment fee, in total, on January 1, (the first day of their enrollment period) and a change in status occurs on February 15. The beneficiary will receive credit for 10 months of the enrollment fee. The beneficiary will lose that portion of the enrollment fee that would have covered the period from February 15 through February 28.

### **Most-Favored Rate**

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

### **National Appropriate Charge Level**

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

### **National Conversion Factor (NCF)**

A mathematical representation of what is currently being paid for similar services nationally. The factor is based on the national allowable charges actually in use.

### **National Disaster Medical System (NDMS)**

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

### **National Prevailing Charge Level**

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

### **National Provider Identifier (NPI)**

The HIPAA Administrative Simplification: Standard Unique Health Identifier for HCPs; Final Rule (45 CFR 162), defines "National Provider Identifier" as a standard unique health identifier for HCPs. The NPI format consists of an all numeric identifier, 10 positions in length, with an International Standard Organization (ISO) standard check-digit in the 10th position (§162.406(a)). The NPI will not contain intelligence about the HCP.

### **Negotiated (Discounted) Rate**

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

### **Network**

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

### **Network Care**

Care provided by the network of contractor-operated providers and facilities (owned, leased, arranged) that link the providers or facilities with the prime contractor as part of the total contracted delivery system. Thus a "network provider" is one who serves TRICARE beneficiaries by agreement with the prime contractor as a member of the TRICARE Prime network or of any other preferred provider network or by any other contractual agreement with the contractor. "Network care" includes any care provided by a "network provider" or any care provided to a TRICARE Prime

enrollee under a referral from the contractor, whether by a “network provider” or not. A “network claim” is a claim submitted for “network care.” (See the definition for “Non-Network Care.”)

### **Network Inadequacy**

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

### **Network Provider**

An individual or institutional provider that is a member of a contractor’s provider network.

### **Nonappealable Issue**

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

### **Non-Availability Statement (NAS)**

A statement issued by a commander (or designee) of a Uniformed Services Medical Treatment Facility (USMTF) that needed medical care being requested by a TRICARE beneficiary cannot be provided at the facility concerned because the necessary resources are not available.

### **Non-Claim Health Care Data**

That data captured by the contractor to complete the required TED record for care rendered to TRICARE beneficiaries in those contractor owned, operated and/or subcontracted facilities where there is no claim submitted by the provider of care.

### **Non-Compliant, Pharmacy**

Patient did not receive the medication for various reasons (e.g., did not pick up the prescription within the given 10 day grace period, pharmacy cancelled the prescription) and as a result the medication is returned to stock. A subsequent reversal is automatically sent to PDTS which will result in the removal of the prescription fill from the patient profile. A reversed or adjusted TED record is also submitted to DHA resulting in a financial credit to the Government.

### **Noncurrent Records**

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

### **Non-DoD Information System (IS)**

An IS that is not owned, controlled, or operated by the DoD, and is not used or operated by a contractor or other non-DoD entity exclusively on behalf of the DoD.

### **Non-DoD TRICARE Beneficiaries**

These are TRICARE-eligible beneficiaries sponsored by non-Department of Defense (DoD) uniformed services (the Commissioned Corps of the U.S. Public Health Service (USPHS), the U.S. Coast Guard, and the Commissioned Corps of the National Oceanic and Atmospheric Administration (NOAA)).

### **Non-Network Care**

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

### **Non-Participating Provider**

A hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider that furnished medical services or supplies to a TRICARE beneficiary, but who did not agree on the TRICARE claim form to participate or to accept the TRICARE-determined allowable cost or charge as the total charge for the services. A nonparticipating provider looks to the beneficiary or sponsor for payment of his or her charge, not TRICARE. In such cases, TRICARE pays the beneficiary or sponsor, not the provider.

### **Non-Prime TRICARE Beneficiaries**

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

### **North Atlantic Treaty Organization (NATO) Member**

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

**Organized Health Care Arrangement (HIPAA/Privacy Definition)**

1. A clinically integrated care setting in which individuals typically receive health care from more than one health care provider;
2. An organized system of health care in which more than one covered entity participates, and in which the participating covered entities hold themselves out to the public as participating in a joint arrangement and participate in joint activities such as utilization review, quality assessment and improvement activities, or payment activities.
3. A group health plan and a health insurance issuer or HMO with respect to such group health plan, but only with respect to PHI created or received by such health insurance issuer or HMO that relates to individuals who are or who have been participants or beneficiaries in such group health plan;
4. A group health plan and one or more other group health plans each of which are maintained by the same plan sponsor; or
5. The group health plans described in paragraph 4 of this definition and health insurance issuers or HMOs with respect to such group health plans, but only with respect to PHI created or received by such health insurance issuers or HMOs that relates to individuals who are or have been participants or beneficiaries in any of such group health plans.

For full details refer to the DoD Health Information Privacy Regulation.

**Other Health Insurance (OHI)**

Primary health insurance coverage other than TRICARE (does not include supplemental insurance plans).

**Other Special Institutional Providers**

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

**Out-Of-Area Care**

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

### **Out-Of-Region Beneficiaries**

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

### **Over-the-Counter (OTC) Medications**

Medications that by law do not require a prescription. OTC items covered by the TRICARE Pharmacy (TPharm) benefit (see [www.tricare.osd.mil/pharmacy](http://www.tricare.osd.mil/pharmacy) for covered items) will be reimbursed by the TPharm contractor when purchased with or without a prescription, as long as the purchase was from a retail pharmacy. Covered OTC's purchased without a prescription from a medical supply house or venue other than a retail pharmacy are under the jurisdiction of the MCSC.

### **Participating Provider**

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

### **Patient Profile, Pharmacy**

A complete record for each beneficiary receiving prescriptions under the TRICARE program including: name, address, telephone number, date of birth, gender, patient identification number (sponsor's SSN and DEERS dependent suffix), DEERS ID, service sponsorship, status category, chronic medical conditions (diagnosis code), allergies and adverse drug experiences, past medication history, prescriptions dispensed, non receipt of prescriptions, status on interventions and prescription problems resolved, Prior Authorizations approved or denied, and any other information supplied by the beneficiary in the patient data form or updates.

### **Pending Claim, Correspondence, Or Appeal**

The claim/correspondence/appeal case has been received but has not been processed to final disposition.

### **Performance Standard**

Standards against which performance shall be measured for specific aspects of a TRICARE contract.

### **Pharmaco-economic Center (PEC)**

The DoD PEC's mission is to improve the clinical, economic, and humanistic outcomes of drug therapy in support of the readiness and managed care missions of the MHS. The PEC is comprised of pharmacists, physicians, and pharmacy technicians from each of the three services, as well as civilian pharmacists and support personnel.

### **Pharmacy and Therapeutics (P&T) Committee**

A DoD Chartered committee with representatives from MTF providers and MTF pharmacists. The P&T Committee's primary role is establishing and maintaining the DoD Uniform Formulary for the purchased care system and the DC system (MTFs).

### **Pharmacy Data Transaction Service (PDTs)**

A bi-directional data transaction service that provides a pharmaceutical data warehouse and electronically transmits encrypted prescription data using NCPDP standards to the pharmacy contractor. The PDTs provides the capability to perform Prospective Drug Utilization Review (ProDUR) and houses prior authorization/medical necessity history by integrating pharmacy data from all three points of service (DC, mail order, and retail pharmacies) with increased clinical screening and medication-related outcomes.

### **Pharmacy Operations Center (POC)**

DoD organization responsible for Tier I and Tier II (systems and software) support of the PDTs project. The POC resolves ProDUR point of service (POS) conflicts between MTFs, the TPharm contractor; monitors quantity limits (which are cumulative between all three points of service); issues NCPDP provider numbers for DC pharmacies; and maintains "lock out" and "include" databases for closed class and mandatory use requirements contracts.

### **Point Of Service (POS) Option**

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

### **Possible Breach**

An incident where the possibility of unauthorized access is suspected (or should be suspected) and has not been ruled out. For example, if a laptop containing PII/PHI is lost, and the contractor does not initially know whether or not the PII/PHI was encrypted, then the incident must initially be classified as a possible breach, because it is impossible to rule out the possibility of unauthorized access to the PII/PHI. In contrast, that possibility can be ruled out immediately, and a possible breach has not occurred, when misdirected postal mail is returned unopened in its original packaging. However, if the intended recipient informs the contractor that an expected package has not been received, then a possible breach exists until and unless the unopened package is returned to the contractor. In determining whether unauthorized access should be suspected, the contractor shall consider at least the following factors:

- How the event was discovered;
- Did the information stay within the covered entity's control;
- Was the information actually accessed/viewed; and

- Ability to ensure containment (e.g., recovered, destroyed, or deleted).

### **Preauthorization**

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

### **Preferred Provider Organization (PPO)**

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

### **Prescriber**

A physician or other individual professional provider of services specifically authorized to prescribe medications or supplies in accordance with all applicable federal and state laws.

### **Prescription**

A legal order from an authorized prescriber to dispense pharmaceuticals or other authorized supplies.

### **Prevailing Charge**

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

### **Preventive Care**

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

### **Primary Care**

Those standard, usual and customary services rendered in the course of providing routine ambulatory health care required for TRICARE beneficiaries. Services are typically, although not exclusively, provided by internists, family practitioners, pediatricians, general practitioners and obstetricians/gynecologists. It may also include services of non-physician providers (under supervision of a physician to the extent required by state law). These services shall include appropriate care for acute illness, accidents, follow-up care for ongoing medical problems and

preventive health care. These services shall include care for routine illness and injury, periodic physical examinations of newborns, infants, children and adults, immunizations, injections and allergy shots, and patient education and counseling (including family planning and contraceptive advice). Such services shall include medically necessary diagnostic laboratory and x-ray procedures and tests incident to such services.

**Primary Care Manager (PCM)**

An MTF provider or team of providers or a network provider to whom a beneficiary is assigned for primary care services at the time of enrollment in TRICARE Prime. Enrolled beneficiaries agree to initially seek all non-emergency, non-mental health care services from their PCMs.

**Primary Caregiver (Respite Care Definition)**

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

**Primary Payer**

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

**Prime Contractor**

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

**Prime Enrollee**

An MHS beneficiary enrolled in TRICARE Prime.

**Prior Authorization, Pharmacy**

For certain drugs, DoD requires the contractor to obtain verification from the prescriber that the beneficiary meets certain criteria to receive the drug. Prior Authorization criteria, when developed by the DoD Pharmacy and Therapeutics Committee, will be provided by the Government to the contractor. In certain circumstances, the contractor will be responsible for developing prior authorization criteria, e.g., quantity limit overrides.

**Priority Correspondence**

Correspondence received by the contractor from the Office of the (ASD(HA)) (OASD(HA)), DHA, and Members of Congress, or any other correspondence designated for priority status by the contractor's management.

**Privacy Act, 5 USC 552a**

A law intended to preserve the personal privacy of individuals and to permit an individual to know what records pertaining to him or her are collected, maintained, used, or disseminated, and to have access to and to have copied at the requestor's expense, all or any portion of such records, and to correct or amend such records. Concomitantly, it requires Government activities which collect,

maintain, use or disseminate any record of an identifiable personal nature in a manner that assures that such action is necessary and lawful; that any information collected is accurate, relevant, timely, and as complete as is reasonably possible and necessary to assure fairness to the individual, and that adequate safeguards are provided to prevent misuse or unauthorized release of such information.

### **Processed To Completion (PTC) (Or Final Disposition)**

**1. Claims.** Claims are PTC, for workload reporting and payment record coding purposes, when all claims received in the current and prior months have been processed to the point where the following actions have resulted:

- All services and supplies on the claim have been adjudicated, payment has been determined on the basis of covered services/supplies and allowable charges applied to deductible and/or denied, and
- Payment, deductible application or denial action has been posted to ADP history.

**2. Correspondence.** Correspondence is PTC when the final reply is mailed to the individual(s) submitting the written inquiry or when the inquiry is fully answered by telephone.

**3. Telephonic Inquiry.** A telephonic inquiry is PTC (resolved) when the final reply is provided by either telephone or letter. A final telephone reply means that the caller's inquiry has been fully responded to, there are no unanswered issues remaining, and no additional call-backs are necessary. If the contractor must take a subsequent action to correct a problem or address an issue raised during the telephone call, the telephone inquiry is considered resolved when the contractor identifies the need for the subsequent action, and so notifies the inquirer. For example, if a claim requires adjustment as a result of a telephone inquiry, the call is resolved when the contractor initiates the claim adjustment and the inquirer is so notified (i.e., it is not necessary to keep the call open until the actual processing of the claim adjustment occurs).

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

### **Procuring Contracting Officer (PCO)**

A government employee having authority vested by a PCO's Warrant to execute, administer, and terminate contracts and orders, and modifications thereto, which obligate Government funds and commit the Government to contractual terms and conditions.

### **Profiled Amount**

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

### **Program Integrity System**

A system required of the contractor by the Government for detecting overutilization or fraud and abuse.

### **Prospective Drug Utilization Review (ProDUR)**

A process used to identify any potential medication problems that may occur, based on a patient's current prescription, applicable patient profile information, and medication history, prior to the point of dispensing. ProDUR is used to detect over-utilization, under-utilization, therapeutic duplication, drug-disease complications, drug interactions, incorrect dosages and duration of therapy.

### **Prospective Review**

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

### **Protected Health Information (PHI) (HIPAA/Privacy Definition)**

IIHI that is:

1. Transmitted by electronic media;
2. Maintained in any medium described in the definition of electronic media; or
3. Transmitted or maintained in any other form or medium.

PHI excludes IIHI in:

1. Education records covered by the Family Educational Right and Privacy Act, as amended, 20 USC 1232g;
2. Records described at 20 USC 1232g(a)(4)(B)(iv); and
3. Employment records held by a covered entity in its role as an employer."

### **Provider**

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

### **Provider Exclusion And Suspension**

The terms "exclusion" and "suspension", when referring to a provider under TRICARE, both mean the denial of status as an authorized provider, resulting in items, services, or supplies furnished by the provider not being reimbursed, directly or indirectly, under TRICARE. The terms may be used interchangeably to refer to a provider who has been denied status as an authorized TRICARE provider based on:

1. A criminal conviction or civil judgment involving fraud;
2. An administrative finding of fraud or abuse under TRICARE;

3. An administrative finding that the provider has been excluded or suspended by another agency of the Federal Government, a state, or a local licensing authority;
4. An administrative finding that the provider has knowingly participated in a conflict of interest situation; or
5. An administrative finding that it is in the best interests of TRICARE or TRICARE beneficiaries to exclude or suspend the provider.

### **Provider Network**

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

### **Provider Termination**

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

### **Psychotherapy Notes (HIPAA/Privacy Definition)**

Notes recorded (in any medium) by a HCP who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

### **Public Health Authority (HIPAA/Privacy Definition)**

An agency or authority of the United States, a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate. The term "public health authority" includes any DoD Component authorized under applicable DoD regulation to carry out public health activities, including medical surveillance activities under DoD Directive 6490.2.

### **Quality Assurance (QA), Pharmacy**

A process for ensuring that effective quality control measures are in place to ensure that pharmaceuticals are dispensed accurately and timely. Quality assurance functions may be performed by both the contractor and the government.

### **Quality Assurance Program**

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

### **Quality Control, Pharmacy**

Processes and procedures employed by the contractor to ensure that pharmaceuticals are dispensed accurately and timely.

### **Quality Improvement**

An approach to quality management that builds upon traditional quality assurance methods by emphasizing (1) the organization and systems (rather than individuals), (2) the need for objective data with which to analyze and improve processes, and (3) the ideal that systems and performance can always improve even when high standards appear to have been met.

### **Receipt Of Claim, Correspondence Or Appeal**

Delivery of a claim, correspondence, or appeal into the custody of the contractor by the post office or other party.

### **Reconsideration**

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

### **Records**

All books, papers, maps, photographs, machine readable materials, or other documentary materials, regardless of physical form or characteristics, made or received by an agency of the United States Government under Federal law or in connection with the transaction of public business or appropriate for presentation by that agency or its legitimate successor as evidence of the organization, functions, policies, decisions, procedures, operations, or other activities of the Government.

### **Records Management**

The area of general administrative management concerned with achieving economy and efficiency in the creation, use and maintenance, and disposition of records. Included in the fulfilling of archival requirements and ensuring effective documentation.

### **Referral**

The process of the contractor directing an MHS beneficiary to a network or non-network provider. (See also Same Day and Seventy-Two Hour Referral.)

## **Referral Management**

Referral Management is the process by which PCM's determine if they need to refer a member either to a specialist or for services to be performed outside of the PCM's office (diagnostic tests, outpatient surgery, home health care, etc.). If a referral is necessary, the PCM also needs to decide to whom the referral is made, for how long, and for what services.

## **Region**

A geographic area determined by the Government for civilian contracting of medical care and other services for TRICARE-eligible beneficiaries.

## **Regional Director (RD)**

The individual responsible for supporting TRICARE contract administration in a specific region and directing the activities of the TRICARE Regional Office (TRO).

## **Regional Director's (RD's) Office**

The responsible organizational entity and designated focal point for Tri-Services health services development and planning for a single, integrated health care network within an identified Health Service Region (HSR).

## **Regional Review Authority (RRA)**

The entity performing PRO functions. The contractor performs the duties of the RRA.

## **Representative**

Any person who has been appointed by a party to the initial determination as counsel or advisor and who is otherwise eligible to serve as the counsel or advisor of the party to the initial determination, particularly in connection with a hearing.

## **Required By Law (HIPAA/Privacy Definition)**

A mandate contained in law that compels a covered entity to make a use or disclosure of PHI and that is enforceable in a court of law. Required by law includes, but is not limited to, court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to HCPs participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits. Required by law includes any mandate contained in a DoD Regulation that requires a covered entity (or other person functioning under the authority of a covered entity) to make a use or disclosure and is enforceable in a court of law. The attribute of being enforceable in a court of law means that in a court or court-martial proceeding, a person required by the mandate to comply would be held to have a legal duty to comply or, in the case of noncompliance, to have had a legal duty to have

complied. Required by law also includes any DoD regulation requiring the production of information necessary to establish eligibility for reimbursement or coverage under TRICARE.

### **Research (HIPAA/Privacy Definition)**

A systematic investigation, including research, development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.

### **Residence**

For purposes of TRICARE, "residence" is the dwelling place of the beneficiary for day-to-day living. A temporary living place during periods of temporary duty or during a period of confinement, such as a residential treatment center, does not constitute a residence. In the case of minor children, the residence of the custodial parent(s) or the legal guardian shall be deemed the residence of the child. In the case of incompetent adult beneficiaries, the residence of the legal guardian shall be deemed the residence of such beneficiary. Under split enrollment, when a dependent resides away from home while attending school, their residence shall be where they are domiciled.

### **Residual Claim**

A claim for health care services rendered during the health care delivery period of one contract, but processed under a different (incoming) contract.

### **Resource Sharing Agreement (External)**

Agreement between the contractor and individual MTF commanders to place an MTF provider in a civilian facility (external resource sharing).

### **Respite Care**

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

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

**2. Limitations On Respite Benefits:**

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

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

### **Resubmissions**

A group of TED records submitted to DHA to correct those TED claims and adjustments which generated edit errors when originally processed by DHA. These groups of records will be identified by the batch number and resubmission in the TED Header Record.

### **Retention Period**

The time period for particular records (normally a series) to be kept.

### **Retiree**

A member or former member of a Uniformed Service who is entitled to retired, retainer, or equivalent pay based on duty in a Uniformed Service.

### **Retrospective Drug Utilization Review**

Monitoring, which occurs after a medication is dispensed, for therapeutic appropriateness, over-utilization and under-utilization, therapeutic duplication, drug-disease contraindications, drug interactions, incorrect dosage or duration of therapy.

### **Retrospective Review**

Evaluation of care already delivered to determine appropriateness of care and conformance to pre-established criteria for utilization. The purpose for this type of review may be to validate utilization decisions made during the review process and/or to validate payment made for care provided (by examining the actual record of treatment).

### **Returned Claim**

A claim the contractor returns to the sender because there is missing information that is needed for processing, and the missing information cannot be obtained from in-house sources.

### **Reversed**

Status of claim once reversal transaction is transmitted for the removal of the PAID claim from a patient's profile.

### **Routine Correspondence**

Any correspondence which is not designated as Priority Correspondence.

### **Same Day Referral**

A referral that must be processed, appointed, and patient seen within 24 hours as medically indicated. This includes STAT, 24 hours, ASAP, and Today referral request priorities from CHCS.

### **Sanction**

A provider exclusion, suspension, or termination.

### **Secondary Payer**

The plan or program whose medical benefits are payable in double coverage situations only after the primary payer has adjudicated the claim.

### **Secretary Of Health And Human Services (HHS) (HIPAA/Privacy Definition)**

The Secretary of HHS or any other officer or employee of HHS to whom the relevant authority has been delegated.

### **Segment (HIPAA/Privacy Definition)**

A group of related data elements in a transaction.

### **Service Point Of Contact (SPOC)**

The Uniformed Services office or individual responsible for coordinating civilian health care for ADSMs who receive care under the Supplemental Health Care Program and the TRICARE Prime Remote Program. The SPOC reviews requests for specialty and inpatient care to determine impact on the ADSM's fitness for duty; determines whether the ADSM shall receive care related to fitness for duty at a medical MTF or with a civilian provider; initiates/coordinates medical evaluation boards; arranges transportation for hospitalized service members when necessary; and provides overall health care management for the ADSMs. The SPOC is also responsible for approving certain medical services not covered under TRICARE that are necessary to maintain fitness-for duty and/or retention on active duty. SPOCs for the Army, Navy/Marines, and Air Force are assigned to the Military Medical Support Office (MMSO). [See "Military Medical Support Office (MMSO)."] See [Chapter 16, Addendum A](#), for information on contacting the SPOCs for all services.

### **Seventy-Two Hour Referral**

A referral that must be processed, appointed, and patient seen within 72 hours as medically indicated.

### **Skilled Nursing Facility (SNF)**

An institution (or a distinct part of an institution) that meets the criteria as set forth in [32 CFR 199.6](#).

### **Skilled Nursing Service**

A service that can only be furnished by an R.N., or L.P.N. or L.V.N., and is required to be performed under the supervision of a physician to ensure the safety of the patient and achieve the medically desired result. Examples of skilled nursing services are intravenous or intramuscular injections, Levin tube or gastrostomy feedings, or tracheotomy aspiration and insertion. Skilled nursing services are other than those services that provide primarily support for the essentials of daily living or that could be performed by an untrained adult with minimum instruction or supervision.

### **Special Checks**

Checks issued outside the normal processing workflow for the purpose of expediting payment of a claim for benefits.

### **Special Inquiries**

Freedom of Information Act requests; Privacy Act requests; information requests by the news media; surveys, audits, and requests by Government agencies (including DoD agencies and entities other than DHA) and Congressional Committees.

### **Specialty Care**

Specialized medical services provided by a physician specialist.

### **Split-Billing**

The process by which claims for beneficiaries who have more than one insurer can have their claims processed for payment with the submission of only one electronic claim (also referred to as coordination of benefits).

### **Split Enrollment**

Refers to multiple family members enrolled in TRICARE Prime under different RDs/contractors, including MCSCs and USFHP DPs.

### **Sponsor**

An active duty member, retiree, or deceased active duty member or retiree, of a Uniformed Service upon whose status his or her family members' eligibility for TRICARE is based.

### **Spouse**

A lawful wife or husband regardless of whether or not dependent upon the active duty member or retiree.

### **Stakeholders**

Any party who has an interest in the success of the contract. Stakeholders include the DoD, the RDs, MTF Commanders, DHA, the MHS, and all employees thereof, contractors, elected officials, and MHS beneficiaries.

### **Standard Transaction (HIPAA/Privacy Definition)**

A transaction that complies with the applicable standard adopted under this part.

### **Start Of Service**

The date the incoming contractor officially begins delivery of health care services, processing claims, and/or delivery of other services in a production environment, as specified in the contract.

### **State (HIPAA/Privacy Definition)**

1. For a health plan established or regulated by Federal law, State has the meaning set forth in the applicable section of the USC for such health plan.
2. For all other purposes, State means any of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, and Guam.

### **Student Status**

A dependent of a member or former member of a Uniformed Service who has not passed his or her 23rd birthday, and is enrolled in a full-time course of study in an institution of higher learning.

### **Subcontractors**

1. Includes, but is not limited to, enrolled program health benefits business entities at whatever level of the contract organization they exist. It does not include institutional or non-institutional providers of health care.
2. In determining whether a business entity is a network first tier subcontractor, consideration is given as to whether or not the entity providing the designated services acts as a broker of care; i.e., the entity itself obtains the medical coverage needed by in turn contracting with institutional and non-institutional providers. Implicit in the determination is size of the offered network; i.e., does this entity provide a large number of contracted providers for a large geographical area?
3. This definition does not exclude business entities that are not specifically addressed herein but whose legal status within the contract organization establishes them as subcontractors because that term may be otherwise defined in the FAR.

### **Subcontracts**

The contractual assignment of elements of requirements to another organization or person for purposes of TRICARE. Unless otherwise specified in the contract, the term also includes purchase orders, with changes and/or modifications thereto.

### **Summary Health Information (HIPAA/Privacy Definition)**

Information that may be IHI, and:

1. That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and
2. From which the information has been deleted, except that the geographic information may be aggregated to the level of a five digit zip code.

### **Supplemental Care**

Medical care received by ADSMs of the Uniformed Services and other designated patients pursuant to an MTF referral (MTF Referred Care). Supplemental Health Care also includes specific episodes of ADSM non-referred civilian care, both emergent and authorized non-emergent care (non-MTF Referred Care).

### **Supplemental Funds**

Funds used to pay for supplemental care.

### **Supplemental Insurance**

Health benefit plans that are specifically designed to supplement TRICARE Standard benefits. Unlike other health insurance (OHI) plans that are considered primary payers, TRICARE supplemental plans are always secondary payers on TRICARE claims. These plans are frequently available from military associations and other private organizations and firms.

### **Suspension Of Claims Processing**

The temporary discontinuance of processing (to protect the Government's interests) of claims for care furnished by a specific provider (whether the claims are submitted by the provider or beneficiary) or claims submitted by or on behalf of a specific TRICARE beneficiary pending action by the Director, DHA, or a designee, in a case of suspected fraud or abuse. The action may include administrative remedies or any other DoD issuance (e.g., DoD issuances implementing the Program Fraud Civil Remedies Act), case development or investigation by DHA, or referral to the DoD-Inspector General (IG) or the Department of Justice (DOJ) for action within their cognizant jurisdictions.

### **Termination**

Termination is the removal of a provider as an authorized TRICARE provider based on a finding that the provider does not meet the qualifications established by [32 CFR 199.6](#) to be an authorized TRICARE provider. This includes those categories of providers who have signed specific participation agreements.

### **Third Party Billing Agent**

Any entity that acts on behalf of a provider to prepare, submit, and monitor claims, excluding those entities that act solely as a collection agency, as established by [32 CFR 199.2\(b\)](#).

### **Third Party Liability (TPL) Claims**

TPL claims are claims in favor of the Government that arise when medical care is provided to an entitled beneficiary for treatment or injury or illness caused under circumstances creating tort liability legally requiring a third person to pay damages for that care. The Government pursues repayment for the care provided to the beneficiary under the provisions and authority of the Federal Medical Care Recovery Act (FMCRA) (42 USC paragraphs 2651-2653).

### **Third Party Liability (TPL) Recovery**

The recovery by the Government of expenses incurred for medical care provided to an entitled beneficiary in the treatment of injuries or illness caused by a third party who is liable in tort for damages to the beneficiary. Such recoveries can be made from the liable third party directly or from a liability insurance policy (e.g., automobile liability policy or homeowners insurance) covering the liable third party. TPL recoveries are made under the authority of the FMCRA (42 USC paragraph 2651 et sec. Other potential sources of recovery in favor of the Government in TPL situations include, but are not limited to, no fault or uninsured motorist insurance, medical payments provisions of insurance policies, and workers compensation plans. Recoveries from such other sources are made under the authority of 10 USC paragraphs 10790, 1086(g), and 1095b.)

### **Third Party Payer**

An entity that provides an insurance, medical service, or health plan by contract or agreement, including an automobile liability insurance or no fault insurance carrier and a workers compensation program or plan, and any other plan or program (e.g., homeowners insurance, etc.) that is designed to provide compensation or coverage for expenses incurred by a beneficiary for medical services or supplies.

### **Timely Filing**

The filing of TRICARE claims within the prescribed time limits as set forth in [32 CFR 199.7](#).

### **Toll-Free Telephones**

All telephone calls are considered toll-free for the purposes of measuring the standards contained in [Chapter 1, Section 3, paragraph 3.4](#), except for those telephone calls to an overseas TRICARE Service Center (TSC).

### **Trading Partner Agreement (HIPAA/Privacy Definition)**

An agreement related to the exchange of information in electronic transactions, whether the agreement is distinct or part of a larger agreement, between each party to the agreement. (For example, a trading partner agreement may specify, among other things, the duties and responsibilities of each party to the agreement in conducting a standard transaction.)

### **Transaction (HIPAA/Privacy Definition)**

The transmission of information between two parties to carry out financial or administrative activities related to health care. It includes the following types of information transmissions:

1. Health care claims or equivalent encounter information.
2. Health care payment and remittance advice.
3. Coordination of benefits.
4. Health care claims status.
5. Enrollment and disenrollment in a health plan.
6. Eligibility for a health plan.
7. Health plan premium payments.
8. Referral certification and authorization.
9. First report of injury.
10. Health claims attachments.
11. Other transactions that may be prescribed by regulation.

### **Transfer Claims**

A claim received by a contractor which is for services received and billed from another contractor's jurisdiction. TRICARE claims and attendant documentation must be referred to the appropriate contractor for processing. Notification shall not be sent to the provider claimant explaining the action taken. Notification shall be sent to the patient claimant explaining the action taken, including the name and address of the correct contractor. Claims for active duty members which are sent to the appropriate Uniformed Service are not considered to be "transfer claims."

### **Transition**

The process of changing contractors who serve a particular area or areas. Transition begins with the Notice of Award to the incoming contractor and is formally completed with the close out procedures of the outgoing contractor, several months after the start work date.

### **Transitional Patients Or Cases**

Patients for whom active care is in progress on the date of a contractor's start work date. If the care being provided is for covered services, the contractor is financially responsible for the portion of care delivered on or after the contractor's start work date.

### **Treatment (HIPAA/Privacy Definition)**

The provision, coordination, or management of health care and related services by one or more HCPs, including the coordination or management of health care by a HCP with a third party; consultation between HCPs relating to a patient; or the referral of a patient for health care from one HCP to another.

### **Treatment Encounter**

The smallest meaningful unit of health care utilization: One provider rendering one service to one beneficiary.

### **Treatment Plan**

A detailed description of the medical care being rendered or expected to be rendered a TRICARE beneficiary seeking approval for inpatient benefits for which preauthorization is required as set forth in [32 CFR 199.4](#). A treatment plan must include, at a minimum, a diagnosis (either ICD-9-CM, ICD-10-CM\*, or DSM-III); detailed reports of prior treatment, medical history, family history, social history, and physical examination; diagnostic test results; consultant's reports (if any); proposed treatment by type (such as surgical, medical, and psychiatric); a description of who is or will be providing treatment (by discipline or specialty); anticipated frequency, medications, and specific goals of treatment; type of inpatient facility required and why (including length of time the related inpatient stay will be required); and prognosis. If the treatment plan involves the transfer of a TRICARE patient from a hospital or another inpatient facility, medical records related to that inpatient stay also are required as a part of the treatment plan documentation.

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

### **Triage**

A method of assessing the urgency of need for medical care using the patient's complaints and medical algorithms or other appropriate methods for analysis and then arranging for care. Medically qualified contractor personnel on 24 hour telephone coverage will perform the function.

### **TRICARE**

The DoD's managed health care program for ADSMs, service families, retirees and their families, survivors, and other TRICARE-eligible beneficiaries. TRICARE is a blend of the military's DC system of hospitals and clinics and civilian providers. TRICARE offers three options: TRICARE Standard Plan, TRICARE Extra Plan, and TRICARE Prime Plan (see definitions).

### **TRICARE Beneficiary**

An individual who has been determined to be eligible for TRICARE benefits, as set forth in [32 CFR 199.3](#).

### **TRICARE Contractor**

An organization with which DHA has entered into a contract for delivery of and/or processing of payment for health care services through contracted providers and for processing of claims for health care received from non-network providers and for performance of related support activities.

### **TRICARE DRG-Based Payment System**

A reimbursement system for hospitals which assigns prospectively-determined payment levels to each DRG based on the average cost of treating all TRICARE patients in a given DRG.

### **TRICARE Encounter Data (TED)**

A data set of information required for all care received/delivered under the contract and provided by the contractor in a government-specified format and submitted to DHA via a telecommunication network. The information in the data set can be described in the following broad categories:

1. Beneficiary identification.
2. Provider identification.
3. Health information:
  - Place and type of service
  - Diagnosis and treatment-related data
  - Units of service (admissions, days, visits, etc.)
4. Related financial information.

### **TRICARE Encounter Data (TED) Record Transmittal Summary**

A single record which identifies the submitting contractor and summarizes, for transmittal purposes, the number of records and the financial information contained within the associated "batch" of TED records.

### **TRICARE Extra**

A PPO-like option, provided as part of the TRICARE program under [32 CFR 199.17](#), where MHS beneficiaries may choose to receive care in facilities of the uniformed services, or from special civilian network providers (with reduced cost-sharing), or from any other TRICARE-authorized provider (with standard cost-sharing).

### **TRICARE For Life (TFL)**

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

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

The DoD organization responsible for managing the TRICARE contracts and day-to-day operations of the TRICARE program.

### **TRICARE Operations Manual (TOM) (6010.56-M)**

The manual which provides instructions and requirements for claims processing and health care delivery under TRICARE.

### **TRICARE Policy Manual (TPM) (6010.57-M)**

A DHA manual which provides the description of program benefits, adjudication guidance, policy interpretations, and decisions implementing the TRICARE Program.

### **TRICARE Plus**

An enrollment option for TRICARE beneficiaries not enrolled in Prime. Beneficiaries are enrolled with a primary care coordinator (PCC) at a MTF. Enrollees are to receive primary care appointments within the TRICARE Prime access standards. TRICARE Plus 'enrollment' will be annotated in DEERS and CHCS. For care from civilian providers, TRICARE Standard/Extra rules will apply. For services payable by Medicare, Medicare rules will apply, with TRICARE as second payer for TRICARE covered services and supplies. Specialty care in the MTF will be on referrals from the primary care provider or on a self-referral basis. Enrollees are not guaranteed specialty care appointments within the TRICARE Prime access standards. There is no enrollment fee. MTFs may limit enrollment based on capability and capacity.

### **TRICARE Prime**

An HMO-like option, provided as part of the TRICARE program under [32 CFR 199.17](#), where MHS beneficiaries elect to enroll in a voluntary enrollment program, which provides TRICARE Standard benefits and enhanced primary and preventive benefits with nominal beneficiary cost-sharing. TRICARE Prime requires beneficiaries to use a PCM located at either the MTF or from the contractor's network except when beneficiaries are exercising their freedom of choice under the Point of Service Option.

### **TRICARE Prime Remote Program (TPR)**

The program designed to provide health care services to ADSMs assigned to remote locations in the United States and the District of Columbia.

**TRICARE Prime Remote (TPR) Work Unit**

A uniformed services work unit whose members are eligible to enroll in the TRICARE Prime Remote (TPR) Program as designated by the Military Services.

**TRICARE Prime Service Area (PSA)**

The geographic area where TRICARE Prime benefits are offered. At a minimum, this includes areas around MTFs and Base Realignment and Closure (BRAC) sites.

**TRICARE Program**

A DoD managed health care program operated under the authority of [32 CFR 199.17\(d\)](#).

**TRICARE Quality Monitoring Contract (TQMC)**

A national-level contractor responsible to DoD and DHA that performs second level reconsiderations for payment denials and focused retrospective quality of care reviews.

**TRICARE Regulation**

32 CFR 199. This regulation prescribes guidelines and policies for the administration of the TRICARE Program for the Army, Navy, Air Force, Marine Corps, Coast Guard, Commissioned Corps of the USPHS, and the Commissioned Corps of the NOAA. It includes the guidelines and policies for the administration of the TRICARE Program.

**TRICARE Representative**

A highly qualified service representative serving within a defined part of a contractor's region, providing information and assistance to providers, whether network or non-network, to Health Benefit Advisors (HBAs) in the service area and to congressional offices.

**TRICARE Standard**

A health care option, provided as part of the TRICARE program under [32 CFR 199.17](#), where MHS beneficiaries may choose to receive care in facilities of the uniformed services, or from any TRICARE authorized providers (with standard cost-sharing).

**TRICARE Systems Manual (TSM) (7950.2-M)**

A DHA manual which provides ADP instructions and requirements for contractors who use the TEDs system for reporting data to DHA.

**Unbundled (Or Fragmented) Billing**

A form of procedure code manipulation which involves a provider separately billing the component parts of a procedure instead of billing only the single procedure code which represents the entire comprehensive procedure.

### **Uniform Formulary**

PL 106-65, DoD Authorization Act of Fiscal Year 2000, at section 701, mandated that DoD develop a uniform formulary to be applied across all points of service within the TRICARE system.

Pharmaceuticals and other supplies authorized for dispensing will be in accordance with TRICARE policy and the Uniform Formulary. Recommendations for the design, structure and composition of the Uniform Formulary are developed by the DoD Pharmacy and Therapeutics (P&T) Committee, with comments by the Uniform Formulary Beneficiary Advisory Panel, and provided to the Executive Director, DHA for approval and implementation.

### **Uniform HMO Benefit**

The health care benefit established by [32 CFR 199.18](#).

### **Uniformed Services**

The Army, Navy, Air Force, Marine Corps, Coast Guard, Commissioned Corps of the USPHS, and the Commissioned Corps of the NOAA.

### **Uniformed Services Clinic (USC)**

A MHS clinic that delivers primary care to ADSMs.

### **Uniformed Services Family Health Plan (USFHP)**

A Government-contracted health plan that offers enrollment in TRICARE Prime to individuals who reside in the geographic service area of a USFHP DP who are eligible to receive care in medical MTFs (except ADSMs). This includes those individuals over age 65 who, except for their eligibility for Medicare benefits, would have been eligible for TRICARE benefits. DPs under the USFHP were previously known as "Uniformed Services Family Treatment Facilities" (USTFs) and are former USPHS hospitals. The service areas of the USFHP designate providers are listed at <http://www.usfhp.org> on the world wide web and under "USTF" in the Catchment Area Directory.

### **United States**

"United States" means the 50 states and the District of Columbia.

### **United States Public Health Service (USPHS)**

An agency within the U.S. Department of HHS which has a Commissioned Corps which are classified as members of the "Uniformed Services."

### **Unprocessable TRICARE Encounter Data (TED)**

TED records transmitted by the contractor to DHA and received in such condition that the basic record identifier information is not readable on the TRICARE data system, i.e., header incorrect, electronic records garbled, etc.

### **Unproven Drugs, Devices, And Medical Treatments Or Procedures**

Drugs, devices, medical treatments or procedures are considered unproven if:

1. FDA approval is required and has not been given;
2. If the device is a FDA Category A Investigational Device Exemption (IDE);
3. If there is no reliable evidence which documents that the treatment or procedure has been the subject of well-controlled studies of clinically meaningful endpoints which have determined its maximum tolerated dose, its toxicity, its safety, and its efficacy as compared with the standard means of treatment or diagnosis;
4. If the reliable evidence shows that the consensus among experts regarding the treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its safety, or its effectiveness as compared with the standard means of treatment or diagnosis.

For further clarification see [32 CFR 199.4\(g\)\(15\)](#).

### **Urgent Care**

Medically necessary treatment that is required for illness or injury that would not result in further disability or death if not treated immediately. The illness or injury does require professional attention, and should be treated within 24 hours to avoid development of a situation in which further complications could result if treatment is not received.

### **Use (HIPAA/Privacy Definition)**

The Privacy Regulation defines "Use" as "with respect to IIHI, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information."

### **Utilization Criteria**

Specific conditions that must be met in order to provide appropriate treatment. DoD-approved criteria to use for screening medical/surgical care and for mental health care as outlined in [Chapter 7](#).

### **Utilization Management**

A set of techniques used to manage health care costs by influencing patient care decision-making through case-by-case assessment of the appropriateness and medical necessity of care either prior to, during, or after provision of care. Utilization management also includes the systematic evaluation of individual and group utilization patterns to determine the effectiveness of the employed utilization management techniques and to develop modifications to the utilization management system designed to address aberrances identified through the evaluation.

### **Utilization Review**

A process of case-by-case examination for consistency of the provider's request for specific treatment(s) (e.g., level of care, procedures, etc.) with preestablished criteria. Specific types of review include (but are not limited to) prospective review, concurrent review, and retrospective review. For the purposes of a TRICARE contract, utilization review will be mandatory for enumerated conditions and treatments in order to generate certification and authorization for care provided.

### **Veteran**

A person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.

**Note:** Unless the veteran is eligible for "retired pay," "retirement pay," or "retainer pay," which refers to payments of a continuing nature and are payable at fixed intervals from the Government for military service neither the veteran nor his or her family members are eligible for benefits under TRICARE.

### **Widow Or Widower**

A person who was a spouse at the time of death of the active duty member or retiree and who has not remarried.

### **Workday**

A day on which full-time work is performed.

### **Worker's Compensation Benefits**

Medical benefits available under any worker's compensation law (including the Federal Employees Compensation Act), occupational disease law, employers liability law, or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure.

### **Workforce (HIPAA/Privacy Definition)**

The Privacy Regulation defines, "Workforce" as "employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity is under the direct control of such entity, whether or not they are paid by the covered entity."

- END -