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TRICARE  
MANAGEMENT ACTIVITY

PCPB

CHANGE 2  
6010.56-M  
MAY 15, 2008

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

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

**CHANGE TITLE:** CONSOLIDATED UPDATE

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

**SUMMARY OF CHANGE(S):** This change brings this Manual up-to-date with published changes in the Aug 2002 TRICARE Operations Manual (TOM), 6010.51-M. The changes included are: Processing of Out-Of-Jurisdiction (OOJ) Claims (Aug 2002 TOM, Change 61); Autism Demonstration Changes (Aug 2002 TOM, Change 62 and Change 64); and Foreign Fee Schedules (Aug 2002 TPM, Change 74). This change also includes administrative changes to remove reporting requirements which are now included in the contract(s) as a deliverable and to make clarifications to existing requirements.

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

This change is made in conjunction with Feb 2008 TPM, Change No. 2, Feb 2008 TRM, Change No. 2, and Feb 2008 TSM, Change No. 2.

Laura Sells  
Chief, Purchased Care Procurement  
Branch

**ATTACHMENT(S):** 75 PAGES  
**DISTRIBUTION:** 6010.56-M

**CHANGE 2**  
**6010.56-M**  
**MAY 15, 2008**

**REMOVE PAGE(S)**

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**CHAPTER 6**

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**APPENDIX B**

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and discuss the dates of the test and information regarding the administration of the Benchmark Test. At this time, TMA will provide the test scenarios to the contractor that are to be used in the development of their test claims.

**Note:** At TMA's discretion, the test must be completed NLT 60 days prior to the start of health care delivery to allow time to make any needed corrections. The pre-benchmark meeting will be conducted at the incoming contractor's claims processing site. Provider and beneficiary data, to include enrollment forms, physician referrals, and authorizations, will be coordinated at the pre-benchmark meeting to ensure that the contractor adequately prepares all files prior to the Benchmark. Electronic transaction requirements shall be discussed to include timing and logistics.

**3.3.2** On the first day of the Benchmark Test, a brief entrance conference will be held with contractor personnel to discuss the schedule of events, expectations and administrative instructions.

**3.3.3** During the Benchmark Test the contractor shall process the claims and provide TMA with all output, including EOBs, summary vouchers, suspense reports, checks, and claims histories. Paper checks and EOBs may be printed on plain paper, with EOB and check overlays. Electronic output is required for electronic transactions.

**3.3.4** The contractor shall provide output for evaluation by the TMA Benchmark Team as the claims are processed to completion. The specific schedule for claims processing and the procedures for providing the output to the Benchmark Team will be discussed with the contractor at the pre-benchmark meeting.

**3.3.5** TMA personnel will compare the Benchmark Test claim output against the benchmark test conditions for each claim processed during the test and provide the findings to the contractor. All appropriate contractor and Benchmark Team personnel shall be present to answer any questions raised during the Benchmark Test claims review.

**3.3.6** At the conclusion of the **on-site portion of the** Benchmark Test, an exit conference may be held with the contractor staff to brief the contractor on all findings identified during the Benchmark. **The initial test results will be provided to** the contractor. The initial Benchmark Test Report will be forwarded to the contractor by TMA within **20** calendar days of the last day of the **on-site** test. For any claims processing errors assessed with which the contractor disagrees, a written description of the disagreement along with any specific references must be included with the claims. The contractor's response to the Initial Benchmark Test Report shall be submitted to the TMA Contracting Officer (CO) within **20** days. Following the contractor's response, TMA shall provide the Final Benchmark Test Report to the contractor within **20** calendar days.

**3.3.7** The contractor shall prepare and submit the initial TED submission to TMA for evaluation during the Benchmark Test. A TED record shall be prepared for each Benchmark claim processed to completion, whether allowed or denied, within two calendar days from the processed date. TED records will not be created for claims removed from the contractor's processing system, i.e., out of jurisdiction transfers. The contractor shall be notified of any TEDs failing the TMA edits. The contractor shall make the necessary corrections and resubmit the TEDs until 100% of the original Benchmark Test TEDs have passed the edits and are accepted by TMA. TEDs submission files related to the Benchmark Tests must be identified by transmission file and batch/voucher numbers prior to submission to TMA.

**3.3.8** The contractor has 45 calendar days from the date of the initial Benchmark Test report to submit the final corrected TEDs to TMA. New TEDs need not be generated to reflect changes created from claims processing corrections, however, all TEDs originally submitted for the Benchmark Test claims which did not pass the TMA edits must continue to be corrected and resubmitted until all edit errors have been resolved and 100% of the TEDs have been accepted by TMA. TEDs submission files related to the Benchmark Tests must be identified by transmission file and batch/voucher numbers prior to submission to TMA.

### **3.4 Operational Aspects**

**3.4.1** The Benchmark Test may be conducted on the contractor's production system or an identical copy of the production system (test system). Whichever system is used for the Benchmark, it must meet all TRICARE requirements and contain all the system interconnections and features of the production system in the contractor's proposal. When the Benchmark Test is conducted on the contractor's production system, the contractor shall prevent checks and EOBs from being mailed to the beneficiaries and providers, and prevent production TEDs from being generated and sent to TMA.

**3.4.2** Certain external test systems and files (e.g., DEERS) are an integral component of the Benchmark Test and the contractor is expected to perform all necessary verifications, and queries, according to TRICARE procedures and policy. The contractor shall coordinate through the TMA, Contract Operations Branch, to ensure that direct interface with any required external test systems (i.e., DEERS) is established and operational prior to the Benchmark Test.

**3.4.3** TEDs shall be generated from the Benchmark Test claims and provided to TMA for processing as scheduled at the pre-benchmark meeting. The contractor shall coordinate with the TMA, O/ATIC, for TED submission procedures.

## **4.0 CONTRACT PHASE-OUT**

### **4.1 Transition Specifications Meeting**

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

### **4.2 Data**

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

- The data contained in the contractor's enrollment information system.

## Enrollment Processing

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

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

### 1.0 ENROLLMENT PROCESSING

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

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

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

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

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

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

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

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

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

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

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

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

**1.6.1** If the enrollment form contains **neither a residence address nor a mailing address, the contractor shall attempt to develop the enrollment form for a residence address. If it is determined the beneficiary does not have an established residence address or that the beneficiary's mailing address differs from the residence address, the contractor shall also develop** the enrollment form for a mailing address.

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

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

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

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

## **2.0 ASSIGNMENT OF PCM**

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

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

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

**2.1.2** All active duty personnel not meeting the requirements for TRICARE Prime Remote (TPR) shall be enrolled to an MTF, not the contractor's network, regardless of capacities.

**2.1.3** When a family member of a sponsor E-1 through E-4 requests a PCM in an MTF that offers TRICARE Prime for any beneficiary category other than active duty, that beneficiary must be assigned an MTF PCM unless capacity has been reached. If overall MTF capacity has not been reached, the MCSC shall request the MTF to shift capacity in DOES to the Active Duty Family Member (ADFM) beneficiary category from another category if necessary to accommodate an E-1 - E-4 ADFM beneficiary's PCM assignment request.

**2.2** MTFs will provide the MCSC a current listing of all Primary Care Locations with associated groups or a current listings of DC PCMs. The list(s) will be made available for the beneficiary's use for the initial selection or change of a PCM. The MCSC will provide guidance to the enrollee in selecting a Primary Care Location or PCM, as appropriate given MTF guidance in the MOU. Upon receipt of an inquiry from a DC enrollee in regards to the person's assigned PCM, the MCSC shall refer the beneficiary to the MTF to which the beneficiary is enrolled.

**2.3** At the time of enrollment, the contractor is responsible for determining the appropriate enrollment Defense Medical Information System Identification (DMIS-ID) based on the regional and MTF MOUs, access standards and/or other specific Government guidance. The contractor shall assign each enrollee a PCMBN at the time of enrollment based on those PCMs available within DOES.

**2.3.1** The contractor will attempt to assign the beneficiary to the PCM requested on the enrollment form if capacity is available. If the preferred PCM is not available, the contractor will use the default PCM for that DMIS.

**2.3.2** If the enrollment form contains a gender or specialty preference, the MCSC will try to assign an appropriate PCM. If the gender or specialty is not available, the beneficiary will be enrolled to the default PCM for that DMIS.

**2.3.3** If there is no PCM preference stated on the enrollment form, the contractor will use the default PCM for that DMIS.

**2.3.4** If there is no DC PCM available in the appropriate DMIS/MTF, nonactive duty beneficiaries may be enrolled to a civilian PCM, by following the procedures specified for such situations in the local MTF MOU.

**2.3.5** If there is no PCM capacity in the MTF for an Active Duty Service Member (ADSM), then the MCSC will contact the MTF for instructions.

**2.4** DOES reflects only those DC PCMs that the MTF has loaded onto the DEERS PCM Repository. Further, DOES will only display PCMs with available capacity for the specific beneficiary's category and age. The contractors cannot add, delete, or modify DC PCMs on the repository.

**2.5** The contractor shall complete all panel PCM reassignments (batch) using a Government-provided systems application, PCM Reassignment System (PCMRS). Panel reassignments may be specified by the appropriate MTF Commander for a variety of reasons, including the rotation or deployment of DC PCMs. MCSCs should expect at least one-half of DC PCM assignments to change each year. These moves may be based on various factors of either the enrollment or the individual beneficiary, including:

- DMIS ID to DMIS ID
- PCM ID to PCM ID
- Health Care Delivery Program (HCDP)
- Sex of beneficiary
- Unit Identification Code (UIC) (active duty only)
- Age of beneficiary
- Sponsor Social Security Number (SSN) (for family moves)
- Name of beneficiary

**2.6** MTFs may request PCM reassignment, including panel reassignments, in several ways, including telephone, e-mail or other electronic submissions. The most common method to request individual PCM reassignments is the telephone. The preferred method for panel reassignments is the batch staging application within PCMRS. Regardless of the submission method, the MTF must provide sufficient information identifying both the PCMs and beneficiaries involved in a move to allow the contractor to reasonably accomplish the move. Thereafter, the contractor shall complete each DC PCM reassignment, both individual and panel reassignment, within three working days of receiving all necessary information from the MTF.

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

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

### **3.0 ENROLLMENT PERIOD**

#### **3.1 Effective Date of Enrollment**

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

**3.1.1** The effective date of enrollment for ADSMs shall be the date the contractor receives the signed enrollment application.

**3.1.2** All other enrollment periods shall begin on the first day of the month following the month in which the enrollment application and any required enrollment fee payment are received by the contractor. If an application and fee are received after the 20th day of the month, enrollment

will be on the first day of the second month after the month in which the contractor received the application. (This recurring principle is referred to as the 20th of the month rule.)

**3.1.3** Enrollees who transfer enrollment continue with the same enrollment period. The enrollment transfer, however, is effective the date the gaining contractor receives a signed enrollment application or transfer application. See TPM, [Chapter 10, Sections 2.1 and 5.1](#) for information on TAMP and other changes in status.

### **3.2 Enrollment Expiration**

**3.2.1** NLT 30 calendar days before the expiration date of an enrollment, the contractor shall send the appropriate individual (sponsor, custodial parent, retiree, retiree family member, survivor or eligible former spouse, etc.) a written notification of the pending expiration and renewal of the TRICARE Prime enrollment and a bill for the enrollment fee, if applicable. The bill shall offer all available payment options and methods. The contractor shall issue a delinquency notice to the appropriate individual 15 calendar days after the expiration date of the enrollment.

**3.2.2** The contractor shall automatically renew enrollments, including those for ADSMs, upon expiration unless the enrollee declines renewal, is no longer eligible for Prime enrollment, or fails to pay any required enrollment fee on a timely basis, including a 30 calendar day grace period beginning the first day following the last day of the enrollment period.

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

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

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

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

### **3.3 Disenrollment**

**3.3.1** The contractor shall automatically disenroll beneficiaries when the appropriate enrollment fee payment is not received by the 30th calendar day following the enrollment period expiration date or the due date for the installment payment. The contractor shall set the disenrollment effective date retroactive to the annual renewal date or the payment due date, whichever applies.

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

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

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

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

## **4.0 ENROLLMENT FEES**

### **4.1 General**

The contractor shall collect enrollment fee payments from TRICARE Prime enrollees as appropriate and shall report those fees, including any overpayments that are not refunded to the enrollee, to DEERS. (See the TSM, [Chapter 3](#).) The Prime enrollee may select one of the following three payment fee options on the Prime Enrollment Application Form. In the event that there are insufficient funds to process a premium payment, the contractor may assess the account holder a fee of up to 20 U.S. dollars (\$20.00).

#### **4.1.1 Annual Payment Fee Option**

An annual installment is collected in one lump sum. For initial enrollments, the contractor shall prorate the fee from the enrollment date to September 30. The contractor shall accept payment of the annual enrollment fee by credit card (e.g., Visa/Mastercard).

#### **4.1.2 Quarterly Payment Fee Option**

Quarterly installments are equal to one-fourth (1/4) of the total annual fee amount. For initial enrollments, the contractor shall prorate the quarterly fee to cover the period until the next fiscal year quarter. (Fiscal quarters begin on January 1, April 1, July 1, and October 1.) The contractor shall collect quarterly fees thereafter. The contractor shall accept payment of the quarterly enrollment fee by credit card (e.g., Visa/Mastercard).

#### **4.1.3 Monthly Payment Fee Option**

Monthly installments are equal to one-twelfth (1/12) of the total annual fee amount. Monthly enrollment fees must be paid through an allotment from retirement pay or through Electronic Funds Transfer (EFTs) from the enrollee's designated financial institution.

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

**4.1.3.2** The contractor shall be responsible for verifying the information necessary to initiate monthly allotments and EFTs.

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

## **4.2 Member Category**

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

## **4.3 Unremarried Former Spouses (URFs) and Children Residing with Them**

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

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

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

## **4.4 Medicare Part B Fee Waiver**

Each Prime enrolled beneficiary under age 65, who maintains enrollment in Medicare Part B, is entitled to a waiver of an amount equivalent to the individual TRICARE Prime enrollment fee. Hence, individual enrollments for such beneficiaries will have the enrollment fee waived. A family enrollment in TRICARE Prime, where one family member is under age 65 and maintains enrollment in Medicare Part B, shall have one-half of the family enrollment fee waived; the remaining half must be paid. For a family enrollment where two or more family members are under age 65 and maintain enrollment in Medicare Part B, the family enrollment fee is waived regardless of the number of family members who are enrolled in addition to those entitled to Medicare Part B.

## **4.5 Mid-Month Enrollees**

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

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

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

**Example:** If the retirement date is May 27, the effective enrollment date will be May 27 and the determined enrollment date will be July 1. Fees will be charged for the period from July 1 forward; no fees will be assessed for the period from May 27 through June 30. Reference the TPM, [Chapter 10, Section 3.1](#).

#### **4.6 Overpayment Of Enrollment Fees**

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

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

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

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

**5.3** The primary means of identification and subsequent referral for enrollment will occur during in-processing. These non-enrolled families may also be referred to the local TSC by the MTF, Commanders, First Sergeants/Sergeants Major, supervisors, Family Support Centers, and others.

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

**5.5** The contractor shall also discuss the potential effective date of the enrollment, explaining that the actual effective date will depend upon the date the enrollment application is received, consistent with current TRICARE rules (i.e., the "20th of the month" rule). The effective date of enrollment shall be determined by the date the enrollment application is received by the MCSC. These enrollments and enrollment refusals should not be tracked, nor the enrollees identified

differently than enrollments initiated through any other process, such as the MCSC's own marketing efforts.

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

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

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

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

**6.2** The contractor shall allow a TRICARE-eligible beneficiary who has less than 12 months of eligibility remaining to enroll in TRICARE Prime until such time as the enrollee loses his/her TRICARE eligibility. The enrollment transaction to DEERS shall reflect the end date of enrollment to be the same as the end date of eligibility on DEERS. The beneficiary shall have the choice of paying the entire enrollment fee or paying the fees on a more frequent basis (e.g., monthly or quarterly). If the enrollee chooses to pay by installments, the contractor shall collect only those installments required to cover the period of eligibility.

**6.3** Contractors shall reimburse the unused portion of the TRICARE Prime enrollment fee to retired TRICARE Prime enrollees and their families who have been recalled to active duty. Contractors shall calculate the reimbursement using monthly pro-rating, and shall report such reimbursements to DEERS. If the reactivated member's family chooses continued enrollment in TRICARE Prime, the family shall begin a new enrollment period and shall be offered the opportunity to keep its PCM, if possible. Any enrollment/fiscal year catastrophic cap accumulations shall be applied to the new enrollment period.

**6.4** The contractor shall reimburse enrollment fees for deceased enrollees upon receiving a written request from the remaining enrollee or the executor of the decedent's estate. The request must include a copy of the death certificate. Reimbursements shall be prorated on a monthly basis and apply both to individual plans where the sole enrollee is deceased and to the conversion of a family enrollment to an individual plan upon the death of one or more family members. For individual enrollments, the contractor shall refund remaining enrollment fees to the executor of the estate. For family enrollments that convert to individual plans, the contractor shall either credit the excess fees to the individual plan or refund them either to the remaining enrollee or to the executor of the decedent's estate, as appropriate. Enrollment fees for family enrollments of three or more members are not affected by the death of only one enrollee and no refunds shall be issued. The contractor shall record all reimbursements of fees in DEERS.

**6.5** The MCSCs shall refund the unused portion of the TRICARE Prime enrollment fee to TRICARE Prime enrollees who become eligible for Medicare Part A based upon disability, End Stage Renal

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Disease (ESRD) or upon attaining age 65, provided the beneficiary' has Medicare Part B coverage. The contractor shall calculate the refund using monthly prorating.

**6.5.1** For Prime enrollees who become Medicare eligible upon attaining age 65 and who maintain Medicare Part B coverage, refunds are required for overpayments occurring on and after the start of health care delivery of all MCS contracts. The contractor shall utilize its files to substantiate any claim of overpayment.

**6.5.2** For Prime enrollees who are under 65 years of age and become Medicare eligible due to disability or ESRD and who maintain Medicare Part B coverage, refunds are required for overpayments starting on the date the enrollee has Medicare Part B coverage. Beneficiaries must provide sufficient documentation to support the overpayment for a refund. The contractor shall supplement the beneficiary's documentation using DEERS and any available internal files, from the current and any prior contracts.

**6.5.3** The contractors are not required to research their files to identify these individuals. If the contractor receives a refund request, then the contractor shall refund the unused portion of the enrollment fee determined to be an overpayment in accordance with policy.

**6.5.4** Medicare eligibles age 65 and over are not eligible to either enroll or remain in TRICARE Prime. Beneficiaries age 65 and over who are not entitled to premium free Medicare Part A remain eligible for TRICARE Prime.

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

- END -

## Chapter 7

# Utilization And Quality Management

Section/Addendum	Subject/Addendum Title
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1	Management
2	Preauthorizations
3	Contractor Relationship With The Military Health System (MHS) TRICARE Quality Monitoring Contractor (TQMC)
4	Clinical Quality Management Program (CQMP)
A	An Important Message From TRICARE
B	Hospital Issued Notices Of Noncoverage
C	Hospital Adjustments



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

## **6.5 Maintenance Of TEPRV With An APN**

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

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

## **6.6 Provider Correspondence**

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

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

## 6.7 Provider Certification Appeals

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

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

## 7.0 OUT-OF-JURISDICTION CLAIMS

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

### 7.1 Totally Out-Of-Jurisdiction

When the contractor receives an **electronic** claim with no services or supplies within its jurisdiction, they shall **transfer** the claim to the appropriate **jurisdictional** contractor **via a HIPAA-compliant 837 transaction** within 72 hours of identifying **the claim** as being out-of-jurisdiction. This includes forwarding retail pharmacy claims to the TPharm contractor and claims for TRICARE/Medicare dual eligibles to the TDEFIC contractor. The transferring contractor shall **not notify** the **provider** claimant of the action taken **nor** provide the address of the contractor to which the claim was forwarded. **The transferring contractor shall not notify the beneficiary claimant of the action taken. The contractor processing the claim may include an EOB message stating that the claim was transferred from another TRICARE contractor.**

## **7.2 Partially Out-Of-Jurisdiction**

When a contractor receives a claim for services or supplies both within and outside its jurisdiction before processing the services or supplies within its jurisdiction, and within 72 hours of identifying the out-of-jurisdiction items, the contractor shall:

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

## **8.0 NON-TRICARE CLAIMS**

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

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

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

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

### **8.2 Veterans Claims**

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

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

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

- END -



#### **4.0 BENEFICIARY EDUCATION**

The beneficiary educational program shall include the distribution of education materials to all eligible households in accordance with [Section 1](#). Educational efforts include supplying educational materials at TSCs participation in “newcomer orientations” at military bases, outreach to National Guard and Reserve units, briefing at mobilization and demobilization sites and conducting general information sessions for all demographic categories (for example, active duty personnel, Active Duty Family Members (ADFM), new retirees and their dependents, dual-eligible beneficiaries). The MCSC may use other communication tools to educate the beneficiaries including the news media ([Section 4](#)), via the World Wide Web (WWW), correspondence ([Section 4](#)), telephone ([Section 4](#)) face-to-face interaction at the TSCs ([Section 3](#)), and via e-mail, videos, CDs and DVDs.

#### **5.0 WWW**

MCSCs may elect to provide a web site for beneficiaries to access information specific to the MCSC’s management of the TRICARE benefit. This web site shall not merely duplicate beneficiary information contained on the TRICARE web site (<http://www.tricare.mil>). Information posted on the MCSC web site will reflect the “look and feel” of the TRICARE web site (<http://www.tricare.mil>), and will be appropriately linked to information on that site. Information contained on the MCSC web site will not substitute for written or telephonic communication with the beneficiary if those communication tools are in the best interest of the beneficiary.

#### **6.0 BENEFICIARY E-MAIL**

MCSCs may elect to communicate with beneficiaries via e-mail. All beneficiary communications must be in accordance with Health Insurance Portability and Accountability Act (HIPAA) and the Privacy Act, and may not substitute for telephone or written communications if those are in the best interest of the beneficiary.

- END -



## Grievances And Grievance Processing

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### 1.0 GRIEVANCE PROCESSING JURISDICTION

The regional contractor with claims processing jurisdiction for the beneficiary's claim is responsible for processing grievances filed by or in behalf of the beneficiary. Should a grievance pertain to an issue that is the responsibility of another contractor, the other contractor will assist the contractor with jurisdiction in resolving the issue.

### 2.0 GRIEVANCE SYSTEM

The contractor shall develop and implement a grievance system, separate and apart from the appeal process. The grievance system shall allow full opportunity for aggrieved parties to seek and obtain an explanation for and/or correction of any perceived failure of a network provider, contractor, or subcontractor personnel to furnish the level or quality of care and/or service to which the beneficiary may believe he/she is entitled. Any TRICARE beneficiary, sponsor, parent, guardian, or other representative who is aggrieved by any failure or perceived failure of the contractor, subcontractor or contracted providers of service or care to meet the obligations for timely, quality care and service at appropriate levels may file a grievance. All grievances must be submitted in writing. The subjects of grievances may be, but are not limited to, such issues as the refusal of a Primary Care Manager (PCM) to provide services or to refer a beneficiary to a specialist, the length of the waiting period to obtain an appointment, undue delays at an office when an appointment has been made, poor quality of care, or other factors which reflect upon the quality of the care provided or the quality and/or timeliness of the service. If the written complaint reveals an appealable issue, the correspondence shall be forwarded to the contractor's appeals unit for a reconsideration review.

### 3.0 CONTRACTOR RESPONSIBILITIES

It is the contractor's responsibility to conduct an investigation and, if possible, resolve the aggrieved party's problem or concern. In this responsibility, the contractor shall:

**3.1** Ensure that information for filing of grievances is readily available to all Military Health System (MHS) beneficiaries within the service area.

**3.2** Maintain a system of receipt, identification, and control which will enable accurate and timely handling. All grievances shall be stamped with the actual date of receipt within three workdays of receipt by the contractor. The date of receipt shall be counted as the first day.

**3.3** Investigate the grievance and document the results within 60 **calendar** days of receipt of the grievance. The contractor shall notify the Procuring Contracting Officer (PCO) of all grievances for which reviews were not completed within 60 days of receipt.

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**3.4** Provide interim written responses by the 30th calendar day after receipt for all grievances not Processed To Completion (PTC) by that date.

**3.5** Take positive steps to resolve any problem identified within 60 days of the problem identification. If the problem cannot be resolved within that period of time, the PCO or Contracting Officer's Representative (COR) shall be informed of the nature of the problem and the expected date of resolution. If there is no resolution to the problem, the contractor shall acknowledge receipt of the grievance and explain to the grievant why the problem cannot be resolved.

**3.6** Written notification of the results of the review shall be submitted to the beneficiary within 60 days of the original receipt of the grievance. The letter will indicate who the grievant may contact to obtain more information and provide an opportunity for the grievant, if not satisfied with the resolution, to request a second review by a different individual.

**3.7** Ensure the involvement in the grievance review process of appropriate medical personnel, including personnel responsible for the contractor's quality assurance program in any case where the grievance is related to the quality of medical care or impacts on utilization review activities.

**3.8** Maintain records for all grievances, including copies of the correspondence, the results of the review/investigation and the action taken to resolve any problems which are identified through the grievance.

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## Department Of Defense (DoD) Enhanced Access To Autism Services Demonstration

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### 1.0 PURPOSE

The Enhanced Access to Autism Services Demonstration (“Demonstration”) will test the feasibility and advisability of permitting TRICARE reimbursement for Educational Interventions for Autism Spectrum Disorders (EIA) delivered by paraprofessional providers, under a modified corporate services model, in the absence of state or industry oversight. The Demonstration will provide information that will enable the Department of Defense (DoD) to determine if: there is increased access to these services; the services are reaching those most likely to benefit from them; and the quality of those services is meeting a standard of care currently accepted by the professional community of providers of these and related services.

### 2.0 BACKGROUND

**2.1** The Military Health System (MHS) is a \$33 billion dollar enterprise, consisting of 76 military hospitals, over 500 military health clinics, and an extensive network of private sector health care partners, which provides medical care for over nine million beneficiaries including Active Duty Service Members (ADSMs) and Active Duty Family Members (ADFM). Preliminary, but internally reliable counts of the number of military-dependent children with autism reveals that among the more than 1.2 million children of active duty personnel, approximately 8,500 carry one of the autism spectrum disorder diagnoses.

**2.2** Autistic spectrum disorders affect essential human behaviors such as social interaction, the ability to communicate ideas and feelings, imagination, and the establishment of relationships with others. A number of treatments, therapies and interventions have been introduced to ameliorate the negative impact of autism on these areas of concern. EIA services have been shown to reduce or eliminate specific problem behaviors and teach new skills to individuals with autism. The Demonstration will permit TRICARE reimbursement for EIA services (referred to as Intensive Behavioral Interventions in the December 4, 2007 **Federal Register** notice on the Demonstration) such as applied behavior analysis (ABA), delivered by paraprofessional providers, under a modified corporate services model, in the absence of state or industry oversight. Neither the TRICARE Basic Program nor the Extended Care Health Option (ECHO) program currently authorize reimbursement for providers working within this type of unregulated corporate structure. Should the Demonstration result in a determination to make a permanent change to the TRICARE benefit to permit reimbursement of services provided by EIA Tutors under a corporate services model, such decision would require a change to the Code of Federal Regulations (CFR).

### **3.0 DEFINITIONS**

#### **3.1 Applied Behavior Analysis (ABA)**

The design, implementation, and evaluation of systematic environmental changes to produce socially significant change in human behavior through skill acquisition and the reduction of problematic behavior. ABA includes direct observation and measurement of behavior and the identification of functional relations between behavior and the environment. Contextual factors; establishing operations, antecedent stimuli, positive reinforcers, and other consequences are used to produce the desired behavior change.

#### **3.2 Autism Spectrum Disorders (ASDs)**

Collective term indicating Autistic Disorder (AD), Pervasive Developmental Disorder Not Otherwise Specified (PDDNOS), and Asperger's Disorder (AS) as defined by the American Psychiatric Association's (APA's) Diagnostic and Statistical Manual, Fourth Edition (DSM-IV-TR). For the purposes of the Demonstration, Childhood Disintegrative Disorder (CDD) is also subsumed under the ASD term.

#### **3.3 Behavior Plan (BP)**

A plan designed to modify behavior through the use of evidence-based practices and techniques. It is based on the direct observation and measurement of behavior as well as a functional behavioral assessment.

**3.3.1** A BP for a child receiving EIA services under this Demonstration must be developed by the Individual Corporate Services Provider (ICSP) directing the delivery of EIA services to the child or EIA Supervisor serving as the principal supervisor for the beneficiary's intervention services delivered through an Organizational Corporate Services Provider (OCSP); and

**3.3.2** Must be submitted to the beneficiary's Primary Care Provider (PCP) or Specialized ASD Provider prior to instituting services on an ongoing basis (evaluation of the beneficiary to produce an initial BP are excluded from this requirement) provided by EIA Tutors or EIA Tutors-in-Training and again at least once every six months; and

**3.3.3** Must identify long and intermediate-term habilitative and behavioral goals and short-term behavioral objectives that are behaviorally defined; and

**3.3.4** Must identify the criteria that will be used to measure achievement of behavioral objectives; and

**3.3.5** Must clearly state the schedule of services planned and the individuals providers to deliver those services; and

**3.3.6** Must specify a tutor staffing pattern for services that:

**3.3.6.1** Reflects the use of multiple tutors to provide intensive services (i.e., greater than 20 hours per week) to a single child to enhance generalization of learned behaviors; or

**3.3.6.2** Reflects the use of a single tutor to provide intensive services when extraordinary circumstances such as scarcity of tutors or clinical contraindications to the use of multiple tutors are present. Such circumstances must be documented in the BP and the Managed Care Support Contractor (MCSC) may request further documentation and with cause, deny the use of a single tutor to provide intensive EIA services of greater than 20 hours per week to a single beneficiary.

**3.3.7** Must specify the predominant location at which EIA services are to be delivered as in the home, specialized clinic/facility, at school, other location, or in no predominant location; and

**3.3.8** Must include a description of how (if at all) EIA services described in the BP are related to (supportive, complementary, etc.) other special education services targeted at ameliorating the core deficits of ASD provided under the child's Individualized Education Program (IEP) or Individualized Family Service Plan (IFSP) developed in accordance with the Individuals with Disabilities Education Improvement Act (IDEA); and

**3.3.9** Must summarize pertinent issues and recommendations for modifying the BP resulting from quarterly treatment progress meetings held with the child's primary caregivers.

### **3.4 Core Deficits Of ASD**

The main signs and symptoms of autism involve language, social behavior, and behaviors concerning objects and routines:

**3.4.1** Communication Deficits. Lack of speech especially when it is associated with the lack of desire to communicate and lack of nonverbal compensatory efforts such as gestures.

**3.4.2** Social Skills Deficits. Children with ASDs universally demonstrate a decreased drive to connect with others and share complementary feeling states. Children with ASDs often do not appear to seek connectedness; they are content being alone, ignore their parents' bids for attention, and seldom make eye contact or bid for others' attention with gestures or vocalizations.

**3.4.3** Restricted, Repetitive, and Stereotyped Patterns of Behavior, Interests, and Activities. Children with ASDs can demonstrate atypical behaviors in a variety of areas including peculiar mannerisms, unusual attachments to objects, obsessions, compulsions, self-injurious behaviors, and stereotypes. Stereotypes are repetitive, nonfunctional, atypical behaviors such as hand flapping, finger movements, rocking, or twirling.

### **3.5 Educational Interventions For Autism Spectrum Disorders (EIA)**

With regard to interventions for ASDs, the American Academy of Pediatrics (AAP) recently defined education as the fostering of acquisition of skills and knowledge to assist a child to develop independence and personal responsibility; it encompasses not only academic learning but also socialization, adaptive skills, communication, amelioration of interfering behaviors, and generalization of abilities across multiple environments. EIA consists of individualized behavioral interventions employed to systematically increase adaptive behaviors and to modify maladaptive or inappropriate behaviors and are most often used on a one-to-one basis. These interventions are

intended to:

**3.5.1** Help young children with ASD achieve independent, full inclusion in a primary general education setting; and

**3.5.2** Produce measurable outcomes that diminish behaviors that interfere with the development and use of language and appropriate social interaction skills or broaden an otherwise severely restricted range of interests; and

**3.5.3** Increase the child's ability to participate in other therapies and environments.

**3.5.4** EIA interventions for children with autism have certain things in common:

- Intervention designed and overseen directly by qualified, well-trained professionals;
- Detailed assessment of each child's skills as well as child and family preferences to determine initial treatment goals;
- Selection of goals that are meaningful for the child and the family;
- Ongoing objective measurement of the child's progress;
- Frequent review of progress data so that goals and procedures can be "fine tuned" as needed;
- Interventions that address developmentally appropriate goals in all skill areas (e.g., communication, social, self-care, play and leisure, motor, and academic skills);
- Target skills are broken down into small parts or steps that are manageable for the child;
- An emphasis on skills that will enable a child to be independent and successful in both the short and the long run;
- Use of multiple behavior analytic procedures -- both adult-directed and child-initiated -- to promote learning in a variety of ways;
- Many opportunities -- specifically planned and naturally occurring -- for each child to acquire and practice skills every day, in structured and unstructured situations;
- Intervention provided consistently and with an intensity requisite to behavioral goals;
- Abundant positive reinforcement for useful skills and socially appropriate behaviors;
- An emphasis on positive social interactions, and on making learning fun;
- No reinforcement for behaviors that are harmful or prevent learning;

- Use of techniques to help trained skills carry over to various places, people, and times and to enable children to acquire new skills in a variety of settings;
- Parent training so family members can teach and support skills during typical family activities;
- Regular meetings between family members and those designing and implementing the intervention program.

**3.5.5** Only EIA services with particular characteristics as elaborated in [paragraph 6.2](#) are covered under the Demonstration.

### **3.6 EIA Progress Report (EPR)**

Is a report on progress made towards achieving the long and intermediate-term habilitative and behavioral goals and short-term behavioral objectives that were identified in the BP.

**3.6.1** An EPR for a child receiving EIA services under this Demonstration must be developed by the EIA Supervisor directing the delivery of EIA services to the child. If more than one EIA Supervisor is directing delivery of services to the child then a single EPR that reflects the activities of all EIA Tutors will be developed by the sponsor-designated lead EIA Supervisor; and

**3.6.2** Must be submitted by the EIA Supervisor along with the required BP to the beneficiary's PCP or Specialized ASD Provider and upon the termination of services under the direction of that EIA Supervisor with a child; and

**3.6.3** Must report on the progress achieved on behavioral objectives identified in the BP; and

**3.6.4** Must document a child's progress towards achieving behavioral objectives through analysis and reporting of quantifiable behavioral data including, but not limited to the following:

- The frequency, quality and intensity of expression of targeted behaviors in natural situations (e.g., in unstructured situations in the home or classroom rather than during treatment) outside of EIA teaching activities; and
- The degree to which a child's responses are unprompted versus prompted; and
- The generalization of learning to significant age-appropriate behaviors that were not the immediate objectives of EIA; and
- Additional elaborative benchmarks and criteria as the Director, TRICARE Management Activity (TMA) or designee determines necessary to insure quality of delivered services.

**3.6.5** Must describe the data collection procedures; and

**3.6.6** Must provide a narrative summary of the data supporting findings of progress or lack of progress in meeting long and intermediate-term habilitative and behavioral goals and short-term behavioral objectives.

**3.6.7** An EPR is not required to be submitted along with that EIA Supervisor's first BP for a child receiving services.

### **3.7 Functional Behavioral Assessment And Analysis**

The process of identifying the variables that reliably predict and maintain problem behaviors. The functional behavioral assessment and analysis process typically involves:

**3.7.1** Identifying the problem behavior(s);

**3.7.2** Developing hypotheses about the antecedents and consequences likely to trigger or support the problem behavior;

**3.7.3** Performing an analysis of the function of the behavior by testing the hypotheses.

### **3.8 Individualized Education Program (IEP)**

IEP means a written statement for a child with a disability that is developed, reviewed, and revised in accordance with IDEA of 2004, Public Law (PL) 108-446 Sec. 614.

### **3.9 Individualized Family Service Plan (IFSP)**

IFSP means a written statement for an infant or toddler with developmental needs as defined by the IDEA of 2004, PL 108-446 Sec. 636.

### **3.10 Provisional Demonstration Eligibility**

To avoid delaying receipt of services under this Demonstration while completing the Demonstration eligibility process, in particular **obtaining a completed IEP or IFSP**, clinical review of a beneficiary's diagnosis, **or** registration in the ECHO, the regional MCSC may grant otherwise eligible-apparent beneficiaries a provisional eligibility status for a period of not more than 120 days during which ECHO and Demonstration benefits will be authorized and payable. This provisional status is portable across the 50 United States and the District of Columbia.

**Note:** The provisional status will terminate upon completion of the eligibility process or at the end of the 120 day period, whichever occurs first. The government liability for Demonstration benefits will terminate at the end of the 120 day period. **A beneficiary's sponsor will be liable for claims paid for Demonstration benefits if it is determined during the provisional period that the beneficiary is not eligible for the Demonstration.**

### **3.11 Special Education (as defined in IDEA)**

The term "special education" means specially designed instruction to meet the unique needs of a child with a disability, including--instruction conducted in the classroom, in the home, in hospitals and institutions, and in other settings and instruction in physical education.

## 4.0 PROVIDERS

### 4.1 Primary Care Provider (PCP)

PCP is the term used in the Demonstration to collectively refer to:

**4.1.1** A Primary Care Manager (PCM) under the TRICARE Prime or TRICARE Prime Remote for Active Duty Family Member (TPRADFM) programs; and

**4.1.2** A PCP under the TRICARE Standard program; and

**4.1.3** Describes a Military Treatment Facility (MTF) provider or team of providers or a network provider to whom a beneficiary is assigned for primary care services at the time of enrollment in TRICARE Prime.

### 4.2 Individual Corporate Services Provider (ICSP)

**4.2.1** Is an individual EIA Supervisor, not incorporated, meeting specified criteria that permit the EIA Supervisor to receive reimbursement for services provided by EIA Tutors implementing their intervention plan.

**4.2.2** The ICSP is responsible for meeting all requirements ascribed to an EIA Supervisor found in [paragraph 4.4](#) as well those in the Participation Agreement ([Addendum A](#)) and include, but are not limited to:

**4.2.2.1** Submitting to the MCSC all necessary documents to support an application for TRICARE authorization; and

**4.2.2.2** Entering into a Participation Agreement approved by the Director, TMA or designee, which complies with the Participation Agreement requirements established by the Director; and

**4.2.2.3** Certifying that all EIA Tutors and EIA Tutors-in-Training employed by or contracted with the ICSP;

- Meet the education, training, experience, and competency requirements; and
- If required, have completed a criminal background check the results of which meet standards as specified in [paragraph 4.5.6](#) prior to the EIA Tutor providing any EIA services, other than joint services with an EIA Supervisor, to TRICARE beneficiaries.

**4.2.2.4** Maintaining for a period of 36 months after the direct employment or contractual relationship between the ICSP and EIA Tutor has ended, documentation detailed enough to permit independent verification that an EIA Tutor has met all applicable requirements; and

**4.2.2.5** Submitting certification on a fiscal year quarterly basis and maintaining documentation of on-going supervision requirements of EIA Tutors and EIA Tutors-in-Training as described in [paragraph 4.2.3](#); and

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##### 4.2.2.6 Submitting notification when:

- An EIA Tutor-in-Training has fully met all TRICARE requirements for an EIA Tutor as elaborated in [paragraph 4.5](#); and
- When an EIA Tutor meets the threshold for reducing the intensity of on-going supervision as defined in [paragraph 4.5.7](#).

**4.2.2.7** Submitting claims to the appropriate TRICARE MCSC using assigned Healthcare Common Procedure Coding System (HCPCS) and **Current Procedural Terminology (CPT)** codes as described in [paragraphs 8.1.1 through 8.1.5](#); and

**4.2.2.8** Certifying on the BP that services designed for delivery to TRICARE beneficiaries meet all requirements of covered EIA services as defined in [paragraph 6.2](#); and

**4.2.2.9** Ensuring BPs and EPRs are completed and forwarded at least 15 business days before authorization for continued EIA services is due to expire to the beneficiary's PCP or Specialized ASD Provider and parent/caregiver.

##### 4.2.3 Supervising EIA Tutors and EIA Tutors-in-Training.

**4.2.3.1** An ICSP supervising an EIA Tutor or EIA Tutor-in-Training shall maintain records of supervision provided. BACB approved feedback forms are one appropriate tool (see [http://www.bacb.com/Downloadfiles/experience\\_supervsn/50331\\_Supervision\\_form.pdf](http://www.bacb.com/Downloadfiles/experience_supervsn/50331_Supervision_form.pdf)). Any other documentation maintained for this purpose must contain at least the information within the BACB form cited in this paragraph as well as the EIA Tutor or Tutor-in-Training **name**. The ICSP shall retain supervision documentation for audit purposes for a period of 36 months after termination of the Participation Agreement by either party; and

**4.2.3.2** Is responsible for submitting documentation of ongoing supervision of EIA Tutors quarterly to the party or parties directed by the Director, TMA or designee. Required is documentation of:

- The number of hours of directly supervised fieldwork during that reporting period; and
- The lifetime total cumulative hours of indirectly supervised fieldwork for EIA Tutors or EIA Tutors-in-Training with less than 500 hours of indirectly supervised fieldwork; and
- The number of delivered service hours billed to TRICARE for that reporting period provided by the EIA Tutor; and
- The name of the supervisor, the EIA Tutor **name** and signatures of the tutor and supervisor. The supervisor must review the forms with the tutor, retain a copy and provide a copy for the tutor.

**4.2.4** Additional information related to EIA Supervisors and their role as Corporate Services Providers (CSPs) may be found under [paragraph 6.0](#).

### 4.3 Organizational Corporate Services Provider (OCSP)

**4.3.1** For the purposes of the Demonstration an OCSP is a corporation, foundation, or public entity that meets the TRICARE definition of a CSP under [32 CFR 199.6\(e\)\(2\)\(ii\)\(B\)](#) that predominantly renders services of a type uniquely allowable as an ECHO benefit. An OCSP may employ directly or contract with EIA Supervisors and EIA Tutors.

**4.3.2** To provide services under the Demonstration, an OCSP must enter into a Participation Agreement approved by the Director, TMA or designee, which complies with the Participation Agreement requirements established by the Director and includes, but is not limited to the requirement to:

**4.3.2.1** Submit to the MCSC all necessary documents to support an application for TRICARE authorization as a CSP; and

**4.3.2.2** Certify that all EIA Tutors and EIA Tutors-in-Training employed by or contracted with the OCSP;

- Meet the education, training, experience, and competency requirements elaborated in [paragraph 4.5](#); and
- If required, have completed a criminal background check the results of which meet standards as specified in [paragraph 4.5.6](#) prior to the EIA Tutor providing any EIA services, other than joint services with an EIA Supervisor, to TRICARE beneficiaries; and

**4.3.2.3** Maintain for a period of 36 months after the direct employment or contractual relationship between the OCSP and EIA Tutor has ended:

- Documentation detailed enough to permit independent verification that an EIA Tutor has met all TRICARE participation requirements as elaborated in [paragraph 4.5](#); and
- That documents ongoing supervision of EIA Tutors and EIA Tutors-in-Training as described in [paragraph 4.2.3.1](#).

**4.3.2.4** Submit certification on a fiscal year quarterly basis and maintaining documentation of on-going supervision requirements of EIA Tutors and EIA Tutors-in-Training as described in [paragraph 4.2.3](#); and

**4.3.2.5** Submit notification when:

- An EIA Tutor-in-Training has fully met all TRICARE requirements for an EIA Tutor; and
- When an EIA Tutor meets the threshold for reducing the intensity of on-going supervision as defined in [paragraph 4.5.7](#).

**4.3.2.6** Submitting claims to the appropriate TRICARE MCSC using assigned HCPCS and CPT codes as described in [paragraphs 8.1.1 through 8.1.5](#); and

**4.3.2.7** Ensure that each beneficiary receiving EIA services for which the OCSP seeks TRICARE reimbursement has been assigned a principal EIA Supervisor employed by or contracted to the OCSP who leads development of the BP, EPR and quarterly family treatment progress meetings; and

**4.3.2.8** Certify on the BP that services designed for delivery to TRICARE beneficiaries meet all requirements of covered EIA services as defined in [paragraph 6.2](#); and

**4.3.2.9** Ensure BPs and EPRs are completed and forwarded at least 15 business days before authorization for continued EIA services is due to expire to the beneficiary's PCP or Specialized ASD Provider and parent/caregiver.

**4.3.3** An OCSP that receives TRICARE reimbursement for the services of directly employed or contracted EIA Tutors and also seeks TRICARE reimbursement for the services of a provider who otherwise would meet qualifications for an EIA Supervisor, may receive reimbursement for those services only if the provider is a TRICARE authorized EIA Supervisor.

#### **4.4 EIA Supervisor**

**4.4.1** TRICARE authorized provider of EIA services meeting the qualifications and requirements elaborated in [paragraph 4.4](#). An EIA Supervisor may also provide supervisory oversight to EIA Tutors and certain other EIA Supervisors. As a service provider an EIA Supervisor consults, provides training to caregivers, conducts behavioral evaluations of children with ASD, and directs behavioral plan development for TRICARE beneficiaries. As a supervisor an EIA Supervisor is a clinical teacher who educates, observes, assesses, and supervises the educational activities and service delivery of EIA Tutors. At the point in which more than one EIA Supervisor acting in the capacity of an ICSP are simultaneously billing for services of EIA Tutors to a single beneficiary, the beneficiary's sponsor shall designate a lead EIA Supervisor who is responsible for submitting unified BPs, EPRs, and shall organize and direct required quarterly family treatment progress meetings.

**4.4.2** A TRICARE authorized EIA Supervisor must meet one or more of the following requirements:

**4.4.2.1** Be a Board Certified Behavior Analyst (BCBA), as certified by the Behavior Analyst Certification Board (BACB) (see <http://www.bacb.com/> for details of certification); or

**4.4.2.2** Be a Board Certified Associate Behavior Analyst (BCABA), as certified by the BACB, who is supervised by a BCBA; or

**4.4.2.3** Be an individual who is currently approved by the BACB to take the BCBA examination; and

- Submits a copy of the approval notification on BACB letterhead that is dated not more than two years prior to the date of application for TRICARE authorization; and
- Who is supervised by or supervises EIA providers jointly with a BCBA; or

Demonstration must notify the MCSC and provide a detailed explanation for the change in status within 30 days of the effective change in certification status.

**4.4.6.4** A decision by the MCSC to revoke TRICARE authorization is final and may not be appealed.

**4.4.7** Roles and responsibilities of an EIA Supervisor who is an employee of or contractor to an OCSP include, but are not limited to:

**4.4.7.1** Submitting information/documentation required to become TRICARE authorized as an EIA Supervisor; and

**4.4.7.2** Maintaining documentation of receiving on-going supervision by or performing joint supervision with a BCBA as is required of certain EIA Supervisors as described in [paragraph 4.4.5](#); and

**4.4.7.3** Serves as a principal supervisor to EIA Tutors and Tutors-in-Training employed by or contracted to the OCSP; and

**4.4.7.4** Serving as the lead in the development of the BP, EPR and quarterly family treatment progress meetings for TRICARE beneficiaries receiving services through the OCSP.

**4.4.7.5** The EIA Supervisor is not required to enter into a Participation Agreement with TRICARE unless he/she also is an ICSP.

**4.4.8** EIA Supervisors may provide services in any state in which they are legally permitted to provide educational services consistent with their training and professional scope of practice. Remote direct supervision as defined in [paragraphs 4.5.8.2.3](#) and [4.5.8.2.5](#) will be considered to have occurred in the state in which the TRICARE beneficiary received EIA services that are being supervised. Therefore, the EIA Supervisor must meet all applicable legal requirements for practicing in that state.

**4.4.9** Additional information related to EIA Supervisors and their role as CSPs may be found under [paragraph 6.0](#).

## **4.5 EIA Tutor**

**4.5.1** A provider of EIA services qualified by meeting TRICARE requirements as outlined in [paragraph 4.5](#) who delivers services to TRICARE beneficiaries only under the supervision of an EIA Supervisor. EIA Tutors work one-on-one with children implementing the BP designed and maintained by the EIA Supervisor and gather quantifiable behavioral data necessary for the EIA Supervisor to evaluate the effectiveness of the BP in achieving identified goals and objectives. An EIA Tutor may not conduct behavioral evaluations, establish a child's BP, or bill independently for services provided to TRICARE beneficiaries.

**4.5.2** Education of the EIA Tutor must be or have been in:

- A United States or Canadian institution of higher education fully or provisionally accredited by a regional, state, provincial or national accrediting body; or

- An institution of higher education located outside the United States or Canada that, at the time the applicant was enrolled and at the time the applicant graduated, maintained a standard of training equivalent to the standards of training of those institutions accredited in the United States; and
- The EIA Tutor must have completed a minimum of 12 semester hours (or their equivalent) of college coursework and currently be enrolled in course of study leading to an associate's or bachelor's degree (psychology, education, social work, behavioral sciences, human development or related fields); or
- Have completed a minimum of 48 semester hours (or their equivalent) of college coursework.

**4.5.3** Classroom training of the EIA Tutor of:

**4.5.3.1** Forty (40) hours are required and may have been completed during or apart from the educational experiences required in the Participation Agreement. The training must have been provided by:

**4.5.3.1.1** A United States or Canadian institution of higher education fully or provisionally accredited by a regional, state, provincial or national accrediting body; or

**4.5.3.1.2** A Joint Commission or Commission on Accreditation of Rehabilitation Facilities accredited health care facility; or

**4.5.3.1.3** A private agency whose primary business activity is the delivery of services to children with developmental disabilities and whose governing board includes one or more BCBA's; or

**4.5.3.1.4** Web-based instruction not provided by an accredited institution of higher education; and

**4.5.3.1.5** In the instance of [paragraphs 4.5.3.1.2, 4.5.3.1.3, and 4.5.3.1.4](#), the training curriculum has been approved by the BACB or a currently certified BCBA.

**4.5.3.2** At a minimum the training must cover the following topics:

**4.5.3.2.1** Introduction to ASD, AS, and ABA and typical child development;

**4.5.3.2.2** Principles of ABA including reinforcement, prompting and fading, shaping, chaining, maintenance and generalization, extinction and punishment;

**4.5.3.2.3** Discrete trial training, natural environment training and discrimination training;

**4.5.3.2.4** Basic functional behavioral assessment;

**4.5.3.2.5** Introduction to verbal behavior and its analysis including mands, tacts, echoics, intraverbals, and feature, function and class;

**4.5.3.2.6** Instructional control procedures including pairing with reinforcement, environmental manipulations, and pacing;

**4.5.3.2.7** Treating challenging behavior including functional assessment and function-based interventions, introduction to preventive interventions, least restrictive/intrusive model of intervention, and antecedent modification strategies;

**4.5.3.2.8** Behavioral data collection, graphing, and basic data analysis;

**4.5.3.2.9** Legal, ethical, and safety issues including working with families and vulnerable populations;

**4.5.3.2.10** Provider standards and ethics;

**4.5.3.2.11** The impact of children with ASD on family members and family function;

**4.5.4** Experience of the EIA Tutor.

**4.5.4.1** Directly and indirectly supervised fieldwork experiences as defined in [paragraph 4.5.8](#) and meeting either of the following are required.

**4.5.4.1.1** Fifty (50) hours directly supervised fieldwork and a minimum of 500 hours indirectly supervised fieldwork. Indirectly supervised fieldwork must have been completed prior to providing EIA services to TRICARE beneficiaries under this Demonstration; or

**4.5.4.1.2** Forty (40) hours directly supervised fieldwork (all hours must be in-person contact between prospective EIA Tutor and supervisor) over no more than 12 weeks must have been initiated and completed within the 12 months prior to providing EIA services to TRICARE beneficiaries under this Demonstration.

**4.5.4.2** Documentation of experience must include:

- An up-to-date resume of work experience. The names of the private or public agencies/employers, dates of service and approximate hours per week shall be included. It should also include a detailed job description of the type of work and the job responsibilities of the applicant in serving children with developmental disabilities;
- The supervisors name(s) and current contact information;
- Letters of reference or written verification of work experience in each setting including job title and dates of service; and
- If applicable, practicum/internship hours must be documented by an official transcript.

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**4.5.5** Competency to provide services to TRICARE beneficiaries is demonstrated by:

**4.5.5.1** Proficiency in therapeutic methodology and understanding of ABA principles per written and field evaluations; and

**4.5.5.2** Competency in the direct, hands-on delivery of services utilizing the ABA methodologies, techniques, processes, and procedures specified in the EIA Tutor classroom training requirement described in [paragraph 4.5.3.2](#).

**4.5.5.3** Documentation that competencies have been tested and the EIA Tutor has performed adequately shall be retained for a period of 36 months after the direct employment or contractual relationship between the EIA Supervisor and EIA Tutor has ended.

**4.5.6** Criminal background check required on EIA Tutors.

**4.5.6.1** Shall include Federal Criminal, State Criminal, County Criminal and Sex Offender reports for the state and county in which the providers are currently working and residing.

**4.5.6.2** Does not need to be repeated if the EIA Tutor has already undergone a criminal background check with the current employer. However, components of the CBC as required in [paragraph 4.5.6.1](#) that have not been previously performed must be completed prior to providing services under the Demonstration.

**4.5.6.3** TRICARE reimbursement of services provided by an EIA Tutor is conditional on successful completion of the criminal background check prior to the EIA Tutor providing any EIA services, other than joint services with an EIA Supervisor, to TRICARE beneficiaries; and

**4.5.6.4** Certification by the ICSP or OCSP that the tutor has not been convicted of any prohibited offenses, including:

- Incest.
- Unlawful sexual contact.
- Abandonment of child.
- Endangering the welfare of a child.
- Child abuse or neglect.
- Spousal abuse.
- Crimes against children (including child pornography).
- Crimes involving violence including rape, sexual assault and homicide committed at any time.
- Physical assault, battery and drug related offenses committed within the past five years.

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**4.5.6.5** If the tutor has been convicted of any offense for which a reasonable person would question the individual's suitability to work with disabled children, the ICSP or OCSP must submit to the MCSC a letter describing mitigating factors and why the tutor is suitable to work with children. Other convictions and arrests for offenses which may make a person unsuitable for employment may contain (but are not limited to) the following characteristics:

- Offenses against the person where physical harm or death has taken place.
- Offenses involving weapons, explosive devices or threat of harm.
- Offenses involving public indecency and obscenity which may have been the result of plea bargain situations.
- Offenses that show a disregard of others, such as reckless endangering, arson.
- Cruelty to animals or deviant behavior.

**4.5.6.6** The decision of the MCSC to deny permission for a tutor to provide EIA Services to TRICARE beneficiaries must be PROVIDED to the initiating supervisor within 14 days and may not be appealed.

**4.5.6.7** If an EIA Tutor or Tutor-in-Training is found on audit NOT to meet the requirements for a criminal background check as described in [paragraph 4.5.6](#), that EIA Tutor or Tutor-in-Training shall be required by the ICSP or OCSP to immediately cease providing EIA services under the Demonstration.

**4.5.7** Ongoing supervision of EIA Tutors.

**4.5.7.1** Who have completed 500 hours of indirectly supervised fieldwork is required. During each 40 hours of services provided to an individual child:

- A minimum of one hour of direct supervision; and
- A minimum of one hour of indirect supervision is required.

**4.5.7.2** Who have NOT YET completed 500 hours of indirectly supervised fieldwork is required. During each 40 hours of services provided to an individual child:

- A minimum of two hours of direct supervision; and
- A minimum of two hours of indirect supervision is required.

**4.5.8** Nature of supervision for EIA Tutor experience and ongoing supervision requirements.

**4.5.8.1** The supervisor must be a TRICARE authorized EIA Supervisor as defined in this section. The supervisor may not be a relative, subordinate or employee of the tutor.

**4.5.8.2** For direct supervision.

**4.5.8.2.1** The supervisor must observe the tutor engaging in behavior analytic activities in the natural environment in real-time; and

**4.5.8.2.2** Observation should concentrate on tutor-child interactions; and

**4.5.8.2.3** Must be conducted in-person or via real-time media such as web-cameras or videoconferencing; and

**4.5.8.2.4** The supervisor must provide specific feedback to tutors on their performance.

**4.5.8.2.5** In extraordinary circumstances where in-person or real-time interactions between supervisor and supervisee are limited, use of video recordings of the tutor engaging in behavior analytic activities and sent to the supervisor for analysis and subsequent discussion and training are permissible.

- Approval of the use of supervision via video recordings is required when more than half of yearly direct supervision is conducted by this method; and
- Is granted via written request by the MCSC on a case-by-case basis; and
- The use of devices to record or transmit audio or video images of beneficiaries while receiving services for which TRICARE is payer requires prior written informed consent (or of the parent/guardian if the child is under 18 years of age).

**4.5.8.3** Indirect supervision entails review and analysis of case specific issues with the intent at troubleshooting problems, offering suggestions for improvement in practice, and providing further opportunities for learning and mentoring.

- Indirect supervision may be conducted in small groups of 10 or fewer participants for no more than half of the indirect supervision hours required; and
- The remainder of the total indirect supervision must consist of one-to-one contact, which may be conducted via real-time media such as web-cameras, videoconferencing, or similar means in lieu of the supervisor being physically present.

## **4.6 EIA Tutor In-Training**

**4.6.1** A provider of EIA services who has fulfilled all of the requirements to qualify as an EIA Tutor except for the experience requirement as described in [paragraphs 4.5.4.1.1](#) or [4.5.4.1.2](#); and

**4.6.2** Is delivering services under the supervision of an EIA Supervisor.

**4.6.3** All other requirements of EIA Tutors are applicable to EIA Tutors-in-Training.

#### 4.7 Jointly Delivered Services

EIA Supervisor-EIA Tutor: Services delivered jointly, in-person, to a TRICARE beneficiary by an EIA Supervisor with an EIA Tutor or EIA Tutor-in-Training, as may be provided during directly supervised fieldwork as defined in [paragraph 4.5.8.2](#), are reimbursable to the ICSP or OCSP as services provided by the EIA Supervisor using HCPCS code **S5108 as specified in [paragraph 8.1](#)**.

#### 4.8 Specialized ASD Provider

A TRICARE authorized provider who is:

**4.8.1** A physician board-certified or board-eligible in behavioral developmental pediatrics, neurodevelopmental pediatrics, pediatric neurology or child psychiatry;

**4.8.2** A physician or Ph.D. educated psychologist working primarily with children with:

- One or more years of supervised fellowship training that included 40 or more hours of clinical experience in comprehensive evaluations for ASD as evidenced by the name, location and dates of the qualifying fellowship; or
- One or more years of supervised on-the-job training that included the performance of ASD diagnostic evaluations an average of twice each month as evidenced by the position, location and dates of the qualifying on-the-job training.

**4.9** All documentation cited in [paragraph 4.0](#) for submission must be provided to the MCSC unless otherwise stated.

#### 5.0 ELIGIBILITY

**5.1** Eligibility for services under ECHO described in [32 CFR 199.5](#) identifies serious physical disability as a qualifying condition. The TRICARE Policy Manual (TPM), [Chapter 9, Section 2.3](#) specifies the criterion as a condition which precludes unaided performance of one or more major life activities including: breathing, cognition, hearing, seeing, and age appropriate ability essential to bathing, dressing, eating, grooming, speaking, stair use, toilet use, transferring, and walking. Children diagnosed with AD, PDDNOS, AS, and CDD will meet this ECHO requirement for a qualifying condition if, based on deficits associated with the disorder, the child is receiving special education and other supportive services as defined in [paragraph 5.2.3](#) under an IEP or IFSP, except as otherwise indicated.

**5.2** Beneficiaries aged 18 months and older eligible for services under the Demonstration must meet all of the following requirements and have their PCP or a Specialized ASD Provider submit information necessary to allow the MCSC to confirm eligibility:

**5.2.1** Registered or in process of registering in the ECHO; and

**5.2.2** Diagnosed with AD, PDDNOS, AS, or CDD, as defined by the DSM-IV-TR.

**5.2.2.1** The qualifying diagnosis may be made by any TRICARE authorized PCP or a Specialized ASD Provider.

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**5.2.2.2** If a diagnosis of ASD had already been made at the time the Demonstration was made available to beneficiaries the child is NOT required to be re-diagnosed with ASD or to complete diagnostic testing as described in [paragraph 5.2.2.3](#) to participate in the Demonstration. However, all children seeking services under the Demonstration must meet the requirements in [paragraph 5.2.3](#).

**5.2.2.3** Standardized diagnostic testing as described in this paragraph is recommended for all children participating in the Demonstration, but is required only for those children in which the provider making a qualifying diagnosis of AD or PDDNOS is not a Specialized ASD Provider.

**5.2.2.3.1** Standardized diagnostic instruments for autism accepted by TRICARE are:

- Autism Diagnostic Observation Schedule
- Autism Diagnostic Interview-Revised
- Pervasive Developmental Disorders Behavior Inventory (PDDBI)

**5.2.2.3.2** Standardized diagnostic instruments utilized to fulfill this requirement other than those cited in this paragraph must be considered to have reliable evidence (see [32 CFR 199.2\(b\)](#)) supporting their use in making the clinical diagnosis of AD or PDDNOS.

**5.2.2.3.3** The results of diagnostic testing shall be reviewed by the child's PCP or Specialized ASD Provider and provided to the MCSC to determine eligibility for the Demonstration if required. If clinical review of the qualifying diagnosis is required under the Demonstration, a copy of the completed diagnostic instrument shall be provided to the MCSC for their use in performing the review.

**5.2.3** Documented in an IEP or IFSP to be receiving special education and such developmental, corrective, and other supportive services (including psychological services, physical and occupational therapy, social work services, counseling services, including rehabilitation counseling) as may be required to assist a child with a disability to benefit from special education. The term does not include a medical device that is surgically implanted, or the replacement of such device; or

**5.2.4** If the child is homeschooled and not required by state law to have an IEP or IFSP the child's PCP or Specialized ASD Provider must certify that the child's disability related to ASD results in dysfunction severe enough to require special education and other supportive services as described in [paragraph 5.2.3](#).

**5.2.5** The child's nonverbal **or verbal** intelligence quotient **must be** measured by a standardized test of intelligence, **within the 12 months of receiving services under the Demonstration in order to qualify for continued participation in the Demonstration.**

**5.2.5.1** Intelligence testing performed prior to the initiation of the Demonstration **or performed by a local education authority or any tester that is or would be eligible as a TRICARE authorized provider** is acceptable in meeting this requirement.

**5.2.5.2** A letter from the beneficiary's PCP or Specialized ASD Provider certifying that the child is unable to participate in intelligence testing is required to continue participation in the Demonstration after the period **described in paragraph 5.2.5.**

**5.2.5.3** The beneficiary's PCP or Specialized ASD Provider is required to recertify the beneficiary's continued inability to participate in intelligence testing every six months **after the certification required in paragraph 5.2.5.2.**

**5.2.5.4** Standardized diagnostic instruments for intelligence accepted by TRICARE (or most current edition if updated) are (all instruments are not appropriate for all age groups – expert advice prior to completing testing is recommended):

- Wechsler Intelligence Scale for Children, Fourth Edition (WISC-IV)
- Wechsler Preschool and Primary Scale of Intelligence, Third Edition (WPPSI-III)
- Differential Ability Scales (DAS II)
- Mullen Scales of Early Learning-AGS Edition (for children under three or with lower mental ages)
- Stanford-Binet Intelligence Scale, Fifth Edition (SB5)
- Bayley Scales of Infant Development (BSID)
- Leiter International Performance Scale-Revised (LIPS-R)

**5.2.6** For children 18 months through eight years of age standardized testing of language skills and adaptive behavior must be completed.

**5.2.6.1** Standardized testing of language skills and adaptive behavior completed within the 24 months prior to initiation of EIA services under the Demonstration meets the requirement of [paragraph 5.2.6.](#)

**5.2.6.2** Testing must be completed within 12 months of initiating services under the Demonstration if the requirement is not fulfilled per [paragraph 5.2.6.1.](#)

**5.2.6.3** Standardized tests in selected functional areas accepted by TRICARE (or most current edition if updated) are:

**5.2.6.3.1** Language skills:

- Reynell Developmental Language Scales (RDLS)
- Test of Pragmatic Language, Second Edition (TOPL-2)
- Preschool Language Scale, Fourth Edition (PLS-4)
- Clinical Evaluation of Language Fundamentals-Preschool (CELF-P)

- Clinical Evaluation of Language Fundamentals, Fourth Edition (CELF-4)
- Test of Language Development: Primary, Third Edition (TOLD-P:3)

**5.2.6.3.2** Adaptive behavior:

- Vineland Adaptive Behavior Scales, Second Edition (VABS-II)

**5.3** Eligibility for benefits under the Demonstration ceases as of 12:01 a.m. of the day following the day of the earliest occurrence of the following events:

**5.3.1** Eligibility for the ECHO program ends; or

**5.3.2** One hundred twenty (120) days from the date of issuance of the Detailed Explanation of Non-Concurrence (DENC) if a qualifying diagnosis is not established per [paragraph 7.1.2](#).

**5.4** The MCSC will notify the beneficiary in writing of the results of an eligibility determination.

**5.5** A determination that a TRICARE beneficiary is not eligible for benefits under the Demonstration is considered a factual determination based on a requirement of the law or regulation and as such is not appealable. Denial of Demonstration services and supplies to an ineligible beneficiary is not appealable.

**5.6** Absence of eligibility for EIA services under the Demonstration does not preclude beneficiaries from receiving otherwise allowable services under ECHO or the TRICARE Basic program.

## **6.0 POLICY**

**6.1** Delivery of services through a modified corporate services model:

**6.1.1** Under [32 CFR 199.6\(e\)\(2\)\(ii\)\(B\)](#), an ECHO outpatient care provider includes an individual, corporation, foundation, or public entity that predominantly renders services of a type uniquely allowable as an ECHO benefit.

**6.1.2** The TRICARE CSP class under [32 CFR 199.6\(f\)](#) accommodates individuals who would meet the criteria for status as a TRICARE authorized individual professional provider as established by [32 CFR 199.6\(c\)](#), but for the fact that they are employed directly or contractually by a corporation or foundation that provides principally professional services which are within the scope of the TRICARE basic program benefit.

**6.1.3** The Demonstration modifies the CSP requirements of [32 CFR 199.6\(f\)](#) to allow hands-on EIA Tutors who engage in the one-on-one treatment with the child, while employed or contracted by and supervised by an authorized EIA Supervisor.

**6.1.4** TRICARE authorized ABA outpatient care providers (as defined in TPM, [Chapter 9, Section 17.1](#)) are generally individual practitioners, and many practices are not incorporated. As a result, they do not meet most of the requirements under [32 CFR 199.6\(f\)](#) to qualify as a CSP. This Demonstration requires EIA Supervisors to meet the following criteria to qualify as an ICSP under

this Demonstration, and receive reimbursement for services provided by EIA Tutors implementing their BP.

**6.1.4.1** Have entered into a Participation Agreement approved by the Director, TMA or designee, which complies with the Participation Agreement requirements established by the Director; and

**6.1.4.2** Employ directly or contractually an individual who meets TRICARE qualifications for an EIA Tutor; and

**6.1.4.3** Maintain all applicable business license requirements of state or local jurisdictions; and

**6.1.4.4** Cooperate fully with a designated utilization and clinical quality management organization which has a contract with the DoD for the geographic area in which the provider does business; and

**6.1.4.5** Render services for which direct or indirect payment is expected to be made by TRICARE only after obtaining TRICARE written authorization.

**6.1.4.6** Payment for otherwise allowable services by EIA Tutors under this Demonstration project may be made to a TRICARE-authorized EIA Supervisor subject to the applicable requirements, exclusions and limitations of this Demonstration.

**6.1.4.7** Otherwise allowable services may be rendered at the authorized EIA provider's place of business, in the beneficiary's home, at school, or other location that is suitable for the type of services being rendered under such circumstances as the Director, TMA or designee, determines to be necessary for the efficient delivery of such services.

**6.1.4.8** The Director, TMA or designee, shall determine whether the appropriate employment or contractual relationship exists between the EIA Supervisor and EIA Tutor. Such determination is conclusive and may not be appealed.

**6.1.5** The Director, TMA or designee, may limit the term of a Participation Agreement for any category or type of provider established by this Demonstration project.

**6.1.6** Both the EIA Supervisor who is an ICSP as well as the EIA Supervisor who is employed by or contracted to a corporation, foundation, or public entity that meets the TRICARE definition of a CSP under [32 CFR 199.6\(e\)\(2\)\(ii\)\(B\)](#) are required to be TRICARE authorized in order to provide services under the Demonstration. They both must;

**6.1.6.1** Meet the minimum education, training, experience, competency and ongoing supervision requirements for EIA Supervisors as established by the Director, TMA or designee; and

**6.1.6.2** Comply with all applicable organizational and individual licensing or certification requirements that are extant in the state, county, municipality, or other political jurisdiction in which the provider renders services; and

**6.1.6.3** Submit proof that professional liability insurance in the amounts of \$1 million per claim and \$3 million in aggregate, unless there are state requirements that are in different amounts, is maintained in the EIA Supervisor's name.

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**6.1.7** EIA Supervisors and the Director, TMA or designee, may terminate the Participation Agreement for CSPs ([Addendum A](#)).

**6.1.8** The Director, TMA or designee, may create discrete types within the allowable tutor category of provider established by this Demonstration to improve the efficiency of TRICARE management.

**6.2** TRICARE will cost-share EIA services that:

**6.2.1** Are primarily focused on implementation of basic principles of ABA and that target behaviors directly associated with the core deficits of ASD; and

**6.2.2** Are focused on behavior in its own right as a target for change. The target behavior is directly observed and quantifiably measured in real-life environments; and

**6.2.3** Utilize quantified behavioral data to identify functional relations between environmental events and behavior through systematic manipulations; and

**6.2.4** Gather quantifiable behavioral data to track progress in reaching behavioral objectives identified in the BP and to direct the periodic modification of the intervention plan to ensure the child's progressive attainment of behavioral objectives; and

**6.2.5** Include the generalization of learned behaviors as goals of the treatment; and

**6.2.6** Periodically incorporate parent training so family members/caregivers can teach and support skills during typical family activities; and

**6.2.7** Require periodic meetings between family members/caregivers and those designing and implementing the intervention program.

**6.3** The maximum cumulative Government cost-share of the total cost of providing benefits through both the Demonstration and the ECHO program (as implemented in [32 CFR 199.5](#)) shall not exceed \$2,500 per ECHO-registered beneficiary in any single month.

**6.4** Training required of parents/caregivers.

**6.4.1** One parent/caregiver in the beneficiary's immediate family as defined in [32 CFR 199.2](#), must complete classroom and practical training (i.e., hands-on training in the application and delivery of EIA services) in each year in which EIA services are provided under this Demonstration. The same family member does not need to meet this requirement every year the beneficiary receives services under the Demonstration.

**6.4.2** Classroom and practical training must focus at a minimum on the following topics: how to implement the BP at home; how behavioral change is measured and how can progress in the child receiving services be tracked; how can parents/caregivers support the principles and methods of EIA service delivered; and how to promote generalization of behaviors learned as a result of EIA services. Additional guidelines for content of and models for caregiver training may be provided as the Director, TMA or designee, determines to be necessary.

**6.4.3** Classroom training is required and must be provided by:

**6.4.3.1** A United States or Canadian institution of higher education fully or provisionally accredited by a regional, state, provincial or national accrediting body; or

**6.4.3.2** A Joint Commission or Commission on Accreditation of Rehabilitation Facilities accredited health care facility; or

**6.4.3.3** A private agency whose primary business activity is the delivery of services to children with ASD and whose governing board includes one or more BCBA's; or

**6.4.3.4** An EIA Supervisor; or

**6.4.3.5** Web-based instruction not provided by an accredited institution of higher education; and

**6.4.3.6** In the instance of [paragraphs 6.4.3.2, 6.4.3.3, 6.4.3.4, and 6.4.3.5](#), the training curriculum has been approved by the BACB or a currently certified BCBA.

**6.4.3.7** Waiver of the classroom training requirement is permitted when the sponsor certifies to the MCSC that a parent/caregiver in the beneficiary's immediate family has previously received classroom training in the content and to the degree required in the Demonstration.

**6.4.4** Practical training is required and:

**6.4.4.1** Must be provided by an EIA supervisor.

**6.4.4.2** An EIA Supervisor may be reimbursed for parent training (as described in TPM, [Chapter 9, Section 8.1](#)).

**6.4.4.3** Practical training may be conducted in groups of no more than three trainees at a time and shall be calculated as two hours of group training meets one hour of the training requirement.

**6.4.4.4** Waiver of practical training is permitted for caregivers who can document to the MCSC that they:

- Meet the definition of an EIA Supervisor as defined in the EIA Supervisor Provider Application; or
- Have ever been approved by the BACB to take the BCBA or BCABA examinations; or
- Have had 30 hours of hands-on training in providing services directly to children and/or adults with autism under the supervision of a BCBA or an individual with a minimum of a Master's degree in ABA or closely related field and eight years of professional experience in implementing, designing, and overseeing behavior analysis services for individuals with autism.

**6.4.4.5** There is no implied obligation for TRICARE authorized EIA Supervisors to provide caregiver practical training under this Demonstration.

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**6.4.5** The Government cost-share is a maximum of \$2,500 per month per beneficiary. Each year in no instance shall the total amount of the Government cost-share paid for training required of parents/caregivers under the Demonstration exceed \$1,500 per individual and \$4,500 per family during each year in which EIA services are received by the beneficiary.

**6.4.6** For parents/caregivers of children receiving services under the Demonstration:

**6.4.6.1** Six hours of classroom training are required in the first year EIA services are provided.

**6.4.6.2** Six hours of practical training is required during each year in which services are provided.

**6.4.6.3** For caregivers of children 18 months through eight years of age only, 10 hours of practical training are required in the first year EIA services are received.

**6.5** Testing and assessment required to establish a diagnosis of ASD shall be considered for coverage under the Basic Program. Testing intended to further characterize the clinical characteristics of a beneficiary diagnosed with ASD shall be considered for coverage under the ECHO.

**6.6** TRICARE will not cost-share:

**6.6.1** The training necessary for an EIA Tutor or EIA Tutor-in-Training to meet the training requirements defined in [paragraph 4.5.3](#).

**6.6.2** Providing or receiving professional supervision required of EIA Supervisors requiring supervision for TRICARE authorization as elaborated in [paragraph 4.4.5](#).

**6.6.3** Program development or administrative fees for the creation or updating of BPs that are separate from costs associated with the direct educational and behavioral assessment of the TRICARE beneficiary.

**6.6.4** For professional costs associated with attending any meeting with officials of Local Education Authorities whose purpose is the development or modification of an IEP/IFSP.

**6.7** TRICARE will cost-share:

**6.7.1** Evaluation of a beneficiary including observation in school, at home, or in the community.

**6.7.2** Professional fees for the creation of EPRs, including data analysis. Also, see [paragraph 8.1](#).

**6.7.3** Jointly delivered services as described in [paragraph 4.7](#).

**6.7.4** The training necessary for parents/caregivers to meet the training requirements defined in [paragraph 6.4](#).

**6.7.5** Professional fees for conducting in-person the required quarterly treatment progress meetings with TRICARE beneficiary's caregivers. Fee will be reimbursed under CPT<sup>1</sup> code 90887. Also, see [paragraph 8.1](#).

## **7.0 OTHER MCSC RESPONSIBILITIES**

**7.1** Clinical review of qualifying diagnosis.

**7.1.1** A qualifying diagnosis made by other than a Specialized ASD Provider requires clinical review:

**7.1.1.1** The clinical review shall be conducted by a Specialized ASD Provider.

**7.1.1.2** The review shall be of the evidence submitted in support of the diagnosis of ASD consistent with practice recommendations from the American Academy of Neurology (Filipek et al. 1999) and the AAP (Johnson & Myers 2007)—to include health, developmental and behavioral histories, physical examination, developmental evaluation, direct observation of behavior, standardized developmental testing, and rule-out of other conditions as dictated by the clinical presentation of the child.

**7.1.1.3** The clinical review shall be conducted within 14 days of the MCSC receiving all documents necessary to determine eligibility in the Demonstration and only if all other eligibility criteria are met.

**7.1.1.4** If clinical review fails to confirm sufficient evidence supporting the diagnosis of ASD, the beneficiary will be provided a DENC that:

- Details the specific aspect(s) of the diagnosis or diagnostic process that does not meet DSM-IV criteria or conform with medically accepted practices as described in [paragraph 7.1.1.2](#); and
- Is approved by the Specialized ASD Provider who performed the clinical review; and
- Shall be provided to the beneficiary no later than 21 calendar days of the MCSC receiving all documents necessary to determine eligibility in the Demonstration; and

**7.1.1.5** The beneficiary will be provided information describing eligibility criteria for the Demonstration, the differences between a PCP and Specialized ASD Provider and written advice on how to identify and contact Specialized ASD Providers that may be available for consultation.

**7.1.1.6** Clinical review of the qualifying diagnosis is not required if the beneficiary does not qualify for participation in the Demonstration based on any other eligibility criteria required for that beneficiary.

**7.1.2** Continued participation in the Demonstration is contingent upon:

**7.1.2.1** MCSC clinical review confirming a qualifying diagnosis; or

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**7.1.2.2** Subsequent qualifying diagnosis made by a Specialized ASD Provider.

**7.2** Review of BP and EPR: The MCSC shall confirm that a BP and EPR (if required) have been reviewed and accepted by the beneficiary's PCP or Specialized ASD Provider prior to authorization of services to be delivered under the Demonstration. PCP or Specialized ASD Provider review of the BP and EPR (if required) is necessary for prior authorization of services for each six months during which services are delivered.

**7.3** Except at initiation of services, the MCSC shall obtain sponsor certification of the following every six months on behalf of each dependent receiving benefits under the Demonstration as a requirement for continuation of services:

**7.3.1** The name and relationship to the beneficiary of the family member fulfilling the parent/caregiver training requirement; and

**7.3.2** The number of hours of classroom and practical training completed by the identified family member during the previous six months; and

**7.3.3** If the family member has completed the required training for the 12 month training requirement period; and

**7.3.4** The total number of family members receiving TRICARE reimbursed training in the previous 12 months; and

**7.3.5** If the caregivers have had any substantive concerns about the ethical behavior or competence of any individuals providing EIA services to the beneficiary.

**7.3.5.1** The MCSC must respond to expressed family concerns about the ethical behavior or competence of EIA service providers by developing a plan of action with the family to address their concerns.

**7.3.5.2** Based on the family's input, the nature of the concerns, and evidence a plan of action might potentially involve contacting the EIA Supervisor, continued monitoring of services delivered, filing of a formal complaint to the BACB or other professional monitoring entity, termination of TRICARE authorization, or discontinuing reimbursement of services provided by an EIA Tutor, among other possible actions.

**7.3.5.3** A letter or letters outlining the plan of action and the outcomes of any actions taken by the MCSC or other parties in response to the issue of concern will be provided to the beneficiary at regular intervals.

**7.4** The MCSC must maintain all documents created by them and submitted to them used to establish eligibility for the Demonstration; and

**7.4.1** A losing contractor, when informed in writing by the beneficiary's sponsor of a transfer of location, or on receipt of a request from the gaining contractor, will forward all documents to the gaining contractor within ten calendar days; or

**7.4.2** The gaining contractor, on receipt of a beneficiary's signed enrollment application, shall request Demonstration eligibility documents from the losing contractor within five calendar days.

**7.5** A finding of non-compliance on required audits of TRICARE EIA Tutor qualification requirements as elaborated in [paragraph 4.5](#) and/or EIA Tutor-in-Training on-going supervision as elaborated in [paragraph 4.2.3](#) will trigger audit of compliance for all for the EIA Tutors and Tutor-in-Training employed or contractor to the ICSP or OCSP.

## **8.0 REIMBURSEMENT**

**8.1** Claims for Demonstration services will be submitted as follows:

**8.1.1** EIA services provided directly to a beneficiary by an EIA Supervisor, inclusive of those services provided when an EIA Tutor or an EIA Tutor-in-Training is present, will be invoiced by the ICSP or OCSP using HCPCS code "S5108, Home care training to home care client, per 15 minutes."

**8.1.2** EIA services provided directly by an EIA Tutor to a beneficiary will be invoiced by the ICSP or OCSP using HCPCS code "H2019, Therapeutic behavioral services, per 15 minutes."

**8.1.3** EIA practical training of family members by an EIA Supervisor will be invoiced by the ICSP or OCSP using HCPCS code "S5110, Home care training, family, per 15 minutes."

**8.1.4** Development of the required EPRs will be invoiced by the ICSP or OCSP using CPT<sup>2</sup> code 99080.

**8.1.5** Conducting the required quarterly treatment progress meetings with the TRICARE beneficiary's caregivers will be invoiced by the ICSP or OCSP using CPT<sup>2</sup> code 90887.

**8.1.6** EIA classroom training will be reimbursed when submitted to the MCSC by the sponsor of the beneficiary enrolled in the Demonstration in accordance with the TPM, [Chapter 9, Section 8.1](#).

**8.2** Reimbursement of claims in accordance with [paragraphs 8.1.1, 8.1.2, and 8.1.3](#) will be the lesser of:

- \$125 per hour for services provided by the EIA Supervisor and \$50 per hour for services provided by the EIA Tutor; or
- Billed charge; or
- Negotiated rate.

**8.3** Reimbursement of claims in accordance with [paragraphs 8.1.4 and 8.1.5](#) will be the CHAMPUS Maximum Allowable Charge (CMAC).

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**9.0 APPLICABILITY**

**9.1** The provisions of this Demonstration are limited to those TRICARE-eligible beneficiaries as stated in [paragraph 5.0](#).

**9.2** This Demonstration is limited to EIA services provided within the 50 United States and the District of Columbia.

**9.3** For this Demonstration, all provisions of the ECHO program as described in [32 CFR 199.5](#) will continue to apply unless specifically modified by the Demonstration notice, and the provisions of the ECHO program in the TRICARE Manuals will continue to apply unless modified by this section.

**10.0 EFFECTIVE DATE**

This Demonstration is effective for claims for services provided on or after March 15, 2008.

- END -

**ARTICLE 3**

**REIMBURSEMENT**

**3.1 Claims for Demonstration services will be submitted as follows:**

(a) EIA services provided directly to a beneficiary by an EIA Supervisor, inclusive of those services provided when an EIA Tutor or an EIA Tutor-in-Training is present, will be invoiced by the **Individual Corporate Service Provider (ICSP)** or **Organizational Corporate (OCSP)** using HCPCS code "S5108, Home care training to home care client, per 15 minutes."

(b) EIA services provided directly by an EIA Tutor to a beneficiary will be invoiced by the ICSP or OCSP using HCPCS code "H2019, Therapeutic behavioral services, per 15 minutes."

(c) EIA practical training of family members by an EIA Supervisor will be invoiced by the ICSP or OCSP using HCPCS code "S5110, Home care training, family, per 15 minutes."

(d) **Development of the required EIA Progress Reports will be invoiced by the ICSP or OCSP using CPT<sup>1</sup> code 99080.**

(e) **Conducting the required quarterly treatment progress meetings with the TRICARE beneficiary's caregivers will be invoiced by the ICSP or OCSP using CPT<sup>1</sup> code 90887.**

**3.2 Reimbursement of claims in accordance with paragraphs (a), (b), and (c) will be the lesser of:**

(a) \$125 per hour for services provided by the EIA Supervisor and \$50 per hour for services provided by the EIA Tutor; or

(b) Billed charge; or

(c) Negotiated rate.

**3.3 Reimbursement of claims in accordance with paragraphs (d) and (e) will be the CHAMPUS Maximum Allowable Charge (CMAC).**

**3.4 ADMINISTRATION**

The EIA Supervisor as the provider of services agrees:

(a) Not to charge a beneficiary for the following:

(1) Services for which the provider is entitled to payment from TRICARE;

(2) Services for which the beneficiary would be entitled to have TRICARE payment made had the provider complied with certain procedural requirements;

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Participation Agreement For Corporate Services Provider (CSP)

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(3) Services not necessary and appropriate for the educational and behavioral management of the presenting disorder;

(4) Services for which a beneficiary would be entitled to payment but for a reduction or denial in payment as a result of quality review; and

(5) Services rendered during a period in which the provider was not in compliance with one or more conditions of authorization.

(b) To submit invoices to the appropriate TRICARE MCSC in accordance with the TOM, [Chapter 18, Section 9, paragraph 8.0](#);

(c) To collect from the TRICARE beneficiary those amounts that the beneficiary has a liability to pay for the TRICARE deductible and cost-share/co-payment;

(d) To provide to the Director, TMA or designee (e.g., MCSC), prompt written notification of the provider's employment of an individual who, at any time during the twelve months preceding such employment, was employed in a managerial, accounting, auditing, or similar capacity by an agency or organization which is responsible, directly or indirectly, for decisions regarding DoD payments to the provider;

(e) To cooperate fully with a designated utilization and clinical quality management organization which has a contract with the DoD for the geographic area in which the provider renders services;

(f) To comply with all applicable TRICARE authorization requirements before rendering designated services or items for which TRICARE cost-share/co-payment may be expected;

(g) To meet such other requirements as the Secretary of Defense may find necessary in the interest of health and safety of the individuals who are provided care and services.

### **3.5 ACCESS TO AND MAINTENANCE OF RECORDS**

The EIA Supervisor as the provider of services agrees:

(a) To permit access by the Director, TMA or designee, to the clinical record of any TRICARE beneficiary, to the financial and organizational records of the provider, and to reports of evaluations and inspections conducted by state or private agencies or organizations; and

(b) To maintain clinical and other records related to individuals for whom TRICARE payment was made for services rendered by the provider, or otherwise under arrangement, for a period of 60 months from the date of service;

(c) To maintain contemporaneous evaluation and intervention services records that substantiate the rationale for the planned course of treatment, the methods, modalities or means of intervention, periodic evaluation of the efficacy of treatment, and the outcome at completion or discontinuation of services as described separately in this agreement.

**ARTICLE 4**

**TERM, TERMINATION, AND AMENDMENT**

4.1 TERM

The term of this agreement shall begin on the date this agreement is signed and shall continue in effect until terminated by either party or until replaced by an updated Participation Agreement as may be required in [paragraph 4.2](#).

4.2 RESUBMISSION OF PARTICIPATION AGREEMENT

An EIA Supervisor must resubmit a Participation Agreement if the new qualification under which the EIA Supervisor may be TRICARE authorized changes that supervisor's requirement for supervision him/herself.

4.3 TERMINATION OF AGREEMENT BY TMA

(a) The Director, TMA or designee, may terminate this agreement upon written notice, for cause, if the EIA Supervisor is found not to be in compliance with the provisions set forth in [32 CFR 199.6](#), or is determined to be subject to the administrative remedies involving fraud, abuse, or conflict of interest as set forth in [32 CFR 199.9](#). Such written notice of termination shall be an initial determination for purposes of the appeal procedures set forth in [32 CFR 199.10](#).

(b) In addition, the Director, TMA or designee, may terminated this agreement without cause by giving the EIA Supervisor written notice of its intent to terminate this agreement 45 days prior to the effective date of such termination.

4.4 TERMINATION OF AGREEMENT BY THE EIA SUPERVISOR

The EIA Supervisor may terminate this agreement by giving the Director, TMA or designee, written notice of such intent to terminate at least 45 days in advance of the effective date of termination. Effective the date of termination, the EIA Supervisor will no longer be recognized as an authorized ICSP provider, **but will continue to be authorized as a TRICARE provider within an OCSF and outside the Demonstration, as an Applied Behavior Analysis (ABA) provider within the Extended Care Health Option (ECHO) program**. Subsequent to termination, the EIA Supervisor may only be reinstated as an authorized ICSP by entering into a new ICSP Participation Agreement.

4.5 AMENDMENT BY TMA

(a) The Director, TMA or designee, may amend the terms of this Participation Agreement by giving 120 days notice in writing of the proposed amendment(s) except when necessary to amend this agreement from time to time to incorporate changes to the 32 CFR 199. When changes or modifications to this agreement result from changes to the 32 CFR 199 through rulemaking procedures, the Director, TMA or designee, is not required to give 120 days written notice. Any such changes to 32 CFR 199 shall automatically be incorporated herein on the date the regulation amendment is effective.

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(b) The EIA Supervisor, not wishing to accept the proposed amendment(s), including any amendment resulting from changes to the 32 CFR 199 accomplished through rulemaking procedures, may terminate its participation as provided for in this Article. However, if the EIA Supervisor notice of intent to terminate its participation is not given at least 30 days prior to the effective date of the proposed amendment(s), then the proposed amendment(s) shall be incorporated into this agreement for services furnished by the EIA Supervisor between the effective date of the amendment(s) and the effective date of termination of this agreement.

**ARTICLE 5**

**EFFECTIVE DATE**

5.1 DATE SIGNED

This Participation Agreement is effective on the date signed by the Director, TMA or designee.

TMA

EIA Supervisor

\_\_\_\_\_  
By: Typed Name and Title

\_\_\_\_\_  
By: Typed Name and Title

Executed on \_\_\_\_\_, 20\_\_\_\_

- END -

## Financial Administration

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### 1.0 GENERAL

All TRICARE requirements regarding Financial Administration shall apply to the TRICARE Overseas Program (TOP) unless specifically waived or superseded by this section or the TRICARE contract for health care support services outside the fifty United States and the District of Columbia (hereinafter referred to as the "TOP contract"). See [Chapter 3](#) for additional instructions.

### 2.0 PAYMENT POLICY

**2.1** Reimbursement of TOP beneficiary claims for overseas health care shall be based upon the lesser of billed charges, the negotiated reimbursement rate, or the government-directed reimbursement rate **foreign fee schedule**. (See [Section 9](#) and the TRICARE Reimbursement Manual (TRM), [Chapter 1, Sections 34 and 35](#) for additional guidelines). Puerto Rico claims shall be reimbursed following stateside reimbursement guidelines. Philippines and Panama claims shall be reimbursed following government-provided foreign fee schedules, unless the TOP contractor has negotiated a lesser rate with a host nation provider.

**2.2** Payment of Skilled Nursing Facility (SNF) claims from Puerto Rico and the U.S. territories (Guam, the **U.S.** Virgin Islands, American Samoa, and the Northern Mariana Islands) shall be processed as routine foreign claims and shall be subject to the Prospective Payment System (PPS), as required under Medicare in accordance with the Social Security Act. These SNFs will be subject to the same rules as applied to SNFs in the U.S. (see the TRM, [Chapter 8](#)). SNF care is not available in other TOP locations.

**2.2.1** Preauthorization is not a requirement for SNF care. TRICARE contractors, at their discretion, may conduct concurrent or retrospective review for Standard and TRICARE for Life (TFL) patients when TRICARE is the primary payer. The review required for the lower 18 Resource Utilization Groups (RUGs) is a requirement for all TRICARE patients when TRICARE is primary (see TRM, [Chapter 8, Section 2, paragraph 4.3.16](#)). There will be no review for Standard or TFL patients where TRICARE is the secondary payer. The existing referral and authorization procedures for Prime beneficiaries will remain unaffected.

**2.2.2** Beneficiaries in the lower 18 RUGs do not automatically qualify for SNF coverage. These beneficiaries will be individually reviewed to determine whether they meet the criteria for skilled services and the need for skilled services (see the TRM, [Chapter 8, Section 2](#)). If these beneficiaries do not meet these criteria, the SNF PPS claim shall be denied.

**2.2.3** The TOP contractor, at their own discretion, may collect Minimum Data Set (MDS) assessment data per the TRM, [Chapter 8, Section 2](#).

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**2.3** The TOP contractor shall be responsible for entering into participation agreements with SNFs in Puerto Rico, Guam, the U.S. Virgin Islands, American Samoa, and the Northern Mariana Islands.

**2.3.1** The TOP contractor, at their own discretion, may conduct any data analysis to identify aberrant SNF PPS providers or those providers who might inappropriately place TRICARE beneficiaries in a high RUG. The contractor shall also assist the TRICARE Area Office (TAO) Directors in obtaining/providing SNF data, for conducting any SNF PPS data analysis they deem necessary.

**2.4** Balance billing provisions do not apply to TOP beneficiary claims for TOP overseas health care paid as billed, since there is no unpaid balance on these claims. Host nation network providers and participating providers are prohibited from balance billing.

**2.5** For health care rendered in Puerto Rico and in the U.S., reimbursement for all TOP beneficiary care shall follow the TRICARE payment policies except as outlined below.

**2.5.1** Non-participating provider claims for Active Duty Service Member (ADSM) health care received in the 50 United States and the District of Columbia shall be paid following TRICARE reimbursement rules for institutional and non-institutional care in that location. The TOP contractor shall make every effort to obtain the provider's agreement to accept, as payment in full, first a rate within the 100% CHAMPUS Maximum Allowable Charge (CMAC) limitation and then second, a rate between 100 and 115% of CMAC. If the latter is not feasible, the contractor shall determine the lowest acceptable rate that the provider will accept. The contractor shall then request a waiver of CMAC limitation from the TAO Director, as the designee of the Chief Operating Office (COO), TMA, to ensure that the patient does not bear any out-of-pocket expense. The waiver request shall include the patient name, ADSM's location, services requested (CPT-4) codes, CMAC rate, billed charge, and anticipated negotiated rate. The contractor must obtain approval from the TAO Director before the negotiation can be concluded. The contractors shall ensure that the approval payment is annotated in the authorization/claims processing system, and that payment is issued directly to the provider, unless there is information presented that the ADSM has personally paid the provider.

**2.5.2** TOP ADSMs who have been required by the provider to make "up front" payment at the time services are rendered may submit a claim for reimbursement directly to the contractor. Normal TRICARE claims processing requirements apply (including any authorization requirements and the use of TRICARE-approved claims forms). If the claim is payable, the contractor shall allow the billed amount and reimburse the ADSM for charges on the claim.

**2.5.3** In no case shall a uniformed service member be subjected to "balance billing" or ongoing collection action by a civilian provider for emergency or authorized care. If the contractor becomes aware of such situations that they cannot resolve, they shall pend the file and forward the issue to the appropriate TAO Director. The appropriate TAO Director will issue an authorization to the contractor for payments in excess of CMAC or other applicable TRICARE payment ceilings, provided the TAO Director has requested and has been granted a waiver from the COO, TMA, or designee.

**2.5.4** Overseas drug claims shall be paid following the instructions in [Section 9](#) and the TRM, [Chapter 1, Section 15](#).

**2.5.5** Overseas ambulance service claims shall be paid following the instructions in [Section 7](#) and [Chapter 8, Section 1](#).

**2.5.6** Payment may be made for ambulance services provided by commercial transport (see [Section 7](#) for additional processing instructions for these claims).

**2.5.7** The provisions of [Chapter 3, Section 2, paragraph 2.2](#) are not applicable to the TOP. The TOP contractor may not require host nation providers who submit claims electronically to accept an electronic remittance advice and to receive payment by Electronic Funds Transfer (EFT). These electronic processes are optional for host nation providers since they may create a financial burden for the provider.

### **3.0 FINANCIAL ADMINISTRATION**

**3.1** The TOP contractor shall follow the Financial Administration non-financially underwritten funds requirements in [Chapter 3](#) with the following exceptions:

**3.1.1** Foreign overseas drafts (local currency) and checks (U.S. currency) shall also reflect "TRICARE Overseas Program".

**3.1.2** Foreign overseas drafts shall also reflect information that indicates the draft is valid for 190 days and if reissue is required/necessary, the draft must be returned to the overseas claims processing contractor with a request for reissuance. The contractor shall issue drafts/checks for Germany claims which look like local German drafts/checks.

**3.2** The TRICARE Encounter Data (TED) for the overseas claims shall be reported on vouchers/batches according to the TRICARE Systems Manual (TSM), [Chapter 2](#) and as follows for remote sites:

**3.2.1** Active Duty Family Member (ADFM) and ADSM remote site claims, excluding health care claims for emergent/urgent care for Navy and Marine Corps ADSM who are either deployed and or deployed on liberty status in a remote site shall be submitted on vouchers instead of batches and shall be paid from the current non-financially underwritten foreign bank account. They shall be submitted like all other claims currently processed from that account.

**3.2.2** Navy deployed and/or deployed on liberty emergent or urgent care claims shall be submitted on a separate voucher. A separate bank account will be established for these beneficiaries. The Automated Standard Application for Payment (ASAP) account on the voucher header will identify the voucher as Navy.

**3.2.3** Marine Corps deployed and/or deployed on liberty emergent or urgent care claims shall be submitted on a separate voucher. A separate bank account will be established for these beneficiaries. The ASAP account on the voucher header will identify the voucher as Marine Corps.

**3.2.4** Retirees and their dependents living in a remote site health care claims shall be submitted on vouchers instead of batches and shall be paid from the current non-financially underwritten bank account. They shall be submitted on the same voucher as all other claims currently processed from that account.

**3.2.4.1** Claims for care rendered in the United States or the District of Columbia to TOP ADSM, ADFM, retirees and their dependents living in a remote overseas site shall be submitted on vouchers and shall be paid from the current non-financially underwritten bank account. They shall be submitted on the same voucher as all other claims currently processed from that account.

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#### Financial Administration

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#### **3.3** For other than remote site claims:

**3.3.1** TRICARE Europe ADSM claims shall be submitted on batches and the contractor shall on a monthly basis, submit a request for payment of TRICARE Europe ADSM overseas claims in the format of a single bill delineated by military branch of service to Defense Finance and Accounting Service (DFAS), Europe. Each bill shall include total weekly charges separated by benefit dollars with administrative charges per claim. Additionally each bill shall be accompanied by a monthly summary report of total expenditures by currency (e.g., for the month of January \$600,000 worth of claims were paid, of the \$600,000, \$300,000 were paid in Euros, \$200,000 were paid in Kronas, etc.). A copy of this report identifying Public Health Service (PHS) and National Oceanic and Atmospheric Administration (NOAA) ADSM claims shall also be sent to the Public Health Service Point of Contact (POC), at Medical Affairs Branch, 5600 Fishers Lane, Room 4C-04, Rockville, MD 20874.

**3.3.2** TOP eligible ADFM claims shall be submitted on vouchers and shall be paid from the current non-financially underwritten bank account. They shall be submitted on the same voucher as all other claims currently processed from that account.

**3.3.3** Retirees and their dependents living overseas claims shall be submitted on vouchers and shall be paid from the current non-financially underwritten or TFL/accrual fund bank accounts. They shall be submitted on the same voucher as all other claims currently processed from that account.

**3.3.4** TOP Prime (ADSM and ADFM) and TOP Standard beneficiary stateside claims for health care shall be submitted on vouchers and shall be paid from the current non-financially underwritten bank account. They shall be submitted on the same voucher as all other claims currently processed from that account.

**3.3.5** Overseas health care claims for stateside beneficiaries whose health care is normally provided under one of the three regional Managed Care Support Contracts (MCSCs) (i.e., beneficiaries enrolled or residing in the 50 United States or the District of Columbia, who receive care while traveling or visiting abroad) shall be processed by the TOP contractor. Claims for these beneficiaries shall be paid from the current non-financially underwritten bank account. This provision does not apply to beneficiaries who are enrolled to the Uniformed Services Family Health Plan (USFHP) or the Continued Health Care Benefit Program (CHCBP). Claims for these beneficiaries are processed by their respective contractor regardless of where the care is rendered.

**3.3.6** TRICARE Latin America/Canada (TLAC) and TRICARE Pacific ADSM claims shall be submitted on vouchers and shall be paid from the current non-financially underwritten bank account. They shall be submitted on the same voucher as all other claims currently processed from that account.

**3.4** The TOP contractor shall provide TRICARE Overseas Currency reports identifying the gain or loss for the month reported to arrive by the 10th calendar day following the month reported. The reports for net gains/losses shall be sent in a electronic format to TMA, Attn: Finance and Accounting Branch, 16401 East Centretch Parkway, Aurora, CO 80011-9066.

**3.4.1** The TOP contractor shall calculate currency gains and losses resulting from payments made to host nations providers and/or beneficiaries in foreign countries. The gains and losses shall be computed based on the exchange rate in effect on the ending date of care. The difference

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between the cost of the foreign currency on the ending date of care and the contractor payment date shall be the gain or loss on the transaction. Payment shall be as follows for:

**3.4.1.1** Net Gain. For months that result in a net gain, the TOP contractor shall forward the report along with their check payable to the Department of Defense (DoD), TMA, for the gain from currency conversion.

**3.4.1.2** Net Loss. TMA will reimburse the TOP contractor for any losses incurred from currency conversion except for current conversion losses from TRICARE Europe ADSM claims. The TRICARE Overseas Currency report shall be accompanied by a letter (invoice) requesting reimbursement for the loss incurred. This payment will not be subject to the Prompt Payment Act (FAR 32.9) as amended, therefore, payment by TMA will usually be made within 5 working days of receipt of the invoice and the TRICARE Overseas Currency report.

**3.4.2** For TRICARE Europe ADSM overseas claims, the TOP contractor shall follow the above procedures for calculating foreign currency gains and losses and reporting requirements. However, the report and net gains/losses shall be sent to DFAS, Europe, or the office designated by DFAS. DFAS will reimburse the contractor for any losses incurred from the currency conversion.

- END -



## 8.0 EOB VOUCHERS

**8.1** The TOP contractor shall follow the EOB voucher requirements in [Chapter 8, Section 8](#), where applicable, with the following exceptions and additional requirements:

**8.1.1** The letterhead on all TOP EOB shall also reflect "TRICARE Overseas Program" and shall be annotated Prime or Standard.

**8.1.2** TOP EOB may be issued on regular stock, shall provide a message indicating the exchange rate used to determine payment and shall clearly indicate that "This is not a bill".

**8.1.3** TOP EOB shall include the toll-free number for beneficiary and provider assistance.

**8.1.4** TOP EOB for overseas enrolled ADSM claims shall be annotated "ACTIVE DUTY."

**8.1.5** For Point of Sale or Vendor pharmacy overseas claims, TOP EOB must have the name of the provider of service on the claim.

**8.1.6** For beneficiary submitted pharmacy claims, TOP EOB shall contain the name of the provider of service, if the information is available. If the information is not available, the EOB shall contain "your pharmacy" as the provider of service.

**8.1.7** The TOP contractor shall insert the provider's payment invoice numbers in the patient's account field on all provider EOBs, if available.

**8.1.8** The following EOB message shall be used on overseas claims rendered by non-network host nation providers who are required to be certified, but have not been certified by the TOP contractor - "Your provider has not submitted documentation required to validate his/her training and/or licensure for designation as an authorized TRICARE provider".

**8.1.9** When a provider's/beneficiary's EOB, EOB and check, or letter is returned as undeliverable, the check shall be voided.

## 9.0 DUPLICATE PAYMENT PREVENTION.

The TOP contractor shall follow the duplicate payment prevention requirements outlined in [Chapter 8, Section 9](#).

## 10.0 DOUBLE COVERAGE.

**10.1** TOP claims require double coverage review as outlined in the TRM, [Chapter 4](#).

**10.2** Beneficiary/provider disagreements regarding the contractor's determination shall be coordinated through the overseas TAO Director for resolution with the contractor.

**10.3** Overseas insurance plans such as German Statutory Health Insurance, Japanese National Insurance (JNI), and Australian Medicare, etc., are considered OHI. When necessary, the TOP contractor may contact the appropriate TAO Director for assistance.

**Note:** If the Japanese insurance points are not clearly indicated on the claim/bill, the TOP contractor shall contact the submitter or the appropriate TOP POC for assistance in determining the Japanese insurance points prior to processing the claim.

### 11.0 THIRD PARTY LIABILITY (TPL)

The TOP contractor shall reimburse TOP claims suspected of TPL and then develop for TPL information. Upon receipt of the information, the contractor shall refer claims/documentation to the appropriate Judge Advocate General (JAG) office, as outlined in the [Chapter 10](#).

### 12.0 REIMBURSEMENT/PAYMENT OF OVERSEAS CLAIMS

When processing TOP claims, the TOP contractor shall follow the reimbursement payment guidelines outlined in the TRM, [Chapter 1, Section 34](#) and the cost-sharing and deductible policies outlined in the TRM, [Chapter 2, Section 1](#), and shall:

**12.1** Reimburse claims for host nation services/charges for care rendered to TOP eligible beneficiaries which is generally considered host nation practice and incidental to covered services, but which would not typically be covered under TRICARE. An example of such services may be, charges from host nation ambulance companies for driving host nation physicians to accidents or private residences, etc.

**12.2** Reimburse **claims** at the **lesser** of the billed amount, **the negotiated reimbursement rate**, or the government established fee schedules (TRM, [Chapter 1, Sections 34 and 35](#)), unless a different reimbursement rate has been established as described in [TPM, Chapter 12, Section 1.3](#).

**12.3** Not reimburse for host nation care/services specifically excluded under TRICARE.

**12.4** Not reimburse for host nation care/services provided in the Philippines unless all of the certification requirements listed in [Section 14](#) have been met.

**12.5** Not reimburse for administrative charges billed separately on claims, except for individual administrative charges for Germany, and other locations as determined by the government. The contractor shall reimburse these charges only in instances when the fee is billed concurrently with the corresponding health care services. If a bill is received for these charges without a corresponding health care service, the charges should be denied.

**12.6** Determine exchange rates as follow:

**12.6.1** Use the exchange rate in effect on the ending date that services were received unless evidence of OHI and then the TOP contractor shall use the exchange rate of the primary insurer, not the rate based on the last date of service to determine the TOP payment amount, and/or;

**12.6.2** Use the ending dates of the last service to determine exchange rates for multiple services.

**12.6.3** Use the exchange rate in [paragraph 12.6.1](#) to determine deductible and copayment amounts, if applicable, and to determine the amount to be paid in foreign currency.

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#### Claims Processing Procedures

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**12.6.4** Overseas drafts/checks and EOBs. Upon completion of processing, checks (payable in U.S. dollars) shall be created by the TOP contractor within 48 hours, after Contract Resource Management (CRM) approval. Drafts (payable in foreign currency units) shall be created by the TOP contractor within 96 hours following CRM approval, unless a different process has been authorized by TMA. Payments that need to be converted to a foreign currency shall be calculated based on the exchange rate in effect on the last date of service listed on the EOB. Drafts/checks shall be matched with the appropriate EOB, and mailed to the beneficiary/sponsor/host nation provider/POC as applicable.

**12.7** The TOP contractor shall convert lump sum payments instead of line items to minimize conversion problems.

**12.8** Provider claims for all overseas locations (excluding claims from Korean providers) will be paid by foreign currency/drafts. Drafts may not be changed to a U.S. dollar check after the contractor has issued a foreign draft. Claims from Korean providers will be paid in U.S. dollars.

**12.9** Foreign overseas drafts (in local currency) are good for 190 days and may be cashed at any time, unless a different process has been established by TMA. U.S. dollar checks are good for 120 days unless a different process has been established by TMA. The provisions of [Chapter 3, Section 4](#) regarding staledated, voided, or returned checks/Electronic Funds Transfers (EFTs) are applicable to the TOP.

**12.10** TOP claims submitted by a beneficiary shall be paid in U.S. dollars, unless there is a beneficiary request on the claim at the time of submission for payment in a foreign currency. The payment may not be changed to U.S. dollars after the foreign draft has been issued.

**12.11** Payment to Germany, Belgium, Finland, France, Greece, Ireland, Italy, Luxemburg, Netherlands, Austria, Portugal, Spain, Cyprus, and Malta shall be made in Euros. As other countries transition to Euro, the TOP contractor shall also switch to Euros.

**12.12** The contractor shall issue drafts/checks for German claims which look like German drafts/checks.

**Note:** In order for TRICARE drafts/checks to look like German drafts/checks, a German address must be used. The TOP contractor may use a corporate address in Germany or the TAO Europe address for this purpose.

**12.13** U.S. licensed Partnership providers claims for treating patients shall be paid based upon signed agreements. Refer to [Section 29](#) for additional information related to the Partnership Program.

**12.14** Pay all beneficiary-submitted claims for TRICARE covered drugs dispensed by a U.S. embassy health clinic to the beneficiary. The contractor is not to make payments directly to the embassy health clinic.

**12.15** Professional services rendered by a U.S. embassy health clinic are not covered by TRICARE/TOP. These services are covered under International Cooperative Administrative Support Services (ICASS) agreements. Embassy providers (acting as PCMs) may refer TOP enrollees to host nation providers, these claims shall be processed per TOP policy and procedures.

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Chapter 24, Section 9

Claims Processing Procedures

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**12.16** Claims for drugs or diagnostic/ancillary services purchased overseas shall be reimbursed by the TOP contractor following applicable deductible/cost-share policies.

**12.17** Not honor any draft request for currency change, except when directed by the appropriate TMA COR, once a foreign currency draft has been issued by the TOP contractor and the draft has been returned with the request.

**12.18** Shall mail the drafts/checks and EOB to host nation providers unless the claim indicates payment should be made to the beneficiary. In conformity with banking requirements, the drafts/checks shall contain the contractor's address. Drafts and EOBs shall be mailed using U.S. postage. Additionally, payments/checks may be made to network providers, with an Embassy address.

**12.19** Benefit payment checks and EOB to Philippine providers, and other nations' providers as directed by the TMA CO, shall be mailed to the place of service identified on the claim. No provider for Philippine providers, and other nations' providers as directed by the TMA CO may be sent to any other address.

**12.20** Inpatient and outpatient claims for TRICARE overseas eligible beneficiaries, including ADSM claims, are to be processed/paid as indicated below:

**12.20.1** The TPharm contractor shall allow TOP ADSM to use the TPharm retail pharmacy network under the same contract requirements as other Military Health System (MHS) eligible beneficiaries (see TPM, [Chapter 8, Section 9.1](#)).

**12.20.2** The TPharm contractor shall allow TOP enrolled ADFM beneficiaries to use their stateside retail pharmacy network under the same contract requirements as other MHS eligibles (see TPM, [Chapter 8, Section 9.1](#)).

**12.20.3** The TOP contractor shall process claims for overseas health care received by TRICARE beneficiaries enrolled to or residing in a stateside MCSC's region following the guidelines outlined in this chapter. Payment shall be made from applicable bank accounts and shall be based on billed charges unless a lower reimbursement rate has been established by the government or the contractor.

**12.21** Provider requests for EFT payment. Upon host nation provider request, the TRICARE Overseas health care support contractor shall provide EFT payment to a U.S. or overseas bank on a weekly basis. Bank charges incurred by the provider for EFT payment shall be the responsibility of the provider. No EFT payment may be made to providers in the Philippines.

**12.22** The TOP contractor shall process 85% of all retained and adjustment TOP claims to completion within 21 calendar days from the date of receipt. Claims pended per government direction are excluded from this standard. However, the number of excluded claims must be reported on the Overseas Weekly/Monthly Workload/Cycletime Aging report. 100% of all claims (both retained and excluded, including adjustments) shall be processed to completion within 90 calendar days from the date of receipt, unless the CO specifically directs the contractor to continue pending a claim or group of claims.

**12.23** Correspondence pended due to stop payment orders, check tracers on foreign banks and conversion on currency. This correspondence is excluded from the routine 45 calendar day

correspondence standard and the priority 10 calendar day correspondence standard. However, the number of excluded routine and priority correspondence must be reported on the Overseas Monthly Workload/Cycletime Aging report.

### **13.0 CLAIMS ADJUSTMENT AND RECOUPMENT**

**13.1** The TOP contractor shall follow the adjustment requirements in [Chapter 10](#) except for the requirements related to financially underwritten funds.

**13.2** The TOP contractor shall follow the recoupment requirements in [Chapter 10](#) for non-financially underwritten funds, except for providers. The contractor shall use the following procedures for host nation provider recoupments. Recoupment actions shall be conducted in a manner that is considered culturally appropriate for the host nation provider's country. The contractor shall:

**13.2.1** Send an initial demand letter.

**13.2.2** Send a second demand letter at 90 days.

**13.2.3** Send a final demand letter at 120 days.

**13.2.4** Refer the case to TMA at 240 days, if the case is over \$600.00, and if under \$600.00 the case shall remain open for an additional four months and then shall be written off at 360 days.

**13.3** Recoupment letters (i.e., the initial letter, the 90 day second request and the 120 day final demand letter) shall be modified to delete references to U.S. law. Invoice numbers shall be provided on all recoupment letters. The TOP contractor shall include language in the recoupment letter requesting that refunds be returned/provided in the exact amount requested.

**13.4** Provider recoupment letters sent to Germany, Italy and Spain, shall be written in the respective language.

**13.5** The TOP contractor may hand write the dollar amount and the host nation provider's name and address, on all recoupment letters.

**13.6** If the recoupment action is the result of an inappropriately processed claim by the TOP contractor, recoupment is the responsibility of the contractor, not the beneficiary/provider.

**13.7** The TOP contractor shall have a TOP bank account capable of receiving/accepting wire transfers from TRICARE Europe overseas for host nation provider recoupment/overpayment returns. The TOP contractor shall accept the amount received as payment against the amount owed. Any fees associated with the wire transfer will be the responsibility of the payer/provider.

### **14.0 DUPLICATE PAYMENT PREVENTION**

The provisions of [Chapter 8, Section 9](#) are applicable to the TOP.

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### Chapter 24, Section 29

#### TRICARE Overseas Program (TOP) Partnership Program

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- 4) Address the MTF Partnership Program in the Commander's annual statement of assurance.
- b. Report annually to the TMA Deputy Director, through their TAO Director and Surgeon General, on all Internal Partnership Agreements. The report should include information on the number of Internal Partnership Agreements in place, new Agreements and expired/ cancelled Agreements during the reporting period, the medical service discipline or provider category associated with the Agreement, and an annual justification (see [Enclosure 4](#)) of the Partnership Program which supports continuation/modification of the Partnership Program and individual Agreements. The report will be due annually in sufficient time for consideration in development of the TRICARE Overseas Area Health Services Plan. The TMA business case analysis (BCA) guidance will be used to conduct BCAs (see [Enclosure 5](#)). If MTFs have questions on how to conduct a BCA, each service Surgeon's General Support Office is listed in [Enclosure 1](#).
- c. Analyze potential applications of the Partnership Program on a case-by-case basis and make a determination prior to entering into each Internal Partnership Agreement that all of the following criteria are met:
  - 1) Use of the Partnership Program will meet a need for health care services that is not adequately being met by, and cannot be met with, existing MTF resources.
  - 2) Use of the Partnership Program is more economical to the Government than referring the need for health care services to the civilian community under TRICARE.
  - 3) Use of the Partnership Program is consistent with the mission of the MTF.
  - 4) Use of the Partnership Program is consistent with high standards of quality health care established for MTFs.
- d. In applying the criteria listed in paragraph 4.c. above, take into account the following points of consideration:
  - 1) In verifying an unmet need for health care services, consider appointment waiting times, number of Non-Availability Statements (NASs) issued for a particular service, TRICARE use in the area, and other pertinent factors.
  - 2) In reviewing cost impacts, make a comparison between TRICARE costs for the health care service in the community without use of the Partnership Program and providing the service through the Partnership Program. The negotiated rate(s) for each Agreement should be a discounted rate off the applicable TRICARE CMAC rate(s) in the state of Alaska, **the Philippines, Panama**, or a negotiated fee schedule in TOP areas appropriately discounting the host nation rate which would normally be applicable if the beneficiary had received care in a "downtown" host nation setting. All negotiated rates shall take into account the extent, if at all, that the Partnership Program provider will be supported by his or her own personnel and other resources under his or her direct control and supervision.
  - 3) Ensure that the Agreement does not compromise the mission of the facility, and that the health care resources to be provided are consistent with the level and type of health care resources generally provided by the MTF, including appropriate consideration of the availability/adequacy of clinical and administrative support and the impact in the areas of ancillary services, appointment and scheduling, etc. resulting from the Internal Partnership Agreement.

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TRICARE Overseas Program (TOP) Partnership Program

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- e. Ensure that all liability issues relating to the Partnership Program are properly addressed and ensure that the civilian Partnership Program Provider has sufficient liability insurance coverage to protect TRICARE beneficiaries as well as the government.
- f. Provide quality assurance controls through the medical staff appointment and reappointment procedures, the specific delineation of clinical privileges, periodic in-depth health care provider review and appraisal, and the stipulation that Partnership Providers adhere to MTF instructions and medical staff bylaws to the same extent required of Military Department health care providers. In addition, Partnership Providers shall be required to comply with the state of Alaska or host nation laws, tax requirements, and applicable licensing requirements, as well as TRICARE requirements for approved authorized provider status. The usual Service procedures will be used to ensure notification of the Federation of State Medical Boards, the National Practitioner Data Bank, and TMA Deputy Director (or designated TMA Partnership Program Manager) of those practitioners who have had their clinical privileges limited, suspended, or revoked while a participant in the Partnership Program.
- g. Monitor partnership visits on a quarterly basis to ensure there is no abuse of the system by partnership providers scheduling medically inappropriate visits. The MTF and applicable service will determine how to monitor this.
- h. Ensure that health care services provided TRICARE beneficiaries under the terms of the Partnership Program are consistent with authorized TRICARE benefits established by regulation and policy. An Internal Partnership Agreement may contain a provision to allow for MTF supplemental care funds to be used to pay a Partnership Program provider for care furnished to ADSMs or for non-active duty TRICARE beneficiaries only if payment to civilian sources of care would otherwise be authorized in accordance with DoD policy on use of supplemental care funds.
- i. In overseas locations, excluding U.S. Territories and the state of Alaska where Medicare is the primary payor, MTFs have the option of offering health care, services under the Internal Partnership Agreement to Medicare-eligible beneficiaries, including TRICARE For Life (TFL) eligibles enrolled in Medicare Part B. Prior to offering any such services to Medicare-eligible beneficiaries under an Internal Partnership Agreement, a determination must be made that such care will be cost effective based on the required BCA and final approval of the Internal Partnership Agreement must be granted.
- j. Ensure that providers who are potential participants in the Partnership Program are given fair selection opportunities to participate in the program through appropriate notification of opportunities, such as notice to local medical and professional societies, and objective selection standards.
- k. Require Partnership Providers to the extent practical to use MTF health care resources, that is, specialty consultants, ancillary services, equipment, and supplies, when such resources are available.
- l. Assist in providing appropriate administrative support as necessary to expedite Partnership Program provider reimbursements, but not in violation of the prohibition against a government employee acting as a representative for a claimant against the government as provided for in 18 USC 203 or 205.

## Acronyms And Abbreviations

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3D	Three Dimensional
AA	Anesthesiologist Assistant
AA&E	Arms, Ammunition and Explosives
AAA	Abdominal Aortic Aneurysm
AAAHC	Accreditation Association for Ambulatory Health Care, Inc.
AAFES	Army/Air Force Exchange Service
AAMFT	American Association for Marriage and Family Therapy
AAP	American Academy of Pediatrics
AAPC	American Association of Pastoral Counselors
AARF	Account Authorization Request Form
AATD	Access and Authentication Technology Division
ABA	American Banking Association Applied Behavioral Analysis
ABMT	Autologous Bone Marrow Transplant
ABPM	Ambulatory Blood Pressure Monitoring
ABR	Auditory Brainstem Response
ACD	Augmentative Communication Devices
ACI	Autologous Chondrocyte Implantation
ACIP	Advisory Committee on Immunization Practices
ACO	Administrative Contracting Officer
ACOG	American College of Obstetricians and Gynecologists
ACOR	Administrative Contracting Officer's Representative
ACS	American Cancer Society
ACTUR	Automated Central Tumor Registry
AD	Active Duty
ADA	American Dental Association American Diabetes Association Americans with Disabilities Act
ADAMHA	Alcohol, Drug Abuse, And Mental Health Administration
ADAMHRA	Alcohol, Drug Abuse, And Mental Health Reorganization Act
ADCP	Active Duty Claims Program
ADD	Active Duty Dependent
ADFM	Active Duty Family Member
ADL	Activities of Daily Living
ADP	Automated Data Processing

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### Appendix A

#### Acronyms And Abbreviations

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ADSM	Active Duty Service Member
AFOSI	Air Force Office of Special Investigations
<b>AGR</b>	<b>Active Guard/Reserve</b>
AHA	American Hospital Association
AHLTA	Armed Forces Health Longitudinal Technology Application
AHRQ	Agency for Healthcare Research and Quality
AI	Administrative Instruction
AIDS	Acquired Immune Deficiency Syndrome
AIIM	Association for Information and Image Management
AIS	Automated Information Systems
AIX	Advanced IBM Unix
AJ	Administrative Judge
ALA	Annual Letter of Assurance
ALB	All Lines Busy
ALL	Acute Lymphocytic Leukemia
ALOS	Average Length-of-Stay
ALS	Action Lead Sheet Advanced Life Support
ALT	Autolymphocyte Therapy
AM&S	Acquisition Management and Support (Directorate)
AMA	Against Medical Advice American Medical Association
AMH	Accreditation Manual for Hospitals
AMHCA	American Mental Health Counselor Association
AML	Acute Myelogenous Leukemia
ANSI	American National Standards Institute
AOA	American Osteopathic Association
APA	American Psychiatric Association American Podiatry Association
APC	Ambulatory Payment Classification
API	Application Program Interface
APN	Assigned Provider Number
APO	Army Post Office
ART	Assisted Reproductive Technology
ARU	Automated Response Unit
ASA	Adjusted Standardized Amount American Society of Anesthesiologists
ASAP	Automated Standard Application for Payment
ASC	Accredited Standards Committee Ambulatory Surgical Center
ASCA	Administrative Simplification Compliance Act
ASCUS	Atypical Squamous Cells of Undetermined Significance

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### Appendix A

#### Acronyms And Abbreviations

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PCS	Permanent Change of Station
PD	Passport Division
PDA	Patent Ductus Arteriosus Personal Digital Assistant
PDDBI	Pervasive Developmental Disorders Behavior Inventory
PDDNOS	Pervasive Developmental Disorder Not Otherwise Specified
PDF	Portable Document Format
PDQ	Physicians's Data Query
PDR	Person Data Repository
PDS	Person Demographics Service
PDTS	Pharmacy Data Transaction System
PE	Physical Examination
PEC	Pharmacoeconomic Center
PEP	Partial Episode Payment
PEPR	Patient Encounter Processing and Reporting
PERMS	Provider Education and Relations Management System
PET	Positron Emission Tomography
PFCRA	Program Fraud Civil Remedies Act
PPF	Partnership For Peace
PPPWD	Program for Persons with Disabilities
Phen-Fen	Pondimin and Redux
PHI	Protected Health Information
PHIMT	Protected Health Information Management Tool
PHP	Partial Hospitalization Program
PHS	Public Health Service
PI	Program Integrity (Office)
PIA	Privacy Impact Assessment (Online)
PIC	Personnel Investigation Center
PIE	Pulsed Irrigation Evacuation
PIN	Personnel Identification Number
PIP	Personal Injury Protection Personnel Identity Protection
PIT	PCM Information Transfer
PIV	Personal Identity Verification
PKI	Public Key Infrastructure
PKU	Phenylketonuria
PL	Public Law
PLS	Preschool Language Scales
PM-DRG	Pediatric Modified-Diagnosis Related Group
PMR	Percutaneous Myocardial Laser Revascularization
PNET	Primitive Neuroectodermal Tumors
PNT	Policy Notification Transaction

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### Appendix A

#### Acronyms And Abbreviations

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POA	Power of Attorney
POC	Pharmacy Operations Center Plan of Care Point of Contact
POL	May 1996 TRICARE/CHAMPUS Policy Manual 6010.47-M
POS	Point of Sale (Pharmacy only) Point of Service Public Official's Statement
POV	Privately Owned Vehicle
PPD	Per Patient Day
PPN	Preferred Provider Network
PPO	Preferred Provider Organization
PPS	Prospective Payment System Ports, Protocols and Services
PPV	Pneumococcal Polysaccharide Vaccine
PQI	Potential Quality Indicator Potential Quality Issue
PR	Periodic Reinvestigation
PRC	Program Review Committee
PRG	Peer Review Group
PRO	Peer Review Organization
ProDUR	Prospective Drug Utilization Review
PROM	Programmable Read-Only Memory
PRP	Personnel Reliability Program
<b>PRPP</b>	<b>Pharmacy Redesign Pilot Project</b>
PSA	Prime Service Area Physician Scarcity Area
PSAB	Personnel Security Appeals Board
PSCT	Peripheral Stem Cell Transplantation
PSI	Personnel Security Investigation
PST	Pacific Standard Time
PT	Pacific Time Physical Therapist Physical Therapy Prothrombin Time
PTA	Pancreas Transplant Alone Percutaneous Transluminal Angioplasty
PTC	Processed To Completion
PTCA	Percutaneous Transluminal Coronary Angioplasty
PTK	Phototherapeutic Keratectomy
PVCs	Premature Ventricular Contractions
QA	Quality Assurance
QC	Quality Control

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QI	Quality Improvement Quality Issue
QII	Quality Improvement Initiative
QIO	Quality Improvement Organization
QIP	Quality Improvement Program
QLE	Qualifying Life Event
QM	Quality Management
QUIG	Quality Indicator Group
RA	Remittance Advice
RAM	Random Access Memory
RAP	Request for Anticipated Payment
RAPIDS	Real-Time Automated Personnel Identification System
RC	Reserve Component
RCN	Recoupment Case Number Refund Control Number
RCS	Report Control Symbol
RD	Regional Director
RDBMS	Relational Database Management System
RDDDB	Reportable Disease Database
REM	Rapid Eye Movement
RFI	Request For Information
RFP	Request For Proposal
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RhoGAM	RRho (D) Immune Globulin
RN	Registered Nurse
RNG	Random Number Generator
RO	Regional Office
ROC	Resumption of Care
ROFR	Right of First Refusal
ROM	Read-Only Memory Rough Order of Magnitude
ROT	Read-Only Table
ROTC	Reserved Officer Training Corps
ROVER	RHHI Outcomes and Assessment Information Set Verification
RPM	Record Processing Mode
RRA	Regional Review Authority
RTC	Residential Treatment Center
RUG	Resource Utilization Group
RV	Residual Volume
RVU	Relative Value Unit
SAAR	System Authorization Access Request
SAD	Seasonal Affective Disorder

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SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier
SAO	Security Assistant Organizations
SAP	Special Access Program
SAS	Sensory Afferent Stimulation
SAT	Service Assist Team
SBCC	Service Branch Classification Code
SBI	Special Background Investigation
SCH	Sole Community Hospital
SCHIP	State Children's Health Insurance Program
SCI	Sensitive Compartmented Information Spinal Cord Injury
SCIC	Significant Change in Condition
SCOO	Special Contracts and Operations Office
SCR	Stell Cell Rescue
S/D	Security Division
SD (Form)	Secretary of Defense (Form)
SEP	Sensory Evoked Potentials
SES	Senior Executive Service
SelRes	Selected Reserve
SF	Standard Form
SGDs	Speech Generating Devices
SHCP	Supplemental Health Care Program
SI	Sensitive Information Small Intestine (transplant) Status Indicator
SIDS	Sudden Infant Death Syndrome
SII	Special Investigative Inquiry
SI/L	Small Intestine-Live (transplant)
SIOP-ESI	Single Integrated Operational plan-Extremely Sensitive Information
SIP	System Identification Profile
SIT	Standard Insurance Table
SMC	System Management Center
SNF	Skilled Nursing Facility
SNS	Sacral Nerve Root Stimulation
SOC	Start of Care
SOFA	Status Of Forces Agreement
SOIC	Senior Officer of the Intelligence Community
SON	Submitting Office Number
SOR	Statement of Reasons
SP	Special Processing Code
SPA	Simple Power Analysis
SPECT	Single Photon Emission Computed Tomography
SPK	Simultaneous Pancreas Kidney (transplant)

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SPOC	Service Point of Contact
SPR	SECRET Periodic Reinvestigation
SQL	Structured Query Language
SRE	Serious Reportable Event
SSA	Social Security Act Social Security Administration
SSAA	Social Security Authorization Agreement
SSAN	Social Security Administration Number
SSBI	Single-Scope Background Investigation
SSL	Secure Socket Layer
SSM	Site Security Manager
SSN	Social Security Number
SSO	Short-Stay Outlier
STF	Specialized Treatment Facility
STS	Specialized Treatment Services
STSF	Specialized Treatment Service Facility
SUDRF	Substance Use Disorder Rehabilitation Facility
SVO	SIT Validation Office
SVT	Supraventricular Tachycardia
SWLS	Satisfaction With Life Scale
TAD	Temporary Additional Duty
TAFIM	Technical Architecture Framework for Information Management
TAMP	Transitional Assistance Management Program
TAO	TRICARE Alaska Office TRICARE Area Office
TARO	TRICARE Alaska Regional Office
TB	Tuberculosis
TBD	To Be Determined
TBE	Tick Borne Encephalitis
TBI	Traumatic Brain Injury
TC	Technical Component
TCP/IP	Transmission Control Protocol/Internet Protocol
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Plan
TDY	Temporary Duty
TED	TRICARE Encounter Data
TEFRA	Tax Equity and Fiscal Responsibility Act
TEOB	TRICARE Explanation of Benefits
TEPRC	TRICARE Encounter Pricing (Record)
TEPRV	TRICARE Encounter Provider (Record)
TET	Tubal Embryo Transfer
TF	Transfer Factor

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TFL	TRICARE For Life
TFMDP	TRICARE (Active Duty) Family Member Dental Plan
TGRO	TRICARE Global Remote Overseas
TGROHC	TGRO Host Country
TIFF	Tagged Imaged File Format
TIL	Tumor-Infiltrating Lymphocytes
TIMPO	Tri-Service Information Management Program Office
TIN	Taxpayer Identification Number
TIPS	Transjugular Intrahepatic Portosystemic Shunt
TIS	TRICARE Information Service
TLAC	TRICARE Latin America/Canada
TLC	Total Lung Capacity
TMA	TRICARE Management Activity
TMA-A	TRICARE Management Activity - Aurora
TMAC	TRICARE Maximum Allowable Charge
TMI&S	Technology Management Integration & Standards
TMOP	TRICARE Mail Order Pharmacy
TMR	Transmyocardial Revascularization
TNEX	TRICARE Next Generation (MHS Systems)
TOB	Type of Bill
TOE	Target of Evaluation
TOL	TRICARE Online
TOM	August 2002 TRICARE Operations Manual 6010.51-M February 2008 TRICARE Operations Manual 6010.56-M
TOP	TRICARE Overseas Program
TPA	Third Party Administrator
TPC	Third Party Collections
TPharm	TRICARE Pharmacy
TPL	Third Party Liability
TPM	August 2002 TRICARE Policy Manual 6010.54-M February 2008 TRICARE Policy Manual 6010.57-M
TPN	Total Parenteral Nutrition
TPOCS	Third Party Outpatient Collections System
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote Active Duty Family Member
TPRADSM	TRICARE Prime Remote Active Duty Service Member
TPRC	TRICARE Puerto Rico Contract(or)
TQMC	TRICARE Quality Monitoring Contractor
TRDP	TRICARE Retiree Dental Program
TRI	TED Record Indicator
TRM	August 2002 TRICARE Reimbursement Manual 6010.55-M February 2008 TRICARE Reimbursement Manual 6010.58-M
TRO	TRICARE Regional Office

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TRPB	TRICARE Retail Pharmacy Benefits
TRRx	TRICARE Retail Pharmacy
TRS	TRICARE Reserve Select
TRSA	TRICARE Reserve Select Application
TSC	TRICARE Service Center
TSF	Target of Evaluation Security Functions
TSM	August 2002 TRICARE Systems Manual 7950.1-M February 2008 TRICARE Systems Manual 7950.2-M
TSP	Target of Evaluation Security Policy
TSR	TRICARE Select Reserve
TSRDP	TRICARE Select Reserve Dental Program
TSRx	TRICARE Senior Pharmacy
TSS	TRICARE Senior Supplement
TSSD	TRICARE Senior Supplement Demonstration
TTY	Teletypewriter
TUNA	Transurethral Needle Ablation
UAE	Uterine Artery Embolization
UB	Uniform Bill
UBO	Uniform Business Office
UCBT	Umbilical Cord Blood Stem Cell Transplantation
UCC	Uniform Commercial Code
UCCI	United Concordia Companies, Inc.
UCSF	University of California San Francisco
UIC	Unit Identification Code
UIN	Unit Identifier Number
UM	Utilization Management
UMO	Utilization Management Organization
UMP	User Maintenance Portal
UPIN	Unique Physician Identification Number
URF	Unremarried Former Spouses
URL	Universal Resource Locator
US	United States
USA	United States of America
USACID	United States Army Criminal Investigation Division
USAF	United States Air Force
USAO	United States Attorneys' Office
USC	United States Code
USCG	United States Coast Guard
USCO	Uniformed Services Claim Office
USD	Undersecretary of Defense
USD (P&R)	Undersecretary of Defense (Personnel and Readiness)
USDI	Undersecretary of Defense for Intelligence

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USFHP	Uniformed Services Family Health Plan
USHBP	Uniformed Services Health Benefit Plan
USMC	United States Marine Corps
USMTF	Uniformed Services Medical Treatment Facility
USN	United States Navy
USPDI	United States Pharmacopoeia Drug Information
USPHS	United States Public Health Service
USPS	United States Postal Service
USPSTF	U.S. Preventive Services Task Force
USS	United Seaman's Service
USTF	Uniformed Services Treatment Facility
UV	Ultraviolet
VA	Veteran Affairs (hospital) Veteran Administration
VAD	Ventricular Assist Device
VAMC	VA Medical Center
VATS	Video-Assisted Thorascopic Surgery
VAX-D	Vertebral Axial Decompression
VD	Venereal Disease
VO	Verifying Office (Official)
VPN	Virtual Private Network
VPOC	Verification Point of Contact
VSAM	Virtual Storage Access Method
VSD	Ventricular Septal Defect
WAC	Wholesale Acquisition Cost
WAN	Wide Area Network
WATS	Wide Area Telephone Service
WC	Worker's Compensation
WEDI	Workgroup for Electronic Data Interchange
WIC	Women, Infants, and Children (Program)
WORM	Write Once Read Many
WRAMC	Walter Reed Army Medical Center
WTC	World Trade Center
WTRR	Wire Transfer Reconciliation Report
X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome
XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer

- END -

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

### **Triage**

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

### **TRICARE**

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

### **TRICARE Beneficiary**

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

### **TRICARE Contractor**

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

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

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