OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
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TRICARE
MANAGEMENT ACTIVITY

PCPB

CHANGE 4
6010.56-M
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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 CHANGE**

PAGE CHANGE(S): See pages 2 through 4.

SUMMARY OF CHANGE(S): This change brings this Manual up-to-date with published changes to the Aug 2002 TRICARE Operations Manual (TOM), 6010.51-M. Included are Changes 67, 68, 69, 70, 71, and 72. This change also revised Clinical Support Agreement requirements (Chapter 15, Section 3); revised electronic claim submission standards (Chapter 1, Section 3); and miscellaneous minor clarifications/corrections.

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

This change is made in conjunction with Feb 2008 TPM, Change No. 4, Feb 2008 TRM, Change No. 4, and Feb 2008 TSM, Change No. 4.

for Debra Hatzel
Laura Sells
Chief, Purchased Care Procurement Branch

ATTACHMENT(S): **235 PAGES**
DISTRIBUTION: **6010.56-M**

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

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Chapter 1 Section 3

TRICARE Processing Standards

1.0 TIMELINESS AND QUALITY STANDARDS OF PERFORMANCE

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

1.1 Preauthorizations/Authorizations

The contractor shall issue determinations on at least:

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

- One hundred percent (100%) of such requests within five working days following receipt of the request and all required information.

1.2 Referrals/Network Adequacy

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

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

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

1.2.3 Behavioral Health Care Appointments

A minimum of 90% of behavioral health care appointment requests received during a

quarter shall result in the establishment of an appointment that meets the access standards set forth in Chapter 11, Section 11, paragraph 2.2.

1.3 Network Adequacy

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

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

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

1.4 Electronic Claims Submittal

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

OPTION YEAR	NORTH	SOUTH	WEST
1	74%	78%	77%
2	77%	81%	80%
3	79%	83%	82%
4	80%	84%	83%
5	81%	85%	84%

1.5 Claims Processing Timeliness

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

1.5.1 Retained Claims

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

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

Chapter 1 Section 7

Transitions

1.0 CONTRACT PHASE-IN

1.1 Start-Up Plan

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

1.2 Transition Specifications Meeting

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

1.3 Interface Meetings

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

2.0 START-UP REQUIREMENTS

2.1 Systems Development

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

2.2 Execution Of Agreements With Contract Providers

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

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

2.3 Provider Certification

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

2.4 Execution Of Memoranda Of Understanding (MOU)

2.4.1 MOU With Military Treatment Facility (MTF) Commanders

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

2.4.2 MOU with TMA Communications and Customer Service (C&CS) Directorate

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

2.5 Phase-In of TRICARE Prime Enrollment

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

2.5.1.1 Enrollment Actions During 45 Day Transition Period

2.5.1.1.1 For enrollments in the region with an effective date prior to the start of health care delivery (e.g., active duty (AD) enrollment, mid-month enrollment; transfer-in), the incoming contractor must effect an enrollment to begin on the start of health care delivery once notified by

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 (since ADSMs must be enrolled but their family members need not be, there is no action required if an ADSM does not have enrolled family members). The bill shall offer all available payment options and methods. The contractor shall issue a delinquency notice to the appropriate individual 15 calendar days after the expiration date of the enrollment.

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).

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.

7.0 WOUNDED, ILL, AND INJURED (WII) ENROLLMENT CLASSIFICATION

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

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

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

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

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

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

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

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

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

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

- Enrollment
- Disenrollment
- Cancel enrollment
- Cancel disenrollment
- Address update
- Contractors can request Policy Notification Transaction (PNT) resend
- Modify begin date
- Modify end date

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

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

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

7.2.2 The Service-specific WII Program will stamp the front page of the DD Form 2876, enrollment application form, with WII 416 for all new enrollments. The begin date will be the date the contractors receive the signed enrollment form. The enrollment form will then be sent to the appropriate contractor who shall perform the enrollment in the DOES and include the following information:

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

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

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

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

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

- END -

Issued Notice of Noncoverage" (Addendum B).

- Institutional providers will inform the contractor within three working days if they issue a notice that the beneficiary no longer requires inpatient care.

- Institutional providers will assure that each case subject to preadmission/preprocedure review has been reviewed and approved by the contractor.

- Institutional providers will agree, when they fail to obtain certification as required, they will accept full financial liability for any admission subject to preadmission review that was not reviewed and is subsequently found to be medically unnecessary or provided at an inappropriate level. (32 CFR 199.15(g))

- The contractor shall reimburse the provider for the costs of photocopying and postage using the same reimbursement as Medicare.

- The contractor shall provide detailed information on the review process and criteria used, including financial liability incurred by failing to obtain preauthorization.

5.0 BENEFIT POLICY DECISIONS

TRICARE Versus Local Policy. TRICARE policies have precedence over any local or internal policy of the contractor or the medical community of the region. However, the contractor shall notify TRICARE Management Activity (TMA) promptly of any conflicts between TRICARE policy and local policy. Variations from policy which expand, reduce, or adjust benefit coverage shall be referred to TMA for approval before being implemented.

6.0 CONCURRENT REVIEW REQUIREMENTS

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

7.0 RETROSPECTIVE REVIEWS RELATED TO DRG VALIDATION

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

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

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

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

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

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

7.6 Outlier Review

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

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

In implementing the quality and utilization review for services not covered by the DRG-based payment system, the requirements of this section shall pertain except that International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) and Current Procedural Terminology, 4th Edition (CPT-4) codes will provide the basis for determining whether diagnostic and procedural information is correct and matches information contained in the medical records.

8.0 RETROSPECTIVE REVIEW REQUIREMENTS FOR OTHER THAN DRG VALIDATION

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

8.1 Admission Review

The medical record must indicate that inpatient hospital care was medically necessary and

Chapter 7 Section 4

Clinical Quality Management Program (CQMP)

1.0 CLINICAL QUALITY MANAGEMENT PROGRAM (CQMP) PLAN

1.1 The contractor shall operate a CQMP which results in demonstrable quality improvement of the quality of health care provided beneficiaries and of the process and services delivered by the contractor.

1.2 The contractor shall fully describe in a written CQMP plan the structural and function components of the program. The CQMP is defined as the integrated processes, both clinical and administrative, that provide a framework for goals and objectives, leadership, structured and operational components, designed to achieve the efficient and effective provision of access to and quality of care. The contractor shall have a written CQMP Plan as described in Exhibit B, Contract Data Requirements List (CDRL), DD Form 1423, P040.

1.3 Clinical Quality Management Program Annual Report (CQMP AR)

Annually, on the date specified by the contract, the contractor shall provide the CQMP AR. As specified in the contract, at the end of the last option year of the contract, the contractor shall submit a final CQMP AR. The report shall link to the annual plan and reflect the status of active Quality Improvement Initiatives (QIIs) and studies. See Exhibit B, Contract Data Requirements List (CDLR), DD Form 1423, A010, for the structure and content of the CQMP AR.

2.0 CQMP STRUCTURAL AND FUNCTIONAL REQUIREMENTS

The contractor shall participate in monthly, or at a frequency determined by the Regional Director (RD), in region level quality management committees. The contractor shall develop and implement written policies and procedures to identify Potential Quality Issues (PQIs), steps to resolve identified problems, suggest interventions to resolve problems, and provide ongoing monitoring of all components of the contractor's operations and the care and treatment of TRICARE beneficiaries.

At a minimum, the contractor shall assess every medical record reviewed for any purpose and any care managed/observed/monitored on an ongoing basis for PQIs in accordance with the following table.

Using the most current National Quality Forum (NQF) Serious Reportable Events (SREs), the contractor shall identify, track, trend, and report interventions to resolve the PQIs and Quality Issues (QIs) using the below minimum indicators/criteria:

EVENT	ADDITIONAL SPECIFICATIONS
Medical, Surgical, Mental Health: Inpatient, Outpatient, and all levels of care throughout the continuum. Events 1 through 6 are NQF SREs.	
1. Surgical Events **a.** Surgery performed on the wrong body part	Defined as any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.
b. Surgery performed on the wrong patient	Defined as any surgery on a patient that is not consistent with the documented informed consent for that patient. Surgery includes endoscopies and other invasive procedures.
c. Wrong surgical procedure performed on a patient	Defined as any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.
d. Retention of a foreign object in a patient after surgery or other procedure	Excludes objects intentionally implanted as part of a planned intervention and objects present prior to surgery that were intentionally retained.
e. Intraoperative or immediately post-operative death in an ASA Class I patient	Includes all ASA Class I patient deaths in situations where anesthesia was administered; the planned surgical procedure may or may not have been carried out. Immediately post-operative means within 24 hours after induction of anesthesia (if surgery not completed), surgery, or other invasive procedure was completed.
2. Product Or Device Events **a.** Patient death or serious disability associated with the use of contaminated drugs, devices, or biologics provided by the health care facility	Includes generally detectable contaminants in drugs, devices, or biologics regardless of the source of contamination and/or product.
b. Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended	Includes, but is not limited to, catheters, drains, and other specialized tubes, infusion pumps, and ventilators.
c. Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in a health care facility	Excludes deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

Chapter 8 Section 8

Explanation Of Benefits (EOB)

1.0 BENEFICIARY, PARENT/GUARDIAN

The contractor shall issue and mail an appropriate and easily understood Explanation Of Benefits (EOB) to the beneficiary (parent/guardian for minors or incompetents) that appropriately describes the action taken for each claim processed to a final determination. The EOB shall be mailed in hardcopy, unless the beneficiary has provided written agreement to receive the EOB electronically. The contractor may elect to provide a monthly summary EOB in lieu of an EOB for each individual claim processed by the contractor.

2.0 NON-PARTICIPATING PROVIDER

The EOB shall be provided to the non-participating provider with the amount allowed so that he/she can determine what amount may be billed to the beneficiary under the balance billing provision (115% of the TRICARE allowable charge). Only the charges of the non-participating provider would normally appear on the EOB; however, the non-participating provider should only be provided with information where there is a "need to know." This means that if other information appears on the EOB that does not pertain to the non-participating provider, the TRICARE contractor is to suppress printing or remove it before sending the EOB to the non-participating provider. The non-participating provider will receive only the EOB and the beneficiary will receive the TRICARE payment.

3.0 NETWORK AND PARTICIPATING PROVIDERS

The contractor shall also issue an EOB to network and participating providers or issue summary vouchers covering multiple claims and beneficiaries in lieu of issuing multiple EOBs. (A summary voucher must be sent at least monthly.) Sufficient information must be included on the vouchers to identify each beneficiary and explain the payment for each line item on each claim. Use of a summary voucher does not change the requirement for a separate EOB to be sent to each beneficiary for each claim. Each contractor shall include adequate identification of the fiscal year involved applicable to the various charges listed on the EOB to help keep the deductible information clear to the beneficiary. If the provider submits the claim electronically, a Health Insurance Portability and Accountability Act (HIPAA)-compliant remittance advice shall be returned to the provider.

4.0 STATE MEDICAID AGENCY

If the claim is from a state Medicaid agency, the EOB copy usually sent to a participating provider shall be sent to the state agency. The contractor shall include the same information on the copy sent to the state as it normally sends to participating providers. If the state has a need which cannot be accommodated except at extra expense, the contractor may negotiate with the state, if it chooses, and if the state is willing to pay for the accommodation.

5.0 EOB ISSUANCE EXCEPTIONS

5.1 Contractors shall not issue an EOB to beneficiaries (parents/guardians of minors or incompetents) when claims involve services related to any of the following diagnoses:

- Abortion
- Acquired Immune Deficiency Syndrome (AIDS)/Human Immunodeficiency Virus (HIV)
- Alcoholism
- Pregnancy
- Substance Abuse
- Sexually Transmitted Diseases (STDs)

5.2 An EOB must be issued to participating providers, except as noted above. The contractor shall provide an EOB to a beneficiary upon request. When a request is made for a normally suppressed EOB, the copy provided may be a facsimile or a hand-produced copy. It must, however, include the required data and be certified by the contractor.

5.3 When a service(s) is denied due to an abortion, a letter of explanation shall be sent, but only when the denial is questioned by the beneficiary. Addendum A, Figure 8.A-4 provides suggested wording for abortion claims that are denied. **The explanation shall be provided only to the beneficiary and participating provider**. The special denial letter shall be sent in an envelope marked "personal". **It is EMPHASIZED that using an EOB is NOT acceptable for denial of abortion services. Only an approved letter may be used**.

6.0 PROCEDURES FOR INFORMING THE BENEFICIARY OF CLAIM ACTION

The processing of claims for the diagnoses listed above, requires sensitivity to the beneficiary's right to privacy. Because of the need for contractors to apply reasonable judgment on a case-by-case basis, TRICARE Management Activity (TMA) has not prescribed specific procedures except in the case of abortion claims. For claims involving services and supplies for the other diagnoses, a phone call to the beneficiary may serve to obtain information on how the beneficiary wishes to have the EOB handled in some instances. In other cases, a request that the provider serve as an intermediary, or a personal letter to the beneficiary, using a plain envelope, may be appropriate. Whatever approach is chosen, contractors must observe the intent, as well as the letter, of the Privacy Act.

7.0 PAYMENT TO THE PROVIDER OR BENEFICIARY IS 99 CENTS OR LESS

Summary voucher payments or individual claims payment checks for $.99 or less, shall be written by the contractor, but NOT mailed to the beneficiary or provider, using an appropriate EOB message. The checks shall be voided. At the end of the year when the contractor issues the provider's Form 1099, the withheld amounts shall NOT be shown on the Form 1099.

8.0 EOB FORMAT

The form design of the EOB is not specifically prescribed. Contractors shall design the form to fit their individual equipment and system needs. The contractor shall provide their toll-free inquiry number on the EOB. Only the last four digits of the Social Security Number (SSN) shall appear on the EOB.

Chapter 8 Addendum A

Figures

Due to the size and nature of the first figure, Figure 8.A-1 can be found on page 2.

FIGURE 8.A-1 DEPARTMENT OF DEFENSE (DoD) DOCUMENT (DD) FORM 2642

TRICARE DoD/CHAMPUS MEDICAL CLAIM **PATIENT'S REQUEST FOR MEDICAL PAYMENT**	*OMB NO. 0720-0006* *OMB approval expires* *Aug 31, 2009*

The public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to the Department of Defense, Executive Services Directorate (0720-0005). Respondents should be aware that notwithstanding any other provision of law, no person shall be subject to any penalty for failing to comply with a collection of information if it does not display a currently valid OMB control number.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE ABOVE ORGANIZATION. RETURN COMPLETED FORM TO THE APPROPRIATE CLAIMS PROCESSOR. IF YOU DO NOT KNOW WHO YOUR CLAIMS PROCESSOR IS, CONTACT A BENEFICIARY COUNSELING AND ASSISTANCE COORDINATOR (BCAC) OR TRICARE MANAGEMENT ACTIVITY (303) 676-3400.

PRIVACY ACT STATEMENT

AUTHORITY: 44 U.S.C. 3101; 10 U.S.C. 1079 and 1086; 38 U.S.C. 1781; E.O. 9397.
PRINCIPAL PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.
ROUTINE USE(S): Information from claims and related documents may be given to the Department of Health and Human Services and/or the Department of Homeland Security consistent with their statutory administrative responsibilities under CHAMPUS; to the Department of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service and private collection agencies in connection with recoupment claims; and to Congressional offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.
DISCLOSURE: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim.

IMPORTANT - READ CAREFULLY

Federal Laws (18 U.S.C. 287 and 1001) provide for criminal penalties for knowingly submitting or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States. Examples of fraud include situations in which ineligible persons knowingly use an unauthorized Identification Card in filing of a CHAMPUS claim; or where providers submit claims for treatment, supplies or equipment not rendered to, or used for TRICARE DoD/CHAMPUS beneficiaries; or where a participating provider bills the beneficiary/patient (or sponsor) for amounts over the CHAMPUS-determined allowable charge; or where a beneficiary/patient (or sponsor) fails to disclose other medical benefits or health insurance coverage.

INCOMPLETE CLAIM FORMS WILL DELAY PAYMENT

NONAVAILABILITY STATEMENT REQUIREMENTS: If the patient resides within the catchment area of a Military Treatment Facility (MTF) (generally within a 40-mile radius of the MTF), you will need to obtain a Nonavailability Statement (NAS) from the MTF for a hospital admission for mental health that is not a bona fide emergency. Without a necessary NAS your claim will be denied.

******

ITEMIZED BILL: Ask your provider to complete the HCFA Form 1500 for you. If the provider refuses, complete this form and attach an itemized bill which must be on the provider's billing letterhead. The bill must contain the following information:

1. Doctor's or provider's name/address (the one that actually provided your care). If there is more than one provider on the bill, circle his/her name;
2. Date of each service;
3. Place of each service;
4. Description of each surgical or medical service or supply furnished;
5. Charge for each service;
6. The diagnosis should be included on the bill. If not, make sure that you've completed block 8a on the form.

DRUGS: Prescription claims require the name of the patient; the name, strength, date filled, days supply, quantity dispensed, and price of each drug; NDC for each drug if available; the prescription number of each drug; the name and address of the pharmacy; and the name and address of the prescribing physician. Billing statements showing only total charges, or canceled checks, or cash register and similar type receipts are not acceptable as itemized statements, unless the receipt provides detailed information required above.

******

TIMELY FILING REQUIREMENTS: All claims must be filed no later than one year after the services are provided; or for inpatient care, one year from the date of discharge. If a claim is returned for additional information, it must be resubmitted by the filing deadline, or within 90 days of the notice -- whichever date is later.

******

WHERE TO OBTAIN ADDITIONAL FORMS: You may obtain additional claim forms from your claims processor, the TRICARE Service Center at the nearest military treatment facility or TRICARE Management Activity. 16401 E. Centretech Pkwy., Aurora, CO 8001 1-9066.

*** * * REMINDER * * ***

Before submitting your claim to the claims processor be sure that you have:

1. **Completed all 12 blocks on the form.** If not signed, the claim will be returned.
2. Verified that the sponsor's SSN is correct.
3. Attached your provider's or supplier's bill which specifically identifies the doctor/supplier that provided your care.
4. Attached an Explanation of Benefits if there is other health insurance, Medicare, or Medicare supplemental insurance.
5. Obtained a Nonavailability Statement if required (see information above).
6. Attached DD Form 2527, "Statement of Personal Injury -Possible Third Party Liability TRICARE Management Activity" if accident or work related. See instruction number 7 on reverse side.
7. Ensured that patient's name, sponsor's name and sponsor's SSN are on all attachments.
8. Made a copy of this claim and attachments for your records.

DD FORM 2642, APR 2007 PREVIOUS EDITION IS OBSOLETE. **COPY 2 - PROCESSOR'S COPY**

FIGURE 8.A-1 DEPARTMENT OF DEFENSE (DoD) DOCUMENT (DD) FORM 2642

1. PATIENT'S NAME *(Last, First, Middle Initial)*

2. PATIENT'S TELEPHONE NUMBER *(Include Area Code)*
DAYTIME ( )
EVENING ( )

3. PATIENT'S ADDRESS *(Street, Apt No., City, State, and ZIP Code)*

4. PATIENT'S RELATIONSHIP TO SPONSOR *(X one)*
☐ SELF ☐ STEPCHILD
☐ SPOUSE ☐ FORMER SPOUSE
☐ NATURAL OR ADOPTED CHILD ☐ OTHER *(Specify)*

5. PATIENT'S DATE OF BIRTH *(YYYYMMDD)*

6. PATIENT'S SEX *(X one)*
☐ MALE ☐ FEMALE

7. IS PATIENT'S CONDITION *(X both if applicable)*
ACCIDENT RELATED? ☐ YES ☐ NO
WORK RELATED? ☐ YES ☐ NO

8a. DESCRIBE CONDITION FOR WHICH THE PATIENT RECEIVED TREATMENT, SUPPLIES OR MEDICATION. IF AN INJURY, NOTE HOW IT HAPPENED. REFER TO INSTRUCTIONS BELOW.

8b. WAS PATIENT'S CARE *(X one)*
☐ INPATIENT? ☐ PHARMACY?
☐ OUTPATIENT?
☐ DAY SURGERY?

9. SPONSOR'S OR FORMER SPOUSE'S NAME *(Last, First, Middle Initial)*

10. SPONSOR'S OR FORMER SPOUSE'S SOCIAL SECURITY NUMBER

11. OTHER HEALTH INSURANCE COVERAGE

a. Is patient covered by any other health insurance plan or program to include health coverage available through other family members? If yes, check the "Yes" block and complete blocks 11 and 12 (see instructions below). If no, you must check the "No" block and complete block 12. Do not provide TRICARE/CHAMPUS supplemental insurance information, but do report Medicare supplements. ☐ YES ☐ NO

b. TYPE OF COVERAGE *(Check all that apply)*
☐ (1) EMPLOYMENT *(Group)* ☐ (3) MEDICARE ☐ (5) MEDICARE SUPPLEMENTAL INSURANCE ☐ (7) OTHER (Specify)
☐ (2) PRIVATE *(Non-Group)* ☐ (4) STUDENT PLAN ☐ (6) PRESCRIPTION DISCOUNT PLAN

	c. NAME AND ADDRESS OF OTHER HEALTH INSURANCE *(Street, City, State, and ZIP Code)*	d. INSURANCE IDENTIFICATION NUMBER	e. INSURANCE EFFECTIVE DATE *(YYYYMMDD)*	f. DRUG COVERAGE?
INSURANCE 1				☐ YES ☐ NO
INSURANCE 2				☐ YES ☐ NO

REMINDER: Attach your other health insurance's Explanation of Benefits or pharmacy receipt that indicates the actual drug cost, amount the OHI paid, and the amount that you paid.

12. SIGNATURE OF PATIENT OR AUTHORIZED PERSON CERTIFIES CORRECTNESS OF CLAIM AND AUTHORIZES RELEASE OF MEDICAL OR OTHER INSURANCE INFORMATION.

a. SIGNATURE
b. DATE SIGNED *(YYYYMMDD)*
c. RELATIONSHIP TO PATIENT

13. OVERSEAS CLAIMS ONLY: PAYMENT IN LOCAL CURRENCY?
☐ YES ☐ NO

HOW TO FILL OUT THE TRICARE/CHAMPUS FORM

You must attach an itemized bill (see front of form) from your doctor/supplier for CHAMPUS to process this claim.

1. Enter patient's last name, first name and middle initial as it appears on the military ID Card. Do not use nicknames.
2. Enter the patient's daytime telephone number and evening telephone number to include the area code.
3. Enter the complete address of the patient's place of residence at the time of service (street number, street name, apartment number, city, state, ZIP Code). Do not use a Post Office Box Number except for Rural Routes and numbers. Do not use an APO/FPO address unless the patient was actually residing overseas when care was provided.
4. Check the box to indicate patient's relationship to sponsor. If "Other" is checked, indicate how related to the sponsor; e.g., parent.
5. Enter patient's date of birth (YYYYMMDD).
6. Check the box for either male or female (patient).
7. Check box to indicate if patient's condition is accident related, work related or both. If accident or work related, the patient is required to complete DD Form 2527, "Statement of Personal Injury - Possible Third Party Liability TRICARE Management Activity," The form may be obtained from the claims processor, BCAC, or TRICARE Management Activity.
8a. Describe patient's condition for which treatment was provided, e.g., broken arm, appendicitis, eye infection. If patient's condition is the result of an injury, report how it happened, e.g., fell on stairs at work, car accident.
8b. Check the box to indicate where the care was given.
9. Enter the Sponsor's or Former Spouse's last name, first name and middle initial as it appears on the military ID Card. If the sponsor and patient are the same, enter "same."
10. Enter the Sponsor's or Former Spouse's Social Security Number (SSN).
11. By law, you must report if the patient is covered by any other health insurance to include health coverage available through other family members. If the patient has supplemental TRICAREiCHAMPUS insurance, do not report. You must, however, report Medicare supplemental coverage. Block 11 allows space to report two insurance coverages. If there are additional insurances, report the information as required by Block 11 on a separate sheet of paper and attach to the claim.
NOTE: All other health insurances except Medicaid and TRICARE/CHAMPUS supplemental plans must pay before TRICARE/CHAMPUS will pay. With the exception of Medicaid and CHAMPUS supplemental plans, you must first submit the claim to the other health insurer and after that insurance has determined their payment, attach the other insurance Explanation of Benefits (EOB) or work sheet to this claim. *The claims processor cannot process claims until you provide the other health insurance information.*
12. The patient or other authorized person must sign the claim. If the patient is under 18 years old, either parent may sign unless the services are confidential and then the patient should sign the claim. If the patient is 18 years or older, but cannot sign the claim, the person who signs must be either the legal guardian, or in the absence of a legal guardian, a spouse or parent of the patient. If other than the patient, the signer should print or type hisiher name in Block 12a. and sign the claim. Attach a statement to the claim giving the signer's full name and address. relationship to the patient and the reason the patient is unable to sign. Include documentation of the signer's appointment as legal guardian, or provide your statement that no legal guardian has been appointed. If a power of attorney has been issued, provide a copy.
13. If this is a claim for care received overseas, indicate if you want payment in the local currency. NOTE: Payment only in some local currencies.

DD FORM 2642 (BACK), APR 2007 **COPY 2 - PROCESSOR'S COPY**

FIGURE 8.A-2 PROVIDER'S NOTARIZED FACSIMILE OR STAMP SIGNATURE AUTHORIZATION

State of _____)
_____)ss
County of_____)

_____ being first duly sworn, deposes and says: I hereby authorize the **(Contractor for TRICARE in the State)** of to accept my facsimile or stamp signature shown below.

(Facsimile, stamp or computer generated signature as it will appear on the claim form.)

as my true signature for all purposes under TRICARE in the same manner as if it were my actual signature, including my agreeing to abide by the TRICARE payment system concept and the remainder of the certification normally signed by the source of care as it appears on all TRICARE claim forms.

Signature

Subscribed and sworn to before me this _____ day of 20____.

_____
Notary Public in and for
_____ County, State of _____

(SEAL)

My Commission expires _____

FIGURE 8.A-3 PROVIDER'S NOTARIZED SIGNATURE AUTHORIZATION

State of _____)
_____)ss
County of_____)

Know all persons by these presents:

That I, _____ have made, constituted and appointed and by these presents do make constitute and appoint _____ my true and lawful attorney-in-fact for me and in my name place and stead to sign my name on claims, for payment for services provided by me submitted to TRICARE. My signature by my said attorney-in-fact includes my agreement to abide by the TRICARE payment system concept and the remainder of the certification appearing on all TRICARE claims forms. I hereby ratify and confirm all that my said attorney-in-fact shall lawfully do or cause to be done by virtue of the power granted herein.

In witness whereof I have hereunto set my hand this _____day of _____ 20___.

Signature

Subscribed and sworn to before me this _____ day of 20____.

_____
Notary Public in and for
_____ County, State of _____

(SEAL)

My Commission expires _____

FIGURE 8.A-4 ABORTION DENIAL NOTICE TO THE BENEFICIARY AND PARTICIPATING PROVIDER

Date: _____
Sponsor's Name: _____
Beneficiary's Name: _____
Type of Service(s): _____
Date of Service(s): _____
Last four digits of
Sponsor's SSN: _____

PERSONAL

_____
To: _____
_____

Dear _____:

The Congress has prohibited TRICARE coverage of abortion service, except where the life of the mother would be endangered if the fetus were carried to term.

The legislation which limits abortion coverage applies two different effective dates to groups of TRICARE beneficiaries. For active-duty military dependents, and military retirees and their dependents, as well as survivors of deceased military members--except for the Coast Guard, the Commissioned Corps of the Public Health Service and the National Oceanic and Atmospheric Administration--the limitation is retroactive to December 29, 1981.

For dependents and retired personnel of the Coast Guard, the Commissioned Corps of the Public Health Service, and the National Oceanic and Atmospheric Administration, the limitation on coverage is retroactive to June 5, 1981.

This means that abortions--except in life-threatening situations--that were performed after these effective dates, will **not** be cost-shared by TRICARE.

Initial review of the claim(s) gave no indication that the circumstances of the abortion would qualify under this exception. Therefore, your claim(s) related to the abortion performed on _____ must be denied.

If you believe the circumstances of the abortion do qualify under the exception, you may request a Reconsideration of the denial decision by submitting a written request for a Reconsideration to this office within 90 days of the date of this notice. Such request must include a copy of this notice and your statement of the matter in dispute along with certification from the attending physician that the abortion was performed because the woman was suffering from a condition that would have endangered her life if the fetus were carried to term. Additional information/documentation which will support your claim should be submitted with your request.

If you have any questions concerning the TRICARE abortion policy, you are urged to contact your Health Benefits Advisor (located at the nearest Uniformed Services medical facility) for more detailed information. You may also contact **(Contractor Name and Address)**.

Sincerely,

- END -

2.1 TED Dupes

The DCS identifies two kinds of duplicate TEDs:

- Those that represent actual overpayments (where two or more payments were actually made and recoupments must be initiated to recover the erroneous payments); and

- Those that were submitted but no actual payments were made (and therefore no recoupment actions need to be initiated).

It is this second kind of duplicate TED that we refer to as a "TED Dupe". TED Dupes most often occur when claims are processed but for some reason are pulled before the checks are actually sent and then re-processed under different claim numbers. If the original claims processed to the point that TEDs were created, submitted, and accepted by TMA, and not subsequently cancelled, the TEDs representing the reprocessed claims (with different claim numbers) will "dupe out" with the original, uncancelled, TEDs residing on the TED database. To the Government, all of those TEDs look like actual payments were made. There is no way for the Government to look at a TED and know that a check was not really issued and sent. They all look as though payments were made.

When a contractor, while researching potential duplicate claims in their system, discovers that a claim was not really paid but is appearing in the DCS as though it had been, the contractor may be tempted to flag the record in the DCS as not being an actual duplicate. This would be incorrect. Since the TEDs in the DCS look to the Government as if actual payment were made, the contractor must flag the TEDs as actual duplicates regardless of whether actual payments were made and recoupments initiated or not. Where a TED appearing in the DCS did not involve an actual payment, it still must be flagged as an actual duplicate and a cancellation submitted even though no recoupment was initiated and no refund received (remember, no check was actually sent) in order to correctly resolve this set. The cancellation will remove the duplicate condition on the TED database.

To resolve a set involving a TED Dupe, the contractor should flag the record as a 'Y' Dupe and populate the **ID Recoup Amount** with the Government paid amount. The contractor should then enter Government paid amount in the **Actual Recoup Amount** field and request that a cancellation TED be created and submitted to TMA. Once TMA receives the cancellation TED record and applies it to the TED database, the cancellation will appear in the set in the DCS as an adjustment. The contractor then needs to flag the cancellation with a 'Y' which will cause the DCS to populate the **Adjust Amount** field with the **Government Paid Amount**. Now the **Actual Recoup Amount** equals the **ID Recoup Amount** and the **Adjusted Amount** equals the **Actual Recoup Amount** and the set can be closed.

Where there are more than two TEDs in the set, resolution of the set may be more complicated but the important point to remember is that TED Dupes are Actual Dupes in the DCS and must be treated as if an actual duplicate payment had been made.

3.0 DEVELOPMENT OF THE SYSTEM

The DCS was developed to facilitate the identification and resolution of actual duplicate payments, increase accountability for recoupments, and verify the submission of TED adjustments to correct duplicate conditions in the TED database. The system was designed to optimize the

efforts of both TMA staff and contractor staff in meeting their respective responsibilities regarding duplicate claim payments.

3.1 TMA And Contractor Benefits

For the TMA, the system provides the tools to ensure that potential and actual duplicate payments are identified, recoupments are received, TED database corrections are made, and contractor standards of performance are met. For contractors, the system provides the tools to facilitate the research of potential duplicate payments and the identification of actual duplicate payments, document recoupment activities, and ensure that corrections to the TED database in the form of adjustments or cancellations are completed.

User defined, pre-formatted reports are included in the DCS to help analyze trends, contractor performance, and processing or procedural problems in contractor operations.

3.2 System Objectives

3.2.1 The system was designed to meet the following objectives:

- To create a user-friendly, cost-effective application using web-based technology;
- To preserve TED data integrity and display only those potential duplicate claims records applicable to each contractor;
- To provide as much data as possible to assist contractors in their efforts to identify actual duplicate payments;
- To improve the detection of actual duplicate claims payments through the use of match criteria that have been found to be successful in identifying duplicate claim payments;
- To automate methods for grouping and displaying institutional and non-institutional potential duplicate TEDs to contractors for research and resolution;
- To automate and simplify methods for contractors to report their determinations as to whether the identified potential duplicate TEDs represent actual duplicate payments and, if they do, to report the corresponding amounts expected to be recouped;
- To automate and simplify methods for contractors to report actual recoupment amounts and provide a mechanism for verifying that TED adjustments/cancellations were submitted and accepted, thereby correcting the duplicate condition in the TED database;
- To automate methods to facilitate TMA and contractor audits and performance monitoring and;
- To provide the capability to generate user defined reports and graphs.

3.2.2 In meeting these objectives, the system provides the tools to monitor timely contractor research and accurate identification of actual duplicate payments and aids in diagnosing processing problems that cause duplicate payments.

4.0 FUNCTIONAL CAPABILITIES OF THE DCS

The DCS is an on-line, real-time, user-friendly system. The DCS employs five different TED-based, duplicate detection match criteria to identify potential duplicate claims. It also accommodates contractor transitions, financially underwritten/non-financially underwritten claims, and duplicate claims payments caused by jurisdictional processing errors. The DCS improves TMA and contractor accountability of actual duplicate payments through the tracking of the amounts identified for recoupment, amounts actually received in refunds or offsets, and TED adjustments or cancellations submitted on receipt of the refunded or offset overpayments. The functional capabilities of the DCS supports the claims resolution process.

4.1 The Claims Resolution Process

The process by which duplicate claims are corrected in the DCS is referred to as the "claims resolution process". To initiate the claims resolution process, the DCS identifies and groups potential duplicate claims into "sets". This enables contractors to view matching claims and conduct the necessary research to determine if one or more claims in a set involve actual duplicate payments.

If one or more of the claims in a set represents an actual duplicate payment, the contractor will identify the duplicate payment by entering a 'Y' (for "Yes") in the **Dupe?** field of that claim. If there are only two claims in the set, the other claim will have a 'N' (for "No") in the **Dupe?** field to indicate it was the original or BASE claim. Only one claim in a set can be the BASE claim. The claims resolution process requires a contractor to enter a reason code to explain the cause of the duplicate payment and the dollar amount to be recouped. Upon receipt of the refund or offset, the contractor will enter the amount actually recouped.

After recording the amount actually recouped for the duplicate claim, the contractor must correct the duplicate condition in the TED database by submitting an adjustment/cancellation TED. When the TED adjustment has been processed and accepted, it will be transmitted to the DCS for processing. This processing, which generally occurs daily, adds adjustment transactions to appropriate sets. When the appropriate adjustment appears in a set, the contractor can verify removal of the duplicate condition from the TED database by flagging the adjustment transaction (i.e., by entering 'Y' in the **TED Adjust?** field of the claim). All claims identified as a duplicate payment must have a 'Y' in the **Dupe?** field, a valid reason code, and an amount identified for recoupment. Duplicate claims may also have an amount actually recouped and an adjustment amount.

The set can now be resolved by clicking the **RESOLVE THE SET** button which invokes the "rules of resolution". (See Section 4, Figure 9.4-1.) The rules state that a set can be resolved to a *Closed* status only if full recoupment has been received or if none of the claims in the set involve duplicate payments. If one of the claims is a duplicate payment but full recoupment was not received, the set can be resolved to a *Validate* status, providing an explanation has been entered to explain why full recoupment was not possible.

4.2 Extracting TED Data To Create And Maintain The Duplicate Claims Databases

Using the duplicate claims detection criteria, the DCS identifies potential duplicate claims from TEDs residing in the TED database. Copies of these claims are extracted from the TED database. At the same time, data elements and values required for system operation are added and the data is loaded to tables on a TMA DB2 Server. These tables comprise the Duplicate Claims Databases. TED data and DCS data residing in the Duplicate Claims databases are accessible to users through the DCS application. See Section 3, paragraph 1.0 for details on the building of the Duplicate Claims databases.

5.0 SYSTEM DESIGN

In technical terms, the DCS is a "web-based" application. This term is used to describe an automated system that provides a user-friendly "web browser" environment on distributed personal computers (PCs) that interface with a transaction-based "server" environment that processes transactions, maintains databases, and optimizes the access and transfer of data between the two environments.

5.1 System Platforms

The DCS utilizes two platforms:

5.1.1 DB2 Server Platform

The DCS system resides on an IBM RS6000 Regatta P Series System. The operating system is Advanced IBM Unix (AIX). The database management system is IBM DB2, utilizing DB2 tables (i.e., the Duplicate Claims databases).

5.1.2 PC Platform

The PC platform is composed of PCs using MSIE, Version 5.5, 6.0, or 7.0, or as directed by the Government. These PCs may be stand-alone or networked computers. The PCs must have Internet access.

User screens include ease-of-use features such as tabs, buttons, scroll bars, shading, colors, **VCR** buttons, dialog boxes, user prompts, help messages, and error messages. These features enhance the display of claims data and facilitate movement from field to field, screen to screen, and claim set to claim set.

5.2 Communications

The two system platforms described above and shown in Figure 9.1-1, operate independently. Data is transmitted from one platform to another through interfaces and a communications network. Users connect to this network and the DCS via contractor-supplied web communications. See the TSM, Chapter 1 for the telecommunications requirements for accessing the TRICARE DCS.

Quick Start Instructions

This section provides instructions for using the Duplicate Claims System (DCS). The following components are necessary to access the system:

- A DCS User ID and password
- Microsoft® Internet Explorer (MSIE), Version 5.5, 6.0, or 7.0, or as directed by the Government
- The Government's DCS web address

Quick Start Instructions assumes familiarity with the personal computer (PC) environment, Windows®, and TRICARE Encounter Data (TED) records. Instructions are presented in the following order:

- Entering and Exiting the System
- Setting a View
- Looking for a Claim Set, Internal Control Number (ICN), or Patient ID
- Identifying a Duplicate Claim
- Resolving a Duplicate Claim Set
- Working with Multi-Contractor Sets
- Creating a Report
- Changing a Password
- Using the HELP System

The DCS verifies that the User ID and password are authorized. This process also identifies the user's organization and determines which claim records from the Duplicate Claims database can be viewed. For example, if the user is associated with Contractor 1, they will have access to Contractor 1 data only. The system uses an **Owner FI** field for each claim set to assign ownership of each set to a specific contractor.

1.0 ENTERING AND EXITING THE DCS

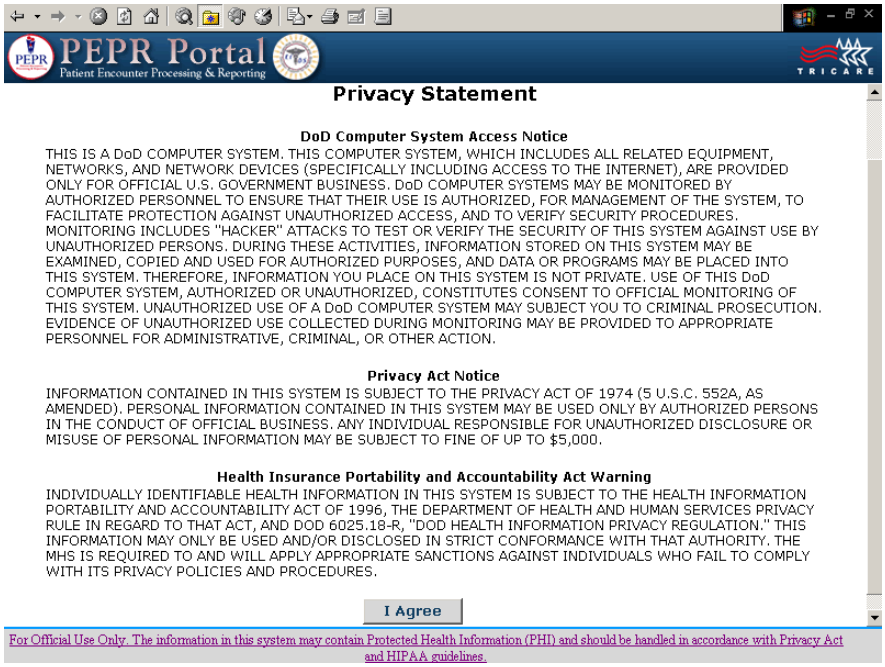
1.1 To access the DCS, start up the MSIE browser. Go to the DCS web address: https://peprsite.csd.disa.mil/pepr/pepr/.

1.2 The COMMON ACCESS CARD (CAC) SCREEN (Figure 9.2-1) will be displayed. Until the CAC process has been implemented, click on the "If you don't have a CAC, click here" option.

FIGURE 9.2-1 COMMON ACCESS CARD (CAC) SCREEN

1.3 The PRIVACY STATEMENT SCREEN in the Patient Encounter Processing and Reporting (PEPR) Portal (Figure 9.2-2) will be displayed. Read it and then click the **I AGREE** button.

FIGURE 9.2-2 PRIVACY STATEMENT SCREEN



1.8 By clicking on the **ACTIVE DATABASE** or **HISTORY DATABASE** button(s), a box with the message: "**Accessing Database. Working... Please wait...**" will be displayed. When access has been achieved, the SET SCREEN will appear with the **Set** tab active (see Figure 9.2-7).

FIGURE 9.2-7 SET SCREEN

1.9 To exit the DCS, click on **F**ile in the menu bar and click on **E**xit to return to the ACCESS SCREEN. The user can then click the **EXIT** button to return to the PEPR PORTAL DCS SCREEN. Then click on **L**ogout on the PEPR Portal Toolbar in the upper right section of the screen.

1.10 To access the training database, click on the **TRAINING DATABASE** button on the ACCESS SCREEN.

1.11 If the user elected to access the **ACTIVE DATABASE**, the first set associated with the FI/ Contractor number will be displayed. The user may move within this set to the CLAIM DETAIL SCREEN or the LINE ITEM DETAIL SCREEN (if the set is a non-institutional set) by clicking on the **Detail** or **Line Item** tab. The user may also view the ADJUSTMENT SCREEN if there is an **Adjustment** tab indicating that an adjustment has been processed for one of the claims in the set. (The **Adjustment** tab will only appear when a TED adjustment associated with the set has been submitted and accepted and has been loaded to the DCS.)

1.12 The user can use the Video Cassette Recorder (**VCR**) buttons at the bottom of the screen to move to the next set (>), the previous set (<), the first set (|<) or the last set (>|). The user can also move to a particular set by clicking on the **#** button

2.0 SETTING A VIEW

2.1 At any time, the user can click the **V**iew function on the menu bar to limit the view to certain categories of claim sets (see Figure 9.2-8). The SELECT DATA VIEW SCREEN, as shown in Figure 9.2-9, allows the user to specify a subset of claim sets to view. The user can select a subset of claim sets by:

- Status code.
- Institutional or non-institutional sets.
- Sets with or without adjustments.
- Single contractor sets or multi-contractor sets.
- Claim match criteria, e.g., exact match, date overlap, Current Procedural Terminology, 4th Edition (CPT-4) code match, etc.
- Sets within a date range for processed to completion (PTC) date, initial load date, current load date, or last update date.
- Sets belonging to a specific region or a specific contractor.
- Only sets with the specified enrollment codes.
- Sets with or without provisional claims.
- Other parameters as available.

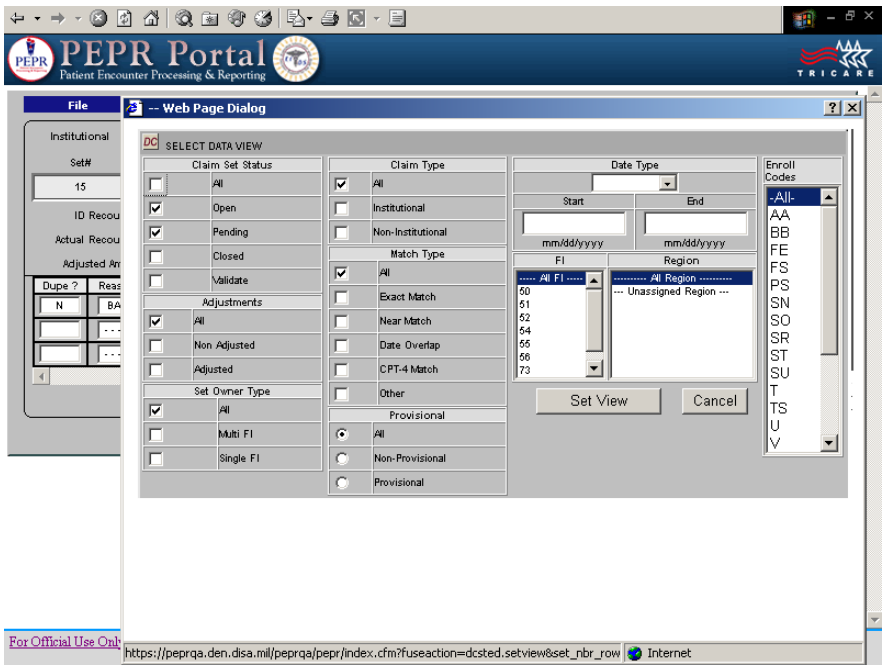
2.2 Sets may be selected by combining various View options. For example, the user may request all claim sets with an *Open* status for the West Region that meet the exact match criteria.

FIGURE 9.2-8 SET A VIEW SCREEN

2.3 When the user uses the **V**iew function, the system will remind the user that a restricted view of claim sets is being displayed by "**A View is Set**!" message on the screen. The **V**iew function also allows the user to "**C**lear a View" and return to full access of all the user's claim sets. If the user views the claim sets by status, the user can view *Open* sets to see the sets that have not been researched enough to determine if a duplicate condition exists. Or the user can view *Pending* sets to see the

sets that have been researched enough to determine that a duplicate payment was made and recoupment is pending. The user can also view sets that are in *Closed* or *Validate* status. See Section 4, paragraph 3.0, for additional details about claim set status.

FIGURE 9.2-9 SELECT DATA VIEW SCREEN



3.0 LOOKING FOR A SPECIFIC SET AND MODIFYING SETS

3.1 At any time, the user can click the **L**ocate function on the menu bar to view a specific set by Set Number, ICN, Sponsor ID, or Patient ID. Upon selection of one of these locate parameters, the system displays the claim set matching the selected parameters. If an ICN or Patient ID was entered, the user can go back to the **L**ocate function and see if other sets match the ICN, Sponsor ID, or Patient ID. If they do, the Locate **N**ext and/or Locate **P**revious options are displayed. If a previous or next option is not relevant to the ICN, Sponsor ID, or Patient ID, these choices are "grayed out" and not available to the user.

3.2 If a claim appears in more than one claim set, the ICN will be displayed in white characters. The user can double-click on the white ICN to view the set in which this same claim appears. When the user double-clicks on the white ICN in the "next" set, the system will prompt the user to move to the "Next" or "Previous" set, as appropriate.

3.3 A shortcut to locating a specific set by set number is provided as a **VCR** button at the bottom of the screen (**#**). To locate a specific set by it's Set Number, click on the **#** button, enter the number in the pop up window that appears and click on the **OK** button.

3.4 In addition to locating a specific set, the user may use the **M**odify function to change the **Owner FI** field of a multi-contractor claim set. (See Section 6, for more information about how and when the user might want to change the **Owner FI** field.) The **M**odify function also allows the user to apply the correct region to a set which has been transferred to the user.

3.5 The choices available in the **M**odify function maintain data integrity by allowing the user to select only those choices that are appropriate to the situation. In other words, the choices available to the user when changing the **Owner FI** of a set include only those **Responsible FI**s associated with the claims in that set.

3.6 The **M**odify function also has a Government option available to a limited number of the TRICARE Management Activity (TMA) users who are authorized to change the status of sets. The system-assigned status of a set will only be overridden by TMA in consult with the applicable contractor.

4.0 IDENTIFYING A DUPLICATE CLAIM

When viewing a claim set, the user should understand that every claim set contains potential duplicate claims, i.e., two or more payments made for the same services for the same beneficiary on the same dates of service. Refer to Section 3, to see the criteria used to select potential duplicate claims. Prior to the implementation of the National Provider Identifier (NPI), the type of match criteria used to select potential duplicate claims ranges from an "Exact" match in which 12 fields are the same, to an "Other" match in which three, four, or five fields are the same, depending on whether the set involves institutional or non-institutional claims. Upon the implementation of the NPI, an "Exact" match will require 14 fields to be the same, and the "Other" match will require three, four, or five fields to be the same.

The user can view these fields and others in the CLAIM DETAIL SCREEN and LINE ITEM DETAIL SCREEN (non-institutional claims only) while researching the claims in the set. Note that institutional claims are matched at the claim level and non-institutional claims are matched at the line item level. The user can print out the data as they appear on these screens by accessing the **F**ile function on the menu bar and selecting **Print**. The user will need to conduct the research on the user's proprietary claims processing system and pull claim copies, when necessary to comply with other contract requirements (e.g., duplicate prevention requirements, recoupments, etc.), to determine if an actual duplicate payment was made.

5.0 RESOLVING A DUPLICATE CLAIM SET

To resolve a claim set, the user must:

- Conduct research
- Determine the amount of overpayment, if any
- Initiate recoupment action, if required
- Record actual refunds/offsets received, if any
- Submit TED adjustments, where required and
- Apply any TED adjustments loaded to the DCS.

5.1 Steps Of Resolution

To resolve a claim set, the user must enter data in at least two fields for sets involving no duplicate overpayments and five fields for sets containing actual duplicate overpayments. (The user may also enter data into three additional, optional fields if the Managed Care Support Contractor (MCSC)/TRICARE Dual Eligible Fiscal Intermediary Contractor (TDEFIC) finds this optional data valuable.)

Note: The user may be prompted to type in an explanation for the data that was entered. This is explained below.

5.1.1 On the CLAIM SET SCREEN, the user may enter a 'Y' in the **Dupe?** field of an institutional claim to identify it as a duplicate payment or enter a 'N' in the **Dupe?** field of an institutional claim to identify it as a non-duplicate payment.For a non-institutional claim, a 'Y' or an 'N' may be entered in the **Dupe?** field on the CLAIM SET SCREEN or in the **Dupe?** field for each individual line item on the LINE ITEM SCREEN. If a 'Y' was entered on the CLAIM SET SCREEN, the system will automatically enter a 'Y' on each line item on the LINE ITEM SCREEN for that claim. The system will also enter, for the user, the paid amount for each line item in the amount identified for recoupment field on the LINE ITEM SCREEN.

Note: Users may remove 'Y' or 'N' flags on individual line items and change the amounts identified for recoupment for any line item on the LINE ITEM SCREEN regardless of whether the system populated the fields or the user.

5.1.2 For each 'Y' or 'N' entered on the CLAIM SET SCREEN, the user must select a valid reason code to explain why the claim is a duplicate or non-duplicate. Some reason codes also require a free-text explanation.

Note: Reason codes are only applied at the claim level on the CLAIM SET SCREEN. Reason codes are not required for each line item on the LINE ITEM SCREEN. In other words, only one reason code per claim is required.

5.1.3 For each 'Y' institutional claim identified as a duplicate payment the user must enter an identified amount for recoupment. For each 'Y' non-institutional claim line item identified as a duplicate payment, the system will enter the line item paid amount by default as the identified amount for recoupment.

Note: These amounts may be changed by the user if necessary.

5.1.4 For each 'Y' institutional or non-institutional claim identified as involving a duplicate payment, enter an amount actually recouped.

5.1.5 On the ADJUSTMENT SCREEN, the user may identify the TED adjustment transaction that corrects the duplicate condition in the TED database by entering a 'Y' in the **TED Adjust?** field of the adjustment displayed for the duplicate claim.

A duplicate claim set can be resolved in one of three ways:

- Indicate that no duplicate condition exits, enter a 'N' in the **Dupe?** field of all non-BASE claims, provide a non-duplicate reason code, and click the **RESOLVE THE SET** button to resolve the set and change the status to *Closed*.

- Indicate that one claim is a duplicate, enter a 'Y' in the **Dupe?** field, enter the amount identified for recoupment, enter the amount actually recouped, flag the appropriate TED adjustment that corrects the duplicate condition in the TED database, and click the **RESOLVE THE SET** button to resolve the set and change the status to *Closed*.

- Indicate that one claim is a duplicate, enter a 'Y' in the **Dupe?** field, enter the amount identified for recoupment, show that the amount actually recouped is less than the amount identified for recoupment, flag the TED adjustment (if any), click the **RESOLVE THE SET** button to resolve the set, enter an explanation for the lesser amount recouped, and allow the system to change the status to *Validate*.

The user can invoke the system's rules of resolution to resolve claim sets by clicking the **RESOLVE THE SET** button. When the **RESOLVE THE SET** button is clicked, the rules of resolution are invoked and the system determines if the set can be moved from *Open/Pending* to *Closed/ Validate*. The end result of the status depends on the conditions in the set.

5.2 Rules Of Resolution

Rule 1: All claims in the set must have 'Y' or 'N' in the **Dupe?** field and a corresponding reason code.

Rule 2: There must be one claim that is labeled the BASE claim. This claim must have a 'N' in the **Dupe?** field.

Rule 3: All 'Y' claims must have an amount identified for recoupment greater than $0.00. When the first three rules are met, the status of the set changes to *Pending*.

Rule 4: If one or more actual duplicates are identified, but no amount can be recouped, the set can be resolved to a status of *Validate* if an explanation is provided.

Rule 5: If one or more actual duplicates are identified but the full amount identified for recoupment cannot be recouped, (i.e., the actual recoupment amount is less than the identified amount for recoupment), the set can be resolved to a status of *Validate* if the total TED adjustment amounts reflect the partial recoupment amount and an explanation for the reason the full amount could not be recouped is provided.

Rule 6: If one or more actual duplicates are identified but the amount actually recouped is $10.00 or less and the contractor does not intend to submit a TED adjustment for $10.00 or less for the refund/offset, the system will permit the set to be resolved to a *Validate* status provided that an explanation is entered.

Rule 7: If one or more actual duplicates are identified and the total amount identified for recoupment equals the total amount actually recouped and the total TED **Adjust Amount** is equal to the total actual recoupment amount, the set can be resolved. The DCS assumes that every duplicate non-institutional claim has corresponding TED adjustments for every line item identified in the DCS as a potential duplicate. Resolution results depend on the following conditions:

- If there is a corresponding TED adjustment for each institutional claim or each non-institutional line item identified as an actual duplicate, the set can be resolved to a *Closed* status without any explanation.

- If there is not a corresponding TED adjustment for each institutional claim or non-institutional line item identified as an actual duplicate, the set can be resolved to a *Validate* status with an explanation for the reason corresponding adjustments were not submitted.

Rule 8: If all claims in the claim set have an 'N' in the **Dupe?** field, a valid 'N' reason code, $0.00 in the amount identified for recoupment and in the amount actually recouped for each claim, the set can be resolved to a *Closed* status. Some reason codes may require an explanation.

Rule 9: To resolve a claim set and change its status to *Closed* or *Validate*, the user must click the **RESOLVE THE SET** button. If the rules of resolution that apply to changing the status of a set from *Open*/*Pending* to *Closed*/*Validate* are met, the status of the set will be changed. If the rules of resolution are not met, the status of the set will not be changed.

Rule 10: The user can click the **UPDATE CHANGES** button to change the status of a claim set from *Open* to *Pending* or from *Pending* to *Open*. If the rules of resolution are not met, the status of the set will not be changed.

Rule 11: The user can leave a set and allow the system to automatically update the database and invoke the rules of resolution for changing the status from *Open* to *Pending* or from *Pending* to *Open*. If the rules of resolution are not met, the status of the set will not be changed.

The rules of resolution delineated above are overruled in three situations:

- In multi-contractor sets, the system ignores the claims in the set in which the **Owner FI** is not the **Responsible FI**, except for the BASE claim. It allows an **Owner FI** to move a set to a *Pending* status if there is one BASE claim and all the **Owner FI**'s claims meet the general conditions for *Pending*. That is: all **Owner FI** claims must have a **Dupe?** field entry and a reason code, there must be one 'Y' claim, and every 'Y' claim must have an identified recoupment amount greater than $0.00. See Section 6, paragraph 2.0, for additional details.

- When a single contractor set is appended with a new claim, the status of the set becomes *Open*. When a multi-contractor set in *Open* status is appended with a new claim, the status of the set remains *Open*. When a multi-contractor set in *Pending* status is appended, the status of the set remains *Pending*. When a multi-contractor set in *Closed* status is appended, the status of the set is changed to *Open*. When a multi-contractor set in *Validate* status is appended, the status of the set is changed to *Pending*. See Section 4, paragraph 5.0, for additional details.

- Rule 8 does not apply to multi-contractor sets. In multi-contractor sets there must be at least one claim with a 'Y' in the **Dupe?** field.

5.3 The RESOLVE THE SET, UPDATE CHANGES, And UNRESOLVE THE SET Buttons

The **RESOLVE THE SET** button and the **UPDATE CHANGES** button perform different resolution functions:

5.3.1 If the user wants to invoke the rules of resolution to see if the status of a set can be changed from *Open* to *Pending* or *Pending* to *Open*, the user must use the **UPDATE CHANGES** button.

5.3.2 If the user wants to invoke the rules of resolution to see if the status of a set can be resolved to a *Closed* or *Validate* status, the user must use the **RESOLVE THE SET** button.

5.3.3 The user cannot resolve a set to *Closed* or *Validate* status with the **UPDATE CHANGES** button.

5.3.4 If the user uses the **RESOLVE THE SET** button, the system will invoke the rules of resolution to determine if the status of the set can be changed to *Closed* or *Validate*. If neither of these conditions are met, the system will explain why the set cannot be resolved and will maintain the current status, i.e., *Open* or *Pending*.

If the user moves to another set after data on a set with an *Open* status has been entered, the system will automatically update the database with this new data and determine if the set meets the conditions for a *Pending* status. The change in status, if appropriate, will be made automatically, just as if the **UPDATE CHANGES** button had been clicked. Similarly, a *Pending* status will be changed to *Open* status if the rules dictate the set no longer meets the conditions for a *Pending* status. Note, however, that even if the set meets the conditions for a *Closed* or *Validate* status, this change will not be made automatically by the system. The user must use the **RESOLVE THE SET** button to change the status of a set to *Closed* or *Validate*.

The **UPDATE CHANGES** button appears on the screen whenever the user enters data. The system alerts the user to the fact that new data has been entered but this data has not been committed to the Duplicate Claims database. When the **UPDATE CHANGES** button has been clicked, the user will be prompted to select one of the following:

- "Yes" to commit the changes to the database
- "No" to rollback all the changes just made
- "Cancel" to terminate the update function and return to the previous screen

If the user chooses to commit the changes to the database, logic will be invoked to determine if the changes meet the rules of resolution for changing the status of the set from *Open* to *Pending* or from *Pending* to *Open*.

If the user chooses to rollback the changes just made, the screen will be reset to the way it was the last time the database was updated.

If the user chooses to cancel the operation, the update will not occur and the user will be back on the screen with the changes displayed but not committed to the database.

Chapter 9 Section 3

Duplicate Claims Data

The Duplicate Claims System (DCS) performs several functions for the maintenance of the DCS databases. First, it identifies, selects, and extracts potential duplicate claims from the TRICARE Encounter Data (TED) database. It then groups potential duplicate claims into sets and stores these claims in the DCS Active database. Subsequently, it identifies adjustment and cancellation transactions processed by the TED system associated with claims in the DCS Active and History databases and attaches these adjustment transactions to their associated sets. In attaching adjustment/cancellation TED records to their associated sets, the system enables users to verify that duplicate payment records have been removed from the TED database.

The DCS performs these functions separate and apart from the proprietary, claims processing systems maintained and operated by the Managed Care Support Contractors (MCSCs) and the TRICARE Dual Eligible Fiscal Intermediary Contractor (TDEFIC). Proprietary claims processing systems maintain claim and encounter processing histories which document the activities associated with the processing and payment of claims and encounters. These systems generate TEDs for submission to the TRICARE Management Activity (TMA). TEDs reflect specific claim/ encounter processing activity and document health care services and associated payment actions. TEDs are in a uniform format to permit claims processing data from various contractors to be integrated into a single database.

Contractors are required to prevent duplicate claim payments. Despite a variety of automated and manual controls established for this purpose, duplicate payments are made. These duplicate payments, appearing as duplicate TEDs, are detectable by TMA. When duplicate payments are identified, contractors are expected to initiate recoupment action. Upon receipt of the refunds or offsets, adjustment TEDs should be submitted to reflect the recoupments. When adjustments are added to the TED database, the duplicate payments are corrected, and the duplicate conditions are removed from the TED database.

The correction of the TED database is a critical function of the DCS. Not only do duplicate TEDs represent overpayments, their very existence in the TED database skew statistics and reduce the confidence of analyses and projections based on this data. Data integrity is compromised if the database is not purged of TEDs representing duplicate payments.

The DCS is not intended to replace or substitute for contractor developed, maintained, and operated duplicate detection and resolution activities within their own claims processing systems. The DCS does not pretend to capture all potential duplicate conditions. If it did, the volume of claim sets would soon become unmanageable. The DCS is an adjunct to contractor systems. It detects and displays most common duplicate conditions but not all. Contractors are still expected to employ their own systems to prevent, detect, and resolve duplicate payment conditions.

1.0 SOURCE OF DUPLICATE CLAIMS DATA

The following describes how TEDs become DCS sets and what happens to these sets over time within the DCS.

1.1 Contractors submit TEDs approximately daily. The TEDs are maintained on a TED database.

1.2 On a monthly basis, TMA reads the TED database and compares the TEDs received during the previous month to TEDs received during the previous 12 months of TED Net data to identify potential duplicate claims. The identified potential duplicate TEDs become the DCS monthly extract.

1.3 TMA also processes the daily TED data received from the contractors and extracts any TED adjustments and cancellations to TEDs previously identified as potential duplicates in a monthly extract and that reside in the DCS. These extracts become the DCS daily extract.

1.4 TMA transfers the extracts to the DB2 Server platform where they are processed and placed into the DCS Active database.

1.5 DCS users work the sets in the DCS Active database.

1.6 After specified conditions have been met and time periods have elapsed, DCS sets are moved to the DCS History database.

1.7 After a specified period of time, the DCS sets are deleted from the DCS History database.

The DCS databases receive TED data through two extracts. The first extract is performed monthly, when TEDs submitted by contractors during the previous month are compared with TEDs submitted during the previous 12 months. Applying five different match criteria for institutional and non-institutional claims (four for each type), the system detects potential duplicate claims and selects these for extraction. See paragraph 2.0, for a description of the five match criteria.

Institutional potential duplicates are identified by the application of the match criteria at the claim level. Non-institutional potential duplicates are identified at the line item level. This distinction is important in understanding how institutional and non-institutional claims are displayed within the claim sets. Refer to Section 4, for details regarding claim set composition.

The second extract is performed following the processing of each payment record cycle, generally on a daily basis. The system maintains a table of all claims selected as potential duplicates during the first extract, and extracts adjustments and cancellations associated with these potential duplicates during the second extract. The system attaches the adjustments and cancellations to the appropriate DCS sets where users can access them.

The DCS databases store claim level data for both institutional and non-institutional claims. Examples of claim level data are: Internal Control Number (ICN), sponsor Social Security Number (SSN), Patient ID, diagnosis code, and the date the TED was processed to completion (PTC).

The system also stores line item data for non-institutional claims. Examples of line item detailed data are: procedure code, place of service, type of service, care begin and end dates.

Addendum A, contains a description of the data elements in the DCS databases.

2.0 CRITERIA USED TO SELECT POTENTIAL DUPLICATE CLAIMS

The DCS uses the criteria described on the following pages to extract TED data and load the DCS databases. Prior to the National Provider Identifier (NPI) implementation, the DCS inspects up to 12 TED data fields in each claim record; on or after the NPI implementation, 14 TED data fields in each claim record. If the claims match on one of the criteria categories, it extracts and groups these claims into sets. The criteria used by the system identifies claims with a high probability of being actual duplicates.

2.1 Match Criteria For Institutional Claims Prior To The NPI Implementation

The following categories of match criteria are used to identify and link two or more matched institutional claims. Figure 9.3-1, shows the specific TED data field match criteria used to select potential institutional duplicate claims.

Exact Match	All 12 fields match.
Near Match	Five fields match and the lesser Billed Amount is within 10% of the larger Billed Amount.
Date Overlap	Three fields match and the beginning date of care of one claim falls between the beginning and ending dates of another.
Other	Four fields match.
Other Inst	Three fields (Patient ID, National Provider Identifier (NPI) - Type II, and Care Begin Date) **OR** Four fields (Patient ID, Provider ID, Provider Sub ID, and Care Begin Date)

FIGURE 9.3-1 DATA FIELD MATCH CRITERIA FOR INSTITUTIONAL CLAIMS PRIOR TO THE NPI IMPLEMENTATION

FIELD NAME	OTHER	DATE OVERLAP	NEAR MATCH	EXACT MATCH
PATIENT ID	X	X	X	X
PATIENT DOB				X
PROVIDER TAX ID	X	X	X	X
PROVIDER SUB ID	X	X	X	X
ADMIT DATE				X
BILL FREQUENCY				X
BILLED AMOUNT			± 10%**	X
ALLOWED AMOUNT				X
CARE BEGIN DATE	X	OVERLAP*	X	X
CARE END DATE			X	X
PRIN DIAGNOSIS				X
DRG CODE				X

* The system determines date overlap as follows: (a) the begin date of care on one claim must be greater than the begin date of care on the other claim and less than the end date of care on the other claim, or (b) the begin date of care on one claim is equal to the begin date of care on the other claim(s) and the end dates of care are not equal.

** The system calculates ± 10% of the Billed Amount as follows: (a) the system takes the higher of the billed amounts and multiplies it by 90%; (b) the system then compares the lower billed amount from the other claim(s) to the 90% figure; (c) the lower billed amount(s) must be ≥ 90% of the higher billed amount.

2.2 Match Criteria For Institutional Claims On Or After The NPI Implementation

The following categories of match criteria are used to identify and link two or more matched institutional claims. Figure 9.3-2, shows the specific TED data field match criteria used to select potential institutional duplicate claims.

Exact Match	All 14 fields match.
Near Match	Four fields match and the lesser Billed Amount is within 10% of the larger Billed Amount.
Date Overlap	Two fields match and the beginning date of care of one claim falls between the beginning and ending dates of another.
Other	Three fields match.

FIGURE 9.3-2 DATA FIELD MATCH CRITERIA FOR INSTITUTIONAL CLAIMS ON OR AFTER THE NPI IMPLEMENTATION

FIELD NAME	OTHER	DATE OVERLAP	NEAR MATCH	EXACT MATCH
PATIENT ID	X	X	X	X
PATIENT DOB				X
PROVIDER ID				X
PROVIDER SUB ID				X
NPI - TYPE II	X	X	X	X
ADMIT DATE				X
BILL FREQUENCY				X
BILLED AMOUNT			± 10%**	X
ALLOWED AMOUNT				X
CARE BEGIN DATE	X	OVERLAP*	X	X
CARE END DATE			X	X
PRIN DIAGNOSIS				X
DRG CODE				X

* The system determines date overlap as follows: (a) the begin date of care on one claim must be greater than the begin date of care on the other claim and less than the end date of care on the other claim, or (b) the begin date of care on one claim is equal to the begin date of care on the other claim(s) and the end dates of care are not equal.

** The system calculates ± 10% of the Billed Amount as follows: (a) the system takes the higher of the billed amounts and multiplies it by 90%; (b) the system then compares the lower billed amount from the other claim(s) to the 90% figure; (c) the lower billed amount(s) must be ≥ 90% of the higher billed amount.

2.3 Match Criteria For Non-Institutional Claims Prior To The NPI Implementation

The following categories of match criteria are used to identify and link two or more matched non-institutional claims. Figure 9.3-3, shows the specific TED data field match criteria used to select potential non-institutional duplicate claims.

Exact Match	All 12 fields match.
Near Match	Six fields match and the lesser Billed Amount is within 10% of the larger Billed Amount.
CPT-4 Code Match	Five fields and the first three characters of the procedure code match.
Other	Five fields match.

would be matched up in one set. Later, however, if claims H and I come in for Sally Jones, both containing a line item for an office visit on October 1, 2005 with Dr. Smith, the system will group the line items with the October 1, 2005 date of service from claims H and I into a new claim set (Claim Set 5). The system will not include them in the claim set containing the line items for the May 1, 2005 office visit (Claim Set 4)--even though the line items are for the same procedure code, for the same beneficiary, and rendered by the same provider---because the beginning dates of care are different. The system will prevent contractors from having to research claims containing line items that are related to different episodes of care within the same claim set.

1.2.2.2 Claim Set 6 contains two claims, J and H, both containing one line item for services rendered to Sally Jones. The line items are for office visits with Dr. Smith on May 1, 2005. Later, claims L and M are received for Sally Jones containing two line items each. Line item 1 on claims L and M is for a minor outpatient surgical procedure for Sally Jones (removal of an ingrown toe nail) by Dr. Smith on May 1, 2005. Line item 2 on both claims are for office visits for Sally Jones on June 1, 2005 with Dr. Smith.

The system will match the May 1, 2005, line items from claims L and M with the line items from claims J and K. Claim Set 6 will now contain four line items from four different claims. However, because line item 2 on claims L and M have a different beginning date of service, (June 1, 2005), the system will create a new claim set (Claim Set 7) for line item 2 of claims L and M. These line items will not be added to Claim Set 6.

As a result, claims L and M will appear in both Claim Set 6 and Claim Set 7, with each claim set containing different line items. When the user is researching claims J, K, L, and M in Claim Set 6, the system will alert the user that claims L and M also appear in another claim set by changing the color of the ICN of claims L and M from black to white. The system will permit the user to move directly to the "next" or "previous" claim set where L and M appear when the user double clicks on the ICNs shown in white.

1.3 Adjustments And Cancellations Associated With Claims In A Set

Following every TED processing cycle, generally on a daily basis, the DCS identifies all accepted adjustment and cancellation TEDs which are associated with any of the TEDs previously extracted as potential duplicates and residing in the DCS Active database. These adjustments and cancellations are extracted from the TED database and added to the applicable claim sets in the DCS Active database.

Adjustments to an institutional potential duplicate claim residing in the DCS are extracted and linked to the appropriate institutional claim set. Adjustments to a line item of a non-institutional potential duplicate claim residing in the DCS are extracted and linked to the appropriate non-institutional claim set.

1.4 ICNs Versus Claims

ICNs in the DCS do not necessarily equate to a claim. A "claim" is identified by an ICN and a time stamp. The DCS considers different time stamps to the same ICN to be unique claims.

2.0 THE PURPOSE OF CLAIM SETS IN THE DCS

The primary purpose of creating claim sets is to establish a method by which potential duplicate claims are linked together. Claim sets are the distinguishing unit of categorization in the DCS. They identify a unique grouping of claims and line items that meet one or more match criteria and therefore are potential duplicates. Each claim set contains at least two claims. Each claim set is identified by:

- A Set Number
- A Status Code
- A Match Type
- An **Owner FI**
- An **Owner Region**

Each set also maintains totals of recoupment activities completed to date. Specifically, the set contains totals of the amounts identified for recoupment, totals of the amounts actually recouped, and totals of the paid amounts of adjustment and cancellation TEDs.

A claim set provides descriptive data about the claims in the set and the status of the set as it moves through the claim set life cycle to final resolution. TED data such as the ICN, PTC date, Patient ID, and other patient, provider and service data are displayed for each claim. Claim sets also contain fields that require contractor entry of data to resolve the set.

3.0 THE CLAIM SET LIFE CYCLE

The DCS is comprised of three databases. The first is the DCS Load database where the TED extracts are processed for "loading" into the DCS Active database. The second is the DCS Active database and the third is the DCS History database. Sets are worked in the Active database. Sets that have met certain criteria and that have resided in the Active database for specified periods of time are archived to the History database. See Section 3, paragraph 1.0 and paragraphs 4.3, 4.4, and 7.0 for details regarding the DCS History database. See Section 3, paragraph 1.0 for information regarding the DCS Load database.

The claim set life cycle is the foundation of the DCS. Claim sets in the DCS are given a claim set life cycle stage, i.e., a set status, to manage the resolution process. The claim set life cycle tracks each claim set as it moves through the resolution process.

In order to resolve a claim set, the contractor must identify actual duplicate claims payments, recoup the overpayments and remove duplicate conditions from the TED database. Or, the contractor must explain why the claims identified as potential duplicates are not actual duplicates (e.g., twins who have received identical services). Additionally, a claim set may contain claims that are in fact actual duplicates yet none or only a portion of the monies identified for recoupment can be collected. In cases such as these, the system allows the contractor to resolve the claim set provided that an explanation for the absent or reduced recoupment is provided. The system has internal controls to ensure that the resolution process includes appropriate contractor action to fully or partially correct the duplicate condition in the TED database.

The claim set life cycle is composed of four stages. Each stage signifies a set status. The *Open* and *Pending* stages are considered "working" stages. Claim sets with an *Open* or *Pending* status

have not been resolved. The *Closed* and *Validate* stages are considered "resolved" stages. Claim sets in the *Closed* or *Validate* status have been resolved and the appropriate rules of resolution satisfied. The four claim set life cycle stages are described below:

3.1 The *Open* Stage Of The Claim Set Life Cycle

This stage is the first stage in the claim set life cycle. The *Open* status is given to all claim sets when they are initially loaded into the DCS Active database. In this stage, claim sets are shown with a status of *Open*, meaning that the claim set has not been researched by the contractor to determine:

- If actual duplicate payments were made on any of the claims in the set;
- The reason why a duplicate payment was made or why the apparent duplicate is not a duplicate; and
- The amount identified for recoupment, where applicable.

3.2 The *Pending* Stage Of The Claim Set Life Cycle

Normally, this is the second stage in the claim set life cycle. A set in *Pending* status means that the set is "Pending Recoupment". This status indicates that the contractor has completed the necessary research to determine which claims are actual duplicates and which claims are non-duplicates. At least one claim in the set must be an actual duplicate in order for the set to be in the *Pending* status. Additionally, all actual duplicates must have an amount identified for recoupment.

3.3 The *Closed* Stage Of The Claim Set Life Cycle

This stage is considered the final stage in the claim set life cycle. It indicates that the claim set has met all of the criteria for the set to be fully resolved. The *Closed* status means that:

- All actual duplicate claims in the set have been identified with an amount identified for recoupment;
- All claims in the set have reason codes assigned;
- The full amount entered in the amount identified for recoupment was received in offsets or refunds; and
- Adjustments were submitted that reflect the recoupments and correct the duplicate conditions on the TED database.

A set also can be *Closed* when all claims in the set are identified as non-duplicates.

3.4 The *Validate* Stage Of The Claim Set Life Cycle

This stage in the claim set life cycle is a final, but conditional, stage. It indicates that the set did not meet the rules of resolution for fully resolving the set. For example, if only 80% of the amount identified for recoupment was collected, the system will not allow the set to be *Closed*.

Validate status means that the full amount identified for recoupment could not be recovered and the reasons and circumstances for the reduced recoupment amount have been explained and that the contractor has "validated" that required recoupment procedures for uncollected debts have been followed. By having a separate status for sets involving incomplete recovery of identified recoupments, contractors and the TMA can readily identify the involved sets and claims within the DCS. *Validate* status means that:

- All actual duplicate claims in the set have an amount identified for recoupment;
- All claims in the set have reason codes assigned;
- The actual amounts recouped by refund or offset have been entered and that less than 100% of the amount identified for recoupment has been collected;
- An explanation for the lower recoupment amount has been entered;
- The TED database has been updated to reflect any refunds received or offsets taken; and
- Required recoupment procedures have been followed as they relate to uncollected debts. The explanation entered into the system must include the user's name, the date, and the reason for the lower recoupment amount.

The *Validate* status is also used in one other circumstance. When the amount actually recouped is $10.00 or less and the contractor chooses not to submit a TED adjustment, an explanation must be entered to that effect, and then the set can be resolved to a *Validate* status.

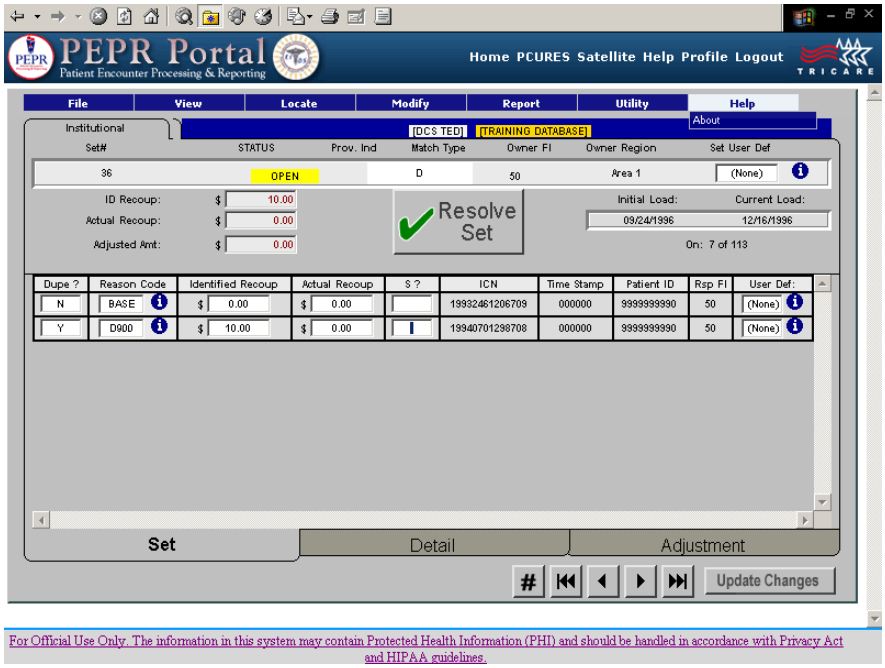
4.0 EXAMPLES OF SETS AT EACH STAGE OF THE CLAIM SET LIFE CYCLE

Each claim set has a status (e.g., *Open*) that corresponds to a stage of the claim set life cycle. The rules of resolution determine which status is given to each set. Figure 9.4-1, is a flow diagram of the rules of resolution. It shows how the rules of resolution dictate changes to claim set status.

The status of a set changes as the user enters data in five fields:

- The **Dupe?** field(s)
- The **Reason Code** field
- The **Identified Recoup** field(s)
- The **Actual Recoup** field
- The **TED Adjust?** field

FIGURE 9.4-3 *OPEN* TO *PENDING* CLAIM SET



In order for the status of a claim set to be changed from *Open* to *Pending*, the contractor must either click the **UPDATE CHANGES** button or leave the claim set and allow the system to make the change. In either case, the system checks for the following conditions:

- All **Dupe?** fields have a 'Y' or 'N'.
- There is at least one 'Y' and one 'N'.
- There is one BASE claim.
- All claims have a reason code.
- All 'Y' claims have an amount identified for recoupment greater than $0.00. (If multi-FI set, see Section 6, paragraph 2.4.)

To save changes, click the **UPDATE CHANGES** button. For an example of the UPDATE CHANGES SCREEN, see Figure 9.4-4. The following options are available:

- "Yes" to save all changes.
- "No" to rollback all changes.
- "Cancel" to quit.

FIGURE 9.4-4 UPDATE CHANGES SCREEN

An example of a *Pending* claim set is shown in Figure 9.4-5. Contractors should not initiate recoupment action on an actual duplicate claim until the set has been moved to *Pending* status.

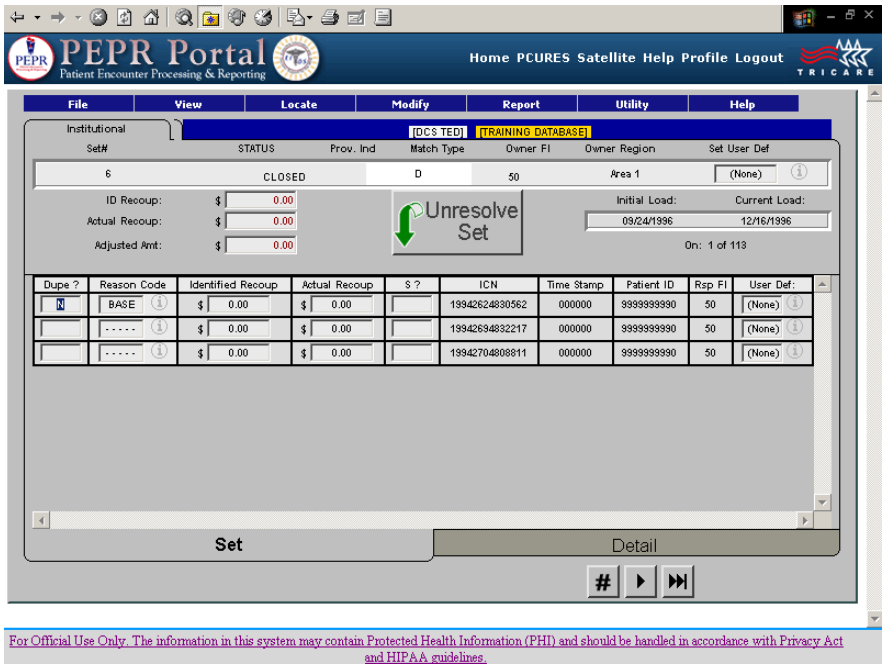
FIGURE 9.4-5 SAMPLE *PENDING* SET

Because the **UPDATE CHANGES** button activates code that determines if a claim set meets the conditions for a *Pending* status, it also can be clicked to change the status from *Pending* back to *Open* when the *Pending* conditions are no longer met.

4.3 *Closed* Claim Sets

This status indicates that the claim set has met the conditions defined in the rules of resolution for full resolution. These conditions require full recoupment of all actual duplicate payments identified in the claim set. Also, TED adjustments corresponding to the amounts actually recouped must be flagged. If the single-contractor set does not contain any actual duplicates, it can be resolved to a *Closed* status provided that each claim has a 'N' in the **Dupe?** field, a valid reason code and, if required, an explanation. If it is a multi-contractor set, it must contain at least one claim with a 'Y' in the **Dupe?** field.

FIGURE 9.4-6 SAMPLE *CLOSED* SET



An example of a claim set in *Closed* status is shown in Figure 9.4-6. As described in Section 2, paragraph 5.3, the **RESOLVE THE SET** button must be clicked to change the status of a claim set to *Closed*. Before this action, the status of the set may be *Open* or *Pending*. To meet the conditions for changing the status to *Closed* when one or more actual duplicates have been identified, the following conditions must be met:

- All **Dupe?** fields must have a 'Y' or 'N'.
- There must be at least one 'Y' and one 'N' in the set.
- All claims must have a valid reason code (some reason codes require a free-text explanation).
- The total amount identified for recoupment must be greater than $0.00.
- The total amount identified for recoupment must equal the total amount actually recouped.
- The total TED adjustment paid amounts flagged must be equal to the total amount actually recouped.
- Every duplicate claim and every duplicate line item must have a corresponding HCSR adjustment.

If no actual duplicates have been identified in a set, the following conditions must be met to change the status to *Closed*:

- All claims in the set must have a 'N' in the **Dupe?** field.
- All claims in the set must have a valid 'N' reason code.
- All **Identified Recoup** and **Actual Recoup** fields must equal $0.00.

Closed claim sets remain on the DCS Active database for two years, at which time they are moved to the DCS History database where they are kept for an additional seven years. The system does not allow users to modify any of the fields in a *Closed* set unless the set is "unresolved" (i.e., moved back to the *Open* or *Pending* status by clicking the **UNRESOLVE THE SET** button). *Closed* sets in the DCS History database are deleted after seven years.

4.4 *Validate* Claim Sets

This status indicates that the claim set has been resolved but the resolution did not meet the *Closed* status conditions, i.e., the full amount was not refunded or offset. The set may meet one of the four conditions for changing the status to *Validate*, as shown in Figure 9.4-7.

FIGURE 9.4-7 CONDITIONS FOR CHANGING CLAIM SET STATUS TO *VALIDATE*

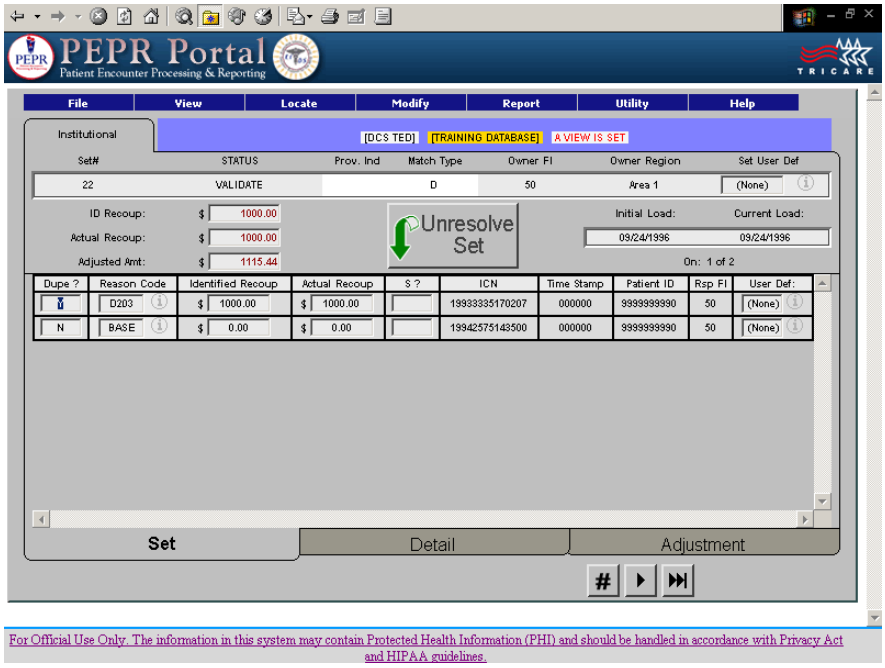
CONDITION 1	CONDITION 2	CONDITION 3	CONDITION 4
The total amount identified for recoupment is not equal to the total amount actually recouped.	The total amount identified for recoupment is equal to the total amount actually recouped.	The total amount identified for recoupment is equal to the total amount actually recouped.	The total amount recouped is less than or equal to $10.00.
and	**and**	**and**	**and**
The sum of the paid amount(s) for all selected adjustments is equal to the total amount actually recouped.	The sum of the paid amount(s) for all selected adjustments is equal to the total amount actually recouped.	The sum of the paid amount(s) for all selected adjustments is equal to the total amount actually recouped.	No adjustment was submitted by the contractor for the $10.00 or less recoupment.
and	**and**	**and**	**and**
The user enters an explanation for the discrepancy in the total amount identified for recoupment and the total amount actually recouped.	There is not a selected adjustment for every claim with a **Dupe?** of 'Y'.	There is at least one selected adjustment for every claim with a **Dupe?** of 'Y'.	The user enters an explanation that no TED adjustment will be submitted for a refund of $10.00 or less.
	and	**and**	
	The user enters an explanation for the discrepancy in the number of adjustments flagged and the number of claims with a **Dupe?** of 'Y'.	There is not a selected adjustment for every non-institutional line item with a **Dupe?** of 'Y'.	
		and	
		The user enters an explanation for the discrepancy in the adjustment line items flagged and the line items with a **Dupe?** of 'Y'.	

An example of a claim set with a *Validate* status is shown in Figure 9.4-8. As shown in this figure, the sum of the amount identified for recoupment, the sum of the amount actually recouped, and the sum of the associated TED adjustment paid amounts satisfy condition 1 for changing the status to *Validate*.

When a user clicks the **RESOLVE** button to resolve a set that does not meet the full recoupment conditions required to change the status to *Closed*, the system will present the user with the condition(s) under which full recoupment requirements were not met. The system will then prompt the user to continue with resolution. If the user elects to continue and the set meets one of the *Validate* conditions, the system will display a pop-up screen requesting an explanation for the *Validate* status. The user is required to type in their name, the date, and explanation for the *Validate* situation.

Validate claim sets remain on the DCS Active database for five years, at which time they are moved to the DCS History database where they are kept for an additional seven years. The system does not allow users to modify any of the fields in a *Validate* set unless the set is "unresolved" (i.e., moved to an *Open* or *Pending* status by clicking the **UNRESOLVE SET** button). *Validate* sets in the DCS History database are deleted after seven years.

FIGURE 9.4-8 SAMPLE *VALIDATE* SET



It should be noted that any *Closed* or *Validate* set may be moved from *Closed* or *Validate* status back to a *Pending* or *Open* status in the DCS Active database by clicking the **UNRESOLVE SET button** (Figure 9.4-9). It should also be noted that if a new potential duplicate claim is identified which belongs in a *Closed* or *Validate* set residing in the DCS Active database, the system will add the new potential duplicate to the *Closed* or *Validate* set and change the status of the set to *Open* or *Pending*.

FIGURE 9.4-9 UNRESOLVE SET

5.0 APPENDING NEW CLAIMS TO EXISTING SETS DURING THE MONTHLY EXTRACT CYCLE

During each monthly extract cycle, new claim sets are added to the DCS Active database. At the same time, if a new claim is identified as a potential duplicate of a claim in an existing set, it is added to the existing set. These sets are called appended sets. As the system appends these new claims to their appropriate sets, the system determines if the current **Owner FI** should be changed. It also determines if the status of the set should be changed.

5.1 Determining The Owner FI Of Appended Sets

The system applies the general rule of assigning the **Owner FI** to the **Responsible FI** of the claim with the latest PTC date if the status of the set is *Open* or *Closed*. If the status of the set is *Pending* or *Validate*, the system ignores this rule and leaves the current assignment of the **Owner FI**.

5.2 Determining The Status Of Appended Sets

All single contractor appended sets become *Open* sets. All multi-contractor appended sets are moved out of a resolved status (i.e., *Closed* or *Validate*) to a working status (i.e., *Open* or *Pending*). For multi-contractor appended sets, the following changes are applied:

- Appended sets in a *Closed* status are changed to *Open* status.
- Appended sets in a *Validate* status are changed to *Pending* status.
- Appended sets in a *Pending* status remain *Pending* sets.
- Appended sets in an *Open* status remain *Open* sets.

6.0 LOAD DATES

The DCS assigns two Load Dates (**Initial Load Date** and **Current Load Date**) to each set when loaded to the DCS. When a set is first loaded, both the **Initial Load Date** and the **Current Load Date** are the same. The **Initial Load Date** remains unchanged throughout the life cycle of the set. The **Current Load Date**, which is used in calculating compliance with the performance standards for the DCS (see Section 9, paragraph 8.0), may change. There are two circumstances under which the **Current Load Date** could change. These circumstances are:

- When the **Owner FI** changes.
- When a set is appended with a new claim.

7.0 HISTORY DATABASE

The DCS History database contains sets that had been in the DCS Active database in *Closed* or *Validate* status for either two or five years respectively. The data in the History database is read only. While users cannot change any data in the History database, they can run reports. Certain TMA and contractor users have permission to "Unarchive" a set in the History database (i.e., move the set back to the DCS Active database where changes may be made. (See Section 2, paragraph 1.0, for instructions for accessing the History database.)

- END -

the **Owner FI**.

2.0 REQUIREMENTS FOR ACCESSING THE SYSTEM

User access to the system is controlled by security procedures that require an individual to have access to the Government's servers and the DCS. Security procedures require a valid user ID and password.

2.1 User ID And Password

A critical component of system security is the assignment of unique user identification numbers (IDs) and passwords for each individual authorized to access the system.

Individual users at contractor and TMA sites have the capability to define their own passwords for accessing the DCS. Users can change these passwords at the time of log on to the Patient Encounter Processing and Reporting (PEPR) Portal.

As previously stated, the system allows access to those functions authorized and associated with particular user IDs. For example, contractors are permitted access only to those potential duplicate claim sets for which they are the **Owner FI**. Also, they are permitted to generate reports based only upon their own data. The same restriction to accessing data applies to the downloading function. TMA users are authorized to access claim sets for any and all contractors. Additionally, they have access to a number of administrative functions, such as generating management reports containing the aging of claims data in the aggregate, by region, or by specific contractor.

2.2 Signing On To The System

After a user has passed the PRIVACY ACT SCREEN, user log-on is directed by a screen that queries the user for an ID and password. The User ID determines what level of access is permitted and what data (claim sets) can be viewed. Once a valid User ID and password are entered, the user is connected to the DCS.

The claim set life cycle and the resolution of duplicate claim sets begin when contractors sign on to the DCS to view and examine potential duplicate claims (see Section 3, paragraph 2.0, for a description of the claims selection criteria). Through menus, contractors can define parameters to create a filter for the types of claim sets they want to view (see paragraph 4.1.2, for details regarding the **V**iew function.)

2.3 Accessing Claims Data

The DCS uses the **Owner FI** field to identify and limit access to claims data. The **Owner FI** is responsible for resolving the claim set. The system allows only the **Owner FI** to view the claim set and enter data to resolve the set. The **Owner FI** is solely responsible for researching and resolving the claim set. No other contractor can view or access a claim set owned by another contractor.

3.0 USER SCREENS

Four user screens display TED data, permit users to enter resolution data, and provide feedback to users on the rules of resolution.

3.1 Becoming Familiar With The Screens

3.1.1 Each claim set uses multiple screens to display data. To access the different screens, users click on tabs. All sets have a CLAIM SET SCREEN and a CLAIM DETAIL SCREEN. If the set is composed of non-institutional claims, it also has a LINE ITEM DETAIL SCREEN. If the set has associated TED adjustments, the set also has an ADJUSTMENT DETAIL SCREEN.

3.1.2 Normally, the first screen to be displayed will be the CLAIM SET SCREEN. This screen reflects the current date and labels the set as either an institutional or non-institutional set. The top section of the screen contains the menu bar for initiating a number of user functions. Below the menu bar, in the upper portion of the screen, are the Set Number, Status, Match Type, Owner FI, Owner Region, and Set Level User Defined Code fields. Totals of individual claim recoupment amounts are also displayed in the upper section. In the lower portion of the screen, claim-level data extracted from TEDs are displayed. The lower portion also contains fields for indicating which claims are duplicates, reason codes, the amounts to be recouped and the amounts actually recouped for each duplicate claim. In addition, fields for entering claim level user defined codes are available as well as a "solicited" field that may be used to distinguish duplicates for which refunds must be solicited from those for which only a TED adjustment is required.

3.1.3 At the bottom of the CLAIM SET SCREEN is a **Detail** tab which allows the user to move to the CLAIM DETAIL SCREEN. Once in the CLAIM DETAIL SCREEN, the user can click on a **Set** tab to move back to the CLAIM SET SCREEN.

3.1.4 The top portion of the CLAIM DETAIL SCREEN contains set information. Below the set information, claim-level detailed data are displayed. Note that left and right arrows and a scroll bar appear on the bottom of the data box to allow the user to scroll through this data. Approximately 50 claim-level fields are shown for each claim.

3.1.5 If a claim set contains non-institutional claims, there will be a **Line Item** tab at the bottom of the CLAIM SET SCREEN and the CLAIM DETAIL SCREEN to allow the user to move to the LINE ITEM DETAIL SCREEN.

3.1.6 Note that the LINE ITEM DETAIL SCREEN has a sort function above the line item data fields. The black dot in the diamond to the left of the Unsorted label indicates that the display is in Internal Control Number (ICN) order (i.e., all line items from one claim are shown before the next claim's line items). If the display contains more than two line items, it may be helpful to sort the display by grouping matched line items. To sort the line items by procedure code, the user clicks on the **SORTED** button just to the left of the **UNSORTED** button.

3.1.7 If a claim set has any adjustments corresponding to institutional claims or non-institutional line items, there will be an **Adjustment** tab at the bottom of all screens. This tab allows the user to move to the ADJUSTMENT SCREEN.

3.1.8 The bottom portion of the ADJUSTMENT SCREEN displays data for each adjusted claim. A vertical scroll bar will appear when appropriate to allow the user to view additional adjustments. Like all DCS system screens, the ADJUSTMENT SCREEN displays TED data. Adjustment data displayed includes claim ICN, TED line item and procedure code, and the paid amount of the adjustment.

3.1.9 All screens were designed to display relevant information to facilitate set resolution. Note that claims data is color-coded so that:

3.1.9.1 Extracted data from the TED database and claim-specific data created by the system appear in black.

3.1.9.2 The total amounts calculated by the system appear in red.

3.1.9.3 Data in user-controlled fields appear in blue or green.

3.1.9.4 ICNs which represent claims in multiple sets appear in white on the CLAIM SET SCREEN.

3.1.9.5 As explained in the preceding paragraphs, user screens have been designed to display claims data and associated adjustments and also provide for user entry of information needed to resolve the set. User screens also display information about the set, showing the Set Number, Set Status, Match Type, Owner FI, and Owner Region.

All screens display **VCR** movement buttons on the bottom of the screen to enable a user to move to another screen of the same set or to move to the first, next, previous, last, or a user designated set contained within the contractor's full or restricted "view." A contractor will have full view of all the sets for which the contractor has been assigned as the **Owner FI** if no restricted views (via the **V**iew function of the menu bar) have been set by the contractor. If, however, the contractor uses the View function to request a restricted view of, for example, only *Pending* institutional sets with an exact match, the contractor will see only those sets. (See paragraph 4.1.2, for a description of the **V**iew function of the menu bar.)

There are four screens that display information about a set:

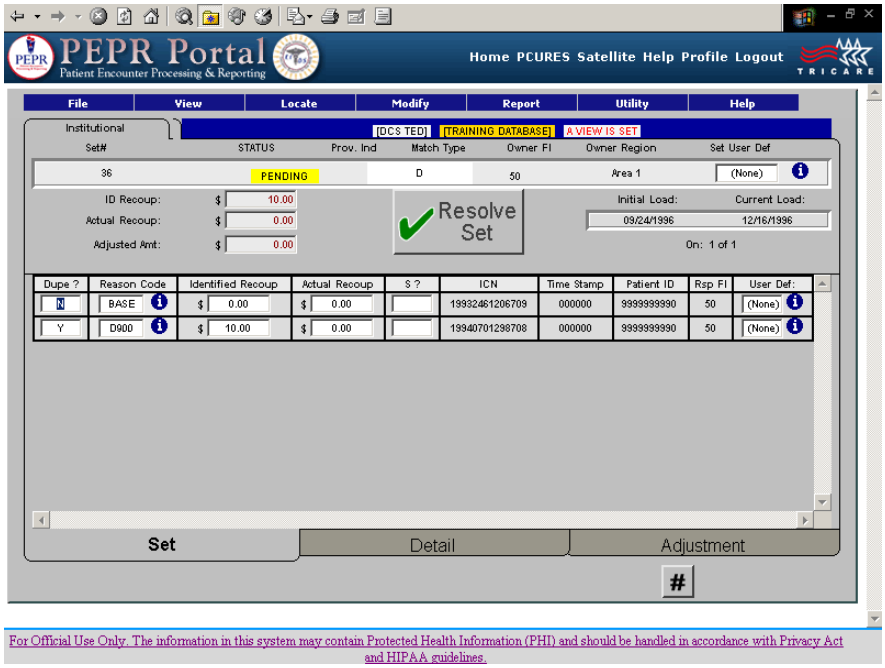
- CLAIM SET SCREEN
- CLAIM DETAIL SCREEN
- LINE ITEM DETAIL SCREEN (Non-institutional sets only)
- ADJUSTMENT SCREEN (Sets with adjustments)

3.2 Claim Set Screen

3.2.1 Set-Level Portion Of The Claim Set Screen

The CLAIM SET SCREEN displays general information about the claim set and the individual claims within the set. It is considered to be the first screen in each set. As shown in Figure 9.5-1, this screen displays system-calculated totals of the amount identified for recoupment, amount actually recouped, and the adjustment amount. Note that these totals are calculated from the entries the user made in the claim level portion of the screen. The screen also displays the Set Number, the Set Status, the Set Match Type, the Owner FI, and the Owner Region. It also displays the initial and current load dates and the set count of the current set versus the total number of sets in the contractor's full or restricted view of the sets, e.g., "53 of 3333", meaning the current set is the 53rd set of a total of 3,333 sets in the current view.

FIGURE 9.5-1 SAMPLE CLAIM SET SCREEN



3.2.2 Set Level User Defined Field

The upper portion of the screen also contains the **Set User Def** field. This field permits users to enter a user defined code to label the set to reflect additional information that the contractor wishes to track or to have available. While users may enter a user defined code, only certain contractor users have permission to define, activate, or de-activate the codes that may be used. User defined codes may be one or two characters in length. (See paragraph 4.1.2 for additional information.)

3.2.3 RESOLVE And UNRESOLVE Buttons

The screen also contains the **RESOLVE THE SET** button if the set is in *Open* or *Pending* status or the **UNRESOLVE THE SET** button if the set is in *Closed* or *Validate* status.

3.2.4 Set Recoupment Amounts

As noted above, the system-calculated totals of the amounts identified for recoupment, amounts actually recouped, and adjustment amounts for this set are based on the entries made by the user in the claim-level portion of this screen, the LINE ITEM SCREEN (for non-institutional sets) and the ADJUSTMENT SCREEN.

3.2.5 Claim Level Portion Of The Claim Set Screen

The claim level portion of the CLAIM SET SCREEN has headers that read: **Dupe?**, **Reason Code**, **Identified Recoup**, **Actual Recoup**, **S?**, **ICN**, **Time Stamp**, **Patient ID**, **Rsp FI**, and **User Def**:. Of these 10 fields, six are designated as user entry fields and four are designated as read-only TED data fields. Specifically, the user-entry fields provide for entry of a 'Y' or 'N' in the **Dupe?** field to

indicate if the claim is an actual duplicate payment or a non-duplicate, along with a valid reason code to explain why this determination was made. It also provides for user entry of specific claim recoupment activity to indicate the amount identified for recoupment (for institutional sets) and the amount actually recouped for each claim identified as an actual duplicate payment. The **Dupe?**, **Reason Code**, **Identified Recoup**, and **Actual Recoup** fields are required fields (when appropriate). The **S?** (Solicited Indicator) and the **User Def**: (User Defined Code) fields are optional.

On non-institutional claims, entering a 'Y' in the **Dupe?** field on the CLAIM SET SCREEN, automatically triggers a system entry of 'Y' in the **Dupe?** field for each line item associated with that claim on the LINE ITEM SCREEN. The system also automatically populates the **Identified Recoup** field for each 'Y' line item on the LINE ITEM SCREEN with the Govt Paid Amount. The system will then enter the sum of the **Identified Recoup** amounts from the LINE ITEM SCREEN into the **Identified Recoup** field on the CLAIM SET SCREEN for that claim. Finally, the system will enter the sum of the claim level **Identified Recoup** amounts in red in the **ID Recoup** field in the upper portion of the CLAIM SET SCREEN. Users have the option of entering individual 'Y' indicators in the **Dupe?** field on the LINE ITEM SCREEN and of changing the individual line item **Identified Recoup** amounts for each line item. The system recognizes these changes and reflects them in the sums appearing on the CLAIM SET SCREEN.

3.2.6 Claim Level Data

The fields in the claim level data portion of the CLAIM SET SCREEN are described below:

- **Dupe?** (Dupeflag) - must be 'Y' for an actual duplicate or 'N' for a non-duplicate
- **Reason Code** - must be a valid reason code for the 'Y' condition (e.g., erroneous dupe override, jurisdictional error) or the 'N' condition (e.g., twins, different service)
- **Identified Recoup** - amount identified for recoupment
- **Actual Recoup** - amount actually recouped
- **S?** - Solicited Indicator. An optional use field that may be used to distinguish duplicate claims for which refunds must be initiated (solicited) as opposed to those for which refunds have been received without recoupment efforts (unsolicited refunds) or received but for which no TED adjustments have been submitted.) It may also be used to designate the record as a "TED Dupe" in which no payment was actually made and for which a TED adjustment must be submitted. A user may enter a 'Y', an 'N', or leave the field blank. (See paragraph 4.2.3 for additional information.)
- **ICN** - the Internal Control Number
- **Time Stamp** - the claim time stamp
- **Patient ID** - Patient Identifier Number
- **Rsp FI** - The contractor responsible for this claim (either the Processing FI who remains currently responsible for correcting any errors associated with the claim or another contractor who, as a result of a contractor transition, is currently responsible

for this claim). The **Responsible FI** for each claim may or may not be the same as the **Owner FI**. Refer to paragraph 1.1, for further explanations of these fields and Section 7, for information regarding mass changes.

- **User Def:** - claim level user defined field. The claim level portion of the screen also contains a User Def: field. This field permits users to enter a user defined code to label a claim to reflect additional information that the contractor wishes to track or to have available. While users may enter a user defined code, only certain contractor users have permission to define, activate, or de-activate the codes that may be used. User defined codes may be one or two characters in length. (See paragraph 4.2.2 for additional information.)

It should be noted that the DCS defines a "claim" as an ICN plus a unique time stamp. This is important, since two claims with the same ICN but with different time stamps may appear as potential duplicates of each other in a claim set.

3.2.7 Action And Movement Buttons And Tabs

Each screen contains several buttons and tabs that allow a user to move from set to set and screen to screen, and also to change the status of a set.

3.2.7.1 The **RESOLVE THE SET** button allows the contractor to invoke the rules of resolution to determine if the set can be resolved to a *Closed* or *Validate* status. If the set is already resolved, the button will read "UNRESOLVE THE SET". In this situation, the button can be used to unresolve the set to a *Pending* or *Open* status.

3.2.7.2 The **UPDATE CHANGES** button allows a contractor to update the Duplicate Claims database with newly entered data. It is a "smart" button in the sense that it only appears after new data has been entered on either screen. The status of a set may change from *Open* to *Pending* or from *Pending* to *Open* when the **UPDATE CHANGES** button is pressed depending on the newly entered data.

3.2.7.3 Screen movement tabs allow a user to navigate among the four DCS screens. For example, the **Detail** tab allows the user to move to the CLAIM DETAIL SCREEN. Two of the screen movement tabs will appear on every set (**Set** tab and **Detail** tab). The other two tabs will appear as appropriate. The **Line Item** tab will appear only on sets containing non-institutional claims. The **Adjustment** tab will only appear when an adjustment has been loaded to the set. The appearance of the **Adjustment** tab notifies a user that associated adjustments exist for this set and enables the user to move to the ADJUSTMENT SCREEN to see them.

3.2.7.4 **VCR** buttons are shown at the bottom of all screens. They allow the user to move from one set to another set, e.g., to the previous set, to the next set, to the last set. The **<** button moves to the previous claim set, the **>** button moves to the next claim set, the **|<** button moves to the first claim set, and the **>|** button moves to the last claim set available to the user. The **#** button, when pressed, prompts the user to enter a specific set number. When entered and the **OK** button is pressed, the user will be taken to the set specified.

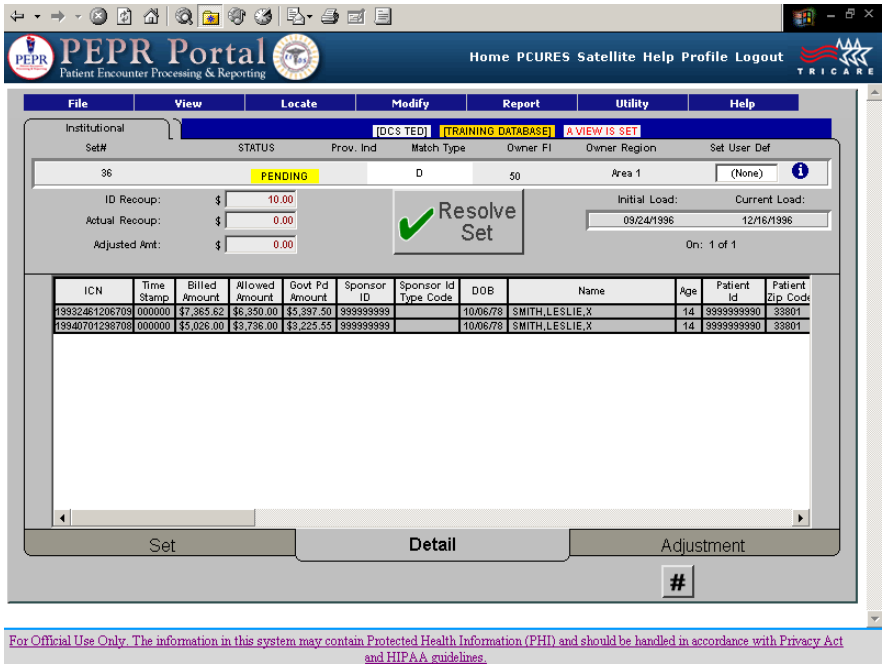
3.3 Claim Detail Screen

This screen displays additional TED data about each claim in the claim set. With the exception of the set level user defined field (**Set User Def**), no data may be changed and no data is entered on this screen. The data displayed is "read-only" and is provided to assist contractors in the research process. The CLAIM DETAIL SCREEN shown in Figure 9.5-2, displays 56 fields of TED and DCS data. This screen shows the following fields for institutional and non- institutional claims in a claim set:

ICN	Time Stamp
PTC Date	Sponsor ID
Patient Name	Patient ID
Patient Zip Code	Patient Date of Birth
PNT Health Services Region Code	Enrollment Code
Amt Allowed	Amt Billed
	Govt Paid
Inst Special Processing Code I	Inst Special Processing Code II
Inst Special Processing Code III	Inst Special Processing Code IV
Special Rate Code	Inst Provider Tax ID
Inst Provider Sub ID	National Provider ID
Inst Provider Group NPI	Inst Provider Zip Code
Inst Provider Network Status Ind.	Type of Institution
Claim Form Type	Bill Frequency
Admission Date	Patient Disposition
Inst Begin Date of Care	Inst End Date of Care
DRG	Principal Diagnosis
Batch Sequence Number	Voucher Sequence Number
Cycle Number	Processing FI
Processing Contract Number	Responsible FI
Responsible Contract Number	Mass Change Level
Risk Indicator	Claim Match Type Code
Reason Code	Solicited Indicator
Claim Level User Def Code	ID Recoup Amt
Actual Recoup Amt	Adjustment Paid Amt
Dupe Flag Indicator	Sponsor ID Type Code
Patient Age	Patient Catchment Area Indicator
Inst Provider Health Services Region Code	Provisional Indicator
Inst Provider Catchment Services Indicator	

Because all of these fields cannot be displayed across the width of one screen, the system provides a scroll bar and left and right arrow buttons at the bottom of the window to permit viewing all of the fields available.

FIGURE 9.5-2 SAMPLE CLAIM DETAIL SCREEN



3.4 Line Item Detail Screen

This screen displays additional details about each non-institutional line item in the claim set. The LINE ITEM DETAIL SCREEN shown in Figure 9.5-3, displays, along with set information common to all screens, 33 fields containing the following line item information about each potential duplicate line item in the set:

Dupe Flag Indicator
Line Item Number
Procedure Code
Type of Service Code
Service End Date
Proc Allowed Amount
ID Recoup Amount
Ninst Provider Sub-ID
Ninst Provider Group NPI
Ninst Provider Specialty
Enrollment Code
Ninst Special Processing Code I
Ninst Special Processing Code III
Pricing Code
Provider Catchment Area Ind
CPT-4 Modifier 2
CPT-4 Modifier 4
ICN
Line Item Match Type Code
Place of Service Code
Service Begin Date
Proc Billed Amount
Proc Govt Paid Amount
Ninst Provider Tax Nbr
Ninst National Provider ID
Ninst Provider Zip Code
Ninst Provider Network Status Ind
Provider Health Services Region Code
Ninst Special Processing Code II
Ninst Special Processing Code IV
Time Stamp
CPT-4 Modifier 1
CPT-4 Modifier 3

specifying a:

- Claim Set Number
- Claim ICN
- Sponsor ID
- Patient ID

When the user selects **L**ocate Value from the **L**ocate menu bar, a pull-down menu appears from which the user can choose a Claim Set Number, ICN, Sponsor ID, or Patient ID. Once one of the choices is selected, the user enters the desired number in a value box and clicks the **OK** button. After a few moments, the system will display the first set meeting the criteria selected.

If a user selects a specific claim set by set number on the pull-down menu (e.g., Claim Set 25), the system will display only the set with the number "25". If a user enters a specific Sponsor ID, Patient ID, or ICN, there may exist other sets in the system that contain claims with the same values. If multiple sets exist in the database that contain the same ICN, Sponsor ID or Patient ID, two options on the **L**ocate pull-down menu become active, i.e., "**L**ocate Next" or "**L**ocate Previous", allowing the user to go to the next or previous claim set containing that ICN or ID.

For example, if a user wants to see all of the sets with claims containing Sponsor ID "123456789", the user will select the "Sponsor ID" and enter "123456789" in the value box on the **L**ocate Value pull-down menu. The system will display the first set containing a claim with a Sponsor ID of "123456789". After viewing this set, the user can again select the **L**ocate function on the menu bar. If additional sets containing this ID exist in the database, the **L**ocate Next option on the pull-down menu is activated. If selected, the system will bring the second set containing Sponsor ID "123456789" into view. The user may continue to request the next claim set until no more are found in the system.

Likewise, if the **L**ocate Previous button is selected, a previous claim set containing the selection criteria will be displayed. The user may continue to request previous claims sets until no more are found in the system. The user can move between claims sets by using the **NEXT** and **PREVIOUS** options.

4.1.4 Modify

The **M**odify function enables a contractor to change the **Owner FI** field in a multi-contractor claim set or assign a contract/region to a multi-contractor claim set received from another contractor.

Each contractor will see two options in this function: **Owner FI** (only if it is multi-FI set) and **Owner Region** (always). The **Owner FI** can select the Owner Region option to change the **Owner Region** assigned to the set. If the set is a multi-contractor set, the **Owner FI** also can select the **Owner FI** option to change the **Owner FI** to another contractor (**Responsible FI**). If a set is transferred to a new **Owner FI**, the new **Owner FI** must select the **Owner Region** option to change the Owner Region from "Region Unknown" to the applicable region associated with that set.

The **M**odify function also has a **G**overnment option for a select group of TMA staff. This option is not visible to contractor users. The **G**overnment option has a **S**tatus function that allows authorized TMA users to change the status of a set. The status of a set will not be changed by a TMA

user without first coordinating the change with the applicable contractor.

4.1.5 Report

The **R**eport function offers a selection of report and graph formats. See Section 8 and Addendum D, for descriptions of the available reports and detailed instructions on using the **R**eport function.

4.1.6 Utility

The **U**tility function enables a user to:

4.1.6.1 View **M**odify FI Explanation - View (but not edit) explanations given for changing the **Owner FI** field in multi-contractor sets.

4.1.6.2 Change or View **V**alidate Explanation - View explanations entered for *Validate* claim sets and edit these explanations.

4.1.6.3 View **R**eason Code Explanation - View (but not edit) explanations associated with certain reason codes. The system requires that certain reason codes be supported by a narrative explanation. Users are prompted for the explanation when certain reason codes are selected.

4.1.6.4 Create, Change, or View **N**otepad - The **N**otepad function provides users with the capability to attach notes or comments to a set. **N**otepad entries are made at the set level. When ownership of a set changes, **N**otepad entries are carried with the set. **N**otepad entries may contain whatever the user wishes. To create or edit a Notepad entry, the user should select the **U**tility function. From the drop-down menu, the user should select "Create, Change, or View **N**otepad". In the screen that appears, the user can enter or edit text or delete the note altogether.

4.1.6.5 **D**ownload - Initiate a download of data to a local PC for ad hoc query and reporting purposes.

4.1.6.6 Modify **S**et User Defined Codes - Available to and used by a limited number of users selected by each contractor to create, modify, activate, de-activate or delete Set Level User Defined Codes for that region. (See paragraph 3.2.2 for additional information.)

4.1.6.7 Modify **C**laim User Defined Codes - Available to and used by a limited number of users selected by each contractor to create, modify, active, de-activate or delete Claim Level User Defined Codes for that region. (See paragraph 3.2.6 for additional information.)

4.1.6.8 **U**narchive Set - This option is only available when the user is in the History database. It may only be used by a limited number of users selected by each contractor. It allows the user to move the set from the History database to the Active database where changes to the set can be made.

Note: Sets that are unarchived will appear in the production database in *Closed* or *Validate* status. On a monthly basis, immediately following the monthly load process, the DCS will sweep the production database for sets that have been in *Closed* status for two years or *Validate* status for five years and will archive, i.e., move, these sets to the history database. If a user unarchives a set

Once codes have been defined, users can click on the blue **i** button on the **User Def:** field on the CLAIM SET SCREEN and a list of entered codes will appear from which to select. By clicking on a code, it will be entered into the field. Use of this field is not required. Contractors may choose to use it or not use it as they see fit. A number of reports include this field on the Report Parameter Selection Form and in the reports themselves. This field is also included in contractor initiated downloads of claim data.

4.2.3 Solicited Indicator Field (S?)

The **Solicited Indicator** field is located in the lower portion of the claim set screen. It is labeled "**S?**" and follows the **Actual Recoup** field. It also appears in the CLAIM DETAIL SCREEN and is labeled "Solicited Indicator." Use of this field is optional but is recommended that contractors use it to help differentiate actual duplicates requiring recoupment from those that require only TED adjustments. A 'Y' in this field indicates that a recoupment will be initiated. A 'N' means that no recoupment action is required (e.g., a refund has already been received or a claim has already been cancelled but a TED adjustment needs to be submitted since duplicate TEDs for the claims reside on the TED database. A blank indicates undetermined.

4.3 Finding Claims in Multiple Sets

The system alerts users when a claim appears in multiple sets. When a claim appears in more than one set, the ICN appears on the CLAIM SET SCREEN in white print. If a claim does not appear in other sets, the ICN will be in black or red print. A user wishing to move to the next set containing the claim with the same ICN and can double click on the ICN. A dialog box will appear with Locate **N**ext and Locate **P**revious options. The user can select either option and the system will display the requested set(s).

5.0 USER ENTRY OF DATA TO RESOLVE CLAIM SETS

The DCS facilitates the resolution of duplicate claims by minimizing the amount of data that must be entered by users. It also provides an easy-to-use environment for data entry.

5.1 The entry of data by contractors is limited to 10 fields. Seven fields appear in the CLAIM SET SCREEN, two fields in the LINE ITEM SCREEN, and one field in the ADJUSTMENT SCREEN, as described below:

5.1.1 On the CLAIM SET SCREEN, the contractor may enter:

- 'Y' or 'N' in the **Dupe?** field [required for institutional]. (**Note**: For non-institutional, see Section 2, paragraph 5.1.)
- A reason code selected from lists built into the system, and a supplemental explanation where necessary (see Addendum B) [required].
- An identified recoupment amount for each actual duplicate identified [required for institutional sets].
- An actual recoupment amount when refunds or offsets are collected [required].

- A user defined code at the set level [optional].
- A user defined code at the claim level [optional].
- A 'Y' or 'N' in the **S?** (Solicited Indicator) field [optional].
- On the LINE ITEM SCREEN, the contractor may enter:
- A 'Y' or 'N' in the **Dupe?** [optional for non-institutional sets] (see Section 2, paragraph 5.1.1).
- An amount in the **Identified Recoup** field (the system will enter the Government Paid Amount here when the user a 'Y' in the **Dupe?** field. (The user may modify this amount.) [optional]

5.1.2 On the ADJUSTMENT SCREEN, the contractor may enter a 'Y' in the TED Adjustment (**TED Adjust?**) field for any claim that has an adjustment displayed on the screen. Note that the adjustment paid amount, which corrects a duplicate condition and resolves a claim set, appears as a negative number in parenthesis. When adjustments are selected in the system, the negative allowed amounts are converted to a positive value when they are added to the total Adjust Amount field and used by the rules of resolution to resolve claim sets.

5.2 After entering data on a CLAIM SET SCREEN, LINE ITEM SCREEN, or ADJUSTMENT SCREEN, a contractor will notice that the **UPDATE CHANGES** button appears. The contractor may click the **UPDATE CHANGES** button to see if a change in status (*Open* to *Pending* or *Pending* to *Open* only) will occur as a result of the newly entered data. Upon clicking the button, the user will be prompted to select one of the following:

- "Yes" to commit to the database the changes just made.
- "No" to rollback all the changes just made.
- "Cancel" to cancel this operation and go back to the screen.

If the user moves off a claim set after entering data (i.e., by clicking one of the **VCR** buttons or by using the **V**iew or **L**ocate functions), but before clicking on the **UPDATE CHANGES** button, the changes will be automatically sent to the database and the set will be updated.

In invoking the rules of resolution by clicking on the **RESOLVE** or **UPDATE CHANGES** button, the user instructs the system to look at the values in the three total amount fields. The three total amount fields are:

- Total Amount Identified for Recoupment (**ID Recoup**), computed from the sum of the amounts the user enters at the claim level on the CLAIM SET SCREEN.
- Total Amount Actually Recouped (**Actual Recoup**), computed from the sum of the amounts the user enters at the claim level on the CLAIM SET SCREEN.
- Total TED Adjustment Paid Amount (**Adjust Amount**), computed from the sum of TED paid amounts on the adjustments flagged with a 'Y' in the TED Adjustment (**TED Adjust?**) field on the ADJUSTMENT SCREEN.

the field unchanged. See paragraph 5.0, for additional information.

1.3 Processing FI Field

This field is a claim-level data element that is extracted from the TED. It contains the FI number of the contractor that originally processed the claim. The **Processing FI** field cannot be changed in the DCS.

2.0 SYSTEM FEATURES UNIQUE TO MULTI-CONTRACTOR CLAIM SETS

The layout of the data and the screens available for viewing and entering data in multi-contractor claim sets is the same as the layout of single contractor claim sets. In multi-contractor sets, though, the contractor who is designated the **Owner FI** can change the **Owner FI** field to designate the other contractor as the **Owner FI**. This process is initiated as follows:

2.1 Click on the **M**odify function on the menu bar.

2.2 Click on the **Owner FI** option from the drop-down menu.

2.3 The system displays the FI number(s) of the other contractor(s) in the set. Click on the contractor to be designated as the new **Owner FI**.

2.4 This feature also requires the current **Owner FI** to document contact with the contractor to which the set will be transferred and provide an explanation for why ownership of and responsibility for resolving the set is being changed. When a new **Owner FI** is assigned, the **Owner Region** field changes to "<to be assigned>". The new **Owner FI** subsequently can click on the **M**odify function, **Owner Region** option, and select the appropriate **Owner Region**.

A system feature unique to multi-contractor sets is the rule for changing the status of a set to Pending. In effect, the system ignores the claims in the set in which the **Responsible FI** is not the **Owner FI**. It allows an **Owner FI** to move a set to a Pending status if there is one BASE claim and all of the **Owner FI**'s claims meet the general conditions for Pending status. That is, all **Owner FI** claims must have a dupeflag and reason code, there must be a 'Y' claim, and every 'Y' claim must have an identified recoupment amount greater than $0.00. According to this rule, the status of a multi-contractor set may change as the **Owner FI** changes. For example, if the **Owner FI** identifies all of their claims as actual duplicates and enters a 'Y' in the **Dupe?** fields, selects reason codes and enters amounts identified for recoupment, and leaves the other contractor's claim as the BASE claim, and clicks the **UPDATE CHANGES** button, the status of the set will move to *Pending*. However, if the **Owner FI** changes the **Owner FI** field to the other contractor that has only the BASE claim, the new **Owner FI** will receive the set in *Open* status. According to the rules, the new **Owner FI** does not have actual duplicate claims with associated amounts identified for recoupment. Since *Pending* status means pending recoupment and since the new **Owner FI**'s claim is the BASE claim and is not one of the duplicates, the set cannot be pending recoupment for the new **Owner FI**. The set would be in Pending status for the old **Owner FI** not the new **Owner FI**.

2.5 Another system feature unique to multi-contractor claim sets is the special logic invoked for multi-contractor appended sets. When a new claim is identified during the monthly extract as a potential duplicate of a claim in an existing set, the set is called an appended set. In appending a new claim to a set, the system applies the general rule of assigning the **Owner FI** to the

Responsible FI of the claim with the latest PTC date if the status of the set is *Open* or *Closed*. If the status of the set is *Pending* or *Validate*, the system ignores this rule and leaves the current assignment of the **Owner FI**. The system also applies special logic to determine the status of multi-contractor appended sets.

The status of multi-contractor sets with an appended claim is determined as follows:

- *Open* sets will remain *Open* because recoupment had not been initiated on the set prior to the new claim being appended.
- *Pending* sets will remain *Pending* to allow the **Owner FI** to complete recoupment of actual duplicate payments prior to determining if additional research is required or if the set should be transferred to another contractor.
- *Validate* sets will be changed to *Pending* to allow the **Owner FI** to determine if the appended claim changes the *Validate* situation prior to determining if additional research is required or if the set should be transferred to another contractor.
- *Closed* sets will be changed to *Open* to allow the **Owner FI** to determine if the appended claim requires additional research or if the set should immediately be transferred to another contractor.

3.0 COORDINATION REQUIREMENTS WHEN WORKING WITH MULTI-CONTRACTOR SETS

Resolution of multi-contractor claim sets requires close coordination between the contractors involved to ensure that research efforts and resolution activities are conducted efficiently, appropriately, and in a timely manner. When researching a multi-contractor set, the **Owner FI** must coordinate with the other contractor(s) involved to determine who is responsible for the duplicate payment(s) and for recouping the overpayment(s). The method of coordination must be negotiated between contractors and may take whatever form is agreeable, i.e., by telephone, fax, e-mail, or combination thereof. This coordination is a courtesy among contractors and should prevent indiscriminate transfers of sets back and forth. If the current **Owner FI** is not responsible for the duplicate payment, the current **Owner FI** should contact the other contractor to advise them of the set, its upcoming transfer, and to discuss or describe the circumstances involved. Ownership of the set must not be changed to another contractor until the receiving contractor has been consulted and an explanation has been entered into the system justifying the switch.

The explanation entered into the system must contain:

- The date the other contractor was contacted.
- The name and telephone number of the person making the contact from the current **Owner FI**.
- The name and telephone number of the person contacted at the contractor to which ownership of the set is being changed.
- A brief explanation for the change of ownership (e.g., "This claim falls within the

6.3 As with all multi-contractor DCS sets, the contractors involved must communicate and coordinate with each other in order to resolve "snowbird" multi-contractor sets. The following steps shall be taken by the contractors to resolve this type of multi-contractor set.

6.3.1 The **Owner FI** of the multi-contractor set shall contact the other contractor(s) involved and advise them of the existence of the set (remember, only the **Owner FI** can see the set). In consultation with each other, if the primary address can be determined from existing information residing with the involved contractors and a decision can be made as to who has jurisdiction for the claim, then the set may be handled as any other multi-contractor set. Existing information may include previous claims history, customer service contacts (by phone, walk-in, or correspondence), DEERS address data, etc. Note that if both contractors have existing claims history and there is no other corroborating information as to the correct primary residence address, then the **Owner FI** must develop for the correct address to determine jurisdiction (see paragraph 6.3.2).

6.3.2 If the primary address cannot be determined from existing information residing with the involved contractors, then the **Owner FI** shall develop for the primary residence address. Development for the primary address shall include: telephone calls to the patient, telephone calls to the provider, sending letters to the patient at both addresses requesting that the patient designate a primary address and requesting that they update DEERS with their primary residence address.

6.3.3 If none of the development efforts succeed and the primary residence address cannot be determined, the **Owner FI** shall contact the other contractor(s) involved and the contractor that processed the claim with the latest PTC date shall be the contractor deemed to have made the overpayment and therefore responsible for initiating recoupment. If that contractor is not the current **Owner FI** of the set, then the set shall be transferred to that contractor. In the rare event that the claims were processed on exactly the same date and at exactly the same time, the contractors, in consultation with each other, may decide which shall initiate recoupment. The actions taken and the decisions made by the contractors shall be documented in the system either in the DCS Notepad or in the dialog box that prompts users for an explanation when transferring sets to another contractor. At a minimum, the documentation shall include the names of the people involved in the discussions from each of the contractors, the date(s), and the decisions made.

- END -

Chapter 9 Section 7

Mass Change Function For Contract Transitions

1.0 CONTRACT TRANSITIONS

When a new contract is awarded, the Government establishes a transition plan for the outgoing and incoming contractors. This plan specifies the schedule for implementing transition activities, e.g., dates when certain types of claims and encounters become the responsibility of the new contractor.

A contractor has access to and can view only those potential duplicate claim sets for which the contractor has responsibility for resolving and is the designated **Owner FI**. When a contract transition occurs, access to the duplicate claim sets must be transferred to the incoming contractor for resolution, in accordance with the transition plan. The date the incoming contractor will assume responsibility for resolving the claim sets owned by the outgoing contractor will be determined during transition meetings. The type of claim sets (e.g., financially underwritten or non-financially underwritten), that will be transferred to the incoming contractor will be determined at transition meetings. The **Responsible FI** field may be changed to an inactive FI 99 for claims that will remain the responsibility of the outgoing contractor.

Under the terms of the transition plan, the incoming contractor will be responsible for resolving the claim sets transferred to them from the outgoing contractor, including all recoupments and submissions of adjustment and cancellation TRICARE Encounter Data (TED) records.

2.0 NEED FOR THE MASS CHANGE FUNCTION

When TEDs representing potential duplicate payments (along with their corresponding adjustment and cancellation TEDs) are extracted from the TED database and loaded into the Duplicate Claims database, ownership (i.e., the **Owner FI** field) of each claim set is assigned. Additionally, a **Responsible FI** is assigned for each claim in the set. (See Section 6, paragraph 1.2, for the definition of this field.) The contractor that is the **Owner FI** is responsible for resolving the set. When a contract transition occurs, responsibility for resolving a set may change. The Mass Change function manages this process by changing the **Responsible FI** field of all claims included in the transition plan. This field may be changed to the incoming contractor or to an inactive FI 99. It also may be left unchanged if the outgoing contractor remains an active contractor. The Mass Change function also changes the **Owner FI** field as appropriate.

For example, Contractor 1 has been using the Duplicate Claims System (DCS) for a year and the DCS has been extracting potential duplicates, creating claim sets and assigning ownership of these sets to this contractor. Effective, February 1, 2008, three states are carved out of this contractor's region and a new region is established. Contractor 2 is awarded the contract for this new region. The transition plan establishes that Contractor 2 will assume full responsibility for resolving potential duplicate claim sets, previously the responsibility of Contractor 1, for these

three states, on June 1, 2008. The DCS will identify the affected non-financially underwritten claims and change the **Responsible FI** field of the affected claims and the **Owner FI** field of the affected sets to Contractor 2 effective June 1, 2008.

3.0 DEFINING MASS CHANGES

The TRICARE Management Activity (TMA) is responsible for initiating the Mass Change function upon determination of the transition plan requirements pertaining to duplicate claims resolution. Mass Changes are initiated by the submission of Mass Change Specification Forms to the TMA Automated Data Processing (ADP) Facilities Management Services Contractor who is responsible for making the changes in the Duplicate Claims database. A sample form is shown in Figure 9.7-1.

The Mass Change Specification Form lists the data fields in the Duplicate Claims database that may be used to identify claims and claim sets whose "ownership" must be changed to accommodate a contract transition. Once a Mass Change is performed, affected claims and claim sets will be accessible to the incoming contractor and removed from the view of the outgoing contractor.

an **Identified Recoup Amount** greater than $0.00, then the **Owner FI** will be changed to the new **Responsible FI**.

5.1.4 If the **Responsible FI** being changed is the owner of the set and the **Responsible FI** is being changed to an FI other than 99, and there is another claim in the set with the same **Responsible FI** as the one being changed, and the claim with the **Responsible FI** being changed has an **Identified Recoup Amount** equal to $0.00, then the **Owner FI** will not be changed.

5.1.5 If the **Responsible FI** being changed is the owner of the set and the **Responsible FI** is being changed to 99, and there are no other claims in the set with an FI other than 99, then the **Owner FI** will be changed to 99.

5.1.6 If the **Responsible FI** being changed is the owner of the set and the **Responsible FI** is being changed to 99, and there are other claims in the set with the same Responsible FI as the one being changed, then the **Owner FI** will not be changed.

5.1.7 If the **Responsible FI** being changed is the owner of the set and the **Responsible FI** is being changed to 99, and there are other claims in the set with an FI other than 99, and there are no other claims in the set with the same **Responsible FI** as the one being changed, and there are no non-FI 99 claims with an **Identified Recoup Amount** greater than $0.00, then the **Owner FI** will be changed to the non-FI 99 claim with the latest Processed To Completion (PTC) date.

5.1.8 If the **Responsible FI** being changed is the owner of the set and the **Responsible FI** is being changed to 99, and there are other claims in the set with an FI other than 99, and there are no other claims in the set with the same **Responsible FI** as the one being changed, and there are non-FI 99 claims with an **Identified Recoup Amount** greater than $0.00, then the **Owner FI** will be changed to the non-FI 99 claim with an **Identified Recoup Amount** greater than $0.00 that has the latest PTC date.

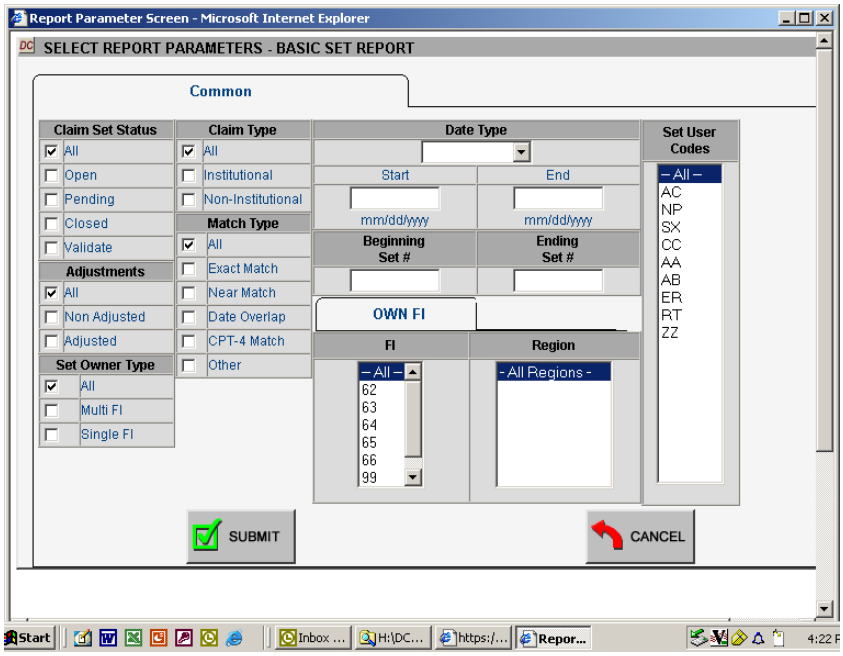
6.0 RESOLUTION ISSUE INVOLVING TRANSITIONED SETS FOLLOWING A MASS CHANGE

During a transition, when the outgoing contractor has ceased entering refund and adjustment data on the DCS, refunds may be received and/or TED adjustments may still be submitted for claims in *Open* and *Pending* sets. In this case, the incoming contractor may be required to resolve the set without knowing the amount of the refund received by the outgoing contractor.

If the actual recoupment amount was zero when the set was transferred from the outgoing contractor, the incoming contractor may apply the adjustment to the set while leaving the actual recoupment amount as zero dollars. Resolution would result in a *Validate* status, requiring an explanation by the incoming contractor that the outgoing contractor did not enter the actual recoupment amount.

- END -

FIGURE 9.8-2 REPORT PARAMETER SCREEN



Note that the system recognizes if the user is a TMA or contractor user and will display the appropriate options. For example, a contractor is able to print only their own data (i.e., sets assigned to this contractor or region) and not data of other contractors. TMA users are able to generate reports containing data from all contractors.

The report parameter screen presents available options for data selection criteria based on the user type and the type of report format selected. For example, some report formats permit users to include institutional data, non-institutional data, or both in a report. Other formats are exclusively dedicated to either institutional or non-institutional data. Some report formats permit users to include data based on a range of dates while others do not.

The parameter screen detects the user type and the report format selected and displays only those data selection criteria options available for the user and the selected format.

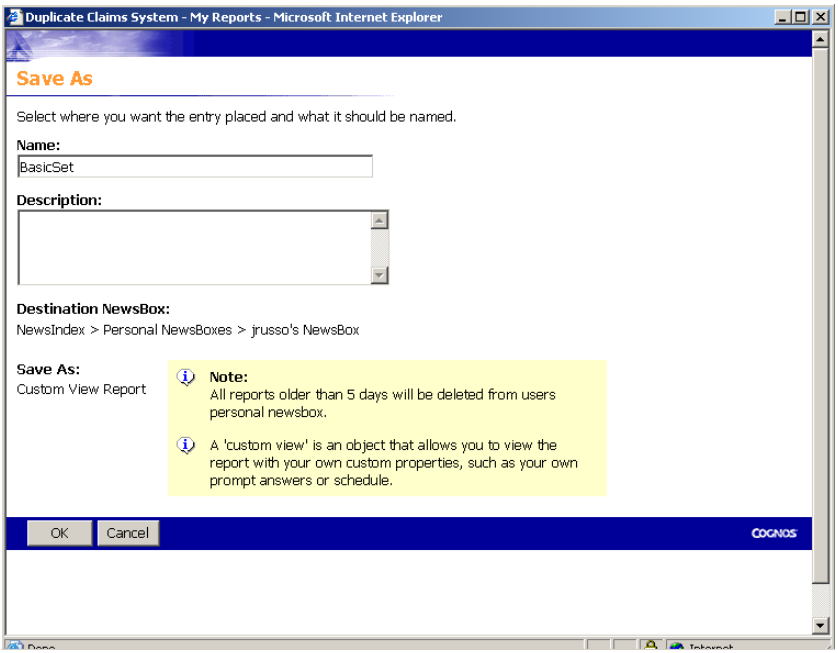
The date range options on the report parameter screen allow a user to specify a selection of sets or claims based on a range of different dates such as:

- Processed To Completion (PTC) Date - the date when the claim was PTC.
- Initial Load Date - the date when the set was initially loaded into the DCS.
- Current Load Date - the date when the set was loaded into the Duplicate Claims database or when a claim was appended to the set or when set ownership was changed as a result of a mass change or a change in the **Owner FI** field.
- Last Update Date - the date when the set was last updated by a user or by the system.

Note: That regardless of the parameters the user selects, the reports will not include any data from provisional sets.

After a user selects a report format and data parameters and selects the **SUBMIT** button, the system displays the SAVE AS SCREEN (Figure 9.8-3). At this time the user can enter a name for the report and may also add a description. This screen allows the user to continue and produce the requested report by selecting the **OK** button or cancel the request and return to the set by selecting the **CANCEL** button.

FIGURE 9.8-3 SAVE AS SCREEN



If the user selects the **OK** button, the system brings the user to the MY REPORTS SCREEN (Figure 9.8-4) that lists all the reports that have been run or requested. The reports that have not been reviewed, will display the caption "New". After five days, the reports on this menu will be deleted automatically. To review and/or print a report, select the report name.

Graphs menu are shown in Figure 9.8-9.

The categories of report formats, in concert with report parameter screen options, provide users with flexible reporting tools to generate a wide range of reports. If a desired report cannot be devised through the use of the available report formats and the parameter screen options, users have the ability to download their data to their local hard drives, perform their own queries, and generate customized reports using their own database management spreadsheet, or report generation software.

See Addendum D for available report formats.

3.0 USING THE UTILITY FUNCTION TO DOWNLOAD DATA FOR ADDITIONAL ANALYSIS

Users have the capability to download duplicate claims data to their local system for additional analyses and reporting. This feature permits downloading of a contractor's data to a local PC, where it can be accessed from a PC-based database management program (e.g., Paradox®, Microsoft Access®, dBase®, etc.) or a spreadsheet program or query/report generator. This feature permits the user to perform analyses and develop reports not available in the DCS. Depending on the volume of data associated with a particular contractor, the process of downloading data could take some time.

3.1 How To Download Data

To initiate a download, a user should first set a view for the data to be downloaded then select **U**tility from the menu bar at the top of the screen, select DOWNLOAD FROM UTILITY SCREEN then a pop-up menu appears explaining that the user can download the current "**V**iew" to local ASCII fixed length tables and save them to a directory of the user's choice by clicking the 'Yes' box. A 'No' box is also provided to cancel or change the request. If the user clicks 'Yes', a matrix is displayed showing the names and brief descriptions of tables that can be downloaded. The user should follow the directions provided and click on the table(s) to be downloaded. A checkmark will appear to indicate the table(s) that have been selected. The user also can change the default directory to specify another directory to which the download should be saved. Tables available for downloading are:

dcset	set level data
dcclm	claim level data
dcutlztn	line item data
dcutladj	adjustment data
dcsetcmt	set level comments
dccmnt	claim level comments
dcsetlog	set log
dcsetusr	set level user defined codes
dcclmusr	claim level user defined codes
dccount	set counts
dccontract	region table
dcfi	FI/Contractor table
dcreas	reason codes
dcenroll	enrollment codes

While the download is being processed, the system will display the message: "**Accessing Database.... Working.... Please Wait**". This process can take several minutes or hours, depending on the number of claims/sets to be downloaded. The download will create ASCII fixed-length text files (files with extension of "txt").

If a user uses the ASCII fixed-length files to generate reports, tables have to be defined in the database management software selected (dBase®, Microsoft Access®, etc.) and the ASCII files imported. Addendum E, contains all of the information necessary to create the files, including the key or index fields.

It should be noted that downloaded files cannot be uploaded to TMA systems. This is a security feature to prevent corruption of the Duplicate Claims database.

From the **U**tility menu, the **Download** pull-down menu allows the user to request a new download or preview previously requested downloads (Figure 9.8-10).

FIGURE 9.8-10 DOWNLOAD MENU

3.2 Specifying Data To Be Downloaded

Data to be downloaded may be specified in two ways. First, users should set a view through the **V**iew function of the menu bar to select specific claim types, set statuses, FIs/regions, match criteria, load dates, PTC dates, owner types, etc. Then, through the **D**ownload feature of the **U**tility function users may specify the data tables to include in the download.

Chapter 9 Section 9

System Implementation And Operational Requirements

This section describes implementation requirements for the Duplicate Claims System (DCS). It also defines policies and procedures for the operation of the system.

1.0 SYSTEM COMPONENTS

The DCS is a web-based application operating as a customized graphical user interface. The application runs under Microsoft® Internet Explorer (MSIE), Version 5.5, 6.0, or 7.0, or as directed by the Government, and interfaces with tables that store the Duplicate Claims database. Access to the DCS will be through MSIE, Version 5.5, 6.0, or 7.0, or as directed by the Government.

2.0 HARDWARE AND SOFTWARE REQUIREMENTS

The requirements below are for user personal computers (PCs), user printers, communications, software, and security.

2.1 Hardware Requirements

There are no specific minimum hardware requirements. As a general rule of thumb, the requirements, as specified by the vendor for the specific version of MSIE should be followed. In addition, using a high bandwidth connection is suggested.

2.2 Printer Requirements

Existing printers may be used for the DCS.

2.3 Communications Requirements

Contractors are required to connect their hardware to the DCS through the Patient Encounter Processing and Reporting (PEPR) Portal using MSIE, Version 5.5, 6.0, or 7.0, or as directed by the Government. The contractor must ensure that the connection has been tested.

2.4 Software Requirements

The software listed below must be installed and operational on each PC.

2.4.1 Operating System Software

No specific requirement.

2.4.2 Communications Software

MSIE, Version 5.5, 6.0, or 7.0, or as directed by the Government.

2.4.3 Application Software

No specific requirement.

2.4.4 Optional Software

Contractors may, at their own option and expense, procure and utilize full version database management software packages such as Microsoft Access®, dBase®, Paradox For Windows®, etc., on the DCS PCs for the purpose of generating customized queries and reports utilizing optionally downloaded ASCII fixed length files that can be created by the DCS. Downloaded ASCII fixed length files may also be imported into Microsoft Excel®.

2.5 Security Requirements

Security procedures require that all contractors identify a Security Manager to be responsible for overseeing the DCS registration process. DCS registration involves the submission of one security document, for each user, which may be copied from this chapter or obtained through the Help Desk. The one document is: TRICARE DCS Account Activation Request Form (Figure 9.9-1). Each DCS user must complete and sign the required form(s).

In order to access the DCS, users must obtain a User ID and an initial password from the TRICARE Management Activity (TMA). User IDs and initial passwords will be issued following receipt and processing of properly completed registration and security forms. Contractor users should provide the required information, and submit the completed form to their DCS Security Manager for signature and transmittal to TMA.

DCS data must be encrypted. Encryption specifications will be provided by TMA. See the TRICARE Systems Manual (TSM), Chapter 1 for additional security and communications requirements.

2.6 DCS Logon And Password Procedures

2.6.1 Change Password

The following are the steps for users to logon to the DCS and change their password.

2.6.1.1 Passwords can be changed upon entering the PEPR Portal when the **Profile** link appears on the PEPR Toolbar (in the upper right side of the screen. Click on the **Profile** link.

2.6.1.2 Select **Change Password** on the USER PROFILE SCREEN and follow the prompts. The **Change Password** form dialog box will appear.

2.6.1.3 The dialog box will ask the user to enter the old password, the new password, and retype the new password in the **Verify** box. Enter all three and click the **Submit** button. If the User ID is

correct and the old, new, and verify passwords are correct, the message "**Password Successfully Updated**" will come back. See paragraph 2.6.4.

2.6.1.4 At the time of the logon, if the user's password is due to expire in 15 or less calendar days, a message box will appear asking the user if they want to change their password now. If the user selects 'No', they will be sent to the DCS. If the user selects 'Yes', they will be sent to the USER PROFILE SCREEN. The USER PROFILE SCREEN will have a **Change Password** option.

2.6.1.5 The user should click on the **Change Password** option and the **Change Password** form dialog box will appear.

2.6.1.6 The user should type in their old password and enter a new password twice. See paragraph 2.6.4.

2.6.1.7 After the user completes this process, they will be returned to the "Welcome to the PEPR Portal" screen where they may click on the **DCS** link that will send them to the "Welcome to the DCS System" screen.

2.6.1.8 The user can click on the "Duplicate Claim System (DCS-TED)". This will bring the user to the "TRICARE Duplicate Claims System" screen where they can click on the **ACTIVE DATABASE**, **HISTORY DATABASE**, **TRAINING DATABASE**, or **EXIT** buttons.

2.6.2 Password Expiration Notifications

2.6.2.1 Passwords must be changed at least every 89 days or as otherwise specified by the government. Beginning 15 days before the password will expire, the user will be told the number of days before the password will expire, and be asked if they want to change the password now. If the user does not change the password by the last day, the User ID will be locked out, and the user must call the Military Health System (MHS) Help Desk to have the User ID re-installed.

2.6.2.2 If a user's password has expired, the system will display a message box informing the user, "**Your password has expired**." Please call the **MHS Help Desk** at **1-800-600-9332**, then follow the prompts to the DCS. This will take the user to the San Antonio Help Desk.

2.6.2.3 Users who have forgotten their passwords must call the **MHS Help Desk** at **1-800-600-9332**, then follow the prompts to the DCS. This will take the user to the San Antonio Help Desk.

2.6.3 Password Process For New Users

2.6.3.1 Upon the receipt and processing of the required registration and security forms (see paragraph 2.7), a TMA representative will notify the Security Manager or the user's supervisor of the new user's User ID and temporary password.

2.6.3.2 Upon login to the PEPR Portal, the new user should now click on the Profile link on the PEPR Portal Toolbar which will bring up the ACCESS SCREEN. The new user should then click on **Change Password** option. The DCS will then display the **Change Password** dialog box. The new user should then enter their temporary password (old password) and enter their new password twice (new, verify).

2.6.3.3 Once the new password is accepted the new user will be taken to the DCS ACCESS SCREEN where they may click on the **ACTIVE DATABASE** or **HISTORY DATABASE** buttons to enter the DCS.

2.6.4 Password Specifications

2.6.4.1 Passwords must be at least nine characters long and not greater than 12.

2.6.4.2 Passwords must contain all four character types with at least two of each of the following: numbers, uppercase letters, lowercase letters, and special characters: **! @ # $ % ^ * ( ) _ .**

2.6.4.3 Passwords must **not** contain any of the following special characters: **\ - ; : " ' / ~ .**

2.6.4.4 A user may not re-use one of their last 12 passwords.

2.6.4.5 Passwords must be changed at least every 89 days or as otherwise specified by the government. Beginning 15 days before the password will expire, the user will be told the number of days before the password will expire, and be asked if they want to change the password now. If the user does not change the password by the last day, the User ID will be locked out, and the user must call the **MHS Help Desk** to have the User ID re-installed.

2.6.4.6 A user cannot change their password more than once in any 24 hour period.

2.6.4.7 Temporary passwords provided by TMA to new users, users whose passwords have expired, or to users who have forgotten their passwords must be changed immediately.

2.6.4.8 If a user attempts to log-on to the DCS with an incorrect password three consecutive times, their User ID will be locked and disabled and the user must call the **MHS Help Desk** at **1-800-600-9332** (follow the prompts to the DCS, this will take the user to the San Antonio Help Desk) to have their User ID unlocked.

2.7 Registration And Security Form - TRICARE DCS Account Activation Request Form (see Figure 9.9-1)

Each individual user must complete and sign the top portion of the TRICARE DCS Account Activation Request Form. The following are the required data elements to be provided by each user:

1. System Access: Select from Web or Client/Server (C/S) Version
   - Select from Web or C/S Version
2. Employment Category

3. Applicant/Requestor Information
   - Rank/GS Level/Title:
   - Name: (Last, First, MI)
   - Complete Office Mailing Address
   - Sponsoring Organization: (Not Project Name)
   - If Contractor, Employer Name (Contractor Name, e.g., PGBA, Humana, TriWest, WPS, Health Net, etc.)
   - Commercial Telephone Number: (include area code)
   - DSN:
   - User's e-mail address:
   - IP Address of Workstation (C/S only):
   - Network Translated IP Address (C/S only):
   - Account Validation PIN: (four digit numeric PIN to use when validating identity)

4. Password Action/Access Authorization Requested
   - Check action Requested: (Select New, Change, Delete, or Other with explanation)
   - Enter User ID if you already have one for the DCS
   - Requested Access: Read Only; Read/Write (see 4.A.)
   - Region Contractor Numbers: (62, 63, 64, 65, FO)

4.A. Special Permissions Data for Read/Write Users (To be completed by requestor's supervisor)
   - Permission to create User Defined Codes? (Requires Prime Contractor approval)
   - Permission to create User Defined Codes? (Requires Prime Contractor approval)

5.A. EIDS Security Awareness Training and Test (Not required for MCSCs)
   - Must have completed the EIDS Security Awareness Training and Test
   - Must have signed and faxed the EIDS Security Awareness Certificate to EIDS

5.B. Proof of Security Awareness Training (Required for MCSCs)

   Must have a letter on file with EIDS verifying internal annual security awareness training requirements.

6. Data Use Agreement (DUA) for Contractor (Not applicable for MCSCs) MHS Contractor and/or non-MHS Employee must provide the following:
   - Employer Name:
   - Project Description requiring this access:
   - The DUA number for this project:
   - Project period of performance:

7. User Security Clearance Level (Mark the appropriate level)

8. TRICARE DCS Account Applicant Signature (All Applicants/Users must read and sign)
   - User's Signature

Once the user has completed this portion of the form, it should be forwarded to the user's supervisor who can provide the permissions data in the 4.A. block of the form. Supervisors should note that only certain users should be granted these permissions since execution of these functions will affect the data in the DCS and may increase the volume of sets required to be worked. Only experienced users should be granted these permissions. Prime contractors should be careful when granting these permissions. The following information must be provided:

- Permission to create User Defined Codes? (A "Yes" requires written or verbal approval from the Prime contractor. The supervisor should obtain the Prime contractor's approval. TMA will verify a "Yes" answer with the Prime contractor.)

- Permission to unarchive sets? (A "Yes" requires written or verbal approval from the Prime contractor. The supervisor should obtain the Prime contractor's approval. TMA will verify a "Yes" answer with the Prime contractor.)

- Supervisor's signature.

- Supervisor's telephone number.

Once the supervisor has completed this portion of the form, it should be forwarded to an individual (preferably an Information Technology Representative) who can provide the Site Hardware and Communications Data in the third block of the form. The following information must be provided:

- Connection established to PEPR Portal? (The answer to this question must be "Yes" before a User ID will be issued. "Yes" verifies that the PC can establish communication with the TMA server. See paragraph 3.0, for server address.

- Location of computer: (building number, unit name, etc.)

Once this portion has been completed the form should be forwarded to the Contractor Security Manager for review and signature.

3.0 CONNECTIVITY

Connectivity will be through the internet to the PEPR Portal via MSIE, Version 5.5, 6.0, or 7.0, or as directed by the Government.

4.0 SYSTEM SUPPORT

4.1 For DCS support, contractors should call the **MHS Help Desk** at **1-800-600-9332**, then follow the prompts to the DCS. This will take the user to the San Antonio Help Desk.

4.2 System upgrades will occur automatically when users sign on to the system.

5.0 SYSTEM INSTALLATION AND TRAINING

5.1 Contractor Installation Responsibilities

Contractors are responsible for installing the MSIE, Version 5.5, 6.0, or 7.0, or as directed by the Government, and Adobe Reader, on their hardware, and establishing connectivity to the PEPR Portal. In addition to the communications software required to establish connectivity to the web-based DCS, contractors are responsible for installing their preferred operating system on their hardware.

5.2 Training

TMA will provide training to prospective users of the DCS. The training may be on-line or in person at a central location. TMA will coordinate with each contractor once the approach is defined.

6.0 CONTRACTOR POINTS OF CONTACT (POC)

To resolve multi-contractor duplicate claim sets, contractors are required to communicate and coordinate with each other (see Section 6). For each regional contract for which a contractor is responsible, the contractor is required to identify at least one individual to serve as the DCS POC. Contractor POCs must be individuals who are, or will be, trained in the use of the DCS, and are able to perform the required research and determine whether a particular claim is within their processing jurisdiction. For each regional contract for which they are responsible, contractors shall provide the name(s), title(s), business address(es), and business telephone number(s) of their POCs to the Procuring Contracting Officer (PCO), with courtesy copies to the Contracting Officer Representatives (CORs) and to the TMA DCS Program Representative. The POCs shall be provided to the PCO no later than (NLT) two weeks prior to implementation of the DCS.

Prior to system implementation, TMA will provide each contractor with the list of all DCS POCs. Whenever a new contract is awarded, TMA will notify all contractors of the new contractor's POC. Once the initial listing is provided to the contractors, it is the responsibility of each contractor to maintain the listing and keep TMA and the other contractors informed of any changes.

7.0 OPERATING PROCEDURES

For each regional contract for which a contractor is responsible, or for the TRICARE Dual Eligible FI Contract (TDEFIC), the contractor shall develop internal operating procedures for the DCS. These internal operating procedures shall designate the responsible areas for the various duplicate claims resolution functions and establish time lines. For example, one contractor may decide that the adjustment unit shall be responsible for scanning the DCS on a weekly basis for the appearance of adjustments submitted and for closing sets. Another contractor may decide that the unit responsible for researching potential duplicate claims should also be responsible for scanning for adjustments and closing the sets on a daily basis.

Contractor contract requirements for overpayment recovery, refunds and offsets, adjustments, etc., including timeliness requirements, apply to the operation of the DCS. As a result, operating procedures must be developed which are consistent with all applicable contract requirements. Procedures must be established to ensure that recoupments are initiated in a timely

manner following the research determination that a duplicate payment had been made. In other words, procedures must specify that after a decision has been made by the person responsible for determining that a duplicate payment was made, recoupment must be initiated in a timely manner and must be consistent with all overpayment recovery timeliness standards.

Contractors shall develop these procedures within 60 days of the date of system implementation and have them available for TMA review.

8.0 CONTRACTOR PERFORMANCE REQUIREMENTS

8.1 Contractors shall use the TRICARE DCS to resolve TMA identified potential duplicate claims payments.

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

8.3 Contractors shall not be responsible for meeting the performance standard during any month in which availability of the DCS is prevented for two working days due to failure of any system component for which the Government is responsible. The Government is responsible for: TMA servers on which the DCS data resides; Government-supplied communications lines, if any; Government-supplied routers, if any; Government-supplied Channel Sending Unit (CSU)/Data Sending Unit (DSU) equipment that connect the routers to the communication lines, if any; and the DCS application software.

8.4 Contractors are responsible for their own PCs, printers, PC operating system software, and in-house communications software and equipment, including in-house Wide Area Network (WAN)/ Local Area Network (LAN) equipment, circuits, and routers. Contractors are responsible for any contractor-supplied communication lines, contractor-supplied routers, and contractor-supplied CSU/DSU equipment that connect the routers to the communication lines. Contractors are responsible for contractor-supplied internal and external networks, network connections to the routers, firewalls, and all software (including operating system, application, and network software) other than the DCS application-related software. Contractors are required to install and maintain hardware with MSIE, Version 5.5, 6.0, or 7.0, or as directed by the Government, and Adobe Reader. Contractors are responsible for maintaining their own networks, including hardware and software (other than the DCS software). TMA will fully support the DCS application software.

8.5 All overpayment recovery, refund, offset collection and adjustment requirements, including timeliness standards, are applicable to the operation of the DCS.

9.0 TRANSITIONS

The date when an incoming contractor will assume full responsibility for resolving all existing potential duplicate claim sets from the outgoing contractor (including completing existing recoupments), and for all new potential duplicate claim sets, shall be determined during transition meetings and be established in the transition plan/schedule.

FIGURE 9.9-1 TRICARE DCS ACCOUNT ACTIVATION REQUEST FORM

TRICARE DUPLICATE CLAIMS SYSTEM ACCOUNT ACTIVATION REQUEST FORM

See Pages 5-6 for Form Instructions and Guidance

Upon Completion of this Form Including Block 9 & Attachment A, Fax to 303.676.3979

1.	**System Access (Please check the system for which you have mission/contract related access requirement)**
	DCS - Web Version DCS
	Client/Server (C/S) Version

2.	**Employment Category (Please check the category that applies)**
	Government Employee, Uniformed Service Member, Military, or Civil Service working within/for DoD MHS
	Contractor working within the DoD Military Health System
	Government Employee, Uniformed Service Member, Military, or Civil Service working for other agency or directorate not a part of the DoD Military Health System
	Contractor working for Government Agency, not a part of the DoD Military Health System
	Other (Please describe) _____

3.	**Applicant/Requestor Information**
Rank/GS Level/Title:	
Name (Last, First, MI):	
Complete Office Mailing Address:	
Sponsoring Organization Name: (Not Project Name)	
If Contractor, Employer Name	
Commercial Telephone Number:	
DSN:	
Email:	
IP Address of Workstation (Client Srvr only):	
Network Translated IP Address (Client Srvr):	
Account Validation PIN: Enter a 4 digit numeric PIN that you will use to validate your identity for account administration purposes. **This must be the same number as entered when registering in the EIDS WebPortal.**	

4. Password Action/Access Authorization Requested

Check action requested: ❑ NEW ❑ CHANGE ❑ DELETE ❑ OTHER _____

If you have a User ID, please enter it here: _____ (If your account has expired, enter your last user ID)

Requested Access: ❑ **READ ONLY** ❑ **READ/WRITE (supervisor must complete 4.A., below)**

Requesting Access to following contractor region number(s)*: _____

* If access to multiple contractor regions is required, all region contractor numbers must be specified.

4.A. Special Permissions Data for READ/WRITE Users (To be completed by requester's supervisor)

Permission to create User Defined Codes? (Requires Prime Contractor approval): ❑ YES ❑ NO

Permission to unarchive sets? (Requires Prime Contractor approval): ❑ YES ❑ NO

Supervisor Signature: _____ **Phone#:** _____

Prime Contractor Signature: _____ **Phone#:** _____

Version 12/6/06 - All previous versions are OBSOLETE

Page 1

Report Descriptions And Examples

REPORT CATEGORY:	Set Report
REPORT MENU HIERARCHY AND FORMAT NAME:	REPORT ⇒SET REPORTS ⇒**BASIC**
PRINTED REPORT TITLE:	Duplicate Claim System Sets Grouped by Set Number
REPORT DESCRIPTION:	This report provides set-level information regarding all of the sets loaded in the Duplicate Claim System. The fields displayed on the report are: Institutional/Non-Institutional Indicator; Set Number; Status; Set Match Type; Multi-Contractor Set? (Y/N); Owner FI; Region; Initial Load Date; Current Load Date; Last Update Date; Adjustments? (Y/N); Total Amount Identified For Recoupment; Total Amount Actually Recouped; Total TED Adjustment Amount; and Set Level User Defined Code.
REPORT PARAMETER OPTIONS:	Users may customize the report by selecting: All "Standard" parameters (Claim Set Status, Adjustments, Set Owner Type, Claim Type, Match Type, Date Type, Set Range, FI, Region) plus Set Level User Defined Codes.
REPORT NOTES:	The data used by this report format is set level data.

Status Code	=	All
Set Number	=	All
Set User Codes	=	All
Adjust Type	=	All
Owner Type	=	All
Claim Type	=	All
Match Type	=	All
Owner FI	=	All
Owner Region	=	All

Date: 4/12/05
Page 1

DUPLICATE CLAIM SYSTEM SETS
GROUPED BY SET NUMBER

50 - Acme Claims Processing

Undetermined Region

INSTITUTIONAL

SET #	STAT	MATCH TYPE	MULTI FI?	OWNER FI	REGION	INITIAL LOAD DATE	CURRENT LOAD DATE	LAST UPDATE DATE	ADJ?	ID RECOUP	ACTUAL RECOUP	ADJUSTMENT AMOUNT	USER CODE
6	C	D	N	50	MDA90504C0050	09/24/1996	12/16/1996	12/31/1996	N	$0.00	$0.00	$0.00	
15	O	N	N	50	MDA90504C0050	09/24/1996	09/24/1996	10/01/1996	Y	$0.00	$0.00	$0.00	
22	V	D	N	50	MDA90504C0050	09/24/1996	09/24/1996	10/02/1996	Y	$1,000.00	$1,000.00	$1,115.44	
INSTITUTIONAL TOTAL											$1,000.00	$1,000.00	$1,115.44

NON-INSTITUTIONAL

SET #	STAT	MATCH TYPE	MULTI FI?	OWNER FI	REGION	INITIAL LOAD DATE	CURRENT LOAD DATE	LAST UPDATE DATE	ADJ?	ID RECOUP	ACTUAL RECOUP	ADJUSTMENT AMOUNT	USER CODE
121	O	E	N	50	MDA90504C00050	09/24/1996	01/24/1997	01/24/1997	Y	$0.00	$0.00	$0.00	
122	V	E	N	50	MDA90504C00050	09/24/1996	01/24/1997	01/24/1997	Y	$0.00	$0.00	$0.00	A4
123	O	E	N	50	MDA90504C00050	09/24/1996	01/24/1997	01/24/1997	Y	$0.00	$0.00	$0.00	
NON-INSTITUTIONAL TOTAL											$0.00	$0.00	$0.00
Undetermined Region TOTAL											$1,000.00	$1,000.00	$1,115.44
50 - Acme Claims Processing TOTAL											$1,000.00	$1,000.00	$1,115.44

FOR OFFICIAL USE ONLY
THIS INFORMATION IS PROTECTED BY THE PRIVACY ACT OF 1974 AND SUBJECT TO THE HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) OF 1996, THE DEPARTMENT OF HEALTH AND HUMAN SERVICES PRIVACY RULE IN REGARD TO THAT ACT, AND THE DOD 6025.18-R, DOD HEALTH INFORMATION PRIVACY REGULATION.

NEW HAMPSHIRE	
ARMY:	**NAVY AND MARINE CORPS:**
Office of the Staff Judge Advocate Headquarters, US Army Garrison Fort Dix ATTN: AFRC FA JAC 5418 S Scott Plaza Fort Dix, NJ 08640-5089	Office of the Judge Advocate General Medical Care Recovery Unit, Norfolk 9053 First Street, Suite 100 Norfolk, VA 23511-3605
AIR FORCE:	**COAST GUARD:**
66 ABW/JA Hospital Recovery 20 Schilling Circle Hanscom AFB, MA 01731	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	**NOAA:**
John F Kennedy Federal Building Room 2250 Boston, MA 02203	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

NEW JERSEY	
ARMY:	**NAVY AND MARINE CORPS:**
Office of the Staff Judge Advocate Headquarters, US Army Garrison Fort Dix ATTN: AFRC FA JAC 5418 S Scott Plaza Fort Dix, NJ 08640-5089	Office of the Judge Advocate General Medical Care Recovery Unit, Norfolk 9053 First Street, Suite 100 Norfolk, VA 23511-3605
AIR FORCE:	**COAST GUARD:**
305 AMW/JA 2901 Falcon Lane McGuire AFB, NJ 08641-5002	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	**NOAA:**
Jacob Javits Federal Building Suite 3908 26 Federal Plaza New York, NY 10278	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

NEW MEXICO	
ARMY:	**NAVY AND MARINE CORPS:**
Office of the Staff Judge Advocate US Army White Sands Missile Range ATTN: CSTE DTC WS SJA Claims Corzier Street, Building 146 White Sands Missile Range, NM 88002-5075	Office Of The Judge Advocate General Medical Care Recovery Unit San Diego 3395 Sturtevant Street, Suite 2 San Diego, CA 92136-5138
AIR FORCE:	**COAST GUARD:**
27 FW/JAD 101 S DL Ingram Blvd Cannon AFB, NM 88103-5219	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	**NOAA:**
1301 Young Street, Room 1138 Dallas, TX 75202	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

NEW YORK	
ARMY:	**NAVY AND MARINE CORPS:**
Office of the Staff Judge Advocate US Military Academy ATTN: MAJA CL Thayer Road, Building 606 West Point, NY 10996-1781	Office of the Judge Advocate General Medical Care Recovery Unit, Norfolk 9053 First Street, Suite 100 Norfolk, VA 23511-3605
AIR FORCE:	**COAST GUARD:**
AFRL/IFOJ 26 Electronic Parkway Rome, NY 13441-4514	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	**NOAA:**
Jacob Javits Federal Building Suite 3908 26 Federal Plaza New York, NY 10278	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

NORTH CAROLINA	
ARMY:	**NAVY AND MARINE CORPS:**
Office of the Staff Judge Advocate Womack Army Medical Center ATTN: MCXC JA Claims Reilly Street, Building 4-2817 Fort Bragg, NC 28307-5000	Office of the Judge Advocate General Medical Care Recovery Unit, Norfolk 9053 First Street, Suite 100 Norfolk, VA 23511-3605
AIR FORCE:	**COAST GUARD:**
43 WG/JA 374 Maynard Street, Suite A Pope AFB, NC 28308-2381	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	**NOAA:**
Sam Nunn Atlanta Federal Center 61 Forsyth Street SW, Suite 5M60 Atlanta, GA 30303-8909	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

NORTH DAKOTA	
ARMY:	**NAVY AND MARINE CORPS:**
Office of the Staff Judge Advocate Headquarters, 24th Infantry Division (Mechanized) and Fort Riley ATTN: AFZN-JA-CL Building 200, Patton Hall Fort Riley, KS 66442-5017	Office of the Judge Advocate General Medical Care Recovery Unit Pensacola 161 Turner Street, Suite B Pensacola, FL 32508-5526
AIR FORCE:	**COAST GUARD:**
5 BW/JA 300 Summit Drive, Suite 211 Minot AFB, ND 58705-5038	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	**NOAA:**
Federal Building 1961 Stout Street, Room 327 Denver, CO 80294-3538	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

OHIO	
ARMY:	**NAVY AND MARINE CORPS:**
Office of the Staff Judge Advocate Headquarters, US Army Armor Center and Fort Knox ATTN: ATZK JA Claims Third Avenue, Building 1310 Fort Knox, KY 40121-5000	Office of the Judge Advocate General Medical Care Recovery Unit Pensacola 161 Turner Street, Suite B Pensacola, FL 32508-5526
AIR FORCE:	**COAST GUARD:**
88 ABW/JAD ATTN: Medical Claims Examiner 5135 Pearson Road, Room 122 Wright-Patterson AFB, OH 45433-5321	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	**NOAA:**
Office of the General Counsel 233 North Michigan Avenue, Suite 700 Chicago, IL 60601-5519	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

OKLAHOMA	
ARMY:	**NAVY AND MARINE CORPS:**
Office of the Staff Judge Advocate Headquarters, US Army Field Artillery Center and Fort Sill ATTN: ATZR-J Post Claims Currie Road, Building 2595 Fort Sill, OK 73503-5100	Office Of The Judge Advocate General Medical Care Recovery Unit San Diego 3395 Sturtevant Street, Suite 2 San Diego, CA 92136-5138
AIR FORCE:	**COAST GUARD:**
OC-ALC/JA 7460 Arnold Street, SE WG Tinker AFB, OK 73145-9002	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	**NOAA:**
1301 Young Street, Room 1138 Dallas, TX 75202	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

OREGON	
ARMY:	**NAVY AND MARINE CORPS:**
Office of the Center Judge Advocate Western Regional Medical Command and Madigan Army Medical Center ATTN: MCHJ-JA Medical Care Recovery Claims 9040 A Fitzsimmons Avenue Tacoma, WA 98431-5000	Office Of The Judge Advocate General Medical Care Recovery Unit San Diego 3395 Sturtevant Street, Suite 2 San Diego, CA 92136-5138
AIR FORCE:	**COAST GUARD:**
92 ARW/JA 1 East Bong Street, Suite 103 Fairchild AFB, WA 99011-9464	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	**NOAA:**
Blanchard Plaza Building, Suite 902 2201 Sixth Avenue Seattle, WA 98121-1833	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

PENNSYLVANIA	
ARMY:	**NAVY AND MARINE CORPS:**
Office of the Staff Judge Advocate Headquarters, US Army Garrison, Fort George G Meade ATTN: ANME JA Claims 2257 Huber Road, Stop 5030 Fort George G Meade, MD 20755-5030	Office of the Judge Advocate General Medical Care Recovery Unit, Norfolk 9053 First Street, Suite 100 Norfolk, VA 23511-3605
AIR FORCE:	**COAST GUARD:**
436 AW/JA 200 Eagle Way, Room 100 Dover AFB, DE 19902-7216	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	**NOAA:**
Public Ledger Building, Suite 418 150 South Independence Mall West Philadelphia, PA 19106-3499	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

PUERTO RICO	
ARMY:	**NAVY AND MARINE CORPS:**
Office of the Staff Judge Advocate Headquarters, US Army Garrison - Fort Buchanan USARSO ATTN: SOJA Affirmative Claims 218 Brooke Street Fort Buchanan, PR 00934-3400	Office of the Judge Advocate General Medical Care Recovery Unit, Norfolk 9053 First Street, Suite 100 Norfolk, VA 23511-3605
AIR FORCE:	**COAST GUARD:**
45 SW/JADH HR Claims 642 Omalley Road Patrick AFB, FL 32925	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	**NOAA:**
Jacob Javits Federal Building Suite 3908 26 Federal Plaza New York, NY 10278	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

RHODE ISLAND	
ARMY:	**NAVY AND MARINE CORPS:**
Office of the Staff Judge Advocate Headquarters, US Army Garrison Fort Dix ATTN: AFRC FA JAC 5418 S Scott Plaza Fort Dix, NJ 08640-5089	Office of the Judge Advocate General Medical Care Recovery Unit, Norfolk 9053 First Street, Suite 100 Norfolk, VA 23511-3605
AIR FORCE:	**COAST GUARD:**
66 ABW/JA Hospital Recovery 20 Schilling Circle Hanscom AFB, MA 01731	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	**NOAA:**
John F Kennedy Federal Building Room 2250 Boston, MA 02203	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

SOUTH CAROLINA	
ARMY:	**NAVY AND MARINE CORPS:**
Office of the Staff Judge Advocate Headquarters, US Army Training Center and Fort Jackson ATTN: ATZJ SJA 9475 Kershaw Road, Room 141 Fort Jackson, SC 29207-5000	Office of the Judge Advocate General Medical Care Recovery Unit, Norfolk 9053 First Street, Suite 100 Norfolk, VA 23511-3605
AIR FORCE:	**COAST GUARD:**
20 FW/JA 504 Shaw Drive, Suite 2025 Shaw AFB, SC 29152-5028	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	**NOAA:**
Sam Nunn Atlanta Federal Center 61 Forsyth Street SW, Suite 5M60 Atlanta, GA 30303-8909	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

SOUTH DAKOTA	
ARMY:	**NAVY AND MARINE CORPS:**
Office of the Staff Judge Advocate Headquarters, 24th Inf Division (Mechanized) and Fort Riley ATTN: AFZN-JA-CL Building 200, Patton Hall Fort Riley, KS 66442-5017	Office of the Judge Advocate General Medical Care Recovery Unit Pensacola 161 Turner Street, Suite B Pensacola, FL 32508-5526
AIR FORCE:	**COAST GUARD:**
28 BW/JA 1000 Ellsworth Street, Suite 2700 Ellsworth AFB, SD 57706-4700	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	**NOAA:**
Federal Building 1961 Stout Street, Room 327 Denver, CO 80294-3538	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

TENNESSEE	
ARMY:	**NAVY AND MARINE CORPS:**
Office of the Staff Judge Advocate Headquarters, 101st Airborne Division (Air Assault) and Fort Campbell ATTN: AFZB JA 127 Forrest Road Fort Campbell, KY 42223-5208	Office of the Judge Advocate General Medical Care Recovery Unit Pensacola 161 Turner Street, Suite B Pensacola, FL 32508-5526
AIR FORCE:	**COAST GUARD:**
AEDC/JA 100 Kindel Drive, Suite B327 Arnold AFB, TN 37389-2327	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	**NOAA:**
Sam Nunn Atlanta Federal Center 61 Forsyth Street SW, Suite 5M60 Atlanta, GA 30303-8909	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

TEXAS

ARMY:

Office of the Staff Judge Advocate
Headquarters, III Corps and Fort Hood
ATTN: AFZF JA Claims
Building 1001, Room 226, 2nd Floor East Wing
1001 761st Tank Battalion Avenue
Fort Hood, TX 76544-5008

NAVY AND MARINE CORPS:

Office of the Judge Advocate General
Medical Care Recovery Unit Pensacola
161 Turner Street, Suite B
Pensacola, FL 32508-5526

AIR FORCE:

37 TRW/JAT
1701 Kenly Avenue, Suite 117
Lackland AFB, TX 78236-5158

Zip Codes

76500 - 76599	78100 - 78199
76900 - 76999	78200 - 78299
77000 - 77099	78300 - 78399
77100 - 77199	78400 - 78499
77200 - 77299	78500 - 78599
77300 - 77399	78600 - 78699
77400 - 77499	78700 - 78799
77500 - 77599	78800 - 78899
77600 - 77699	78900 - 78999
77700 - 77799	79700 - 79799
77800 - 77899	79800 - 79899
77900 - 77999	79900 - 79999
78000 - 78099	

7 BW/JA
466 5th Street, Suite 220
Dyess AFB, TX 79607-1240

Zip Codes

75000 - 75099	76600 - 76899
75100 - 75999	79100 - 79699
76000 - 76499	

COAST GUARD:

Commandant (G-WRP-2)
US Coast Guard Headquarters
2100 Second Street SW, Room 5502
Washington, DC 20593

DHHS:

1301 Young Street, Room 1138
Dallas, TX 75202

NOAA:

Office of the Assistant General Council for Administration
General Law Division, Room 586C
1401 Constitution Avenue NW
Washington, DC 20230

UTAH	
ARMY:	**NAVY AND MARINE CORPS:**
Office of the Staff Judge Advocate Headquarters, 7th Infantry Division and Fort Carson ATTN: AFZC JA C 7086 Albanese Loop Fort Carson, CO 80913-4309	Office Of The Judge Advocate General Medical Care Recovery Unit San Diego 3395 Sturtevant Street, Suite 2 San Diego, CA 92136-5138
AIR FORCE:	**COAST GUARD:**
00-ALC/JAD 6026 Cedar Lane Hill AFB, UT 84056-5812	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	**NOAA:**
Federal Building 1961 Stout Street, Room 327 Denver, CO 80294-3538	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

VERMONT	
ARMY:	**NAVY AND MARINE CORPS:**
Office of the Staff Judge Advocate Headquarters, US Army Garrison Fort Dix ATTN: AFRC FA JAC 5418 S Scott Plaza Fort Dix, NJ 08640-5089	Office of the Judge Advocate General Medical Care Recovery Unit, Norfolk 9053 First Street, Suite 100 Norfolk, VA 23511-3605
AIR FORCE:	**COAST GUARD:**
AFRL/IFOJ 26 Electronic Parkway Rome, NY 13441-4514	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	**NOAA:**
John F Kennedy Federal Building Room 2250 Boston, MA 02203	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

VIRGINIA	
ARMY:	**NAVY AND MARINE CORPS:**
Office of the Staff Judge Advocate US Army Combined Arms Support Command and Fort Lee ATTN: ATCL JA (Affirmative & Personal Injury Claims) 441 First Street Fort Lee, VA 23801-1507	Office of the Judge Advocate General Medical Care Recovery Unit, Norfolk 9053 First Street, Suite 100 Norfolk, VA 23511-3605
AIR FORCE:	**COAST GUARD:**
1 FW/JAD ATTN: Medical Claims Examiner 33 Sweeney Blvd Langley AFB, VA 23665-2198	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	**NOAA:**
Public Ledger Building, Suite 418 150 South Independence Mall West Philadelphia, PA 19106-3499	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

WASHINGTON	
ARMY:	**NAVY AND MARINE CORPS:**
Office of the Center Judge Advocate Western Regional Medical Command and Madigan Army Medical Center ATTN: MCHJ-JA Medical Care Recovery Claims 9040 A Fitzsimmons Avenue Tacoma, WA 98431-5000	Office Of The Judge Advocate General Medical Care Recovery Unit San Diego 3395 Sturtevant Street, Suite 2 San Diego, CA 92136-5138
AIR FORCE:	**COAST GUARD:**
92 ARW/JA 1 East Bong Street, Suite 103 Fairchild AFB, WA 99011-9464	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	**NOAA:**
Blanchard Plaza Building, Suite 902 2201 Sixth Avenue Seattle, WA 98121-1833	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

WEST VIRGINIA	
ARMY:	**NAVY AND MARINE CORPS:**
Office of the Staff Judge Advocate US Army Combined Arms Support Command and Fort Lee ATTN: ATCL JA (Affirmative & Personal Injury Claims) 441 First Street Fort Lee, VA 23801-1507	Office of the Judge Advocate General Medical Care Recovery Unit, Norfolk 9053 First Street, Suite 100 Norfolk, VA 23511-3605
AIR FORCE:	**COAST GUARD:**
89 AW/JAD ATTN: Claims Department 1535 Command Drive, Suite AA-203 Andrews AFB, MD 20762-7002	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	**NOAA:**
Public Ledger Building, Suite 418 150 South Independence Mall West Philadelphia, PA 19106-3499	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

WISCONSIN	
ARMY:	**NAVY AND MARINE CORPS:**
Office of the Command Judge Advocate Headquarters, US Army Garrison, Fort McCoy ATTN: AFRC FM JA 100 East Headquarters Road Fort McCoy, WI 54656-5253	Office of the Judge Advocate General Medical Care Recovery Unit Pensacola 161 Turner Street, Suite B Pensacola, FL 32508-5526
AIR FORCE:	**COAST GUARD:**
375 AW/JA 101 Heritage Drive, Suite 210 Scott AFB, IL 62225-5001	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	**NOAA:**
233 North Michigan Avenue, Suite 700 Chicago, IL 60601-5519	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

WYOMING	
ARMY:	**NAVY AND MARINE CORPS:**
Office of the Staff Judge Advocate Headquarters, 7th Infantry Division and Fort Carson ATTN: AFZC JA C 7086 Albanese Loop Fort Carson, CO 80913-4309	Office Of The Judge Advocate General Medical Care Recovery Unit San Diego 3395 Sturtevant Street, Suite 2 San Diego, CA 92136-5138
AIR FORCE:	**COAST GUARD:**
90 SW/JA 6307 Randall Avenue, Suite 209 FE Warren AFB, WY 82005-3207	Commandant (G-WRP-2) US Coast Guard Headquarters 2100 Second Street SW, Room 5502 Washington, DC 20593
DHHS:	**NOAA:**
Federal Building 1961 Stout Street, Room 327 Denver, CO 80294-3538	Office of the Assistant General Council for Administration General Law Division, Room 586C 1401 Constitution Avenue NW Washington, DC 20230

2.0 TRICARE OVERSEAS CLAIMS

Under authority of Department of Defense Directive 5515.8, responsibility for claims against the United States and claims for the United States in overseas areas is assigned to a single Military Department for each country. DD Forms 2527 and claims identified as appropriate for investigation of possible recovery under the Federal Medical Care Recovery Act (FMCRA) should be sent to the following claims offices including TRICARE Europe (TE) active duty member overseas claims:

2.1 Department Of The Army

- Services in Austria, Belgium, El Salvador, France, Federal Republic of Germany, Grenada, Honduras, Korea, Marshall Islands, Switzerland, and countries not assigned to another Service for responsibility (Army claims only):

  Department of the Army
  Commander
  US Army Claims Service
  ATTN: JACS-TC
  4411 Llewellyn Avenue
  Fort George G Meade, MD 20755-5360

2.2 Department Of The Navy

- Services in Bahrain, Greece, Iceland, Israel, Portugal, and United Arab Emirates:

  Office of the Judge Advocate General
  Code 353
  200 Stovell Street
  Alexandria, VA 22332

- Services in Italy:

  Naval Legal Service Office, EURSWA
  ATTN: Claims
  PSC 817 Box 8
  FPO AE 09622-0008

- Services in countries not assigned to another Service for responsibility (Navy claims only):

  Office of the Judge Advocate General
  Medical Care Recovery Unit, Norfolk
  9053 First Street, Suite 100
  Norfolk, VA 23511-3605

2.3 Department Of The Air Force:

- Services in Australia, Azores, Canada, Cyprus, Denmark, Egypt, India, Japan, Luxembourg, Morocco, Nepal, the Netherlands, Norway, Oman, Pakistan, Saudi Arabia, Spain, Turkey, the United Kingdom, and claims involving, or generated by, the United States Central Command (CENTCOM) and the United States Special Operations Command (USSOC), and countries not assigned to another service for responsibility (Air Force claims only):

  AFLOA/JACC
  112 Luke Avenue, Suite 343
  Bolling AFB, DC 20032-8000

- END -

Chapter 11 Section 1

Education Requirements

The education of TRICARE beneficiaries, TRICARE providers, and Military Health System (MHS) staff and providers will be accomplished through a collaborative effort between the TRICARE Management Activity (TMA) Communications and Customer Service (C&CS) Directorate, the Managed Care Support Contractors (MCSCs), and other TRICARE contractors. This collaboration will ensure information and education about the TRICARE Program, policies, health care delivery requirements, and changes and/or addition to benefits are effectively provided. Educational activities include research and analysis to determine targeted audience and the provision of educational materials, and training programs and briefings in accordance with the Section 2. The Government will furnish all printed educational materials, except for regional providers. The MCSC and/or other TRICARE contractors will be responsible for the individual distribution of Government-furnished materials.

1.0 EDUCATION PLAN

The MCSC shall submit an annual education plan to inform and educate TRICARE beneficiaries, TRICARE and MHS staff, and providers on all aspects of TRICARE programs. C&Cs and the TRICARE Regional Office (TRO) will review the plan, and provide concurrence or appropriate feedback for recommended changes.

2.0 INTERFACE REQUIREMENTS

2.1 TMA C&CS will meet with each MCSC and TRICARE contractor within 60 calendar days after contract award to develop and establish a Memorandum of Understanding (MOU). The MOU will establish the review and approval process for annual education plans, and identify the TMA process for obtaining education materials. The MOU shall also address the ordering and bulk shipment of materials. The MOU shall be effective No Later Than (NLT) 30 days following the meeting between TMA C&CS and the contractor.

2.2 The MCSC shall participate in monthly TRICARE beneficiary and provider workgroup meetings, comprised of the TROs marketing representatives, OCONUS marketing representative and the TRICARE Beneficiary Publications Office/C&CS. As advisors, the contractors shall provide unique perspectives, ideas, and recommendations regarding the development and maintenance of TRICARE educational materials to the group. The goal of the monthly meetings is to present status updates on production, address issues, and provide new information and propose new ideas for products and/or initiatives. All requests for marketing and educational materials shall be submitted by the contractor via the appropriate TRO for review and consideration. Approval shall be based on justification that supports a uniform image and consistency in the provision of TRICARE Program information, and available funding. The contractor shall provide a primary and alternate representative for attendance and participation in the monthly meetings, to be held approximately 12 times per contract year in the Washington, DC area. Meetings may be attended via teleconference, video telecommunications, or in person, as directed by the Government.

3.0 REQUIRED EDUCATIONAL MATERIALS

The Government will furnish all printed educational materials. Materials developed by the Government and distributed in support of the TRICARE program will be selected on the basis of recommendations by contractors, program managers, the Services, TMA leadership and others with interests and concerns about the information being provided to TRICARE beneficiaries and other stakeholders. Materials are not limited to printed products and may include CDs, videos, DVDs and other collateral material. C&CS and the TROs will review all recommendations and will prioritize products in accordance with funding availability. The Government will have final approval authority. The MCS and/or other TRICARE contractors will be responsible for the distribution of Government-furnished materials to MHS beneficiaries. The Government will provide all enrollment materials for distribution by the MCSC to MHS beneficiaries. The enrollment form will be provided electronically.

4.0 DISSEMINATION OF INFORMATION

4.1 NLT 30 days prior to the start of health care delivery, and annually thereafter, the MCSC shall mail one TRICARE Handbook to all MHS beneficiary households in the region based on Defense Enrollment Eligibility Reporting System (DEERS) data. The MCSC shall furnish enrollment information and forms, network provider information, Health Care Finder (HCF) information, claims forms, claim completion instructions, the TRICARE Handbook, the Provider Handbook, DEERS information and other informational materials upon request to beneficiaries, sponsors, providers, and Congressional Offices. The MCSC shall establish and maintain effective communications with all beneficiaries (see Section 4). The MCSC shall forward to TMA/C&CS and the TMA Regional Director (RD) copies of informational bulletins and/or EOB stuffers mailed to beneficiaries.

4.2 Annually, the MCSC shall be responsible for all provider education, which may include producing and distributing an annual Provider Handbook, newsletters, and/or bulletins. Copies of all products distributed to providers, will be provided to TMA C&CS, Congressional offices, Beneficiary Counseling and Assistance Coordinators (BCACs), Debt Collection Assistance Officers (DCAOs), and Health Benefits Advisors (HBAs) in the region. The MCSC may use any method of distribution that ensures timely response by all providers. The Government reserves the right to evaluate the success of the MCSC provider relations effort via scientific surveys and other data collection efforts with the network providers.

4.3 The MCSC shall distribute quarterly newsletter to all TRICARE Prime enrollees, including active duty personnel, dual-eligible beneficiaries, congressional offices, and HBAs. The MCSC shall also distribute one Standard and one TRICARE For Life (TFL) annual newsletter to non-enrolled beneficiaries using information contained in DEERS or provided by beneficiaries. Newsletters will be no more than six double-sided pages in length (8½" x 11"). The MCSC may use any method of distribution that ensures timely delivery to all recipients.

4.4 The TDEFIC contractor shall maintain a supply of beneficiary newsletters and bulletins. The TDEFIC contractor shall provide a copy of the most recent information to any interested beneficiary, upon request.

5.0 ORDERING EDUCATION MATERIALS

Initial requests for desired educational materials shall be submitted in accordance with paragraph 2.2 to TMA C&CS during the development of the MOU after initial award of the MCS contract. Within 30 days of the request C&CS will host a meeting with the TRICARE Beneficiary Publication Committee. The contractor shall provide one representative for attendance and participation in the work group meeting to be held in the Washington, DC area. Meetings may be attended via teleconference, video telecommunications or in person, as directed by the Government. Requests for additionally designed educational materials not included in the initial request shall be submitted to TMA C&CS in accordance with paragraph 2.2. As stated, for each contract year, the committee will conduct one extensive meeting to determine the core educational materials to be developed for the following fiscal year. Contractors may be required by their TRO to participate in this extensive, possibly multi-day, meeting in Washington, DC area. Upon determination of the core products, MCSCs will submit request for copies required and delivery dates requested. The contractors shall provide TMA C&CS with a single Point Of Contact (POC) and address(es) for delivery of educational materials.

6.0 MEDICAL MANAGEMENT TRAINING

The contractor shall participate in Health Affairs (HA) sponsored medical management training as requested, to include coordination of training schedules and the development of the agenda and training materials. Each contractor will participate in two four-day training sessions per year in their respective region. The location of the training will be designated by HA.

- END -

2.5.3.2 The contractor shall inform beneficiaries they may call back for additional assistance in the event they are unable to make an appointment that will occur within a time frame that is satisfactory to them. The contractor shall offer to make one attempt to call the beneficiary within three business days, at a time during normal working hours chosen by the beneficiary, to determine if the beneficiary has made an appointment within a time frame satisfactory to the beneficiary. If the contractor learns during this return call that the ADSM or ADFM has made an appointment, the contractor shall request information about the number of days from the appointment request until the date of the appointment.

2.5.4 Alternative 2

2.5.4.1 ADSMs having MTF or MMSO authorization for private sector behavioral health care and ADFMs who either do not desire an MTF appointment or for whom no MTF appointment is available, may request the contractor to establish a conference call between the contractor, the beneficiary, and a provider's office. The contractor shall participate in the three-way conversation only long enough to confirm that the provider is willing to provide an appointment to a TRICARE patient. The ADSM or ADFM will make the actual appointment with the provider. Before disengaging from the call, the contractor shall ask the beneficiary to call back for additional assistance in the event the beneficiary is unable to obtain an appointment that will occur within a time frame satisfactory to the beneficiary. The contractor shall establish conference calls with non-network providers only if there is an insufficient number of network providers available.

2.5.4.2 If while attempting to establish a conference call with a provider's office, the contractor reaches only the provider's answering service or answering machine, the contractor shall offer the beneficiary the opportunity to leave their contact information with the answering service or on the answering machine so that the provider can contact them to arrange an appointment. Unless the beneficiary requests termination of the process sooner, attempts at establishing a conference call with a live person in the office of a provider willing to provide an appointment to a TRICARE patient shall continue until successful or until the beneficiary has had the opportunity to leave their contact information for three providers, whichever comes first.

2.5.4.3 The contractor shall offer to make one attempt to call the beneficiary within three business days, at a time during normal working hours chosen by the beneficiary, to determine if the beneficiary has made an appointment within a time frame satisfactory to the beneficiary. If the contractor learns during this return call that the ADSM or ADFM has made an appointment, the contractor shall request information about the number of days from the appointment request until the date of the appointment.

2.6 Data Requirements List for Collection and Reporting

The contractor shall collect/measure data about the use of this provider locator and appointment service and provide the following quarterly reports to the Government:

- Total number of calls answered that were from beneficiaries eligible to use the assistance service.
- Total number of ADSMs who contacted the assistance telephone number.
- Total number of enrolled ADFMs who contacted the assistance telephone number.

- Total number of ADSMs and ADFMs who, after contacting the assistance telephone number, stated they had an emergent behavioral health issue or were assessed through their answers given to a set of screening questions to have an emergent behavioral health issue.

- Number and percent of beneficiaries calling the assistance number who selected Alternative 1.

- Percent of beneficiaries selecting Alternative 1 who chose to be contacted in a follow-up call by the contractor.

- Number and percent of beneficiaries selecting Alternative 1 and choosing to be contacted in a follow-up call by the contractor who, during the follow-up call, stated they were unable to make an appointment that would occur within a time frame satisfactory to them.

- Average number of days from the date an appointment was made until the date the appointment was scheduled to occur as stated by beneficiaries during follow-up calls from the contractor to beneficiaries who had chosen Alternative 1 and who, subsequently, had secured an appointment.

- Number and percent of beneficiaries calling the assistance number who selected Alternative 2.

- Percent of beneficiaries selecting Alternative 2 who chose to be contacted in a follow-up call by the contractor.

- Number and percent of beneficiaries selecting Alternative 2 and choosing to be contacted in a follow-up call by the contractor who, during the follow-up call, stated they were unable to make an appointment that would occur within a time frame satisfactory to them.

- Average number of days from the date an appointment was made until the date the appointment was scheduled to occur as stated by beneficiaries during follow-up calls from the contractor to beneficiaries who had chosen Alternative 2 and who, subsequently, had secured an appointment.

- Number of times the contractor directed ADSMs or ADFMs to non-network providers due to lack of available appointments with MTF or network providers.

- END -

3.0 APPEAL REQUIREMENTS

For all appeals at all levels:

3.1 Must Be Filed In A Timely Manner

The appealing party must comply with the "allowed time to file" requirements established by 32 CFR 199.10 and 199.15 (see Section 3, paragraph 1.4).

3.2 Must Be An Appealable Issue

Services or supplies must have been rendered by a TRICARE authorized provider, the denial of which raises a disputed question of fact which, if resolved in favor of the appealing party, would result in an extension of TRICARE benefits or approval as a TRICARE-authorized provider. Examples of nonappealable issues may be found at Section 3, paragraph 1.3.2.

3.3 Must Be An Amount In Dispute

There must be an amount in dispute before an appeal can be accepted (see paragraph 4.0). This involves the following requirements:

- In a case involving an appeal of denial of authorization in advance of the actual services, the amount in dispute will be the estimated allowable charge for the services requested.
- There must be a legal obligation on the part of the beneficiary, parent, guardian, or sponsor to pay for the service or supply.
- Payment or authorization of TRICARE benefits for the service or supply must have been denied in whole or in part.
- When the Episode Of Care (EOC) involves the services of both network and non-network providers, only the claims submitted by the non-network providers will be considered in determining the amount in dispute.

Note: A non-network provider appealing a denial of its authorized TRICARE provider status will be deemed to have met any required amount in dispute. Also, the amount in dispute will be considered to have been met in an appeal of a request for authorization of benefits for obtaining services or supplies unless the estimated allowable charge involved in such a request would be less than the required amount in dispute.

Example: A TRICARE beneficiary who had been hospitalized for 10 days was notified by the contractor that benefits would terminate on the 15th day. The beneficiary left the hospital on the 15th day and filed an appeal on the basis that continued hospitalization was medically necessary. In this case, there would be no basis for the appeal. The beneficiary left the hospital on the day TRICARE benefits terminated and expenses were no longer incurred; therefore, there was no amount in dispute. The beneficiary would be advised that there could be no appeal since there was no amount in dispute.

3.4 Must Be A Proper Appealing Party

See paragraph 1.0.

3.5 Must Be In Writing

All appeal requests must be in writing and submitted by a proper appealing party. A signature is not required if a determination can be made that the request was submitted by a proper appealing party. If it cannot be determined that the appeal request was submitted by a proper appealing party, the proper appealing party shall be instructed by the contractor that a proper appeal, must be filed within 20 calendar days of the contractor's letter or by the appeal filing deadline, whichever is later. A verbal request for a reconsideration cannot be accepted. When telephone calls are received or personal visits occur which relate to an adverse initial determination, the contractor shall make every effort to satisfy the inquirer's complaint, inquiry, or question, including advising the inquirer of his or her right to appeal, if applicable. If an appropriate appealing party or representative submits a letter which includes both an appealable issue and a grievance, the appeal and grievance shall be processed separately under the appropriate appeal and grievance provisions of the TRICARE Operations Manual (TOM).

4.0 AMOUNT IN DISPUTE

An amount in dispute is required for an adverse determination to be appealable. Although some amount must be in dispute for a reconsideration, unless specifically waived (e.g., the appeal involves denial of certification as a TRICARE authorized provider), there is no established minimum dollar amount. If the contractor's reconsideration determination is less than fully favorable to the appealing party and the remaining amount in dispute is less than $50, no further appeal rights are available (i.e., $50 or more must be in dispute for a reconsideration to be accepted at the TQMC, or a formal review to be accepted at TMA). Three hundred dollars or more, shall be in dispute for the case to be accepted as a hearing. The determination of "amount in dispute" affects the appealing party's rights and must be carefully evaluated, including, when appropriate, multiple claims for the same service and related claims. Under TRICARE Prime, if the beneficiary has no liability, other than a nominal per visit copayment, there is no amount in dispute (this does not preclude a Prime enrollee from appealing a preadmission/preprocedure denial determination). If the services at issue are not a benefit under TRICARE, and the provider is a network provider, the Prime or Extra beneficiary shall be held harmless by the network provider, unless the beneficiary is properly informed that the care is not covered (or probably is not covered) and agrees in advance to pay for the care. An agreement to pay can be evidenced by, e.g., a progress note in the beneficiary's medical record, entered contemporaneously with the occurrence of the event. (Refer to Chapter 5, Section 1, paragraph 2.5 for additional information regarding "hold harmless".)

4.1 Calculating The Amount In Dispute

The "amount in dispute" is calculated as the actual amount the contractor would pay if the services and/or supplies involved in the dispute were determined to be payable.

4.1.1 Examples Of Excluded Amounts

Example 1: Amounts in excess of the TRICARE-determined allowable charge or cost are excluded.

entity attempt to bill the program or if payment has been issued after the effective date of exclusion. It will not be necessary for the contractor to issue a separate letter notifying the provider or network pharmacy of the sanction action.

5.1.2.2 Ensuring that a sanctioned provider, pharmacy, or entity is not included in the network. If cancellation of a network, or if applicable, participating provider agreement is required, the contractor shall ensure that the network provider or network pharmacy whose contract has been cancelled clearly understands his/her status. This shall be accomplished by providing notice, by certified mail, return receipt requested, that the network provider's or network pharmacy's agreement has been cancelled.

5.1.2.3 Issuing a special beneficiary notice (Addendum A, Figure 13.A-9) for claims having a date of service following the effective date of the DHHS/OIG exclusion. The contractor shall also ensure that proper notification is given to all Health Benefit Advisors (HBAs) within the provider's service area (approximately 100 miles). TRICARE Regional Office (TRO) staff in the geographical area(s) of the provider's practice shall also be given notice of sanction action taken.

5.1.2.4 Initiating appropriate reinstatement action. DHHS/OIG will advise on the monthly listing if and when a previously sanctioned provider or pharmacy is reinstated. That is the date that the contractor is to use for reinstatement. The contractor does not need to advise the provider or pharmacy of the reinstatement by DHHS/OIG, but will be responsible for ensuring that the provider or entity meets the regulatory requirements as an authorized TRICARE provider or pharmacy. See Section 7, for additional guidance. The same agencies originally advised of sanction shall also be notified of the reinstatement.

5.2 Contractor Actions Under TRICARE Exclusion Authority - 32 CFR 199.9

5.2.1 The contractor is required to provide written notice to TMA PI of any TRICARE provider or pharmacy who meets the criteria under the exclusion authority granted TRICARE. The notice must include appropriate documentation relevant to the situation (e.g., provider or pharmacy poses unreasonable potential for fraud).

5.2.2 The contractor will be notified immediately of an exclusion action taken by the TMA PI and is responsible for:

5.2.2.1 Ensuring that no payment is made to a sanctioned provider, pharmacy, or entity for care provided on or after the date of the TMA action. Neither the provider, pharmacy, entity, nor the patient will be entitled to TRICARE cost-sharing once the exclusion is effective. The contractor must notify TMA PI should a provider, pharmacy, or entity attempt to bill the program after the effective date of exclusion. It will not be necessary for the contractor to issue a separate letter notifying the provider or pharmacy of the sanction action. However, notice of sanction action taken by TMA shall be given to all HBAs located within the provider's service area (approximately 100 miles) of the practice address of the excluded provider. TROs in the geographical area(s) of the provider's practice shall also be given notice of sanction action taken.

5.2.2.2 Ensuring that a sanctioned provider, pharmacy, or entity is not included in the network. If cancellation of a network provider agreement is required, the contractor shall ensure that the network provider whose contract has been cancelled clearly understands his/her status. This shall

be accomplished by providing notice, by certified mail, return receipt requested, that the network provider's or network pharmacy's agreement has been cancelled (a copy to be provided to TMA PI).

5.2.2.3 Issuing a special notice to any beneficiary who submits a claim or for whom a claim is submitted, which includes services involving a sanctioned provider. The notice may be enclosed with the Explanation of Benefits (EOB), whether the claim is payable or not, or a separate letter may be sent. The substance of the message should be similar to the example shown under Addendum A, Figure 13.A-9.

5.2.2.4 Initiating appropriate action, as instructed, following reversed or vacated decisions issued by the TMA PI or termination of sanction action by TMA. The same agencies originally advised of sanction shall also be notified of the reinstatement.

5.3 Contractor Actions Under TRICARE Exclusion Authority - 32 CFR 199.15

5.3.1 Under the TRICARE regulation, the provisions of 42 CFR 1004.1-1004.80 (Imposition of Sanctions by a PRO) shall apply to the TRICARE program as they do the Medicare program, except that the functions specified in those sections for the DHHS/OIG shall be the responsibility of TRICARE. As such, contractors shall adopt the DHHS PRO procedures and rules set forth under 42 CFR 1004.

5.3.2 The 32 CFR 199.15 establishes the process for imposition of sanctions on health care practitioners and providers of health care services by a QIO. The process includes:

- Setting forth certain obligations imposed on practitioners and providers of service under TRICARE;
- Establishing criteria and procedures for the reports required from QIOs when there is failure to meet those obligations;
- Specifying the policies and procedures for making determinations on violations and imposing sanctions; and
- Defining the procedures for appeals by the affected party and the procedures for reinstatements.

5.3.3 After meeting the objectives and requirements of the review system under 32 CFR 199.15 and taking appropriate action(s) as a result of the review, the contractor is required to notify TRICARE of all recommended actions.

5.3.4 Following notification to TRICARE PI of the proposed recommended action to sanction under the provisions of 32 CFR 199.15, TMA PI will follow the procedures set forth in 32 CFR 199.9.

5.4 Contractor Requirements For Terminating a Provider or Network Pharmacy

When a provider's or network pharmacy's status as an authorized TRICARE provider is ended, the contractor will initiate termination action based on a finding that the provider, pharmacy, or entity does not meet the qualifications to be an authorized provider, etc. Foreign providers of care can be terminated from the contractor's network if it is determined that they are engaged in

Chapter 14 Section 2

Reports And Plans

1.0 SUBMISSION REQUIREMENTS

Reports and plans shall be submitted as required by the Contract Data Requirements Lists (CDRLs), DD Forms 1423, incorporated into the contract.

2.0 METHOD OF SUBMISSION

2.1 All deliverables shall be submitted to TMA via the E-commerce Extranet (https://tma-ecomextranet.ha.osd.mil/). This system allows the contractor to log on to a secure system and upload the required deliverables (contract plans, reports, etc.). The system is accessed via the Internet through a workstation browser. The application is "thin client" meaning that no software needs to be installed on the client workstation and no software is downloaded into the browser. Javascript and cookies need to be enabled in the browser to utilize the application. The application is best viewed at a resolution of 1024 x 768 pixels in an Internet Explorer (IE) browser. The system must be accessed using the Secure Socket Layer (SSL) protocol (https://) and is protected by individually assigned user name and password. Access to the Extranet must be requested using the E-Commerce Extranet Access Form which will be provided by the Government. While files are being submitted over the Internet they are encrypted within the secure layer. When files are stored on the TRICARE server, they are renamed with a randomly generated name of varying length. Access to information is granted to users at the contract level. Information submitted by one contractor will not be accessible to any other contractor.

2.1.1 Certain deliverables as identified by the government will require entry of specific metric data from the deliverable into a template prior to uploading the deliverable.

2.1.2 All deliverables will require submission into the Extranet in a format approved by the Government to include Microsoft® Office Excel, Word, PDF, or other specified format.

2.2 Delivery of deliverables to other agencies (government and contractors) as specified by the government is the responsibility of the contractor. Delivery will be in a method and format as determined by the government.

- END -

Chapter 15 Section 3

Clinical Support Agreement (CSA) Program

1.0 GENERAL

The CSA Program represents a requirement for the contractor to provide needed clinical personnel to the Military Treatment Facility (MTF) Commanders in those situations where the MTF Commander has determined that it is in the Government's interest to obtain clinical personnel through this program. The requesting organization is responsible for funding all actions issued under the CSA Program.

2.0 LIMITS

2.1 Resources available through the CSA Program are limited to individuals in the following categories:

- Personnel of the type set forth in 32 CFR 199.6(c)(3) as an independent professional provider who meet the criteria contained in 32 CFR 199 and who also meet the credentialing requirements delineated in this chapter; or,

- Personnel who provide general clinical support, including but not limited to, nurses, x-ray technicians, laboratory technicians, pharmacists, etc.

2.2 Under the authority of 10 United States Code (USC) 1095 and 32 CFR 220.8, CSA providers shall not bill for any form of third party payment. The MTF participating in the CSA Program will bill for and retain all funds available from a third party.

2.3 No beneficiary receiving services from a CSA provider shall be charged a copayment, cost-share, and/or deductible.

2.4 No CSA Program costs shall be included as underwritten health care costs or supplemental health care costs.

2.5 CSAs for personnel obtained on a personal services basis must comply with DoD Instruction 6025.5, "Personal Services Contracts for Health Care Providers," January 6, 1995.

3.0 PROGRAM REQUIREMENTS

3.1 Personnel

The contractor shall prepare and submit a detailed technical and cost proposal within the time frame specified in the Government request. No services shall be provided under this section until a formal contract action is executed by a TRICARE Management Activity (TMA) Contracting Officer (CO).

3.1.1 Individual Professional Providers

The contractor shall furnish individual professional providers who meet or exceed the criteria contained in 32 CFR 199.6, TRICARE Policy Manual (TPM), Chapter 11, and the requirements of this chapter. The contractor shall provide personnel accepted and credentialed by the MTF within 90 calendar days of receiving the executed contract action, or within the time frame otherwise established between the parties and identified within the Performance Work Statement/ Statement of Work/Specification.

3.1.2 Clinical Support Personnel

The contractor shall furnish clinical support personnel who are licensed or certified to practice in the state and their speciality where such licensing or certification is available and meet the requirements of the facility where the individual will practice. Clinical support personnel obtained on a personal services basis must meet the licensure requirements of 10 USC Section 1094. The facility specific requirements will be contained in each Performance Work Statement/ Statement of Work/Specification.

The contractor shall provide clinical support personnel accepted and credentialed by the MTF within 60 calendar days of receiving the executed contract action, or within the time frame otherwise established between the parties and identified within the Performance Work Statement/ Statement of Work/Specification. The contractor shall provide health care personnel with credentials that allow the MTF to award privileges in accordance with the specifications contained in the Performance Work Statement/Statement of Work/Specification. The contractor shall provide the documentation supporting the fulfillment of the requirements to the MTF where the individual will work 30 calendar days prior to the individual's first day of work.

3.1.3 Supervision Of CSA Personnel

3.1.3.1 CSA personnel may be obtained on a personal services basis or a non-personal services basis as specified in the Performance Work Statement/Statement of Work Specifications. The contractor shall supervise all CSA personnel obtained on a non-personal services basis for the purpose of directing the terms and conditions of employment. This does not preclude MTF oversight on administrative aspects of patient care activities, such as scheduling, peer review, QA, etc. Contractor furnished personnel shall comply with privileging requirements, utilization review/ management criteria and procedures, quality assessment procedures and criteria, and peer review and quality of care reviews in accordance with the policy, procedures, and regulatory provisions established for Government practitioners (32 CFR 199.15, 199.16, and TPM, Chapter 11).

3.1.3.2 All CSA personnel shall comply with all MTF specific requirements including all local Employee Health Program (EHP), Federal Occupational Safety Act and Health Act (OSHA), Bloodborn Pathogens Program (BBP) requirements, Department of Defense (DoD) Information Assurance Certification And Accreditation Process (DIACAP) requirements, and MTF training requirements.

3.1.4 Credentialing of CSA Program Personnel

3.1.4.1 The contractor shall provide to the MTF individual professional providers who meet the credentialing and privileging requirements of 32 CFR 199.6. In addition, the staff members must

agree to comply with the licensing and credentialing directives of the MTF and to fully participate in MTF quality assessment and improvement activities required by the MTF. The contractor shall provide the MTF Commander with the original and one copy of all information on credentials for civilian providers working in the MTF. (The original document will be returned upon the completion of the MTF credentialing process.) The contractor is responsible for querying the National Practitioner Data Bank (NPDB) about each provider upon initial appointment and every two years thereafter and for providing the MTF Commanders with copies of the NPDB report each time one is received on a CSA professional provider. DoD requirements for the basic credentials and privileging of health care providers are set forth in 32 CFR 199.6 and DoD Directives (DoDD) 6025.6, 6025.11, and 6024.14. The contractor shall provide the MTF Commanders with all documentation required by these and all applicable Army, Navy, or Air Force directives at least 30 calendar days prior to the provider's first day of work in an MTF.

3.1.4.2 The contractor shall credential all clinical support personnel in accordance with the Performance Work Statement/Statement of Work/Specification. The contractor shall provide the documentation supporting the fulfillment of the requirements to the MTF where the individual will work 30 calendar days prior to the individual's first day of work.

3.1.5 Contractor Liability for CSA Program Personnel

The contractor shall be solely liable for negligent acts or omissions of personnel supplied by the contractor on a non-personal services basis. The contractor shall ensure that all individual professional providers and clinical support personnel provided on a non-personal services basis maintain full professional liability insurance as required by the contract.

- END -

Chapter 16 Section 1

General

1.0 INTRODUCTION

The TRICARE Prime Remote (TPR) program provides health care to Active Duty Service Members (ADSMs) in the United States and the District of Columbia (DC) who meet the eligibility criteria listed below.

2.0 ELIGIBILITY

Contractors have no responsibility for determining eligibility or for deciding in which region an ADSM shall enroll. Regional Directors (RDs) will furnish contractors with enrollment information (refer to paragraph 3.0). If a contractor receives a claim for care provided to an ADSM who is not enrolled in TPR or who is not enrolled in TRICARE Prime at a Military Treatment Facility (MTF), the contractor shall process the claim according to the applicable guidelines of the Supplemental Health Care Program (SHCP) (Chapter 17).

Note: ADSM Astronauts assigned to the Johnson Space Center in Houston, Texas must and shall be enrolled in TPR.

3.0 TPR PROGRAM UNITS

The RD will supply the contractor with an electronic directory, updated as needed, that lists, by region, the designated TPR zip codes for the contractor's region(s). The RD will also provide unit listings to the contractor so that the contractor can mail educational materials to the units. In some instances, individual member listings (as opposed to units) may be provided.

4.0 BENEFITS

4.1 ADSMs enrolled in the TPR program are eligible for the Uniform Health Maintenance Organization (HMO) Benefit, even in areas without contractor networks. Some benefits (see Section 2 and Addendum B) require review by the member's Service Point of Contact (SPOC) so that the services are aware of fitness-for-duty issues. In addition, if the contractor determines that services on a TPR enrollee's claim are not covered under the Uniform Benefit, or that the provider of services is not a TRICARE-authorized provider, or that the provider has not been certified as a TRICARE-authorized provider, the contractor shall supply the claim information (Addendum C) to the SPOC for a coverage determination. The contractor shall continue with provider certification procedures but shall follow SPOC direction for claim payment with no delay even if the provider certification process is not completed. The SPOC may authorize health care services not included in the Uniform Benefit and services furnished by providers who are not TRICARE-authorized/certified providers. The contractor shall not make claims payments to sanctioned or suspended providers (see Chapter 13, Section 6). The claim shall be denied if a sanctioned or suspended provider bills for services.

SPOCs do not have the authority to overturn TMA or Department of Health and Human Services (DHHS) provider exclusions. See Section 2 for referral and authorization requirements.

4.2 SPOC-authorized services will be covered even if they are not ordinarily covered under the TRICARE Prime program and/or if they are supplied by a provider who is not TRICARE-authorized or certified. A SPOC authorization shall be deemed to constitute referral, authorization, and direction to bypass edits as appropriate to ensure payment of SPOC-approved claims. Contractors shall implement appropriate measures to recognize SPOC authorization in order to expedite claims processing.

5.0 SPOC

Special Uniformed Service controls and rules apply to ADSMs due to unique military requirements to maintain readiness. The Services will always retain health care oversight of their personnel through their SPOCs. The SPOC serves as liaison among the ADSM, the ADSM's Uniformed Service, and the contractor for managing the ADSM's health care services. The SPOC reviews referrals for proposed care as well as information about care already received in order to determine impact on an individual's fitness for duty (see Section 2 and Addendum C for referral and review/authorization procedures). The SPOC, the PCM (if assigned) and the contractor shall work together in making arrangements for the ADSM's required examinations. The SPOC will provide the protocol, procedures, and required documentation through the contractor to the provider for these examinations. For required care that may not be obtainable in the civilian community, the SPOC will refer the ADSM to a military MTF or other military source of care. Refer to Addendum A for the addresses and telephone numbers of the SPOCs.

6.0 APPEAL PROCESS

6.1 If the contractor, at the direction of the SPOC, denies authorization of, or authorization for reimbursement, for a TPR enrollee's health care services, the contractor shall, on the Explanation of Benefits (EOB) or other appropriate document, furnish the enrollee with clear guidance for requesting a reconsideration from or filing an appeal with the SPOC (see paragraph 6.2). The SPOC will handle only those issues that involve SPOC denials of authorization or authorization for reimbursement. The contractor will handle allowable charge issues, grievances, etc.

6.2 A TPR enrollee must appeal SPOC denials of authorization or authorization for reimbursement through the SPOC rather than through the contractor. If the enrollee disagrees with a denial, the first level of appeal will be through the SPOC. The enrollee may initiate the appeal by contacting his/her SPOC. If the SPOC upholds the denial, the SPOC will notify the enrollee of further appeal rights with the appropriate Surgeon General's office.

6.3 If the denial is overturned at any level, the SPOC will notify the contractor and the ADSM.

6.4 The contractor shall forward all written inquiries and correspondence related to SPOC denials of authorization, or authorization for reimbursement to the appropriate SPOC. The contractor shall refer telephonic inquiries related to SPOC denials to 1-888-MHS-MMSO.

7.0 ACTIVE DUTY FAMILY MEMBERS (ADFMs) AND OTHERS

TRICARE-eligible ADFMs accompanying ADSMs who are either eligible for or enrolled in the TPR program may enroll in TRICARE Prime Remote for Active Duty Family Members (TPRADFMs) Program in accordance with Section 6.

8.0 TPR PROGRAM DIFFERENCES

8.1 ADSMs have no cost-shares, copayments or deductibles.

8.2 If the contractor has not established a network of PCMs in a remote area, a TPR designated ADSM will still be enrolled without a PCM assigned. The ADSM without an assigned PCM will be able to use a local TRICARE-authorized provider for primary health care services without SPOC review.

8.3 Point of Service (POS) cost-sharing and deductible amounts do not apply to ADSMs enrolled in the TPR program. If an ADSM receives primary care without a referral or authorization, the enrolling contractor shall process the claim and make payment if the care meets all other TRICARE requirements (i.e., the care is medically necessary, a benefit of TRICARE Prime, furnished by an authorized/certified provider, etc.). If services do not meet the requirements of TRICARE Prime, the contractor shall supply the claim information to the SPOC for coverage determination. See Section 2, paragraph 5.3.2 for information on self-referred care.

8.4 Annual ADSM re-enrollment is not required.

8.5 If the armed forces determine that an active duty member is eligible for the TPR program, enrollment of the member is mandatory, unless there are service-specific issues that merit assignment to a military PCM, or if the ADSM elects to waive access standards and enrolls to an MTF (subject to unit commander/supervisor approval).

8.6 There will be no application by the contractor of Other Health Insurance (OHI) processing procedures for ADSM TPR claims.

8.7 If Third Party Liability (TPL) is involved in a claim, ADSM claim payment will not be delayed during the development of TPL information from the ADSM.

8.8 Enrollment jurisdiction may be based on the location of the military work unit instead of the ADSM's residence. This is determined by the Services.

8.9 TPR coverage may include health care services not included under the Uniform HMO Benefit (paragraph 4.0).

8.10 Payment may be made for services furnished by providers who are not TRICARE-authorized or certified (paragraph 4.0).

- END -

Chapter 16 Section 3

Marketing, Enrollment, And Support Services

1.0 MARKETING

Enrollment in the TRICARE Prime Remote (TPR) Program is mandatory for Active Duty Service Members (ADSMs) who qualify for the program (see Section 1, paragraph 2.0); therefore, the Managed Care Support Contractor (MCSC) shall limit marketing activities for TPR-enrollees to distributing the marketing materials provided by the Government. The Regional Director (RD) will determine the initial supply of materials required and the MCSC shall forward materials to the TPR Program Units. The contractor shall include enrollment forms for the TPR Program in the ADSM marketing materials.

2.0 ENROLLMENT

2.1 The RD will, on an as needed basis, but at least semi-annually, provide the contractor with an update to the TPR directory of units whose members are eligible for enrollment in the program according to Section 1, paragraph 3.0.

2.2 An enrollment application (supplied by the contractor) must be completed and signed by either the ADSM or the ADSM's unit commander for each ADSM enrolling in the TPR Program. The completed and signed application will be submitted to the contractor. The effective date for TPR Program enrollment is the date the ADSM or the ADSM' s unit commander signed the enrollment application.

2.3 ADSM enrollment in the TPR Program will be for the tour of duty. Enrollment transfers or disenrollments will occur upon change of duty location out of the region, transfer into an Military Treatment Facility (MTF)/clinic Prime Service Area (PSA), retirement, or separation from the service. The ADSM will be responsible for notifying the contractor when an enrollment transfer is needed. The contractor shall follow enrollment portability and transfer procedures in Chapter 6, Section 2.

2.4 The contractor shall enroll the ADSM into the Defense Enrollment Eligibility Reporting System (DEERS) via DEERS Online Enrollment System (DOES). The TPR enrollment card is provided by Defense Manpower Data Center (DMDC). When processing TPR enrollment applications from ADSM Astronauts, the contractor shall not assign the astronauts to a network or other TRICARE authorized Primary Care Manager (PCM). The National Aeronautics and Space Administration (NASA) providers shall provide primary care for the ADSM Astronauts and the contractor shall use the PCM (unassigned) procedure when enrolling ADSM Astronauts into the TPR program. The contractor shall coordinate referrals and authorizations from the NASA providers for TPR enrolled ADSM Astronauts in accordance with Section 2, paragraph 5.2 and it's subordinate paragraphs.

3.0 PRIMARY CARE MANAGER (PCM) ASSIGNMENT

At the time of enrollment, an ADSM will select (or will be assigned) a PCM in the local community, if available. An ADSM without an assigned PCM may use a local TRICARE-authorized provider for primary care.

4.0 EDUCATION

4.1 The Government will provide all education materials **unique** to the TPR Program. Educational issues include the PCM concept (and what procedures to follow when a network PCM is not assigned), how to access care in and out of the area using the contractor, how to access specialty care through the contractor and Service Point of Contact (SPOC), and information on filing medical claims.

4.2 The Government will provide all TPR enrollees with information about how to obtain self-care manuals. The contractor shall give ADSMs and their family members the option of participating in health promotion and wellness programs offered in MTF PSAs.

4.3 Educational activities in the TPR Program areas shall involve the joint efforts of the service unit of the ADSM, the SPOCs, the Service Medical Departments, the RD, and the contractor. The contractor shall distribute TMA-supplied educational materials unique to the TPR Program. The contractor is responsible for postage, envelopes, and mailing costs for distributing educational material.

5.0 The contractor shall include TPR Program information and updates as part of all TRICARE briefings. The contractor may propose alternative methods for supplying educational information to ADSMs eligible to enroll in the TPR Program.

6.0 SUPPORT SERVICES

6.1 General

The requirements and standards in Chapters 1 and 11, apply to the TPR Program unless otherwise stated in this chapter.

6.2 Inquiries

6.2.1 The contractor shall designate a point of contact for Government (RD, TRICARE Management Activity (TMA), and Uniformed Service) inquiries related to the TPR Program. The contractor may establish a dedicated unit for responding to inquiries about the TPR Program and the Supplemental Health Care Program (SHCP). The contractor shall respond to all inquiries-- written, telephone, walk-in, etc.-- that are not related to dental care or to SPOC reviews of medical care. The contractor shall forward all inquiries that specifically address dental care or SPOC review of medical care to the active duty dental claims processor or the TPR enrollee's SPOC for response. The requirements and standards in Chapter 1, Section 3, apply to TPR inquiries.

6.3 Toll-Free Telephone Service

The contractor shall provide toll-free telephone access for TPR Program beneficiary inquiries. This toll-free access may also serve the SHCP beneficiaries. See Chapter 1, Section 3 for telephone standards. The contractor shall handle provider inquiries through the contractor's provider inquiry system.

- END -

to payment. If a required authorization is not on file for a non-enrollee, then the contractor will place the claim in a pending status and will forward copies of appropriate documentation to SPOC for determination. See Addendum B for SPOC referral and review procedures.

1.4.2.1 If the SPOC authorizes care, the claim shall be processed for payment.

1.4.2.2 If the SPOC determines that the civilian health care was not authorized, the contractor shall follow normal TRICARE requirements for issuing EOB and summary vouchers.

2.0 COVERAGE

2.1 Normal TRICARE coverage limitations will not apply to services rendered for supplemental health care for ADSMs. For ADSMs, the Director, TRICARE Management Activity (TMA), at the request of an authorized official of the uniformed service concerned, may authorize coverage for services that would not have ordinarily been covered under TRICARE policy based on that such waiver is necessary to assure adequate availability of health care services to active duty members. TRICARE coverage limits apply to services to TRICARE-eligible covered beneficiaries provided under the SHCP. In no case shall a payment be made for outpatient institutional services listed on the inpatient only procedure list except for inpatient procedures performed in an emergency room on a beneficiary who dies prior to admission. Reference the TRICARE Reimbursement Manual (TRM), Chapter 13, Section 2, paragraph 3.4. On occasion care may be referred or authorized for services from a provider of a type which is not TRICARE authorized. The contractor shall not make claims payments to sanctioned or suspended providers. (See Chapter 13, Section 6.) The claim shall be denied if a sanctioned or suspended provider bills for services. MTFs do not have the authority to overturn TMA or Department of Health and Human Services (DHHS) provider exclusions. TRICARE utilization review and utilization management requirements will not apply.

2.2 Unlike a normal TRICARE authorization, an MTF or SPOC authorization shall be deemed to constitute referral, authorization, eligibility verification, and direction to bypass provider certification and Non-Availability Statement (NAS) rules. The contractor shall take measures as appropriate to enable them to distinguish between the two authorization types.

2.3 Ancillary Services

The Regulation governing the SHCP requires that each service under the SHCP be authorized, with very limited exceptions. For purposes of SHCP claims processing, an MTF authorization for care will be deemed to include authorization of any ancillary services directly and clearly related to the specific episode of health care authorized (e.g., evaluation or treatment of a specific medical condition). Any questions of whether a particular service is related to the care already authorized should be resolved by means of seeking MTF authorization for the service in question.

2.4 Provision Of Respite Care For The Benefit Of Seriously Ill Or Injured Active Duty Members

2.4.1 The National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2008 established respite care and other extended care benefits for members of the Uniformed Services (including RC members) who incur a serious injury or illness while on active duty. The eligibility rules and exclusions contained in 32 CFR 199.5(e)(3) and (5) do not apply to the provision of respite benefits

for an ADSM. See Appendix B for definitions, terms, and limitations applicable to the respite care benefit.

2.4.2 ADSMs may qualify for respite care benefits regardless of their enrollment status. ADSMs in the 50 United States and the District of Columbia may qualify if they are enrolled in TRICARE Prime, TPR, or not enrolled and receiving services in accordance with the non-enrolled/non-referred provisions for the use of SHCP funds. ADSMs outside the 50 United States and the District of Columbia may qualify if they are enrolled to TOP Prime (with enrollment to an MTF), TRICARE Global Remote Overseas (TGRO), TRICARE Puerto Rico, or not enrolled and receiving services in accordance with the non-enrolled/non-referred provisions for ADSM care overseas (see the TPM, Chapter 12).

Note: Respite care benefits must be performed by a TRICARE-authorized Home Health Agency (HHA), regardless of the ADSM's location (see 32 CFR 199.6(b)(4)(xv) for HHA definition).

2.4.3 There are no cost-shares or copays for ADSM respite benefits when those services are approved by the member's Direct Care System (DCS) case manager or other appropriate DCS authority (i.e., Military Medical Support Office (MMSO) Service Point of Contact (SPOC), the enrolled or referring MTF, TRICARE Area Office (TAO), or Community-Based Health Care Organization (CBHCO)).

2.4.4 All SHCP requirements and provisions of Chapters 16 and 17 apply to this benefit unless changed or modified by this paragraph. The appropriate chapter for the status of the ADSM shall apply. Contractors shall follow the requirements and provisions of these chapters, to include MTF or MMSO referrals and authorizations, receipt and control of claims, authorization verification, reimbursement and payment mechanisms to providers, reimbursement specifying no cost-share, copay, or deductible to be paid by the ADSM, use of CHAMPUS Maximum Allowable Charges (CMACs)/Diagnosis Related Groups (DRGs) when applicable, and TRICARE Encounter Data (TED) submittal.

2.4.5 Contractors shall follow the provisions of the TRICARE Systems Manual (TSM), Chapter 2, Sections 2.8 and 6.4 regarding the TED special processing code for the ADSM respite benefit. Claims should indicate an appropriate procedure code for respite care (CPT[1] 99600 or HCPCS S9122-S9124) and shall be reimbursed based upon the allowable charge or the negotiated rate.

2.4.6 Respite care services and requirements are as follows:

2.4.6.1 Respite care is authorized for a member of the Uniformed Services on active duty and has a qualifying condition as defined in Appendix B.

2.4.6.2 Respite care is available if an ADSM's plan of care includes frequent interventions by the primary caregiver(s).

2.4.6.3 ADSMs receiving respite care are eligible to receive a maximum of 40 respite hours in a calendar week, no more than five days per calendar week and no more than eight hours per calendar day. No additional benefit caps apply.

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2.4.6.4 Respite benefits shall be provided by a TRICARE-authorized HHA and are intended to mirror the benefits under the TRICARE ECHO Home Health Care (EHHC) program described in the TPM, Chapter 9, Section 15.1.

Note: Contractors are not required to enroll ADSMs in the ECHO program (or a comparable program) for this respite benefit.

2.4.6.5 Authorized respite care does not cover care for other dependents or others who may reside in or be visiting the ADSM's residence.

2.4.6.6 In addition, consistent with the requirement that respite care services shall be provided by a TRICARE-authorized HHA, services or items provided or prescribed by a member of the patient's family or a person living in the same household are excluded from respite care benefit coverage.

2.4.6.7 The contractor shall follow the reimbursement methodology for the similar respite care benefit found in the TPM, Chapter 9, as modified by ADSM SHCP reimbursement methodology contained in Chapters 16 and 17 (for ADSMs located in the 50 United States and the District of Columbia) or TOP reimbursement methodology contained in the TPM, Chapter 12 (for ADSMs located outside the 50 United States and the District of Columbia).

2.4.7 Should other services or supplies not outlined above, or otherwise available under the TRICARE program, be considered necessary for the care or treatment of an ADSM, a request may be submitted to the MMSO, MTF, or TAO for authorization of payment.

3.0 ENROLLMENT STATUS EFFECT ON CLAIMS PROCESSING

3.1 Active duty claims shall be processed without application of a cost-share, copayment, or deductible. These are SHCP claims.

3.2 Claims for TRICARE Prime enrollees who are in MTF inpatient status shall be processed without application of a cost-share, copayment, or deductible. These are SHCP claims.

3.3 Claims for services provided under the current MOU between the DoD (including Army, Air Force, and Navy/Marine Corps facilities) and the DHHS (including the Indian Health Service, Public Health Service, etc.) are not SHCP claims. They should be adjudicated under the claims processing provisions applicable to those specific agreements.

3.4 Claims for services provided under any local MOU between the DoD (including the Army, Air Force and Navy/Marine Corps facilities) and the Department of Veterans' Affairs (DVA) are not SHCP claims. They should be adjudicated under the claims processing provisions applicable to those specific agreements. (Claims for services provided under the current national MOA for Spinal Cord Injury (SCI), Traumatic Brain Injury (TBI), and Blind Rehabilitation are covered, see Section 2, paragraph 3.1.)

3.5 Claims for participants in the Comprehensive Clinical Evaluation Program (CCEP) shall be processed for payment solely on the basis of MTF authorization. There will not be a cost-share, copayment, or deductible applied to these claims. These are SHCP claims.

3.6 Claims for non-TRICARE eligibles shall be processed for payment solely on the basis of MTF or SPOC authorization. There will not be a cost-share, copayment, or deductible applied to these claims. These are SHCP claims.

3.7 Outpatient claims for non-TRICARE Medicare eligibles will be returned to the submitting party for filing with the Medicare claims processor. These are not SHCP or TRICARE claims.

4.0 MEDICAL RECORDS

The current contract requirements for medical records shall also apply to ADSMs in this program, with the additional requirement that ADSMs must also be given copies directly. Narrative summaries and other documentation of care rendered (including laboratory reports and X-rays) shall be given to the ADSM for delivery to his/her Primary Care Manager (PCM) and inclusion in his/her military health record. The contractor shall be responsible for all administrative/copying costs. Under no circumstances will the ADSM be charged for this documentation. Network providers shall be reimbursed for medical records photocopying and postage costs incurred at the rates established in their network provider participation agreements. Participating and non-participating providers shall be reimbursed for medical records photocopying and postage costs on the basis of billed charges. ADSMs who have paid for copied records and applicable postage costs shall be reimbursed for the full amount paid to ensure they have no out of pocket expenses. All providers and/or patients must submit a claim form, with the charges clearly identified, to the contractor for reimbursement. ADSM's claim forms should be accompanied by a receipt showing the amount paid.

5.0 REIMBURSEMENT

5.1 Allowable amounts are to be determined based upon the TRICARE payment reimbursement methodology applicable to the services reflected on the claim, (e.g., DRGs, mental health per diem, CHAMPUS Maximum Allowable Charge (CMAC), Outpatient Prospective Payment System (OPPS), or TRICARE network provider discount). Reimbursement for services not ordinarily covered by TRICARE and/or rendered by a provider who cannot be a TRICARE authorized provider shall be at billed amounts. Cost-sharing and deductibles shall not be applied to supplemental health care claims.

5.2 Claims with codes on the TRICARE inpatient only list performed in an outpatient setting will be denied, except in those situations where the beneficiary dies in an emergency room prior to admission. Reference the TRM, Chapter 13, Section 2, paragraph 3.4. Professional providers may submit with modifier CA. No bypass authority is authorized for inpatient only procedure editing. Bypass authority is authorized for codes contained on the Government No Pay List when the service is authorized by the MTF.

5.3 Pending development and implementation of recently enacted legislative authority to waive CMACs under TRICARE, the following interim procedures shall be followed when necessary to assure adequate availability of health care to ADSMs under SHCP. If required services are not available from a network or participating provider within the medically appropriate time frame, the contractor shall arrange for care with a non-participating provider subject to the normal reimbursement rules. The contractor initially shall make every effort to obtain the provider's agreement to accept, as payment in full, a rate within the 100% of CMAC limitation. If this is not feasible, the contractor shall make every effort to obtain the provider's agreement to accept, as

payment in full, 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 and communicate the same to the referring MTF. A waiver of CMAC limitation must be obtained by the MTF from the Regional Director (RD), as the designee of the Chief Operating Officer (COO), TMA, before patient referral is made to ensure that the patient does not bear any out-of-pocket expense. Upon approval of a CMAC waiver by the RD, the MTF will notify the contractor who shall then conclude rate negotiations, and notify the MTF when an agreement with the provider has been reached. The contractor shall ensure that the approved 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. In the case of non-MTF referred care, the contractor shall submit the waiver request to the RD.

5.4 Eligible uniformed service members and/or referred patients who have been required by the provider to make "up front" payment at the time services are rendered will be required to submit a claim to the contractor with an explanation and proof of such payment. For eligible uniformed service members, if the claim is payable without SPOC review the contractor shall allow the billed amount and reimburse the ADSM for charges on the claim. If the claim requires SPOC review the contractor shall pend the claim to the SPOC for determination. If the SPOC authorizes the care the contractor shall allow the billed amount and reimburse the ADSM for charges on the claim.

- Supplemental health care claims for uniformed service members and all MTF inpatients receiving referred civilian care while remaining in an MTF inpatient status shall be promptly reimbursed and the patient shall not be required to bear any out of pocket expense. If such payment exceeds normally allowable amounts, the contractor shall allow the billed amount and reimburse the patient for charges on the claim. As a goal, no such claim should remain unpaid after 30 calendar days.

5.5 In no case shall a uniformed service member be subjected to "balance billing" or ongoing collection action by a civilian provider for referred, 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 referring MTF or SPOC, as appropriate, for determination. The referring MTF or SPOC will issue an authorization to the contractor for payments in excess of CMAC or other applicable TRICARE payment ceilings, provided the referring MTF or SPOC has requested and has been granted a waiver from the COO, TMA, or designee.

6.0 END OF PROCESSING

6.1 EOB

An EOB shall be prepared for each supplemental health care claim processed, and copies sent to the provider and the patient in accordance with normal claims processing procedures. For all SHCP claims, the EOB will include the statement that this is a supplemental health care claim, not a TRICARE claim. The EOB will also indicate that questions concerning the processing of the claim must be addressed to the TRICARE Service Center (TSC) or SPOC, as appropriate. Any standard TRICARE EOB messages which are applicable to the claim are also to be utilized, e.g., "No authorization on file."

6.2 Appeal Rights

6.2.1 For supplemental health care claims, the appeals process in Chapter 12, applies, as limited herein. If the care is still denied after completion of a review to verify that no miscoding or other clerical error took place and the MTF/SPOC will not authorize the care in question, then the notification of the denial shall include the following statement: "If you disagree with this decision, please contact (**insert MTF name/SPOC here**)." TRICARE appeal rights shall pertain to outpatient claims for treatment of TRICARE eligible patients. The SPOC will handle only those issues that involve SPOC denials of authorization or authorization for reimbursement. The contractor shall handle allowable charge issues, grievances, etc.

6.2.2 An ADSM will appeal SPOC denials of authorization or authorization for reimbursement through the SPOC--not through the contractor. If the ADSM disagrees with a denial, the first level of appeal will be through the SPOC who will coordinate the appeal with the appropriate RD. The ADSM may initiate the appeal by contacting his/her SPOC or by calling the MMSO at 1-888-647-6676. If the SPOC upholds the denial, the SPOC will notify the ADSM of further appeal rights with the appropriate Surgeon General's office. If the denial is overturned at any level, the SPOC will notify the contractor and the ADSM.

6.2.3 The contractor shall forward all written inquiries and correspondence related to SPOC denials of authorization or authorization for reimbursement to the appropriate SPOC. The contractor shall refer telephonic inquiries related to SPOC denials to 1-888-MHS-MMSO.

7.0 TRICARE ENCOUNTER DATA (TED) SUBMITTAL

The TED for each claim must reflect the appropriate data element values. The appropriate codes published in the TRICARE Systems Manual (TSM) are to be used for supplemental health care claims.

8.0 CONTRACTOR'S RESPONSIBILITY TO RESPOND TO INQUIRIES

8.1 Telephonic Inquiries

Inquiries relating to the SHCP need not be tracked nor reported separately from other inquiries received by the contractor. Most SHCP inquiries to the contractor should come from MTFs/claims offices, the Service Project Officers, TMA, or the SPOC. In some instances, inquiries may also come from Congressional offices, patients, or providers. To facilitate responsiveness to SHCP inquiries, the contractor shall provide MTFs/claims offices, the Service Project Officers, TMA, and the SPOC a specific telephone number, different from the public toll-free number, for inquiries related to the SHCP Claims Program. The line shall be operational and continuously staffed according to the hours and schedule specified in the contractor's TRICARE contract for toll-free and other service phone lines. It may be the same line as required in support of TPR under Chapter 16. The telephone response standards of Chapter 1, Section 3, shall apply to SHCP telephonic inquiries.

8.1.1 Congressional Telephonic Inquiries

The contractor shall refer any congressional telephonic inquiries to the referring MTF or the SPOC, as appropriate, if the inquiry is related to the authorization or non-authorization of a specific claim or episode of treatment. If it is a general congressional inquiry regarding the SHCP

claims program, the contractor shall respond or refer the caller as appropriate.

8.1.2 Provider And Other Telephonic Inquiries

The contractor shall refer any other telephonic inquiries it receives, including calls from the provider, service member or the MTF patient, to the referring MTF or the SPOC, as appropriate, if the inquiry pertains to the authorization or non-authorization of a specific claim. The contractor shall respond as appropriate to general inquiries regarding the SHCP.

8.2 Written Inquiries

8.2.1 Congressional Written Inquiries

For MTF-referred care, the contractor shall refer written congressional inquiries to the Service Project Officer of the referring MTF's branch of service if the inquiry is related to the authorization or non-authorization of a specific claim. For non-MTF referred care, the inquiry shall be referred to the SPOC. When referring the inquiry, the contractor shall attach a copy of all supporting documentation related to the inquiry. If it is a general congressional inquiry regarding the SHCP, the contractor shall refer the inquiry to the TMA. The contractor shall refer all congressional written inquiries within 72 hours of identifying the inquiry as relating to the SHCP. When referring the inquiry, the contractor shall also send a letter to the congressional office informing them of the action taken and providing them with the name, address and telephone number of the individual or entity to which the congressional correspondence was transferred.

8.2.2 Provider And Service Member (Or MTF Patient) Written Inquiries

The contractor shall refer provider and service member or MTF patient written inquiries to the referring MTF or the SPOC, as appropriate, if the inquiry pertains to the authorization or non-authorization of a specific claim. The contractor shall respond as appropriate to general written inquiries regarding the SHCP.

8.2.3 MTF Written Inquiries

The contractor shall provide a final written response to all written inquiries from the MTF within 10 work days of the receipt of the inquiry, or if appropriate, refer the inquiry to the SPOC upon receipt of the inquiry.

9.0 SHCP AGING CLAIMS REPORT

The Government intends to take action on all referrals to the SPOC as quickly as possible. To support this objective, the SPOC must be kept apprised of those claims on which the contractor cannot take further action until the SPOC has completed its reviews and approvals.

- END -

Chapter 18

Demonstrations

Section/Addendum	Subject/Addendum Title
1	General
2	Department Of Defense (DoD) Cancer Prevention And Treatment Clinical Trials Demonstration Figure 18.2-1 Sample Of Authorization Letter To Be Issued To Institution Verifying TRICARE Eligibility For Said Patient To Be Enrolled In NCI Sponsored Studies Figure 18.2-2 Sample Of Authorization Letter For DoD Cancer Prevention And Treatment Clinical Trials Demonstration Figure 18.2-3 Sample Of Denial Letter For DoD Cancer Prevention And Treatment Clinical Trials Demonstration Figure 18.2-4 Sample Of Notification Letter To Be Issued To Geographical Contractor Of Patient's Enrollment In The DoD Cancer Prevention And Treatment Clinical Trials Demonstration
3	Department Of Defense (DoD) In-Utero Fetal Surgical Repair Of Myelomeningocele Clinical Trial Demonstration Figure 18.3-1 Demonstration Protocol
4	Expanded Eligibility Under The National Defense Authorization Act For Fiscal Years 2004 And 2005 (NDAA FY 2004 And 2005) Figure 18.4-1 Under Secretary Of Defense For Personnel And Readiness Memorandum
5	Department Of Defense (DoD) Weight Management Demonstration
6	Department Of Defense (DoD) Tobacco Cessation Demonstration
7	Department Of Defense (DoD) Alcohol Abuse Prevention And Education Demonstration
8	TRICARE Demonstration Project For The State Of Alaska - Critical Access Hospital (CAH) Payment Rates Figure 18.8-1 Critical Access Hospitals (CAHs) In Alaska And Their CCRs On Or After July 1, 2007 Figure 18.8-2 Critical Access Hospitals (CAHs) In Alaska And Their CCRs On Or After July 1, 2008
9	Department Of Defense (DoD) Enhanced Access To Autism Services Demonstration
10	Operation Noble Eagle/Operation Enduring Freedom Reservist And National Guard Benefits Demonstration
A	Participation Agreement For Autism Demonstration Corporate Services Provider (ACSP)

9.0 TMA AND CONTRACTOR RESPONSIBILITIES

9.1 TMA will provide:

- A special fund for the purpose of the demonstration.
- Periodic review and evaluation of the Demonstration claims adjudication process.
- Communications and Customer Service (C&CS) functions to properly inform and periodically update the patient and provider communities regarding the terms of the Demonstration.

9.2 The contractor shall:

9.2.1 Verify the patient's eligibility on DEERS. If the patient is authorized to receive the care under the Demonstration, but DEERS reflects that the patient is not eligible, a statement shall be added to the authorization letter indicating before benefits can be paid, the patient must be listed as eligible on DEERS. If a patient is listed on DEERS as being eligible as of the date enrollment begins, all services provided as a result of participation in an NICHD sponsored study shall be covered. This also applies to patients whose treatment is in process when the Demonstration expires.

9.2.2 Issue an authorization to the applicant provider and patient once a determination is made regarding eligibility and/or a particular protocol.

9.2.3 Refer eligible patients to BCC for initial screening and protocol information for participation in the study.

9.2.4 Furnish a list of enrollees in the Demonstration to the contractor's Program Integrity Unit with instructions to run an annual post-payment report to determine if hospitals are receiving additional unlawful payments as a result of also receiving payment under TRICARE. If such payment exists, it shall be the responsibility of the contractor to initiate recoupment action for any Demonstration benefits paid in error. This function will be supervised by the TMA Program Integrity Office (PI).

9.2.5 Establish and maintain a database of patients participating in the Demonstration. The database shall include the patient's name, sponsor's Social Security Number (SSN), name and number of protocol, treatment, hospital name and address and total cost. The database shall also include the date the TRICARE beneficiary was either accepted, or denied enrollment into the clinical trial and the patient shall be carried in the database until the Demonstration ends.

10.0 CLAIMS PROCESSING REQUIREMENTS

10.1 Claims under the NICHD clinical trial demonstration project shall be processed by the South Region. Jurisdiction edits shall not apply thereby ensuring that claims are paid and submitted to the TMA in accordance with current requirements for not at risk funds.

10.2 Verify TRICARE-eligibility on the DEERS prior to payment.

10.3 Both institutional and professional charges shall be reimbursed based on billed charges.

10.3.1 The NICHD participating MOMS Centers shall submit all charges on the basis of fully itemized bills. Each service and supply shall be individually identified and submitted on the appropriate claim forms.

10.3.2 Claims for medical care required as a result of participation in an NICHD sponsored study for in-utero fetal repair of myelomeningocele or treatment that is not a TRICARE benefit (i.e., the Demonstration's pre-natal protocol portion), shall be processed and paid under the South Region.

10.3.3 Cost-shares and deductibles applicable to TRICARE will also apply under the Demonstration. For TRICARE Prime enrollees, including those enrolled in USFHP, applicable copays will apply.

10.3.4 The contractor shall query the DEERS Catastrophic Cap and Deductible Data base (CCDD) to determine the status of deductible and catastrophic cap met amounts for TRICARE-eligible beneficiaries at the time the costs are listed on the voucher for processing and payment. The contractor shall determine what expenses to apply to the deductible and catastrophic cap and report these to the CCDD. These expenses shall be reported at the same time the costs are listed on the voucher for processing, prior to payment of the claim.

10.4 Double coverage provisions apply. Acceptable evidence of processing by the double coverage plan is outlined in the TRICARE Reimbursement Manual (TRM), Chapter 4. In double coverage situations, the Demonstration will pay the balance after the OHI has paid.

10.5 Claims shall be paid from the applicable non-underwritten bank accounts, see Chapter 3, and submitted through normal TRICARE Encounter Data (TED) processing as required in the TSM with the applicable coding for clinical trials.

10.6 Once in-utero fetal surgical repair of the myelomeningocele becomes a TRICARE benefit, claims for treatment shall be processed and paid based on the regional contractor's implementation date for the change. If a claim spans the implementation date, the contractor shall process and pay those charges on the claim that are prior to the implementation date and the regional contractor shall process the remaining charges under its at-risk contract. The contractor shall notify the provider the claim has been split for processing of charges as of the date of implementation for the TRICARE benefit. If the patient is an inpatient at the time in-utero fetal surgical repair of the myelomeningocele becomes a TRICARE benefit, and the claim is subject to the DRG-based payment, then the claim cannot be split. Under these circumstances, the entire claim shall be processed and paid under the Demonstration.

10.7 A Non-Availability Statement (NAS) is not required under the Demonstration.

Chapter 18 Section 8

TRICARE Demonstration Project For The State Of Alaska - Critical Access Hospital (CAH) Payment Rates

1.0 PURPOSE

Under this demonstration project, TRICARE will reimburse Critical Access Hospitals (CAH) in the state of Alaska in a similar manner as they are reimbursed under Medicare. This demonstration project will test adopting a Medicare-like CAH reimbursement methodology prior to nationwide implementation, in those states that have established State Flex Programs. It will also test CAH provider participation in TRICARE, beneficiary access to care, cost of health care services, military medical readiness, morale and welfare. This demonstration will be conducted under statutory authority provided in 10 United States Code (USC) 1092.

2.0 BACKGROUND

2.1 Hospitals are authorized TRICARE institutional providers under 10 USC 1079(j)(2) and (4). Under 10 USC 1079(j)(2), the amount to be paid to hospitals, Skilled Nursing Facilities (SNFs), and other institutional providers under TRICARE, "shall be determined under joint regulations... which provide that the amount of such payments shall be determined to the extent practicable in accordance with the same reimbursement rules as apply to payments to providers of services of the same type under [Medicare].". Under 32 CFR 199.14(a)(1)(ii)(D)*(1)* through *(9)* it specifically lists those hospitals that are exempt from the Diagnosis Related Groups (DRG)-based payment system. CAHs are not listed as excluded, thereby making them subject to the DRG-based payment system. CAHs are not listed as exempt, because at the time this regulatory provision was written, CAHs were not a recognized entity.

2.2 Legislation enacted as part of the Balanced Budget Act (BBA) of 1997 authorized states to establish State Medicare Rural Hospital Flexibility Programs, under which certain facilities participating in Medicare could become CAHs. CAHs represent a separate provider type with their own Medicare conditions of participation as well as a separate payment method. Since that time, a number of hospitals, acute care and general, as well as Sole Community Hospitals (SCHs), have taken the necessary steps to be designated as CAHs. Since the statutory authority requires TRICARE to apply the same reimbursement rules as apply to payments to providers of services of the same type under Medicare to the extent practicable, TRICARE must proceed with publication of a proposed and final rule to exempt CAHs from the DRG-based payment system and adopt a method similar to Medicare principles for these hospitals when it becomes practicable to implement. The purpose of the demonstration is to test implementation immediately for CAHs in the state of Alaska.

3.0 POLICY

3.1 Otherwise covered services and supplies provided by CAHs in the state of Alaska shall be reimbursed for inpatient and outpatient facility services at the lesser of the billed charge or on the basis of 101% of their allowable and reasonable costs. That is, an overall inpatient Cost-To-Charge Ratio (CCR) and overall outpatient CCR, obtained from data on the hospital's most recent Medicare cost report will be multiplied by the billed charge; the resulting amount will be increased by 1%. This amount shall be compared to the billed charge and the lesser of the two shall be paid to the provider.

3.2 The following inpatient CCRs shall be effective for inpatient admission on or after July 1, 2007. The outpatient CCRs shall be effective for outpatient facility services with dates of service on or after July 1, 2007.

FIGURE 18.8-1 CRITICAL ACCESS HOSPITALS (CAHs) IN ALASKA AND THEIR CCRs ON OR AFTER JULY 1, 2007

NAME	INPATIENT CCR	OUTPATIENT CCR
Valdez Regional Health Authority (VRHA)	2.1029	1.3978
Providence Seward Medical & Care Center (PSMCC)	0.6799	0.7674
Sitka Community Hospital (SCH)	1.0100	0.8098
Petersburg Medical Center (PMC)	0.9762	0.8901
Wrangell Medical Center (WMC)	0.9445	0.7574
Providence Kodiak Island Medical Center (PKIMC)	0.6992	0.6079
Cordova Community Medical Center (CCMC)	1.0544	1.3456
Norton Sound Health Corporation (NSHC)	1.0438	1.1183
Ketchikan General Hospital (KGH)	0.5770	1.1669

3.3 The following inpatient CCRs shall be effective for inpatient admission on or after July 1, 2008. The outpatient CCRs shall be effective for outpatient facility services with dates of service on or after July 1, 2008.

FIGURE 18.8-2 CRITICAL ACCESS HOSPITALS (CAHs) IN ALASKA AND THEIR CCRs ON OR AFTER JULY 1, 2008

NAME	INPATIENT CCR	OUTPATIENT CCR
Valdez Regional Health Authority (VRHA)	1.5739	1.2364
Providence Seward Medical & Care Center (PSMCC)	0.9906	0.6405
Sitka Community Hospital (SCH)	1.0852	0.8717
Petersburg Medical Center (PMC)	0.8958	0.8895
Wrangell Medical Center (WMC)	0.8391	0.7346
Providence Kodiak Island Medical Center (PKIMC)	0.6340	0.5586
Cordova Community Medical Center (CCMC)	0.6026	0.8697

FIGURE 18.8-2 CRITICAL ACCESS HOSPITALS (CAHs) IN ALASKA AND THEIR CCRs ON OR AFTER JULY 1, 2008 (CONTINUED)

NAME	INPATIENT CCR	OUTPATIENT CCR
Norton Sound Health Corporation (NSHC)	1.0967	0.8851
Ketchikan General Hospital (KGH)	0.6827	0.6711

3.4 The TRICARE Management Activity (TMA) shall provide a list of CAHs in the state of Alaska to the MCSC and the inpatient and outpatient CCRs to be used for this demonstration. The CCRs shall be updated on an annual basis using the most recent CCRs for each hospital. TMA shall provide the updated inpatient and outpatient CCRs to the contractor and the updated inpatient and outpatient CCRs shall be effective as of July 1 of each respective year, with the first update occurring effective July 1, 2008.

3.5 Payment for TRICARE covered outpatient services provided by physicians and other non-institutional individual professional providers in the state of Alaska shall be reimbursed in accordance with the Federal Register (FR) notice published on November 20, 2006 (71 FR 67112-67113). That is, TRICARE will adopt a rate that is 1.35 times the current TRICARE allowable rate. These rates are included in the CHAMPUS Maximum Allowable Charge (CMAC) file that is provided to each of the Managed Care Support Contractors (MCSCs).

3.6 The TRICARE cost-shares, copayments, and deductibles applicable to hospitals shall also apply to the services provided by CAHs under this demonstration.

3.7 The CAH portion of the state of Alaska demonstration excludes those Indian Health Service (IHS) facilities that are also CAHs. IHS facilities will continue to be reimbursed the DRG or the negotiated rate for inpatient care, the lower of the billed charge or negotiated rate for outpatient facility care, and the CMAC rates for Alaska for care rendered by individual professional providers.

4.0 MCSC RESPONSIBILITY

4.1 The MCSC for the state of Alaska shall price and process inpatient and outpatient facility claims under this demonstration using the reimbursement methods described in paragraph 3.0.

4.2 Out-Of-Jurisdiction Claims

4.2.1 In the event the MCSC for the state of Alaska receives an out-of-jurisdiction claim, the MCSC shall price the claim using the methods described in paragraph 3.0. Once the claim has been priced, the claim shall be forwarded to the appropriate contractor based on the jurisdiction provisions found in Chapter 8, Section 2.

4.2.2 In the event that a north or south MCSC or other TRICARE contractor receives a claim from one of the CAHs under this demonstration, the claim shall be sent to the MCSC for the state of Alaska to be priced using the provision of this demonstration. Once the claim has been priced by the state of Alaska MCSC, the claim shall be forwarded to the appropriate contractor based on the jurisdiction provisions found in Chapter 8, Section 2. The claim shall be sent to the fax number: 1-715-843-8435, Attn: CAH Processing.

5.0 EFFECTIVE DATE

5.1 The portion of the state of Alaska demonstration that provides for 1.35 times the current TRICARE allowable rate took effect on February 1, 2007.

5.2 The enhanced portion of the state of Alaska demonstration that provides for 101% of reasonable costs for inpatient and outpatient facility reimbursement to CAHs shall be effective for inpatient admissions on and after July 1, 2007, and for outpatient facility services with dates of service on or after July 1, 2007.

- END -

Chapter 18 Section 9

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

1.0 PURPOSE

The Enhanced Access to Autism Services Demonstration ("Demonstration") provides TRICARE reimbursement for Educational Interventions for Autism Spectrum Disorders (EIA). This Demonstration will enable the Department of Defense (DoD) to determine whether:

- There is increased access to these services;
- The services are reaching those most likely to benefit from them;
- The quality of those services is meeting a standard of care currently accepted by the professional community of providers, including the Behavior Analyst Certification Board (BACB); and
- Requirements are met for State licensure and certification where such exists.

2.0 BACKGROUND

2.1 The Military Health System (MHS) includes 63 military hospitals, over 500 military health clinics, and an extensive network of private sector health care partners, that provides medical care for more than nine million beneficiaries, including Active Duty Service Members (ADSMs) and Active Duty Family Members (ADFMs).

2.2 Autistic Spectrum Disorders (ASD) affect essential human behaviors such as social interaction, the ability to communicate ideas and feelings, imagination, and the establishment of relationships with others. DoD estimates that 8,500 of the 1.2 million children of ADSMs have been diagnosed with one of the ASDs.

2.3 A number of EIA services, such as Applied Behavior Analysis (ABA), have been introduced to ameliorate the negative impact of autism. Currently, ABA is the only EIA service accepted within the MHS as having been shown to reduce or eliminate specific problem behaviors and teach new skills to individuals with ASD. ABA therapy is rendered by TRICARE-authorized providers as a Special Education benefit under the Extended Care Health Option (ECHO). Only those individuals who are licensed or certified by a State or certified by the BACB (http://www.bacb.com) as a Board Certified Behavior Analyst (BCBA) or a Board Certified Associate Behavior Analyst (BCABA) are eligible to be TRICARE-authorized providers of ABA.

2.4 The Demonstration will permit TRICARE reimbursement for EIA services, referred to as Intensive Behavioral Interventions in the Federal Register Demonstration Notice (72 FR 68130,

December 4, 2007), delivered by paraprofessional providers under a modified Corporate Services Provider (CSP) model.

3.0 DEFINITIONS

3.1 Applied Behavior Analysis (ABA)

A well-developed discipline with a mature body of scientific knowledge, established standards for evidence-based practice, distinct methods of service, recognized experience and educational requirements for practice, and identified sources of requisite education. Information regarding the content of ABA is contained in the BACB Behavior Analysis Task List, available at http://www.bacb.com/Downloadfiles/AutismTaskList/708AutismTaskListF.pdf.

3.2 Autism Spectrum Disorders (ASD)

3.2.1 Collective term indicating Autistic Disorder (AD), Childhood Disintegrative Disorder (CDD), Asperger's Syndrome (AS), and Pervasive Developmental Disorder Not Otherwise Specified (PDDNOS) as defined by the American Psychiatric Association's (APA's) Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR).

3.2.2 Significant symptoms associated with ASD include communication and social behavior deficits, and behaviors concerning objects and routine.

3.2.2.1 Communication deficits include a lack of speech, especially when associated with the lack of desire to communicate and lack of nonverbal compensatory efforts such as gestures.

3.2.2.2 Social Skills Deficits. Children with ASD demonstrate a decreased drive to interact with others and share complementary feeling states. Children with ASD often appear to be content being alone, ignore their parents' and others' bids for attention with gestures or vocalizations and seldom make eye contact.

3.2.2.3 Restricted, Repetitive, and Stereotyped Patterns of Behavior, Interests, and Activities. Children with ASD 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.

3.3 Behavior Plan (BP)

A written assessment of the objectives and goals of behavior modification and the specific evidence-based practices and techniques to be utilized. Requirements for the BP are specified in paragraph 7.0.

3.4 Educational Interventions For Autism Spectrum Disorders (EIA)

Individualized interventions, as specified in the BP, to systematically increase adaptive behaviors and modify maladaptive or inappropriate behaviors. Under the Demonstration, only ABA, as defined by the BACB, is authorized and reimbursable.

3.5 EIA Progress Report (EPR) And Updated BP

A report of the individual's progress towards achieving the behavioral goals and objectives specified in the BP. The report also revises the BP to reflect new or modified goals, objectives and strategies. Requirements for the EPR and the updated BP are specified in paragraphs 7.2 and 7.3, respectively.

3.6 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:

- Identifying the problem behavior(s); and
- Developing hypotheses about the antecedents and consequences likely to trigger or support the problem behavior; and
- Performing an analysis of the function of the behavior by testing the hypotheses.

3.7 Individuals With Disabilities Education Act (IDEA)

Public Law 108-446, December 3, 2004 (20 U.S.C. 1400 et seq.): The United States law that entitles all children, including those with a disability, to a Free Appropriate Public Education (FAPE).

3.8 Individualized Family Service Plan (IFSP)

A multidisciplinary assessment and plan that specifies the unique strengths, services and resources needed by an infant or toddler (age zero to three years) with a developmental disability or who is at risk for such, and his/her family.

3.9 Individualized Education Program (IEP)

A multidisciplinary assessment and plan that specifies the objectives, goals and related services associated with providing a FAPE to a child with a disability.

3.10 Special Education

Specially designed instruction to meet the unique FAPE needs, as specified in the IEP, of a child with a disability.

4.0 PROVIDERS

4.1 Primary Care Provider (PCP)

A collective reference within the Demonstration 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 TRICARE-authorized family practice, general medicine, internal medicine, and pediatric physicians under the TRICARE Standard program; and

4.1.3 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 Autism Demonstration Corporate Services Provider (ACSP)

An individual, 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 under the ECHO and which meets the requirements specified in paragraph 5.1.

4.3 EIA Supervisor

An individual TRICARE authorized provider meeting the requirements specified in paragraph 5.2 who provides supervisory oversight of EIA Tutors.

4.4 EIA Tutor

An individual who meets the requirements specified in paragraph 5.3 and delivers EIA services to TRICARE beneficiaries under the supervision of an EIA Supervisor. EIA Tutors work one-on-one with children in accordance with the BP and gather behavioral data necessary for the EIA Supervisor to evaluate the effectiveness of the BP. An EIA Tutor may not conduct behavioral evaluations, establish a child's BP, or submit claims for services provided to TRICARE beneficiaries.

4.5 Specialized ASD Provider

A TRICARE authorized provider who is a:

- Physician board-certified or board-eligible in behavioral developmental pediatrics, neurodevelopmental pediatrics, pediatric neurology or child psychiatry; or
- Ph.D. clinical psychologist working primarily with children.

5.0 EIA PROVIDER REQUIREMENTS

5.1 ACSPs shall:

5.1.1 Submit evidence to the Managed Care Support Contractor (MCSC) that professional liability insurance in the amounts of one million dollars per claim and three million dollars in aggregate, unless State requirements specify greater amounts, is maintained in the ACPS's name.

5.1.2 Submit claims to the appropriate MCSC using the assigned Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes specified in paragraph 9.0.

5.1.3 Submit to the MCSC all documents necessary to support an application for designation as a TRICARE ACSP; and

5.1.4 Enter into a Participation Agreement (Addendum A) approved by the Director, TRICARE Management Activity (TMA) or designee; and

5.1.5 Employ directly or contract with EIA Supervisors and/or EIA Tutors; and

5.1.6 Certify that all EIA Supervisors and EIA Tutors employed by or contracted with the ACSP meet the education, training, experience, competency, supervision and Demonstration requirements specified herein; and

5.1.7 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 EIA services are provided under the Demonstration; and

5.1.8 Maintain employment or contractual documentation in accordance with applicable Federal, State, and local requirements and corporate policies regarding EIA Supervisors and EIA Tutors; and

5.1.9 Comply with all applicable requirements of the Government designated utilization and clinical quality management organization for the geographic area in which the ACSP provides EIA services; and

5.1.10 Comply with all other requirements applicable to TRICARE-authorized providers.

5.2 EIA Supervisor shall:

5.2.1 Have a current, unrestricted State-issued license to provide ABA services; or

5.2.2 Have a current, unrestricted State-issued certificate as a provider of ABA services; or

5.2.3 Be certified by the BACB (http://www.bacb.com) as either a BCBA or a BCABA where such state-issued license or certification is not available; and

5.2.4 Enter into a Participation Agreement (Addendum A) approved by the Director, TMA or designee; and

5.2.5 Employ directly or contract with EIA Tutors; and

5.2.6 Report to the MCSC within 30 days of notification of a BACB sanction issued to the EIA Supervisor for violation of BACB disciplinary standards (http://www.bacb.com/pages/prof_standards.html) or notification of loss of BACB certification. Loss of BACB certification shall result in termination of the Participation Agreement with the EIA Supervisor with an effective date of such notification. Termination of the Participation Agreement by the MCSC may be appealed to the TMA in accordance with the requirements of Chapter 13; and

5.2.7 Ensure that the quality of the services provided by EIA Tutors meet the minimum evidence-based standards as indicated by the current BACB Task List, the BACB Professional Disciplinary Standards, the BACB Guidelines for Responsible Conduct for Behavior Analysts, and current BACB rules and regulations; and

5.2.8 Maintain all applicable business licenses and employment or contractual documentation in accordance with Federal, State, and local requirements and the EIA Supervisor's business policies regarding EIA Tutors; and

5.2.9 Meet all applicable requirements of the states in which they provide EIA services, including those of states in which they provide remote supervision of EIA Tutors and oversee EIA services provided where the beneficiary resides; and

5.2.10 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

5.2.11 Comply with all other applicable requirements to TRICARE-authorized providers.

5.3 EIA Tutor:

5.3.1 Prior to providing EIA services under the Demonstration, shall have completed 40 hours of classroom training in ABA techniques in accordance with the BACB Guidelines for Responsible Conduct for Behavior Analysts (http://www.bacb.com), undergone a criminal background check as specified in paragraph 5.4.3; and

- Completed a minimum of 12 semester hours of college coursework in psychology, education, social work, behavioral sciences, human development or related fields and be currently enrolled in a course of study leading to an associate's or bachelor's degree by an accredited college or university; or

- Completed a minimum of 48 semester hours of college courses in an accredited college or university; or

- A High School diploma or GED equivalent and have completed 500 hours of employment providing ABA services as verified by the ACSP.

5.3.2 Receive no less than two hours supervision per month from the EIA Supervisor, in accordance with the BACB Guidelines for Responsible Conduct for Behavior Analysts.

5.4 Provider Background Review

5.4.1 The MCSC shall obtain a Criminal History Review, as specified in Chapter 4, Section 1, paragraph 9.0, for ACSPs who are individual providers with whom the MCSC enters into a Participation Agreement.

5.4.2 ACSPs, other than those specified in paragraph 5.4.1, shall:

5.4.2.1 Obtain a Criminal History Review of EIA Supervisors whom the ACSP employs directly or with whom the ACSP enters into a contract.

5.4.2.2 Obtain a Criminal Background Check of EIA Tutors whom the ACSP employs directly or with whom the ACSP enters into a contract.

5.4.3 The EIA Supervisor shall obtain a Criminal Background Check of EIA Tutors the Supervisor employs directly or with whom the Supervisor enters into a contract to supervise the EIA Tutor. The Criminal Background Check of EIA Tutors shall:

5.4.3.1 Include current Federal, State, and County Criminal and Sex Offender reports for all locations the EIA Tutor has resided or worked during the previous 10 years; and

5.4.3.2 Be completed prior to the EIA Tutor providing services to TRICARE beneficiaries.

6.0 BENEFICIARY ELIGIBILITY REQUIREMENTS

6.1 TRICARE beneficiaries who request participation in the Demonstration shall:

6.1.1 Be at least 18 months of age; and

6.1.2 Be registered in the ECHO; and

6.1.3 Have been diagnosed with an ASD specified in paragraph 3.2 by a TRICARE-authorized PCP or Specialized ASD Provider; and

6.1.4 Provide the MCSC with the beneficiary's IFSP or the IEP documenting that the beneficiary is receiving Early Intervention Services or Special Education, respectively.

Note: If the child is home schooled or enrolled in a private school and not required by State law to have an IEP, the child's PCP or Specialized ASD Provider must certify to the MCSC that the child requires participation in the Demonstration.

6.2 Eligibility for benefits under the Demonstration ceases as of 12:01 a.m. of the day after:

- The Demonstration ends; or
- Eligibility for the ECHO program ends.

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

7.0 BP REQUIREMENTS

The initial BP, the EPR, and updated BP shall be developed by the ACSP directing the delivery of EIA services and shall include the name/title/address of the preparer and the elements specified in paragraphs 7.1 through 7.3 to the extent applicable.

7.1 The initial BP shall include:

7.1.1 The beneficiary's name, date of birth, date the Functional Behavioral Assessment and Analysis was completed, sponsor's Social Security Number (SSN), name of the referring provider, background and history, goals and objectives, parental training, summary and recommendations.

7.1.2 Background and history shall include:

7.1.2.1 Information that clearly demonstrates the beneficiary's condition, diagnosis, and family history; and

7.1.2.2 How long the beneficiary has been receiving EIA services; and

7.1.2.3 Identification of any services or therapies being received through community resources (e.g., state waiver programs, Medicaid, services available through a Regional or Community Center); and

7.1.2.4 How the ACSP will coordinate EIA services with available community services; and

7.1.3 Goals and objectives of the EIA services shall include:

7.1.3.1 A detailed description of the targeted skills and behaviors that will be addressed through the EIA sessions and the objectives that will be measured, which may include:

- Communication skills
- Mental health issues
- Vocational skills
- Adaptive skills
- Motor skills
- Academic skills
- Cognitive skills
- Developmental skills
- Behavior skills
- Social skills
- Medical and quasi-medical issues

7.1.3.2 Administration of any diagnostic tests that will assess skill acquisition or behavior modification; and

7.1.3.3 The frequency and method of assessing the beneficiary's progress towards achieving the goals and objectives.

7.1.4 Parental training shall be included in the BP. Parental training shall be provided while billable EIA services are being provided to the beneficiary. The BP shall include a detailed plan that specifies how parents will be trained to:

7.1.4.1 Implement and reinforce skills and behaviors; and

7.1.4.2 Receive support to implement strategies within a specified setting.

7.1.5 Summary and recommendations of the BP shall include the extent of parent/caregiver involvement that will be expected to support the plan.

7.1.6 The initial BP shall be reviewed and updated by the ACSP at six-month intervals and submitted to the MCSC for review and authorization of EIA services.

7.2 The EPR shall include:

7.2.1 Beneficiary's name, date of birth, inclusive dates of the evaluation period, sponsor's SSN, name of the referring provider; and

7.2.2 A summary of the child's progress; and

7.2.3 A summary of the child's challenges to meet the goals and objectives; and

7.2.4 A summary of parent/caregiver participation in implementing the BP during the evaluation period.

7.2.5 Recommendations for continued EIA services.

7.3 The updated BP shall include:

7.3.1 The data elements specified in paragraph 7.1; and

7.3.2 The dates of the plan being updated; and

7.3.3 The number of EIA hours of services to be provided each month by the EIA Supervisor and the EIA Tutor.

7.4 The ACSP shall provide an information copy of the BP, the EPR, and the updated BP to the beneficiary's PCP or ASD Specialized provider, within 10 calendar days of completion.

8.0 POLICY

8.1 Under the Demonstration, TRICARE will reimburse only EIA services that meet the minimum standards established by the current BACB Task List, the BACB Professional Disciplinary Standards, the BACB Guidelines for Responsible Conduct for Behavior Analysts, and current BACB rules and regulations when rendered by providers who meet all applicable requirements specified herein.

8.2 All EIA services under this Demonstration require prior written authorization by the Director, TMA or designee.

8.3 The following are eligible for reimbursement under the Demonstration:

8.3.1 Evaluation of a beneficiary using the Functional Behavioral Assessment and Analysis.

8.3.2 Development of the initial BP, the EPR, and the updated BP.

8.3.3 EIA services rendered directly to a TRICARE beneficiary on a one-on-one basis. Group EIA sessions are not a TRICARE benefit.

8.3.4 EIA services rendered jointly, in-person, during directly supervised fieldwork of the EIA Tutor by the EIA Supervisor. Only the services provided by the Supervisor will be reimbursed as specified in paragraph 9.1.

8.3.5 Quarterly, in-person meetings between the EIA Supervisor and the beneficiary's primary caregivers.

8.4 The maximum cumulative Government liability for benefits provided to a beneficiary by the ECHO and the Demonstration is $2,500 per month.

9.0 REIMBURSEMENT

9.1 Claims for Demonstration services will be submitted by the ACSP on a Centers for Medicare and Medicaid (CMS) 1500 (08/05) as follows:

9.1.1 Functional Behavioral Assessment and Analysis.

9.1.1.1 During the first month the beneficiary is enrolled in the Demonstration, the ACSP will be authorized and reimbursed by the MCSC for not more than four hours for conducting the initial Functional Behavioral Assessment and Analysis and establishing the initial BP.

9.1.1.2 The Functional Behavioral Assessment and Analysis and initial BP will be invoiced using HCPCS code "S5108, Home care training to home care client, per 15 minutes."

9.1.1.3 Reimbursement for the Functional Behavioral Assessment and Analysis includes the intellectual work and diagnostic evaluation required to establish the initial BP.

9.1.1.4 Reassessment of established Demonstration participants will be conducted as part of the ACSP's routine supervision services and is not separately reimbursable.

9.1.2 EIA Services rendered jointly by an EIA Supervisor and an EIA Tutor, in-person, during directly supervised fieldwork of the Tutor by the Supervisor, will be invoiced using HCPCS code "S5108, Home care training to home care client, per 15 minutes."

9.1.3 EIA services provided directly by an EIA Tutor will be invoiced using HCPCS code "H2019, Therapeutic behavioral services, per 15 minutes."

9.1.4 Development of the required EPR and updated BP will be invoiced using CPT[1] code 99080, "Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form."

9.1.5 Conducting the required quarterly progress meetings with the TRICARE beneficiary's caregivers will be invoiced using CPT[1] code 90887, "Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible person, or advising them how to assist patient."

9.2 Reimbursement of claims in accordance with paragraphs 9.1.1 through 9.1.5 will be the lesser of:

- The CHAMPUS Maximum Allowable Charge (CMAC); or

[1] CPT only © 2006 American Medical Association (or such other date of publication of CPT). All Rights Reserved.

- $125 per hour for services provided by the EIA Supervisor and $50 per hour for services provided by the EIA Tutor; or
- The negotiated rate; or
- The billed charge.

10.0 ADDITIONAL MCSC RESPONSIBILITIES

The MCSC shall:

10.1 Consider and advise beneficiaries of the availability of community based or funded programs and services, when authorizing Demonstration benefits.

10.2 Maintain all documents related to the Demonstration in accordance with Chapter 2.

10.3 Forward to the "gaining" MCSC all Demonstration related documents within 10 calendar days of being notified that a beneficiary is transferring to a location under the jurisdiction of another MCSC.

10.4 Review the beneficiary's BP prior to authorizing Demonstration services.

Note: The Functional Behavioral Assessment and Analysis specified in paragraph 9.1.1 will be authorized by the MCSC prior to development of the BP.

10.5 Conduct annual audits on at least 20% of each ACSP's EIA Tutors for compliance with the requirements specified in paragraph 5.3. Upon determining non-compliance with one or more EIA Tutor qualification requirements, the MCSC will immediately initiate a compliance audit of all EIA Tutors employed by or contracted with that ACSP.

11.0 APPLICABILITY

11.1 This Demonstration is limited to TRICARE beneficiaries who meet the requirements specified in paragraph 6.0.

11.2 This Demonstration is limited to the 50 United States and the District of Columbia.

11.3 All provisions of the ECHO program apply to the Demonstration unless specifically modified by the Federal Register Demonstration Notice (72 FR 68130, December 4, 2007) or by this Section.

12.0 EXCLUSIONS

TRICARE will not cost-share:

12.1 Training of EIA Tutors as specified in paragraph 5.3.1.

12.2 Charges for program development, administrative services, and the assessment required for developing the EPR and updating the BP.

12.3 More than one Enhanced Access to Autism Services Demonstration service provided to the same beneficiary during the same time period, such as is the case of the supervision of the Tutor specified in paragraph 5.3.2.

12.4 Training of parents specified in paragraph 7.1.4.

13.0 EFFECTIVE DATE

This Demonstration is effective for claims for services provided in accordance with this Section on or after March 15, 2008.

- END -

Chapter 18 Section 10

Operation Noble Eagle/Operation Enduring Freedom Reservist And National Guard Benefits Demonstration

1.0 PURPOSE

The purpose of this demonstration is to test if the Military Health System (MHS), with certain flexibility in operation, can ensure timely access to health care during a national crisis, maintain clinically appropriate continuity of health care to family members of activated reservists and guardsmen, appropriately limit the extraordinary out-of-pocket expenses for those family members, and remove potential barriers to health care access by families.

2.0 BACKGROUND

2.1 A number of reservists and members of the National Guard are being ordered to active duty in support of operations that result from the terrorist attacks on the World Trade Center (WTC) and the Pentagon on September 11, 2001. These individuals are being ordered to active duty under Executive Order 13223, 10 U.S.C. 12302, 10 U.S.C. 12301(d), or 32 U.S.C. 502(f). Such operations include for example, Operation Noble Eagle and Operation Enduring Freedom.

2.2 In many cases, reservist families live far from Military Treatment Facilities (MTFs), and are not supported by TRICARE provider networks. Some doctors do not participate in TRICARE, and by law may bill beneficiaries for up to 15% above TRICARE allowable amounts. Family members of reservists could face undue financial hardships if they use such providers.

2.3 In some cases family members of activated reservists and members of the National Guard are in the middle of a course of medical care (e.g., obstetrical care) which would be disrupted if the family member were suddenly required to continue their care at a military treatment facility.

2.4 Most reservists and members of the National Guard are enrolled in a commercial health plan when they are called to active duty. Since in nearly every case they will have paid a deductible under their commercial health plan, they would be unfairly penalized if they had to meet a second deductible under TRICARE for care provided to their family members.

3.0 POLICY

3.1 Effective September 14, 2001, this demonstration is authorized for family members of reservists or members of the National Guard as described in paragraph 2.1. These beneficiaries will be identified by Special Indicator (SI) Code "02" on the Defense Enrollment Eligibility Reporting System (DEERS).

3.2 The TRICARE Encounter Data (TED) record for each Noble Eagle/Enduring Freedom claim must reflect the Special Processing Code "NE".

3.3 Claims are to be paid from financially underwritten funds. On claims for care from non-participating professional providers, contractors shall allow the lesser of the billed charges or the balance billing limit (115% of the allowable charge). If the charges on a claim from a non-participating professional provider are exempt from the balance billing limit, the contractor shall allow the billed charges. This applies to all claims from non-participating professional providers for services rendered to Standard beneficiaries. In double coverage situations, normal double coverage requirements shall apply.

Note: This special demonstration payment provision does not apply to Prime beneficiaries. Family members of reservists or members of the National Guard who are called to active duty in support of Operation Noble Eagle/Operation Enduring Freedom and who are enrolled in Prime will be protected when they receive services outside the network under the provisions of Chapter 8, Section 5.

3.4 In order to protect beneficiaries from incurring greater out-of-pocket costs under these special procedures, the beneficiary cost-share for these claims will be limited to what it would have been in the absence of the higher allowable amount under this demonstration. That is, the cost-share is 20% of the lesser of the CHAMPUS Maximum Allowable Charge (CMAC) or the billed charge. Any amounts that are allowed over the CMAC will be paid entirely by TRICARE.

3.5 TED records submitted for these non-participating professional claims that are reimbursed at the lesser of the balance billing limit or the billed charge are to be identified with Pricing Rate Code "W" but only if the allowed amount is greater than the CMAC. If the billed charge equals or is less than the CMAC, Pricing Rate Code "W" is not to be used. On the other hand, when the claim is reimbursed as billed because the billed charge is greater than the CMAC but less than the balance billing limit or the charges are exempt from the balance billing limit, Pricing Rate Code "W" is to be used.

3.6 All Non-Availability Statement (NAS) requirements are waived for beneficiaries identified by DEERS Special Indicator Code "02". TED records submitted for these beneficiaries are to use Care Authorization (CA)/NAS Exception Reason 9, "TRICARE Demonstration Project".

3.7 The TRICARE Standard and Extra deductible is waived for all beneficiaries identified by DEERS Special Indicator Code "02".

4.0 EVALUATION

4.1 The evaluation will assess the impact that the higher payment rates have on beneficiary access to care.

4.2 The evaluation will assess the financial impact of the higher payment rates.

4.3 The evaluation will assess the impact on the continuity of care for beneficiaries whose claims were paid at the higher rates and for whom the NAS requirements were waived.

4.4 The evaluation will assess the financial impact of waiving the deductibles for these beneficiaries.

5.0 EFFECTIVE DATES

This demonstration is effective for claims for services provided on or after September 14, 2001, and before November 1, 2009.

- END -

Chapter 18 Addendum A

Participation Agreement For Autism Demonstration Corporate Services Provider (ACSP)

NAME OF ACSP: _____

ADDRESS: _____

TELEPHONE: _____

TAX IDENTIFICATION NUMBER (TIN) OR SOCIAL SECURITY NUMBER (SSN): _____

ARTICLE 1

RECITALS

1.1 IDENTIFICATION OF PARTIES

This Autism Demonstration Corporate Services Provider (ACSP) Participation Agreement ("Participation Agreement") is between the United States of America through the TRICARE Management Activity (TMA), a field activity of the Office of the Assistant Secretary of Defense (Health Affairs) (OASD(HA)) and _____, doing business as _____ (hereinafter "ACSP").

1.2 AUTHORITY FOR ACSPs AS TRICARE-AUTHORIZED PROVIDERS

The authority to designate ACSPs as authorized TRICARE providers resides with the Department of Defense (DoD) Demonstration authority under 10 U.S.C. 1092. This authority ceases upon termination of the Enhanced Access to Autism Services Demonstration Project ("Demonstration") as determined by the Director, TMA or designee.

1.3 PURPOSE OF PARTICIPATION AGREEMENT

The purpose of this Participation Agreement is to:

(a) Establish the undersigned ACSP as an authorized provider of Educational Interventions for Autism Spectrum Disorders (EIA) services;

(b) Establish the terms and conditions that the undersigned ACSP must meet to be an authorized provider under the Demonstration.

ARTICLE 2

REFERENCES

2.1 REQUIREMENTS

By reference, the requirements set forth in the TRICARE Operations Manual (TOM), Chapter 18, Section 9, are incorporated into this Participation Agreement and shall have the same force and effect as if fully set out herein.

2.2 GENERAL AGREEMENT

The undersigned ACSP agrees to render appropriate EIA services to eligible beneficiaries as specified in the TOM, Chapter 18, Section 9.

ARTICLE 3

REIMBURSEMENT

3.1 Claims for Demonstration services will be submitted on a Centers for Medicare and Medicaid Services (CMS) 1500 (08/05) by the ACSP in accordance with the TOM, Chapter 18, Section 9, paragraph 9.0.

3.2 The ACSP shall:

(a) Submit claims to the appropriate TRICARE Managed Care Support Contractor (MCSC) in accordance with paragraph 3.1 and the TOM, Chapter 18, Section 9; and

(b) Collect the monthly sponsor cost-share specified in the TRICARE Policy Manual (TPM), Chapter 9, Section 16.1; and

(c) Not bill the sponsor/beneficiary for:

(1) Services for which the provider is entitled to TRICARE reimbursement; and

(2) Services that are denied due to provider non-compliance with all applicable requirements in the TOM, Chapter 18, Section 9.

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 or superseded as specified herein.

4.2 TERMINATION OF AGREEMENT BY TMA

(a) The Director, TMA or designee, may terminate this agreement upon written notice, for cause, if the ACSP 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 ACSP written notice not less than 45 days prior to the effective date of such termination.

4.3 TERMINATION OF AGREEMENT BY THE ACSP

The ACSP may terminate this agreement by giving the Director, TMA or designee, written notice not less than 45 days prior to the effective date of such termination. Effective the date of

termination, the ACSP will cease being a TRICARE-authorized provider of Demonstration services. Subsequent to termination, an ACSP may be reinstated as a TRICARE- authorized provider of Demonstration services only by entering into a new Participation Agreement.

4.4 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.

(b) An ACSP who does not accept the proposed amendment(s), including any amendment resulting from changes to 32 CFR 199 accomplished through rulemaking procedures, may terminate its participation as provided for in this Article. However, if the ACSP notice of intent to terminate its participation is not given at least 30 days prior to the effective date of the proposed amendment(s), the proposed amendment(s) shall be incorporated into this agreement for services furnished by the ACSP 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	ACSP
_____	_____
By: Typed Name and Title	By: Typed Name and Title

Executed on _____, 20____

- END -

Chapter 20 Section 3

Claims Processing For Dual Eligibles

1.0 GENERAL

Claims under the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) will be adjudicated under the rules set forth below. In general, TRICARE pays secondary to Medicare and any other coverage.

2.0 DETERMINING PAYMENTS DUE AFTER COORDINATION WITH MEDICARE

2.1 Special double coverage procedures are to be used for all claims for beneficiaries who are eligible for Medicare, including active duty dependents who are age 65 and over as well as those beneficiaries under age 65 who are eligible for Medicare for any reason. For specific instructions, refer to the TRICARE Reimbursement Manual (TRM), Chapter 4, Section 4.

3.0 EXCEPTIONS TO TIMELY CLAIMS FILING

3.1 Medicare

The contractor may grant exceptions to the claims filing deadline if Medicare accepted the claim as timely. If submitted by the beneficiary, the claim must be submitted within 90 calendar days from the date of Medicare's adjudication to be considered for a waiver.

3.2 Other Health Insurance (OHI)

Reference Chapter 8, Section 3, paragraph 2.5.

4.0 CLAIMS DEVELOPMENT REQUIREMENTS

4.1 Medicare Providers

4.1.1 The contractor shall accept the Medicare certification of individual professional providers who have a like class of individual professional providers under TRICARE without further authorization. An exception to this general rule occurs if there is information indicating Medicare, TRICARE or other federal health care program integrity violations by the physician or other health care practitioner. In such cases the Managed Care Support Contractor (MCSC) shall seek guidance from TRICARE Management Activity (TMA) Program Integrity (PI) prior to accepting the Medicare certification as valid for TRICARE purposes. Individual professional providers without a like class (e.g., chiropractors) under TRICARE shall be denied.

4.1.2 TRICARE claims which TRICARE processes after Medicare, do not need to be developed to the individual provider level for home health or group practice claims.

4.1.3 Electronic "cross over" claims received from Medicare after Medicare completes its claims processing do not need a beneficiary or provider signature. For paper claims, when TRICARE is second pay to Medicare and a Medicare EOB is attached, the contractor does not need to develop for provider or beneficiary signature. Signature on file requirements of Chapter 8, Section 4 apply.

4.2 Civilian Services Rendered To Military Treatment Facility (MTF) Inpatients

Civilian claims for TRICARE dual eligible beneficiaries shall be processed by Medicare first without consideration of the Supplemental Health Care Program (SHCP).

4.3 Preauthorization Requirements

Services outlined in the TRICARE Policy Manual (TPM), Chapter 1, Section 7.1 require preauthorization, and if necessary, review of waivers of the day limits for dual eligible beneficiaries when TRICARE is the primary payer. As secondary payer, TRICARE will rely on and not replicate Medicare's determination of medical necessity and appropriateness in all circumstances where Medicare is primary payer (see the TRM, Chapter 4, Section 4). In the event that TRICARE is primary payer for these services and preauthorization was not obtained, the contractor shall obtain the necessary information and perform a retrospective review.

5.0 UTILIZATION MANAGEMENT

Any utilization management provisions applied under the TRICARE Managed Care Support Services (MCSSS) contracts, except for those specifically required by the TPM, TRM, or TRICARE Operations Manual (TOM), shall not apply under TDEFIC. Region-specific requirements shall not apply.

6.0 END OF PROCESSING

6.1 Beneficiary Cost-Shares

End Of Processing. Beneficiary cost-shares shall be based on the following when TRICARE is the primary payer. If the services were received by a TRICARE Prime enrollee (as indicated on DEERS), the contractor shall apply the Prime copayments. For a TRICARE Standard beneficiary, if a provider is known to be a network provider (e.g., Veteran Affairs Medical Center (VAMC)), the Extra cost-shares shall be applied. In all other cases, the TRICARE Standard cost-shares shall be applied.

6.2 Application Of Catastrophic Cap

Only the actual beneficiary out-of-pocket liability remaining after TRICARE payments will be counted for purposes of the annual catastrophic loss protection.

6.3 Appeals And Grievances

6.3.1 Initial Determinations

Services and supplies denied payment by Medicare will not be considered for coverage by TRICARE if the Medicare denial of payment is appealable under the Medicare appeal process. If, however, a Medicare appeal results in some payment by Medicare, the services and supplies

covered by Medicare will be considered for coverage by TRICARE. Services and supplies denied payment by Medicare will be considered for coverage by TRICARE, if the Medicare denial of payment is not appealable under the Medicare appeal process. The appeal procedures set forth in Chapter 12 are applicable to initial denial determinations by TRICARE under TDEFIC.

6.3.2 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 contractor or subcontractor personnel to furnish the level or quality of 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 or subcontractor to meet the obligations for timely, quality service may file a grievance. All grievances must be submitted in writing. If the written complaint reveals a TRICARE appealable issue, the correspondence shall be forwarded to the contractor's appeals unit for a reconsideration review. If the complaint reveals a Medicare appealable issue or regards care for which Medicare was the Primary payer and the issue does not involve any actions by a TRICARE contractor, the complaint shall be forwarded to Medicare for resolution. The beneficiary shall be notified that the complaint was forwarded to Medicare and the address and phone number of where the complaint was forwarded.

7.0 TED SUBMISSION

For every claim processed to completion, the TDEFIC contractor shall submit a TRICARE Encounter Data (TED) record to TMA in accordance with the requirements of the TRICARE Systems Manual (TSM).

8.0 TRICARE PROCESSING STANDARDS

All TRICARE Processing Standards in Chapter 1, Section 3 apply except for Chapter 1, Section 3, paragraph 1.2, and the following wording replaces the Chapter 1, Section 3, paragraph 1.7.1, Claim Payment Errors, requirements: "The absolute value of the payment errors shall not exceed 1.5% of the total billed charges."

- END -

Chapter 20 Section 4

Other Contract Requirements

1.0 CUSTOMER SERVICE

1.1 Telephone Inquiries

The contractor must provide nationwide around-the-clock toll-free telephone access to a customer service staff in order to enable providers and TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) beneficiaries to determine claims status as well as general TDEFIC information. Access outside of normal business hours for a Continental United States (CONUS) caller's time zone may be by automated means, such as provision for leaving messages and/or for obtaining information via an automated response mechanism. During normal CONUS business hours, callers must be offered the option of speaking live with a customer service representative. Responses must be furnished within the time frames mandated under TDEFIC.

1.2 Written Inquiries

The contractor must respond promptly and meaningfully to all written inquiries, including inquiries received via e-mail. Responses must be furnished within the time frames mandated under TDEFIC.

2.0 REFERRALS

All Military Health Systems (MHS) beneficiaries are allowed under the Managed Care Support (MCS) contract requirements to contact the TRICARE Service Center (TSC) for referrals to network providers. This shall continue with TRICARE/Medicare dual eligible individuals under TDEFIC. The Managed Care Support Contractor (MCSC) shall provide the TDEFIC beneficiary with the name, telephone number, and address of network providers of the appropriate clinical speciality located within the beneficiary's geographic area. The MCSC is not required to make appointments with network providers.

3.0 CONTRACTOR'S RESPONSIBILITY IN PROGRAM INTEGRITY

In relation to TDEFIC, at any time the contractor receives an allegation of fraudulent behavior, or any type of improper activity relating to either a beneficiary or provider submitted claim, the contractor shall review the claim to ensure it was processed properly by the TDEFIC contractor. Following completion of the review, if an error in payment is not detected, the contractor shall follow the requirements in Chapter 13.

4.0 MEDICARE CROSSOVER FEES

Medicare crossover fees are paid to Medicare contractors by the TRICARE Management Activity (TMA) contractors. These fees cover the transmission of data on paid claims from the

Medicare contractor to TMA contractors in order to facilitate TMA processing as second payer on the TRICARE For Life (TFL) claims. The contractor shall submit non-TRICARE Encounter Data (TED) vouchers covering these expenses to TMA on an as needed basis, generally once or twice a month.

5.0 THIRD PARTY RECOVERY CLAIMS

Any inpatient or outpatient claim with a diagnosis code of 800-999 which exceeds a TRICARE liability of $500 shall be considered a potential third party claim and shall be developed with the questionnaire, "Statement of Personal Injury - Possible Third Party Liability DD Form 2527." The remainder of Chapter 10, Section 5, paragraph 5.1.1 continues to apply.

- END -

multiple service locations. Upon TRICARE Area Office (TAO) Director request, the contractor shall provide copies of licensure/certification information for host nation providers.

4.5 The TOP contractor shall deny claims from non-certified host nation providers when TMA has directed that the country's host nation providers must be specially certified in order to receive TRICARE payments. See Section 14 for additional certification requirements.

- END -

Chapter 24 Section 26

Civilian Health Care (CHC) Of Uniformed Service Members

1.0 GENERAL

Active Duty Service Members (ADSMs) who are on permanent assignment in a location outside the 50 United States and the District of Columbia must enroll in TRICARE Overseas Program (TOP) Prime or TOP Prime Remote. ADSMs are not CHAMPUS-eligible and do not have the option to use TRICARE Standard or the Point of Service (POS) option under TOP Prime or TOP Prime Remote. Service members who would normally receive care from a host nation provider may be directed to transfer their care to a Military Treatment Facility (MTF). These controls ensure the maintenance of required fitness-for-duty oversight for TOP ADSMs. Refer to Section 9 for claims processing instructions.

2.0 CONTRACTOR RESPONSIBILITIES

2.1 ADSMs who are enrolled in TOP Prime must obtain a referral/authorization from their MTF Primary Care Manager (PCM) for all non-emergent health care services obtained from a host nation network or non-network provider. ADSMs who are enrolled in TOP Prime Remote must seek authorization from the TOP contractor for all non-emergent specialty and inpatient care. ADSMs not enrolled in TOP who are on Temporary Additional Duty/Temporary Duty (TAD/TDY), deployed, deployed on liberty, or in an authorized leave status outside the fifty United States and the District of Columbia shall follow referral/authorization guidelines for TOP Prime Remote enrollees.

2.2 If an ADSM seeks host nation care without appropriate authorization, they put themselves at financial risk for claims payment. They are also at risk for potential compromise of medical readiness posture, flight status, or disability benefits, and they may be subject to disciplinary action for disregarding service-specific policy. Lost work time may be charged as ordinary leave.

2.3 Each TRICARE Area Office (TAO) shall establish processes for ADSM referrals/authorizations in remote locations, including referrals for routine screenings and military-specific requirements. These processes may vary by region. The TOP contractor shall comply with TAO guidance regarding ADSM referrals/authorizations, to include screening specialty care referrals to assist with the identification of potential fitness-for-duty issues to the designated government Point of Contact (POC).

2.4 Normal TRICARE coverage limitations will not apply to services that have been authorized for coverage for TOP ADSMs. Services that have been authorized for TOP ADSMs will be covered regardless of whether they would have ordinarily been covered under TRICARE policy.

2.5 When an MTF referral directs evaluation or treatment of an ADSM's condition, as opposed to directing a specific service(s), the TOP contractor shall use its best business practices in determining the services encompassed within the Episode of Care (EOC), indicated by the referral. The services may include laboratory tests, radiology tests, echocardiogram, holter monitors, pulmonary

function tests, and routine treadmills associated with that EOC. A separate MTF authorization for these services is not required. If a civilian provider requests additional treatment outside of the original EOC, the contractor shall contact the referring or enrolling MTF for approval.

2.6 The TOP contractor shall process self-referred TOP ADSM claims according to the provisions of Section 9.

Note: TOP MTFs are responsible for processing claims for MTF-referred ADSM care.

2.7 The TOP contractor shall use the same best business practices as used for other TOP Prime or TOP Prime Remote enrollees in determining EOC when ADSM claims are received with lines of care that contain both MTF-referred and non-referred lines. Claims received which contain services outside the originally referred EOC on an ADSM must come back to the PCM for approval. Laboratory tests, radiology tests, echocardiograms, holder monitors, pulmonary function tests, and routine treadmills associated with that EOC may be considered part of the originally requested services and do not need to come back to the PCM for approval.

2.8 When an ADSM leaves a remote TOP assignment as a result of Permanent Change of Station (PCS) or other service-related change of duty status, the PCM shall provide a complete copy of medical records, to include copies of specialty and ancillary care documentation, to ADSMs within 30 calendar days of the ADSM's request for the records. The ADSM may also request copies of medical care documentation (specialty care visits and discharge summaries) on an ongoing, EOC basis. Records provided by host nation providers in languages other than English may be submitted to the TOP contractor for translation into English according to the terms of the contract. Network host nation providers shall be reimbursed for medical records photocopying and postage costs incurred at the rates established in their network provider participation agreements. Non-network host nation providers shall be reimbursed for medical records photocopying and postage costs on the basis of billed charges unless the government has directed a lower reimbursement rate. ADSMs who have paid for copied records and applicable postage costs shall be reimbursed for the full amount paid to ensure they have no out-of-pocket expenses. All providers and/or ADSMs must submit a claim form, with the charges clearly identified, to the contractor for reimbursement.

Note: The purpose of copying medical records is to assist the ADSM in maintaining accurate and current medical documentation. The contractor shall not make payment to a host nation provider who photocopies medical records to support the adjudication of a claim.

2.9 Provision of Respite Care For The Benefit of Seriously Ill or Injured Active Duty Members

2.9.1 The provisions of the Chapter 17, Section 3 and the TRICARE Systems Manual (TSM), Chapter 2, Sections 2.8 and 6.4 regarding respite care for seriously ill or injured ADSMs are applicable in locations outside the 50 United States and the District of Columbia where TRICARE-authorized Home Health Agencies (HHAs) have been established.

2.9.2 The respite care benefit is applicable to ADSMs enrolled to TOP Prime, TOP Prime Remote, and to any ADSM referred by an overseas MTF or TAO.

2.9.3 All normal ADSM authorization and case management requirements for the TOP apply to the ADSM respite care benefit.

- END -

Appendix A

Acronyms And Abbreviations

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
AC	Active Component
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
ACSP	Autism Demonstration Corporate Services Provider
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
ADSM	Active Duty Service Member
AF	Atrial Fibrillation
AFOSI	Air Force Office of Special Investigations
AGR	Active Guard/Reserve
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 Undetermind Significance
ASD	Assistant Secretary of Defense Atrial Septal Defect Autism Spectrum Disorder
ASD(C3I)	Assistant Secretary of Defense for Command, Control, Communications, and Intelligence
ASD(HA)	Assistant Secretary of Defense (Health Affairs)
ASD (MRA&L)	Assistant Secretary of Defense for Manpower, Reserve Affairs, and Logistics
ASP	Average Sale Price
ATB	All Trunks Busy
ATO	Approval to Operate
AVM	Arteriovenous Malformation
AWOL	Absent Without Leave
AWP	Average Wholesale Price
B&PS	Benefits and Provider Services
B2B	Business to Business
BACB	Behavioral Analyst Certification Board
BBA	Balanced Budget Act
BBP	Bloodborne Pathogen
BBRA	Balanced Budget Refinement Act
BCABA	Board Certified Associate Behavior Analyst
BCAC	Beneficiary Counseling and Assistance Coordinator
BCBA	Board Certified Behavior Analyst
BCBS	Blue Cross Blue Shield
BC	Birthing Center
BCC	Biostatistics Center
BI	Background Investigation
BIPA	Benefits Improvement Protection Act
BL	Black Lung
BLS	Basic Life Support
BMT	Bone Marrow Transplantation
BP	Behavioral Plan
BPC	Beneficiary Publication Committee
BPS	Beneficiary and Provider Services
BRAC	Base Realignment and Closure
BRCA	BReast CAncer
BS	Bachelor of Science
BSID	Bayley Scales of Infant Development
BSR	Beneficiary Service Representative
BWE	Beneficiary Web Enrollment
C&A	Certification and Accreditation
C&CS	Communications and Customer Service

C/S	Client/Server
CA	Care Authorization
CA/NAS	Care Authorization/Non-Availability Statement
CABG	Coronary Artery Bypass Craft
CAC	Common Access Card
CAD	Coronary Artery Disease
CAF	Central Adjudication Facility
CAH	Critical Access Hospital
CAP/DME	Capital and Direct Medical Education
CAPD	Continuous Ambulatory Peritoneal Dialysis
CAPP	Controlled Access Protection Profile
CAT	Computerized Axial Tomography
CB	Consolidated Billing
CBC	Cypher Block Chaining
CBHCO	Community-Based Health Care Organizations
CBSA	Core Based Statistical Area
CC	Common Criteria Criminal Control (Act)
CC&D	Catastrophic Cap and Deductible
CCDD	Catastrophic Cap and Deductible Data
CCEP	Comprehensive Clinical Evaluation Program
CCMHC	Certified Clinical Mental Health Counselor
CCN	Case Control Number
CCPD	Continuous Cycling Peritoneal Dialysis
CCR	Cost-To-Charge Ratio
CCTP	Custodial Care Transitional Policy
CD	Compact Disc
CDC	Centers for Disease Control and Prevention
CDCF	Central Deductible and Catastrophic Cap File
CDD	Childhood Disintegrative Disorder
CDH	Congenital Diaphragmatic Hernia
CD-I	Compact Disc - Interactive
CDR	Clinical Data Repository
CDRL	Contract Data Requirements List
CD-ROM	Compact Disc - Read Only Memory
CDT	Current Dental Terminology
CEIS	Corporate Executive Information System
CEO	Chief Executive Officer
CEOB	CHAMPUS Explanation of Benefits
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CFS	Chronic Fatigue Syndrome

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
CHAMPVA	Civilian Health and Medical Program of the Department of Veteran Affairs
CHBC	Criminal History Background Check
CHBR	Criminal History Background Review
CHC	Civilian Health Care
CHCBP	Continued Health Care Benefits Program
CHCS	Composite Health Care System
CHEA	Council on Higher Education Accreditation
CHKT	Combined Heart-Kidney Transplant
CHOP	Children's Hospital of Philadelphia
CI	Counterintelligence
CIA	Central Intelligence Agency
CIF	Central Issuing Facility
CIO	Chief Information Officer
CIPA	Classified Information Procedures Act
CJCSM	Chairman of the Joint Chiefs of Staff Manual
CL	Confidentiality Level (Classified, Public, Sensitive)
CLIA	Clinical Laboratory Improvement Amendment
CLIN	Contract Line Item Number
CLKT	Combined Liver-Kidney Transplant
CLL	Chronic Lymphocytic Leukemia
CMAC	CHAMPUS Maximum Allowable Charge
CMHC	Community Mental Health Center
CML	Chronic Myelogenous Leukemia
CMN	Certificate(s) of Medical Necessity
CMO	Chief Medical Officer
CMP	Civil Money Penalty
CMS	Centers for Medicare and Medicaid Services
CMVP	Cryptographic Module Validation Program
CNM	Certified Nurse Midwife
CNS	Central Nervous System Clinical Nurse Specialist
CO	Contracting Officer
COB	Close of Business Coordination of Benefits
COBC	Coordination of Benefits Contractor
COBRA	Consolidated Omnibus Budget Reconciliation Act
CoCC	Certificate of Creditable Coverage
COCO	Contractor Owned-Contractor Operated
COE	Common Operating Environment
CONUS	Continental United States
COO	Chief Operating Officer

COOP	Continuity of Operations Plan
COPA	Council on Postsecondary Accreditation
COPD	Chronic Obstructive Pulmonary Disease
COR	Contracting Officer's Representative
CORF	Comprehensive Outpatient Rehabilitation Facility
CORPA	Commission on Recognition of Postsecondary Accreditation
COTS	Commercial-off-the-shelf
CPA	Certified Public Accountant
CPE	Contract Performance Evaluation
CPI	Consumer Price Index
CPI-U	Consumer Price Index - Urban (Wage Earner)
CPNS	Certified Psychiatric Nurse Specialists
CPR	CAC PIN Reset
CPT	Chest Physiotherapy Current Procedural Terminology
CPT-4	Current Procedural Terminology, 4th Edition
CQMP	Clinical Quality Management Program
CQMP AR	Clinical Quality Management Program Annual Report
CQS	Clinical Quality Studies
CRM	Contract Resource Management (Directorate)
CRNA	Certified Registered Nurse Anesthetist
CRT	Computer Remote Terminal
CSA	Clinical Support Agreement
CSE	Communications Security Establishment (of the Government of Canada)
CSP	Corporate Service Provider Critical Security Parameter
CST	Central Standard Time
CSU	Channel Sending Unit
CSV	Comma-Separated Value
CSW	Clinical Social Worker
CT	Central Time Computerized Tomography
CTC	Computed Tomographic Colonography
CTCL	Cutaneous T-Cell Lymphoma
CTEP	Cancer Therapy Evaluation Program
CVAC	CHAMPVA Center
CVS	Contractor Verification System
CY	Calendar Year
DAA	Designated Approving Authority
DAO	Defense Attache Offices
DBA	Doing Business As
DC	Direct Care
DCAA	Defense Contract Audit Agency

DCAO	Debt Collection Assistance Officer
DCID	Director of Central Intelligence Directive
DCII	Defense Clearance and Investigation Index
DCIS	Defense Criminal Investigating Service
DCN	Document Control Number
DCP	Data Collection Period
DCR	Developed Character Reference
DCS	Duplicate Claims System
DCSI	Defense Central Security Index
DD (Form)	Department of Defense (Form)
DDAS	DCII Disclosure Accounting System
DDP	Dependent Dental Plan
DDS	DEERS Dependent Suffix
DE	Durable Equipment
DECC	Defense Enterprise Computing Center
DED	Dedicated Emergency Department
DEERS	Defense Enrollment Eligibility Reporting System
DELM	Digital Epiluminescence Microscopy
DENC	Detailed Explanation of Non-Concurrence
DepSecDef	Deputy Secretary of Defense
DES	Data Encryption Standard
DFAS	Defense Finance and Accounting Service
DG	Diagnostic Group
DGH	Denver General Hospital
DHHS	Department of Health and Human Services
DHP	Defense Health Program
DIA	Defense Intelligence Agency
DIACAP	DoD Information Assurance Certification And Accreditation Process
DII	Defense Information Infrastructure
DIS	Defense Investigative Service
DISA	Defense Information System Agency
DISCO	Defense Industrial Security Clearance Office
DISN	Defense Information Systems Network
DISP	Defense Industrial Security Program
DITSCAP	DoD Information Technology Security Certification and Accreditation Process
DLAR	Defense Logistics Agency Regulation
DLE	Dialyzable Leukocyte Extract
DM	Disease Management
DMDC	Defense Manpower Data Center
DME	Durable Medical Equipment
DMEPOS	Durable medical equipment, prosthetics, orthotics, and supplies
DMI	DMDC Medical Interface

DMIS	Defense Medical Information System
DMIS-ID	Defense Medical Information System Identification (Code)
DMLSS	Defense Medical Logistics Support System
DMZ	Demilitarized Zone
DNA	Deoxyribonucleic Acid
DNA-HLA	Deoxyribonucleic Acid - Human Leucocyte Antigen
DNACI	DoD National Agency Check Plus Written Inquiries
DO	Doctor of Osteopathy Operations Directorate
DOB	Date of Birth
DoD	Department of Defense
DoD AI	Department of Defense Administrative Instruction
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DoDIG	Department of Defense Inspector General
DoD P&T	Department of Defense Pharmacy and Therapeutics (Committee)
DOE	Department of Energy
DOEBA	Date of Earliest Billing Action
DOES	DEERS Online Enrollment System
DOHA	Defense Office of Hearings and Appeals
DOJ	Department of Justice
DOLBA	Date of Latest Billing Action
DOS	Date Of Service
DP	Designated Provider
DPA	Differential Power Analysis
DPI	Designated Providers Integrator
DPO	DEERS Program Office
DRA	Deficit Reduction Act
DREZ	Dorsal Root Entry Zone
DRG	Diagnosis Related Group
DRPO	DEERS RAPIDS Program Office
DSAA	Defense Security Assistance Agency
DSC	DMDC Support Center
DSCC	Data and Study Coordinating Center
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSM-III	Diagnostic and Statistical Manual of Mental Disorders, Third Edition
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DSMC	Data and Safety Monitoring Committee
DSMO	Designated Standards Maintenance Organization
DSO	DMDC Support Office
DSU	Data Sending Unit
DTF	Dental Treatment Facility

DTR	Derived Test Requirements
DTRO	Director, TRICARE Regional Office
DUA	Data Use Agreement
DVA	Department of Veterans Affairs
DVAHCF	Department of Veterans Affairs Health Care Finder
DVD	Digital Video Disc
DWR	DSO Web Request
Dx	Diagnosis
DXA	Dual Energy X-Ray Absorptiometry
ECAS	European Cardiac Arrhythmia Society
EHRA	European Heart Rhythm Association
E-ID	Early Identification
E-NAS	Electronic Non-Availability Statement
E&M	Evaluation & Management
E2R	Enrollment Eligibility Reconciliation
EAL	Common Criteria Evaluation Assurance Level
EAP	Ethandamine phosphate
EBC	Enrollment Based Capitation
ECA	External Certification Authority
ECG	Electrocardiogram
ECHO	Extended Care Health Option
ECT	Electroconvulsive Therapy
ED	Emergency Department
EDC	Error Detection Code
EDI	Electronic Data Information Electronic Data Interchange
EDIPI	Electronic Data Interchange Person Identifier
EDIPN	Electronic Data Interchange Person Number
EDI_PN	Electronic Data Interchange Patient Number
EEG	Electroencephalogram
EEPROM	Erasable Programmable Read-Only Memory
EFM	Electronic Fetal Monitoring
EFMP	Exceptional Family Member Program
EFP	Environmnetal Failure Protection
EFT	Electronic Funds Transfer Environmental Failure Testing
EGHP	Employer Group Health Plan
E/HPC	Enrollment/Health Plan Code
EHHC	ECHO Home Health Care Extended Care Health Option Home Health Care
EHP	Employee Health Program
EIA	Educational Interventions for Autism Spectrum Disorders
EIDS	Executive Information and Decision Support

EIN	Employer Identification Number
EIP	External Infusion Pump
EKG	Electrocardiogram
ELN	Element Locator Number
ELISA	Enzyme-Linked Immunoabsorbent Assay
E/M	Evaluation and Management
EMC	Electronic Media Claim Enrollment Management Contractor
EMDR	Eye Movement Desensitization and Reprocessing
EMG	Electromyograma
EMTALA	Emergency Medical Treatment & Active Labor Act
ENTNAC	Entrance National Agency Check
EOE	Evoked Otoacoustic Emission
EOB	Explanation of Benefits
EOBs	Explanations of Benefits
EOC	Episode of Care
EOG	Electro-oculogram
EOMB	Explanation of Medicare Benefits
ePHI	electronic Protected Health Information
EPO	Erythropoietin Exclusive Provider Organization
EPR	EIA Program Report
EPROM	Erasable Programmable Read-Only Memory
ER	Emergency Room
ERISA	Employee Retirement Income and Security Act of 1974
ESRD	End Stage Renal Disease
EST	Eastern Standard Time
ESWT	Extracorporeal Shock Wave Therapy
ET	Eastern Time
ETIN	Electronic Transmitter Identification Number
EWPS	Enterprise Wide Provider System
EWRAS	Enterprise Wide Referral and Authorization System
F&AO	Finance and Accounting Office(r)
FAR	Federal Acquisition Regulations
FASB	Federal Accounting Standards Board
FBI	Federal Bureau of Investigation
FCC	Federal Communications Commission
FCCA	Federal Claims Collection Act
FDA	Food and Drug Administration
FDB	First Data Bank
FDL	Fixed Dollar Loss
Fed	Federal Reserve Bank

FEHBP	Federal Employee Health Benefit Program
FEL	Familial Erythrophagocytic Lymphohistiocytosis
FEV_1	Forced Expiratory Volume
FFM	Foreign Force Member
FHL	Familial Hemophagocytic Lymphohistiocytosis
FI	Fiscal Intermediary
FIPS	Federal Information Processing Standards (or System)
FIPS PUB	FIPS Publication
FISH	Fluorescence In Situ Hybridization
FISMA	Federal Information Security Management Act
FL	Form Locator
FMCRA	Federal Medical Care Recovery Act
FOBT	Fecal Occult Blood Testing
FOC	Full Operational Capability
FOIA	Freedom of Information Act
FPO	Fleet Post Office
FQHC	Federally Qualified Health Center
FR	Federal Register Frozen Records
FRC	Federal Records Center
FTE	Full Time Equivalent
FTP	File Transfer Protocol
FX	Foreign Exchange (lines)
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GAO	General Accounting Office
GBL	Government Bill of Lading
GDC	Guglielmi Detachable Coil
GFE	Government Furnished Equipment
GHz	Gigahertz
GIFT	Gamete Intrafallopian Transfer
GIQD	Government Inquiry of DEERS
GP	General Practitioner
GPCI	Geographic Practice Cost Index
H/E	Health and Environment
HAC	Health Administration Center Hospital Acquired Condition
HAVEN	Home Assessment Validation and Entry
HBA	Health Benefits Advisor
HBO	Hyperbaric Oxygen Therapy
HCC	Health Care Coverage
HCDP	Health Care Delivery Program

HCF	Health Care Finder
HCFA	Health Care Financing Administration
HCG	Human Chorionic Gonadotropin
HCIL	Health Care Information Line
HCP	Health Care Provider
HCPC	Healthcare Common Procedure Code (formerly HCFA Common Procedure Code)
HCPCS	Healthcare Common Procedure Coding System (formerly Healthcare Common Procedure Coding System)
HCPR	Health Care Provider Record
HCSR	Health Care Service Record
HDC	High Dose Chemotherapy
HDC/SCR	High Dose Chemotherapy with Stem Cell Rescue
HDL	Hardware Description Language
HEAR	Health Enrollment Assessment Review
HEDIS	Health Plan Employer Data and Information Set
HepB-Hib	Hepatitis B and Hemophilus influenza B
HHA	Home Health Agency
HHA PPS	Home Health Agency Prospective Payment System
HHC	Home Health Care
HHC/CM	Home Health Care/Case Management
HHRG	Home Health Resource Group
HHS	Health and Human Services
HI	Health Insurance
HIC	Health Insurance Carrier
HICN	Health Insurance Claim Number
HINN	Hospital-Issued Notice Of Noncoverage
HIPAA	Health Insurance Portability and Accountability Act (of 1996)
HIPPS	Health Insurance Prospective Payment System
HIQH	Health Insurance Query for Health Agency
HIV	Human Immunodeficiency Virus
HL7	Health Level 7
HLA	Human Leukocyte Antigen
HMAC	Hash-Based Message Authentication Code
HMO	Health Maintenance Organization
HNPCC	Hereditary Nonpolposis Colorectal Cancer
HPA&E	Health Program Analysis & Evaluation
HPSA	Health Professional Shortage Area
HPV	Human Papilloma Virus
HRG	Health Resource Group
HRS	Heart Rhythm Society
HRT	Heidelberg Retina Tomograph Hormone Replacement Therapy

HSCRC	Health Services Cost Review Commission
HTML	HyperText Markup Language
HTTP	HyperText Transfer (Transport) Protocol
HTTPS	Hypertext Transfer (Transport) Protocol Secure
HUAM	Home Uterine Activity Monitoring
HUD	Humanitarian Use Device
HUS	Hemolytic Uremic Syndrome
HVPT	Hyperventilation Provocation Test
IA	Information Assurance
IATO	Interim Approval to Operate
IAVA	Information Assurance Vulnerability Alert
IAVB	Information Assurance Vulnerability Bulletin
IAVM	Information Assurance Vulnerability Management
IAW	In accordance with
IC	Individual Consideration Integrated Circuit
ICASS	International Cooperative Administrative Support Services
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICF	Intermediate Care Facility
ICMP	Individual Case Management Program
ICMP-PEC	Individual Case Management Program For Persons With Extraordinary Conditions
ICN	Internal Control Number
ICSP	Individual Corporate Services Provider
ID	Identification Identifier
IDE	Investigational Device Exemption Investigational Device
IDEA	Individuals with Disabilities Education Act
IDET	Intradiscal Electrothermal Therapy
IDME	Indirect Medical Education
IdP	Identity Protection
IE	Interface Engine Internet Explorer
IEP	Individualized Educational Program
IFSP	Individualized Family Service Plan
IG	Implementation Guidance
IGCE	Independent Government Cost Estimate
IHI	Institute for Healthcare Improvement
IHS	Indian Health Service
IIHI	Individually Identifiable Health Information
IIP	Implantable Infusion Pump
IM	Information Management Intramuscular

IMRT	Intensity Modulated Radiation Therapy
IND	Investigational New Drugs
INR	International Normalized Ratio Intramuscular International Normalized Ratio
INS	Immigration and Naturalization Service
IOC	Initial Operational Capability
IOD	Interface Operational Description
IOLs	Intraocular Lenses
IOM	Internet Only Manual
IORT	Intra-Operative Radiation Therapy
IP	Inpatient
IPC	Information Processing Center (outdated term, see SMC)
IPN	Intraperitoneal Nutrition
IPPS	Inpatient Prospective Payment System
IPS	Individual Pricing Summary
IPSEC	Secure Internet Protocol
IQ	Intelligence Quotient
IQM	Internal Quality Management
IRB	Institutional Review Board
IRR	Individual Ready Reserve
IRS	Internal Revenue Service
IRTS	Integration and Runtime Specification
IS	Information System
ISN	Investigation Schedule Notice
ISO	International Standard Organization
ISP	Internet Service Provider
IT	Information Technology
ITSEC	Information Technology Security Evaluation Criteria
IV	Initialization Vector Intravenous
IVF	In Vitro Fertilization
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCOS	Joint Chiefs of Staff
JFTR	Joint Federal Travel Regulations
JNI	Japanese National Insurance
JTF-GNO	Joint Task Force for Global Network Operations
JUSDAC	Joint Uniformed Services Dental Advisory Committee
JUSMAC	Joint Uniformed Services Medical Advisory Committee
JUSPAC	Joint Uniformed Services Personnel Advisory Committee
KB	Knowledge Base
KO	Contracting Officer
LAA	Limited Access Authorization

LAC	Local Agency Check
LAK	Lymphokine-Activated Killer
LAN	Local Area Network
LASER	Light Amplification by Stimulated Emission of Radiation
LCF	Long-term Care Facility
LDL	Low Density Lipoprotein
LDLT	Living Donor Liver Transplantation
LOC	Letter of Consent
LOD	Letter of Denial/Revocation
LOI	Letter of Intent
LOS	Length-of-Stay
LOT	Life Orientation Test
LPN	Licensed Practical Nurse
LSIL	Low-grade Squamous Itraepithelial
LSN	Location Storage Number
LTC	Long-Term Care
LUPA	Low Utilization Payment Adjustment
LVEF	Left Ventricular Ejection Fraction
LVN	Licensed Vocational Nurse
LVRS	Lung Volume Reduction Surgery
MAC	Maximum Allowable Charge Maximum Allowable Cost
MAC III	Mission Assurance Category III
MAID	Maximum Allowable Inpatient Day
MB&RB	Medical Benefits and Reimbursement Branch
MCIO	Military Criminal Investigation Organization
MCS	Managed Care Support
MCSC	Managed Care Support Contractor
MCSS	Managed Care Support Services
MCTDP	Myelomeningocele Clinical Trial Demonstration Protocol
MD	Doctor of Medicine
MDI	Mental Developmental Index
MDR	MHS Data Repository
MDS	Minimum Data Set
MEC	Marketing and Education Committee
MEI	Medicare Economic Index
MEPS	Military Entrance Processing Station
MEPRS	Medical Expense Performance Reporting System
MFCC	Marriage and Family Counseling Center
MGCRB	Medicare Geographic Classification Review Board
MGIB	Montgomery GI Bill
MHO	Medical Holdover

MHS	Military Health System
MHSO	Managing Health Services Organization
MHSS	Military Health Services System
MI	Myocardial Infarction
MI&L	Manpower, Installations, and Logistics
MIA	Missing In Action
MIDCAB	Minimally Invasive Direct Coronary Artery Bypass
MIRE	Monochromatic Infrared Energy
MMA	Medicare Modernization Act
MMP	Medical Management Program
MMSO	Military Medical Support Office
MMWR	Morbidity and Mortality Weekly Report
MNR	Medical Necessity Report
MOA	Memorandum of Agreement
MOMS	Management of Myelomeningocele Study
MOP	Mail Order Pharmacy
MOU	Memorandum of Understanding
MPI	Master Patient Index
MR	Medical Review Mentally Retarded
MRA	Magnetic Resonance Angiography
MRI	Magnetic Resonance Imaging
MRPU	Medical Retention Processing Unit
MS	Microsoft®
MSA	Metropolitan Statistical Area
MSC	Military Sealift Command
MSIE	Microsoft® Internet Explorer
MSP	Medicare Secondary Payer
MST	Mountain Standard Time
MSUD	Maple Syrup Urine Disease
MSW	Masters of Social Work Medical Social Worker
MT	Mountain Time
MTF	Military Treatment Facility
MV	Multivisceral (transplant)
MVS	Multiple Virtual Storage
MWR	Morale, Welfare, and Recreation
N/A	Not Applicable
N/D	No Default
NAC	National Agency Check
NACI	National Agency Check Plus Written Inquiries
NACLC	National Agency Check with Law Enforcement and Credit

NADFM	Non-Active Duty Family Member
NARA	National Archives and Records Administration
NAS	Non-Availability Statement
NATO	North Atlantic Treaty Organization
NAVMED	Naval Medical (Form)
NBCC	National Board of Certified Counselors
NCCI	National Correct Coding Initiatives
NCF	National Conversion Factor
NCI	National Cancer Institute
NCPAP	Nasal Continuous Positive Airway Pressure
NCPDP	National Council of Prescription Drug Program
NCQA	National Committee for Quality Assurance
NCVHS	National Committee on Vital and Health Statistics
NDAA	National Defense Authorization Act
NDC	National Drug Code
NDMS	National Disaster Medical System
NED	National Enrollment Database
NETT	National Emphysema Treatment Trial
NF	Nursing Facility
NHLBI	National Heart, Lung and Blood Institute
NHSC	National Health Service Corps
NICHD	National Institute of Child Health and Human Development
NIH	National Institutes of Health
NII	Networks and Information Integration
NIPRNET	Nonsecure Internet Protocol Router Network
NIS	Naval Investigative Service
NISPOM	National Industrial Security Program Operating Manual
NIST	National Institute of Standards and Technology
NLT	No Later Than
NMES	Neuromuscular Electrical Stimulation
NMOP	National Mail Order Pharmacy
NMR	Nuclear Magnetic Resonance
NMT	Nurse Massage Therapist
NOAA	National Oceanic and Atmospheric Administration
NoPP	Notice of Private Practices
NOSCASTC	National Operating Standard Cost as a Share of Total Costs
NP	Nurse Practitioner
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPR	Notice of Program Reimbursement
NPS	Naval Postgraduate School

NQF	National Quality Forum
NRC	Nuclear Regulatory Commission
NTIS	National Technical Information Service
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claims Committee
O/ATIC	Operations/Advanced Technology Integration Center
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)
OASD (H&E)	Office of the Assistant Secretary of Defense (Health and Environment)
OASD (MI&L)	Office of the Assistant Secretary of Defense (Manpower, Installations, and Logistics)
OASIS	Outcome and Assessment Information Set
OB/GYN	Obstetrician/Gynecologist
OBRA	Omnibus Budget Reconciliation Act
OCE	Outpatient Code Editor
OCHAMPUS	Office of Civilian Health and Medical Program of the Uniformed Services
OCONUS	Outside of the Continental United States
OCR	Office of Civil Rights
OCSP	Organizational Corporate Services Provider
OD	Optical Disk
OGC	Office of General Counsel
OGP	Other Government Program
OHI	Other Health Insurance
OHS	Office of Homeland Security
OIG	Office of Inspector General
OMB	Office of Management and Budget
OP/NSP	Operation/Non-Surgical Procedure
OPD	Outpatient Department
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
OSA	Obstructive Sleep Apnea
OSAS	Obstructive Sleep Apnea Syndrome
OSD	Office of the Secretary of Defense
OSHA	Occupational Safety and Health Act
OSS	Office of Strategic Services
OT	Occupational Therapy (Therapist)
OTC	Over-The-Counter
OUSD	Office of the Undersecretary of Defense
OUSD (P&R)	Office of the Undersecretary of Defense (Personnel and Readiness)
P/O	Prosthetic and Orthotics
P&T	Pharmacy And Therapeutics (Committee)
PA	Physician Assistant
PACAB	Port Access Coronary Artery Bypass

$PACO_2$	Partial Pressure of Carbon Dioxide
PAO_2	Partial Pressure of Oxygen
PAK	Pancreas After Kidney (transplant)
PAP	Papanicolaou
PAT	Performance Assessment Tracking
PatID	Patient Identifier
PAVM	Pulmonary Arteriovenous Malformation
PBM	Pharmacy Benefit Manager
PC	Personal Computer Professional Component
PCA	Patient Controlled Analgesia
PCDIS	Purchased Care Detail Information System
PCI	Percutaneous Coronary Intervention
PCM	Primary Care Manager
PCMBN	PCM By Name
PCMRA	PCM Research Application
PCMRS	PCM Panel Reassignment (Application) PCM Reassignment System
PCO	Procurement (Procuring) Contracting Officer
PCP	Primary Care Physician Primary Care Provider
PCS	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
PFP	Partnership For Peace
PFPWD	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
PK	Public Key
PKE	Public Key Enabling
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
POA	Power of Attorney Present On Admission
POA&M	Plan of Action and Milestones
POC	Pharmacy Operations Center Plan of Care Point of Contact
POL	May 1996 TRICARE/CHAMPUS Policy Manual 6010.47-M
POS	Point of Sale (Pharmacy only) Point of Service Public Official's Statement
POV	Privately Owned Vehicle
PPD	Per Patient Day
PPN	Preferred Provider Network
PPO	Preferred Provider Organization
PPP	Purchasing Power Parity
PPS	Prospective Payment System Ports, Protocols and Services
PPSM	Ports, Protocols, and Service Management
PPV	Pneumococcal Polysaccharide Vaccine
PQI	Potential Quality Indicator Potential Quality Issue

PR	Periodic Reinvestigation
PRC	Program Review Committee
PRG	Peer Review Group
PRO	Peer Review Organization
ProDUR	Prospective Drug Utilization Review
PROM	Programmable Read-Only Memory
PRP	Personnel Reliability Program
PRPP	Pharmacy Redesign Pilot Project
PSA	Prime Service Area Physician Scarcity Area
PSAB	Personnel Security Appeals Board
PSCT	Peripheral Stem Cell Transplantation
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
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
RDDB	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
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) Special Indicator (code) 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
SPA	Simple Power Analysis
SPECT	Single Photon Emission Computed Tomography
SPK	Simultaneous Pancreas Kidney (transplant)
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
SUBID	Sub-Identifier
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
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
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
USFHP	Uniformed Services Family Health Plan
USHBP	Uniformed Services Health Benefit Plan
USMC	United States Marine Corps
USMTF	Uniformed Services Medical Treatment Facility
USN	United States Navy
USPDI	United States Pharmacopoeia Drug Information
USPHS	United States Public Health Service
USPS	United States Postal Service
USPSTF	U.S. Preventive Services Task Force
USS	United Seaman's Service
USTF	Uniformed Services Treatment Facility
UV	Ultraviolet
VA	Veterans Affairs (hospital) Veterans Administration

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)
WII	Wounded, Ill, and Injured
WLAN	Wireless Local Area Network
WORM	Write Once Read Many
WRAMC	Walter Reed Army Medical Center
WTC	World Trade Center
WTRR	Wire Transfer Reconciliation Report
WTU	Warrior Transition Unit
X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome
XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer

- END -

Appendix B

Definitions

Absent Treatment

Services performed by Christian Science practitioners for a person when the person is not physically present. Technically, "Absent Treatment" is an obsolete term. The current Christian Science terminology is "treatment through prayer and spiritual means," which is employed by an authorized Christian Science practitioner either with the beneficiary being present or absent. However, to be considered for coverage under TRICARE, the beneficiary must be present physically when a Christian Science service is rendered, regardless of the terminology used.

Abuse

Any practice that is inconsistent with accepted sound fiscal, business, or professional practice which results in a TRICARE claim, unnecessary cost, or TRICARE payment for services or supplies that are:

1. Not within the concepts of medically necessary and appropriate care, as defined in the Regulation (32 CFR 199), or

2. That fail to meet professionally recognized standards for Health Care Providers (HCPs).

The term "abuse" includes deception or misrepresentation by a provider, or any person or entity acting on behalf of a provider in relation to a TRICARE claim.

Note: Unless a specific action is deemed gross and flagrant, a pattern of inappropriate practice will normally be required to find that abuse has occurred. Any practice or action that constitutes fraud, as defined by the Regulation (32 CFR 199), would also be abuse.

Access, Health Care

The ability to receive necessary health care services of high quality within the time frames, at the locations and from the providers that satisfy patient needs and desires.

Access, Information

1. The availability of or the permission to consult records, archives, or manuscripts.

2. The ability and opportunity to obtain sensitive, classified, or administratively controlled information or records.

Access Standards

Beneficiary access standards broken into three categories, each defined as follows:

1. Urban. A five digit zip code in which the population density is greater than 3,000 persons per square mile.

2. Suburban. A five digit zip code in which the population density is between 1,000 and 3,000 persons per square mile.

3. Rural. A five digit zip code in which the population density is less than 1,000 persons per square mile.

Action Plan

A contractor's plan for achieving a goal through the use of specific resources based on a time-oriented schedule of activities.

Active Duty

Full-time duty in the Uniformed Services of the United States. It includes duty on the active list, full-time training duty, annual training duty, and attendance while in the active Military Service, at a school designated as a Service school by law or by the Secretary of the Military Department concerned.

Active Duty Member

A person on active duty in a Uniformed Service under a call or order that does not specify a period of 30 days or less.

Activities of Daily Living (ADL) (Respite Care Definition)

Care that consists of providing food (including special diets), clothing and shelter; personal hygiene services; observation and general monitoring; bowel training or management (unless abnormalities in bowel function are of a severity to result in a need for medical or surgical intervention in the absence of skilled services); safety precautions; general preventive procedures (such as turning to prevent bedsores); passive exercise; companionship; recreation; transportation; and other such elements of personal care that can reasonably be performed by an untrained adult with minimal instruction or supervision. ADL may also be referred to as "essentials of daily living".

Adjunctive Dental Care

Dental care that is medically necessary in the treatment of an otherwise covered medical (not dental) condition, is an integral part of the treatment of such medical condition, and is essential to the control of the primary medical condition; or, is required in preparation for or as the result of dental trauma which may be or is caused by medically necessary treatment of an injury or disease (iatrogenic).

Adjustment

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

Adjustment, Identification Of (Receipt)

An adjustment may be generated by a telephonic, written or personal inquiry, appeal decision, or as the result of a contractor's internal review. The adjustment is identified when the contractor's staff determines the issue requires an additional payment, cancellation, or a change to the Beneficiary History and Deductible Files (see definition) or when notice is received from TRICARE Management Activity (TMA) that an adjustment is required. In the case of recoupments, the adjustment is "identified" for reporting purposes, with receipt of the payment by the contractor.

Administrative Fee, Pharmacy

The offered price that represents all administrative charges relative to prescription, prior authorization and medical necessity determination transaction processing.

All-Inclusive Per Diem Rate

The TMA-determined rate that encompasses the daily charge for inpatient care and, unless specifically excepted, all other treatment determined necessary and rendered as part of the treatment plan established for a patient.

Allowable Charge

The TRICARE-determined level of payment to physicians and other categories of individual professional providers based on one of the approved reimbursement methods set forth in the TRM. As used by TRICARE, the allowable charge shall be the lowest of the billed charge, the prevailing charge, or the maximum allowable prevailing charge.

Allowable Charge Complaint

A request for review of a contractor determination of allowable charge for covered services and supplies furnished under TRICARE. The allowable charge complaint does not fall within the meaning of an "appeal", in the technical sense, but does require a careful contractor review of the claim processing to ensure accuracy of the allowance made.

Allowable Charge Reduction

The difference between the reimbursement determination made by a contractor and the amount billed by the provider of care (prior to determination of applicable cost-shares and deductibles).

Allowable Cost

The TRICARE-determined level of payment to hospitals or other institutions, based on one of the approved reimbursement methods described in 32 CFR 199.14. Allowable cost may also be referred to as the TRICARE-determined reasonable cost.

Amount In Dispute

The amount of money, determined under 32 CFR 199, that TRICARE would pay for medical services and supplies involved in an adverse determination being appealed if the appeal were resolved in favor of the appealing party. See 32 CFR 199.10 for additional information concerning the determination of "amount in dispute" under the Regulation.

Appeal

A formal written request by a beneficiary, a participating provider, a provider denied authorized provider status under TRICARE, or a representative, to resolve a disputed question of fact. See 32 CFR 199 and the TRICARE Operations Manual (TOM).

Appropriate Medical Care

Services that have been:

1. Performed in connection with the diagnosis or treatment of disease or injury, pregnancy, mental disorder, or well-baby care which are in keeping with the generally accepted norms for medical practice in the United States;

2. Rendered by an authorized individual professional provider who is qualified to perform such medical services by reason of his or her training and education and is licensed or certified either by the state where the service is rendered or appropriate national organization, or who otherwise meets TRICARE standards; and

3. Furnished economically. "Economically" means that the services are furnished in the least expensive level of care or medical environment adequate to provide the required medical care regardless of whether or not that level of care is covered by TRICARE.

Authorization For Care

The determination that requested treatment is medically necessary, delivered in the appropriate setting, a TRICARE benefit, and that the treatment will be cost-shared by DoD through its contract.

Authorized Provider

A hospital or institutional provider, physician, or other individual professional provider, or other provider of services or supplies specifically authorized to provide benefits under TRICARE in 32 CFR 199.6. Any physician listed in 32 CFR 199.6 who holds a valid license to practice medicine in the state where he/she practices shall be an authorized provider. Providers not specifically listed in 32 CFR 199.6 are not considered authorized providers unless they are included in a TRICARE demonstration program.

Authorized Supplies, Pharmacy

Non-drug items (usually used in conjunction with the administration of a drug) approved by the DoD P&T Committee for inclusion in the formulary, and appearing on the formulary web site at http://www.pec.ha.osd.mil.

Automated Data Processing (ADP)

A system for recording and processing data on magnetic media, ADP cards, or any other method for mechanical/electronic processing and manipulation or storage of data.

Average Wholesale Price (AWP)

The wholesale list price of a drug, as published by First Data Bank. Most discounting formulas use AWP as a reference point (e.g., AWP - 18%) to determine actual cost. DSCP uses First Data Bank (FDB) to obtain access to this information.

Backup System

A separate, off-site automated data processing system with similar operating capabilities which will be activated/used in case of a major system failure, damage, or destruction. This includes back-up data sets, software and hardware requirements, and trained personnel.

Balance Billing

The practice of a provider billing a beneficiary the difference between the TRICARE allowed amount and the billed charges on a claim. Participating providers and network providers may not collect from all sources an amount which exceeds the TRICARE allowed amount. Non-participating providers may not collect an amount which exceeds the balance billing limit (115% of the allowed charge). If the billed charge is less than the balance billing limit, then the billed charge is the maximum amount that can be collected by the non-participating provider. (See the TRICARE Reimbursement Manual (TRM), Chapter 3, Section 1.)

Basic Program

The primary medical benefits authorized under Chapter 55 of Title 10, United States Code (USC), and set forth in 32 CFR 199.4.

Benchmark

A TRICARE clerical and automated systems test using claims and other documents created or approved by TMA and processed by the contractor. The contractor's output is compared to predetermined results prepared or approved by TMA to determine the accuracy, completeness and operational characteristics of the contractor's clerical and automated systems components. The purpose of the benchmark is to identify clerical and automated systems deficiencies which must be corrected before claims can be processed in accordance with TMA requirements. The comprehensiveness of the benchmark will vary depending on the number and type of conditions tested.

Beneficiary History File

A system of records consisting of any record or subsystem of records, whether hard copy, microform or automated, which reflects diagnosis, treatment, medical condition, or any other personal information with respect to any individual, including all such records acquired or utilized by the contractor in delivery of health care services, in the development and processing of claims, or in performing any other functions under a TRICARE contract.

1. **Hard Copy Claim and Microform Files.** These files may include:

- Claim forms (TRICARE or other claim form approved by TMA)
- DoD Document (DD) Form 1251, Non-Availability Statement (NAS)
- Reports and related documentation pertaining to professional review of treatment
- Powers of Attorney
- Other Statements of Legal Guardianship
- Receipts (Itemized Bills)
- Other Insurance Payment Information (or EOB)
- Medical Reports (Mental illness case files, Durable Medical Equipment (DME), Medical Necessity Statement, Emergency Admission Statement, progress reports, nursing notes, operative reports, test results, etc.).
- Timely Filing Waiver
- Claim-Related Correspondence
- Appeals Case File
- Any other contractor developed documentation which is used for recording and documenting care and payment for care by network providers of care.

2. **Automated History Files.** The electronically maintained record of a beneficiary's medical care and related administrative data, including such data on charges, payments, deductible status, services received, diagnoses, adjustments, etc.

Beneficiary Liability

The legal obligation of a beneficiary, his or her estate, or responsible family member to pay for the costs of medical care or treatment received. Specifically, for the purposes of services and supplies covered by TRICARE, beneficiary liability includes any annual deductible amount, cost-sharing amounts, or, when a provider does not submit a claim on a participating basis on behalf of the beneficiary, amounts above the TRICARE-determined allowable cost or charge. Beneficiary liability also includes any expenses for medical or related services and supplies not covered by TRICARE.

Explanation Of Benefits (EOB)

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

Extraordinary Physical Or Psychological Condition (Respite Care Definition)

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

Federal Records Center (FRCs)

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

Files Administration

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

Fiscal Year (FY)

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

Format (HIPAA/Privacy Definition)

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

Formulary

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

Fragmented Billing

(See "Unbundled Billing")

Freedom Of Choice

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

Freedom Of Information Act (FOIA)

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

Freestanding

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

Full Mobilization

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

Gag Clause

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

Good Faith Payments

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

Grievance

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

Grievance Process

A contractor developed and managed system for resolving beneficiary grievances.

Group Health Plan (HIPAA/Privacy Definition)

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

1. Has 50 or more participants (as defined in section 3(7) of ERISA, 29 USC 1002(7)); or

2. Is administered by an entity other than the employer that established and maintains the plan.

HCPCS (HIPAA/Privacy Definition)

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

Health Benefits Advisors (HBAs)

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

Health Care (HIPAA/Privacy Definition)

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

Health Care Clearinghouse (HIPAA/Privacy Definition)

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

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

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

Health Care Finder (HCF)

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

Health Care Finder (HCF) System

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

Health Care Provider (HCP)

1. An individual or institution licensed or otherwise authorized to practice medicine or deliver health care services, supplies, or equipment.

2. For purposes of the Transaction and Code Sets Regulation and the Privacy Regulation, a provider of medical or health services and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business.

Health Information (HIPAA/Privacy Definition)

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

Health Insurance Issuer (HIPAA/Privacy Definition)

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

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

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

Health Oversight Agency (HIPAA/Privacy Definition)

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

Health Plan (HIPAA/Privacy Definition)

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

HHS Regulation (HIPAA/Privacy Definition)

45 CFR Parts 160-164.

Homebound (Respite Care Definition)

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

Hospital Day

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

ICD-9-CM

A technical reference, **International Classification of Diseases, 9th Edition, Clinical Modification**. It is a required reference and coding system for diagnoses in processing TRICARE claims for medical care.

Immediate Family

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

Independent Laboratory

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

Indirect Treatment Relationship (HIPAA/Privacy Definition)

A relationship between an individual and a HCP in which:

1. The health care provider delivers health care to the individual based on the orders of another health care provider; and

2. The health care provider typically provides services or products, or reports the diagnosis or results associated with the health care, directly to another health care provider, who provides the services or products or reports to the individual.

Individual (HIPAA/Privacy Definition)

The person who is the subject of PHI.

Individual Consideration (IC) Procedure

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

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

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

1. Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

- That identifies the individual; or
- With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Intervention, Pharmacy

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

Intervention Report, Pharmacy

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

Initial Determination

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

Initial Payment

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

Inpatient Care

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

Inquiry

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

Institution-Affiliated

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

Institution-Based

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

Institutional Provider

A HCP which meets the applicable requirements established by 32 CFR 199.6.

Internal Control Number (ICN)

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

Investigational Drugs

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

Laboratory And Pathological Services

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

Law Enforcement Official (HIPAA/Privacy Definition)

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

1. Investigate or conduct an official inquiry into a potential violation of law; or

2. Prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.

Legacy Identifier (HIPAA/Privacy Definition)

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

Limited Data Set (HIPAA/Privacy Definition)

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

Machine-Readable Records/Archives

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

Maintain Or Maintenance (HIPAA/Privacy Definition)

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

Major Diagnostic Category (MDC)

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

Managed Care Support Contractor (MCSC)

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

Marketing

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

Maximum Allowable Prevailing Charge

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

Maximum Defined Data Set

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

Medicaid

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

Medical

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

Medical Claims History File

Refer to Beneficiary History File.

Medical Necessity

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

Medical Necessity Determination

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

Medical Supplies And Dressings (Consumables)

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

Medical Management

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

Medicare

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

Medicare Economic Index (MEI)

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

Medication Error

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

Mental Health Therapeutic Absence

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

Microcopy

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

Microfiche

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

Microfilm

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

Microform

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

Military Health System (MHS) Beneficiary

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

Military Medical Support Office (MMSO)

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

Military Treatment Facility (MTF)

A military hospital or clinic.

Military Treatment Facility (MTF) Optimization

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

Military Treatment Facility (MTF)-Referred Care

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

Mobilization Plan - TRICARE

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

Monthly Pro-Rating

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

Most-Favored Rate

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

National Appropriate Charge Level

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

National Conversion Factor (NCF)

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

National Disaster Medical System (NDMS)

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

National Prevailing Charge Level

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

National Provider Identifier (NPI)

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

Negotiated (Discounted) Rate

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

Network

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

Network Care

Care provided by the network of contractor-operated providers and facilities (owned, leased, arranged) that link the providers or facilities with the prime contractor as part of the total contracted delivery system. Thus a "network provider" is one who serves TRICARE beneficiaries by agreement with the prime contractor as a member of the TRICARE Prime network or of any other preferred provider network or by any other contractual agreement with the contractor. "Network care" includes any care provided by a "network provider" or any care provided to a TRICARE Prime enrollee under a referral from the contractor, whether by a "network provider" or not. A "network claim" is a claim submitted for "network care." (See the definition for "Non-Network Care.")

Network Inadequacy

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

Network Provider

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

Nonappealable Issue

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

Non-Availability Statement (NAS)

A statement issued by a commander (or designee) of a Uniformed Services Medical Treatment Facility (USMTF) that needed medical care being requested by a TRICARE beneficiary cannot be provided at the facility concerned because the necessary resources are not available. Requirement for a non-availability statement will be limited to inpatient mental health care, but may, at the direction of the (ASD(HA)), be extended to other specific types of care. TRICARE Prime enrollees are exempt from NAS requirements, even under the Point-of-Service option. All other beneficiaries residing within the MTF's 40 mile catchment area require an NAS as specified.

Non-Claim Health Care Data

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

Non-Compliant, Pharmacy

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

Noncurrent Records

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

Non-DoD TRICARE Beneficiaries

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

Non-Network Care

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

Non-Participating Provider

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

Non-Prime TRICARE Beneficiaries

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

North Atlantic Treaty Organization (NATO) Member

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

Organized Health Care Arrangement (HIPAA/Privacy Definition)

1. A clinically integrated care setting in which individuals typically receive health care from more than one health care provider;

2. An organized system of health care in which more than one covered entity participates, and in which the participating covered entities hold themselves out to the public as participating in a joint arrangement and participate in joint activities such as utilization review, quality assessment and improvement activities, or payment activities.

3. A group health plan and a health insurance issuer or HMO with respect to such group health plan, but only with respect to PHI created or received by such health insurance issuer or HMO that relates to individuals who are or who have been participants or beneficiaries in such group health plan;

4. A group health plan and one or more other group health plans each of which are maintained by the same plan sponsor; or

5. The group health plans described in paragraph 4 of this definition and health insurance issuers or HMOs with respect to such group health plans, but only with respect to PHI created or received by such health insurance issuers or HMOs that relates to individuals who are or have been participants or beneficiaries in any of such group health plans.

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

Other Health Insurance (OHI)

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

Other Special Institutional Providers

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

Out-Of-Area Care

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

Out-Of-Region Beneficiaries

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

Over-the-Counter (OTC) Medications

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

Participating Provider

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

Patient Profile, Pharmacy

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

Pending Claim, Correspondence, Or Appeal

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

Performance Standard

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

Pharmacoeconomic Center (PEC)

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

Pharmacy and Therapeutics (P&T) Committee

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

Pharmacy Data Transaction Service (PDTS)

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

Pharmacy Operations Center (POC)

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

Point Of Service (POS) Option

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

Preauthorization

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

Preferred Provider Organization (PPO)

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

Prescriber

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

Prescription

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

Prevailing Charge

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

Preventive Care

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

Primary Care

Those standard, usual and customary services rendered in the course of providing routine ambulatory health care required for TRICARE beneficiaries. Services are typically, although not exclusively, provided by internists, family practitioners, pediatricians, general practitioners and obstetricians/gynecologists. It may also include services of non-physician providers (under supervision of a physician to the extent required by state law). These services shall include appropriate care for acute illness, accidents, follow-up care for ongoing medical problems and preventive health care. These services shall include care for routine illness and injury, periodic physical examinations of newborns, infants, children and adults, immunizations, injections and allergy shots, and patient education and counseling (including family planning and contraceptive advice). Such services shall include medically necessary diagnostic laboratory and x-ray procedures and tests incident to such services.

Primary Care Manager (PCM)

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

Primary Caregiver (Respite Care Definition)

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

Primary Payer

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

Prime Contractor

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

Prime Enrollee

An MHS beneficiary enrolled in TRICARE Prime.

Prior Authorization, Pharmacy

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

Priority Correspondence

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

Privacy Act, 5 USC 552a

A law intended to preserve the personal privacy of individuals and to permit an individual to know what records pertaining to him or her are collected, maintained, used, or disseminated, and to have access to and to have copied at the requestor's expense, all or any portion of such records, and to correct or amend such records. Concomitantly, it requires Government activities which collect, maintain, use or disseminate any record of an identifiable personal nature in a manner that assures that such action is necessary and lawful; that any information collected is accurate, relevant, timely, and as complete as is reasonably possible and necessary to assure fairness to the individual, and that adequate safeguards are provided to prevent misuse or unauthorized release of such information.

Processed To Completion (PTC) (Or Final Disposition)

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

- All services and supplies on the claim have been adjudicated, payment has been determined on the basis of covered services/supplies and allowable charges applied to deductible and/or denied, and

- Payment, deductible application or denial action has been posted to ADP history.

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

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

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

Procuring Contracting Officer (PCO)

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

Profiled Amount

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

Program Integrity System

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

Prospective Drug Utilization Review (ProDUR)

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

Prospective Review

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

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

IIHI that is:

1. Transmitted by electronic media;

2. Maintained in any medium described in the definition of electronic media; or

3. Transmitted or maintained in any other form or medium.

PHI excludes IIHI in:

1. Education records covered by the Family Educational Right and Privacy Act, as amended, 20 USC 1232g;

2. Records described at 20 USC 1232g(a)(4)(B)(iv); and

3. Employment records held by a covered entity in its role as an employer."

Provider

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

Provider Exclusion And Suspension

The terms "exclusion" and "suspension", when referring to a provider under TRICARE, both mean the denial of status as an authorized provider, resulting in items, services, or supplies furnished by the provider not being reimbursed, directly or indirectly, under TRICARE. The terms may be used interchangeably to refer to a provider who has been denied status as an authorized TRICARE provider based on: 1) a criminal conviction or civil judgment involving fraud, 2) an administrative finding of fraud or abuse under TRICARE, 3) an administrative finding that the provider has been excluded or suspended by another agency of the Federal Government, a state, or a local licensing authority, 4) an administrative finding that the provider has knowingly participated in a conflict of interest situation, or 5) an administrative finding that it is in the best interests of TRICARE or TRICARE beneficiaries to exclude or suspend the provider.

Provider Network

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

Provider Termination

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

Psychotherapy Notes (HIPAA/Privacy Definition)

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

Public Health Authority (HIPAA/Privacy Definition)

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

Quality Assurance (QA), Pharmacy

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

Quality Assurance Program

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

Quality Control, Pharmacy

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

Quality Improvement

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

Receipt Of Claim, Correspondence Or Appeal

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

Reconsideration

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

Records

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

Records Management

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

Referral

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

Referral Management

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

Region

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

Regional Director (RD)

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

Regional Director's (RD's) Office

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

Regional Review Authority (RRA)

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

Representative

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

Required By Law (HIPAA/Privacy Definition)

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

Research (HIPAA/Privacy Definition)

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

Residence

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

Residual Claim

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

Resource Sharing Agreement (External)

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

Respite Care

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

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

2. Limitations On Respite Benefits:

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

- The services performed by the primary caregiver are those that can be performed safely and effectively by the average non-medical person without direct supervision of a health care provider after the primary caregiver has been trained by appropriate medical personnel.

- Respite care services are limited to a maximum of eight hours per calendar day, five days per calendar week.

Resubmissions

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

Retention Period

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

Retiree

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

Retrospective Drug Utilization Review

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

Retrospective Review

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

Returned Claim

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

Reversed

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

Routine Correspondence

Any correspondence which is not designated as Priority Correspondence.

Same Day Referral

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

Sanction

A provider exclusion, suspension, or termination.

Secondary Payer

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

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

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

Segment (HIPAA/Privacy Definition)

A group of related data elements in a transaction.

Service Point Of Contact (SPOC)

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

Seventy-Two Hour Referral

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

Skilled Nursing Facility (SNF)

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

Skilled Nursing Service

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

Special Checks

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

Special Inquiries

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

Specialty Care

Specialized medical services provided by a physician specialist.

Split-Billing

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

Split Enrollment

Refers to multiple family members enrolled in TRICARE Prime under different RDs/contractors, including Managed Care Support (MCS) contractors and Uniformed Services Family Health Plan (USFHP) designated providers.

Sponsor

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

Spouse

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

Stakeholders

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

Standard Transaction (HIPAA/Privacy Definition)

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

Start Of Service

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

State (HIPAA/Privacy Definition)

1. For a health plan established or regulated by Federal law, State has the meaning set forth in the applicable section of the USC for such health plan.

2. For all other purposes, State means any of the several States, the District of Columbia, the Commonwealth of Puerto Rico, the U.S. Virgin Islands, and Guam.

Student Status

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

Subcontractors

1. Includes, but is not limited to, enrolled program health benefits business entities at whatever level of the contract organization they exist. It does not include institutional or non-institutional providers of health care.

2. In determining whether a business entity is a network first tier subcontractor, consideration is given as to whether or not the entity providing the designated services acts as a broker of care; i.e., the entity itself obtains the medical coverage needed by in turn contracting with institutional and non-institutional providers. Implicit in the determination is size of the offered network; i.e., does this entity provide a large number of contracted providers for a large geographical area?

3. This definition does not exclude business entities that are not specifically addressed herein but whose legal status within the contract organization establishes them as subcontractors because that term may be otherwise defined in the FAR.

Subcontracts

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

Summary Health Information (HIPAA/Privacy Definition)

Information that may be IIHI, and:

1. That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and

2. From which the information has been deleted, except that the geographic information may be aggregated to the level of a five digit zip code.

Supplemental Care

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

Supplemental Funds

Funds used to pay for supplemental care.

Supplemental Insurance

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

Suspension Of Claims Processing

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

Termination

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

Third Party Liability (TPL) Claims

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

Third Party Liability (TPL) Recovery

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

Third Party Payer

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

Timely Filing

The filing of TRICARE claims within the prescribed time limits as set forth in 32 CFR 199.7.

Toll-Free Telephones

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

Trading Partner Agreement (HIPAA/Privacy Definition)

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

Transaction (HIPAA/Privacy Definition)

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

1. Health care claims or equivalent encounter information.

2. Health care payment and remittance advice.

3. Coordination of benefits.

4. Health care claims status.

5. Enrollment and disenrollment in a health plan.

6. Eligibility for a health plan.

7. Health plan premium payments.

8. Referral certification and authorization.

9. First report of injury.

10. Health claims attachments.

11. Other transactions that may be prescribed by regulation.

Transfer Claims

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

Transition

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

Transitional Patients Or Cases

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

Treatment (HIPAA/Privacy Definition)

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

Treatment Encounter

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

Treatment Plan

A detailed description of the medical care being rendered or expected to be rendered a TRICARE beneficiary seeking approval for inpatient benefits for which 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.

TRICARE Encounter Data (TED)

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

1. Beneficiary identification.

2. Provider identification.

3. Health information:

- Place and type of service
- Diagnosis and treatment-related data
- Units of service (admissions, days, visits, etc.)

4. Related financial information.

TRICARE Encounter Data (TED) Record Transmittal Summary

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

TRICARE Extra

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

TRICARE For Life (TFL)

Benefit for Medicare eligibles, based on age. TRICARE is secondary payor when service is a benefit of both Medicare and TRICARE.

TRICARE Management Activity (TMA)

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

TRICARE Operations Manual (TOM) (6010.56-M)

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

TRICARE Policy Manual (TPM) (6010.57-M)

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

TRICARE Plus

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

TRICARE Prime

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

TRICARE Prime Remote Program (TPR)

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

TRICARE Prime Remote (TPR) Work Unit

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

TRICARE Prime Service Area (PSA)

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

TRICARE Program

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

TRICARE Quality Monitoring Contract (TQMC)

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

TRICARE Regulation

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

TRICARE Representative

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

TRICARE Standard

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

TRICARE Systems Manual (TSM) (7950.2-M)

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

Unbundled (Or Fragmented) Billing

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

Uniform Formulary

PL 106-65, DoD Authorization Act of Fiscal Year 2000, at section 701, mandated that DoD develop a uniform formulary to be applied across all points of service within the TRICARE system. Pharmaceuticals and other supplies authorized for dispensing will be in accordance with TRICARE policy and the Uniform Formulary. Recommendations for the design, structure and composition of the Uniform Formulary are developed by the DoD Pharmacy and Therapeutics (P&T) Committee, with comments by the Uniform Formulary Beneficiary Advisory Panel, and provided to the Executive Director, TMA for approval and implementation.

Uniform HMO Benefit

The health care benefit established by 32 CFR 199.18.

Uniformed Services

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

Uniformed Services Clinic (USC)

A MHS clinic that delivers primary care to ADSMs.

Uniformed Services Family Health Plan (USFHP)

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

United States

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

United States Public Health Service (USPHS)

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

Unprocessable TRICARE Encounter Data (TED)

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

Unproven Drugs, Devices, And Medical Treatments Or Procedures

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

1. FDA approval is required and has not been given;

2. If the device is a FDA Category A Investigational Device Exemption (IDE);

3. If there is no reliable evidence which documents that the treatment or procedure has been the subject of well-controlled studies of clinically meaningful endpoints which have determined its maximum tolerated dose, its toxicity, its safety, and its efficacy as compared with the standard means of treatment or diagnosis;

4. If the reliable evidence shows that the consensus among experts regarding the treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its safety, or its effectiveness as compared with the standard means of treatment or diagnosis.

For further clarification see 32 CFR 199.4(g)(15).

Urgent Care

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

Use (HIPAA/Privacy Definition)

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

Utilization Criteria

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

Utilization Management

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

Utilization Review

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

Veteran

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

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

Widow Or Widower

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

Workday

A day on which full-time work is performed.

Worker's Compensation Benefits

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

Workforce (HIPAA/Privacy Definition)

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

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