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TRICARE  
MANAGEMENT ACTIVITY

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## CORRECTED COPY

### PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR TRICARE OPERATIONS MANUAL (TOM), FEBRUARY 2008

The TRICARE Management Activity has authorized the following addition(s)/revision(s).

**CHANGE TITLE:** TRICARE LOGO

**CONREQ:** 15377

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

**SUMMARY OF CHANGE(S):** This change to the TOM provides instructions on the use and reproduction of the TRICARE® trademark. This change will ensure any reproduction of the mark must be in full compliance with the requirements set forth in the TRICARE® Brand Style Guide. This change also updates the division name for the Beneficiary Education and Support Division (BE&SD).

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

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

  
Reta M. Michak  
Director, Operations Division

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## Contract Administration And Instructions

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### 1.0 TRICARE MANUALS

These include the TRICARE Operations Manual (TOM), TRICARE Policy Manual (TPM), TRICARE Reimbursement Manual (TRM), and TRICARE Systems Manual (TSM). The TRICARE Manuals are the principal vehicles for general operating instructions to all health care delivery contractors and may be accessed at <http://manuals.tricare.osd.mil/>. The official archive copies of these documents are maintained at TRICARE Management Activity (TMA). The documents and all official changes to them will be maintained at TMA in an electronic medium using the PDF (Portable Document Format) format, and are available at the above web site. Distribution of paper copies will be on an exception basis. Regardless of publication medium, their printed and displayed appearance will be identical. The principal means of distribution will be via an electronic notification of publication and the contractor's subsequent download of the manual or change from the above web site. All proposed changes to these documents will be distributed for review and comment in an electronic medium, using PDF as the document format, and comments must be returned to TMA in an acceptable electronic format. Contractors shall furnish the TMA Procuring Contracting Officer (PCO) with designated point(s) of contact and e-mail address(es) for review and comment on proposed manual changes, and notification of final publication of manual changes.

### 2.0 IMPLEMENTATION OF MANUAL CHANGES

The contractor shall implement changes in requirements as specified by the PCO. If a contractor is unable to comply by the effective date, the PCO shall be notified in writing. The notification shall include the reasons for the noncompliance and a plan for reaching compliance. The proposal shall include milestones, if appropriate, and a firm date for completion.

### 3.0 COMMUNICATIONS WITH TMA

The contractor shall:

**3.1** Provide complete replies to TMA requests for Rough Order Of Magnitude (ROM) estimates, comments, and/or cost estimates on proposed changes to the manuals **no later than 30 days from the date of the request**. In addition, in the event of an urgent need imposed by law or a program requirement under which significant loss to the Government would result from delay, a period of less than 30 days will be imposed, whether it is a major or minor change.

**3.2** Provide timely responses to all requests for information directed to them by TMA.

**3.3** Use assigned Contracting Officer's Representative (COR) at TMA as the initial POC for program interpretation or other forms of **operational** guidance.

#### 4.0 TMA-REQUIRED MEETINGS

Generally, a 14 calendar day notice will be provided for all meetings hosted by TMA. The Managed Care Support Contractor (MCSC) shall provide representation at two regional MCSC/ TRICARE Regional Office (TRO), and two regional provider conferences. The MCSC shall provide up to four contractor representatives at up to four additional meetings at the direction of the PCO per contract year.

#### 5.0 TMA DELEGATION OF RESPONSIBILITY

Responsibility has been delegated to TMA, Beneficiary Education and Support Division (BE&SD) to perform the following:

- Grant exceptions to the claims filing deadline;
- Grant "good faith payments";
- Waive the signature requirements on TRICARE claims;
- Adjudicate and process unique claims requiring special handling, and claims for emergency care provided by a Department of Veterans Affairs (DVA) facility or a facility under the Bureau of Indian Affairs (BIA);
- Authorize benefits for which the authority has not otherwise been delegated to other TRICARE officials or MCSCs;
- Authorize an "override" of information contained on Defense Enrollment Eligibility Reporting System (DEERS), pending a system update, based on appropriate documentation regarding eligibility under the law, regulation and policy.

- END -

## Transitions

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### 1.0 CONTRACT PHASE-IN

#### 1.1 Start-Up Plan

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

#### 1.2 Transition Specifications Meeting

The incoming contractor shall attend a two to four day meeting with the outgoing contractor and 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 Beneficiary Education and Support Division (BE&SD)**

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

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

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

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

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

the outgoing contractor of the new enrollment. (Defense Manpower Data Center (DMDC) may run a report at the end of the transition period that reflects new additions.)

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

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

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

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

## **2.6 Transfer Of Enrollment Files**

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

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

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

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

## 2.7 Enrollment Fees

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

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

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

## 2.8 Phase-In Requirements Related to the Health Care Finder (HCF) Function

The hiring and training of service center HCF function staff shall be completed NLT 40 calendar days prior to the start of health care delivery for TRICARE Prime in each PSA. HCF function space will be occupied and all equipment and supplies in place NLT 40 calendar days prior to the start of health care delivery. The provider/beneficiary community shall be advised of the procedures for accessing the HCF function NLT 40 calendar days prior to the start of health care delivery.

## 2.9 Phase-In Requirements of the TSCs

**2.9.1** In the event the incoming contractor will utilize the existing TSCs of the outgoing contractor, the outgoing contractor shall allow reasonable access to the incoming contractor throughout the transition period to install communication lines, equipment and other essential work to fully manage and operate the TSCs.

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

### 2.9.3 Acquisition of Resources

All TSC and Field Representatives shall be fully trained and available for all duties no less than 40 calendar days prior to initiation of health care services.

## **2.10 Claims Processing System and Operations**

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

### **2.10.1 Contractor File Conversions and Testing**

The incoming contractor shall perform initial conversion and testing of all Automated Data Processing (ADP) files (e.g., provider files, pricing files, and beneficiary history) NLT 30 calendar days following receipt of the files from the outgoing contractor(s). All ADP file conversions shall be fully tested and operational for the Benchmark (see [paragraph 3.0](#)). Integration testing will be conducted to validate the contractor's internal interfaces to each of the TRICARE Military Health Systems (MHSs). This testing will verify the contractor's system integration, functionality, and implementation process. The incoming contractor shall be responsible for the preparation and completion of Integration Testing prior to the start of Benchmark Testing.

TMA Test Managers will work with the contractor to plan, execute and evaluate the Integration Testing efforts. The contractor shall identify a primary and a back-up Testing Coordinator to work with the TMA Test Managers. The Testing Coordinator is responsible for contractor testing preparations, coordination of tests, identification of issues and their resolution, and verification of test results. A web application will be available for use by contractor Test Coordinators to report and track issues and problems identified during integration testing.

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

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

**2.10.2.2** During the 180 calendar days after the start of health care delivery when both the incoming and outgoing contractors are processing claims, both contractors shall maintain close interface on history update exchanges and provider file information. During the first 60 calendar days of dual operations, the contractors shall exchange beneficiary history updates with each contractor's claims processing cycle run. Thereafter, the exchange shall not be less than twice per week until the end of dual processing. The incoming contractor shall assume total responsibility for the maintenance of the TRICARE Encounter Provider Record (TEPRV) beginning with the start of health care delivery. The incoming contractor will coordinate and cooperate with the outgoing contractor to ensure that the outgoing contractor can continue to process claims accurately; conversely, the outgoing contractor has responsibility to notify the incoming contractor of any changes in provider status that they become aware of through their operations.

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

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

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

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

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

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

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

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

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

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

from the MTF. The contractor shall make this notification by any mutually agreeable method specified in the MOU. The contractor shall not make the MTF enrollment effective unless notified by the MTF to do so.

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

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

**8.5.4** At any time during the enrollment period, if the contractor determines there is no signed travel time waiver on file for a current MTF enrollee who resides more than 30 minutes from the MTF, the contractor shall, at the next annual TRICARE Prime renewal point, require the beneficiary to waive the primary and specialty care ATC standards before the enrollment will be renewed. (This includes monitoring address changes received by the contractor from all sources.) The contractor shall notify the beneficiary of this waiver requirement no later than two months before expiration of the annual enrollment period. The language for all beneficiary notices shall be reviewed and concurred on by the TRO prior to being sent to beneficiaries. (The TRO will coordinate notices with TMA **BE&SD** prior to approval.)

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

**8.5.5** For each approved enrollment to an MTF where the beneficiary has waived access standards (whether by DD Form 2876 or BWE), the contractor shall retain the enrollment request in a searchable electronic file until 24 months after the beneficiary is no longer enrolled to the MTF. The contractor shall provide the retained file to a successor contractor at the end of the final option period.

**8.5.6** When an enrollment request requires MTF Commander or TRO Director approval, any contractual requirements relating to processing timeliness for enrollment requests will begin when

the contractor has obtained direction from the MTF Commander or TRO Director regarding waiver approval or disapproval.

**8.5.7** The contractor shall apprise the MTF Commander (or designee) of all enrollees to the MTF who have waived their ATC travel standards. The contractor shall separate the information into two categories, those who reside within 100 miles of the MTF and those who reside 100 miles or more from the MTF. This notification shall be by any mutually agreement means specified in the MOU between the contractor and the MTF Commander.

## **8.6 Civilian Enrollees**

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

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

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

- END -

authorization prior to receiving payment for the care listed at [Chapter 7, Section 2](#), authorization may be requested following the care. Whether the authorization is requested before or after care, all qualified care shall be authorized for payment. The contractor shall emphasize the need for concerned persons to contact a Beneficiary Counseling Assistance Coordinator (BCAC)/Health Benefits Advisor (HBA) or the contractor for assistance.

**2.3** Because of the high risk that many services requiring special authorization may be denied, the contractor shall offer preauthorization for the care to all TRICARE beneficiaries who reside within its jurisdiction. The contractor shall process all requests for such authorization whether submitted by the beneficiary, sponsor or provider requesting authorization on behalf of the beneficiary.

**2.4** The contractor shall issue notification of preauthorization/authorization or waiver to the beneficiary or parent/guardian or a minor or incompetent adult, the provider, and to its claims processing staff. Notification may be made in writing by letter, or on a form developed by the contractor. These forms and letters are all referred to as TRICARE authorization forms. The contractor shall not issue an authorization for acute, inpatient mental health care for more than seven calendar days at a time.

**2.5** The contractor shall document authorizations. The contractor must also maintain an automated authorization file or an automated system of flagging to ensure claims are processed consistent with authorizations. The contractor shall verify that the beneficiary, sponsor, provider, and service or supply information submitted on the claim are consistent with that authorized and that the care was accomplished within the authorized time period.

**2.6** Prime enrollees receiving emergency care or authorized care from non-network, non-participating providers shall be responsible for only the Prime copayment. On such claims, contractors shall allow the amount the provider may collect under TRICARE rules; i.e., if the charges on a claim are subject to the balance billing limit (refer to the TRICARE Reimbursement Manual (TRM), [Chapter 3, Section 1](#) for information on balance billing limit), the contractor shall allow the lesser of the billed charges or the balance billing limit (115% of allowable charge). If the charges on a claim are exempt from the balance billing limit, the contractor shall allow the billed charges. Refer to the TRM, [Chapter 2, Section 1](#) for information on claims for certain ancillary services.

**2.7** The requirement that a TRICARE Prime enrollee obtain a referral/authorization from their PCM to receive the H1N1 immunization from a non-network, TRICARE-authorized provider has been temporarily waived from October 1, 2009 to May 1, 2010. During this period, Prime enrollees may obtain the H1N1 immunization from a non-network TRICARE-authorized provider without prior authorization or PCM referral. POS cost-shares normally associated with non-referred care obtained by Prime enrollees from non-network providers without appropriate authorization will not apply during this period.

### **3.0 FAILURE TO COMPLY WITH PREAUTHORIZATION - PAYMENT REDUCTION**

During claims processing, provider payments shall be reduced for failure to comply with the preauthorization requirements for certain types of care. See the TRM, [Chapter 1, Section 28](#), for more information.

#### **4.0 PSYCHIATRIC RESIDENTIAL TREATMENT CENTERS (RTCs)**

**4.1** Before any claims for RTC care may be paid, an authorization must be on file. The dates of service on the claim form and the name of the facility plus the Employer Identification Number (EIN) with suffix must correspond with the dates of the approval and the facility indicated on the authorization. If the beneficiary resides outside of the contractor's region, the contractor responsible for payment shall pay the claims at the rate determined by TRICARE Management Activity (TMA). When the contractor issues an RTC authorization, it shall flag its files to preclude payment of any family or collateral therapy that is billed in the name of the RTC patient. That cost is the responsibility of the RTC, unless, as part of its negotiated agreement, the contractor agrees to a separate payment for such care. Under the TMA-determined rates, family therapists may bill separately from the RTC (outside the all-inclusive rate) only if the therapy is provided to one or both of the parents residing a significant distance from the RTC. In the case of residents of a region, geographically distant family therapy must be certified by the contractor in order for cost-sharing to occur.

**4.2** If a claim for admission or extension is submitted and no authorization form is on file, the claim shall not be paid. For network claims, the contractor may deny or develop in accordance with its agreements with network providers. For non-network claims, the contractor shall deny the claim.

**4.3** For any claims submitted for inpatient care at other than the RTC, the contractor shall pay the claim if the care was medically necessary. Claims for RTC care during the period of time the beneficiary was receiving care from another inpatient facility shall be denied. If the RTC has been paid and a claim for inpatient hospital care is received and the care was medically necessary, the contractor must pay the inpatient hospital claim and recover the payment from the RTC.

#### **5.0 GRANDFATHERED CUSTODIAL CARE CASES**

A list of the beneficiaries who qualified for custodial care benefits prior to June 1, 1977, has been furnished to the contractor with instructions to flag the file for those beneficiaries on the list who are within its region. Claims received for those beneficiaries, for which no authorization is on file, are to be suspended and the contractor shall notify the TMA, Beneficiary **Education and Support** Division (**BE&SD**). Refer to [32 CFR 199.4](#).

#### **6.0 REFERRAL AND AUTHORIZATION PROCESS**

The contractor shall process referrals in accordance with the following:

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

Referrals from the MTF shall include all of the following information, at a minimum, unless otherwise specified. Contractors shall receive the MTF referral via fax (or by other electronic means agreed upon by the MTF and the Managed Care Support Contractor (MCSC)). The MTF is not required to provide diagnosis or procedure codes. The MCSC shall translate the narrative descriptions into standard diagnosis and procedure codes. The contractor shall ensure that care received outside the MTF and referred by the MTF (for MTF enrollees) is properly entered into the contractor's claims processing system to ensure the appropriate adjudication of claims.

## 6.0 GOOD FAITH PAYMENT

**6.1** With prior approval from TMA, a contractor may make a good faith payment to a participating provider, or allow a previous payment to stand, for care provided to a patient, but only in the following situations.

- An ineligible patient holds an ID card showing TRICARE eligibility and the provider exercised reasonable care in accepting the apparently valid ID card as evidence of eligibility; or
- An ineligible patient/person enrolls in Prime, claims are filed and denied as TRICARE ineligible, and the contractor can document via evidence from DEERS that the individual had in fact been shown on DEERS as eligible on the date of Prime enrollment and for the period covering the dates of medical care.

**6.2** Whether the claim is initially paid or denied, the provider is expected to make reasonable efforts to collect payment from the ineligible patient prior to requesting approval of a good faith payment. Documentation of the unsuccessful effort is to be submitted to the Beneficiary **Education and Support Division (BE&SD)**, TMA, Aurora, Colorado, Attn: Good Faith Payment Considerations with the request. Immediately prior to submitting a request for approval of a good faith payment, the contractor shall recheck the current DEERS records to confirm that the person is not eligible and include the documentation of the results. The contractor is not financially responsible for making good faith payments. The contractor's costs will be separately reimbursed by the Government.

**6.3** If the contractor made payment to the participating provider, the contractor shall advise the participating provider and the patient of the patient's ineligibility and then follow recoupment procedures. If, during the recoupment process, the participating provider alleges that he or she relied on the information on the patient's ID card showing TRICARE eligibility, the contractor shall forward the file to TMA **BE&SD** for consideration of a good faith payment and advise the participating provider of the action taken. The file shall include documentation of all contact with the participating provider and patient.

**6.4** If the contractor has not made payment to the participating provider, the contractor shall deny the claim based upon ineligibility of the patient. If the participating provider alleges that he/she/it relied on the information on the patient's ID card showing TRICARE eligibility, the contractor shall forward the file to TMA **BE&SD** and advise the participating provider of the action taken. The file shall include documentation of all contacts with the participating provider and patient.

**6.5** If TMA notifies the contractor that a good faith payment has been granted, the contractor shall terminate collection from the provider, refund any monies collected from the provider and initiate recoupment against the ineligible beneficiary.

**6.6** A provider who erroneously furnishes services and/or supplies to an ineligible patient as a result of careless identification procedures is not entitled to a good faith payment. Defense Manpower Data Center (DMDC) is responsible for providing beneficiaries with accurate and appropriate means of identification.

## **6.7 TEDs Related to Good Faith Payments**

**6.7.1** If a previously made payment is determined to be eligible for a good faith payment, the contractor may adjust the payment from underwritten to non-underwritten by cancelling the initial TRICARE Encounter Data (TED) (financially underwritten) record and submitting a new (non-financially underwritten) TED record. Any subsequent collection actions shall be initiated and reported per [Section 4](#).

**6.7.2** Claims that have not been paid which are determined to be eligible for a good faith payment, may be paid to the provider from the non-financially underwritten bank account. If paid from the non-financially underwritten account, any subsequent collection actions shall be initiated and reported per [Section 4](#).

## **7.0 OVERPAYMENTS RESULTING FROM ALLEGED MISINFORMATION**

An allegation by a patient or provider that information obtained from an Health Benefits Advisor (HBA), contractor, or other party caused the overpayment does not alter the liability for the overpayment, nor is it grounds for termination of recoupment activity.

## **8.0 DENIAL OF BENEFITS PREVIOUSLY PROVIDED**

In those instances in which clarification, interpretation or a change in the TRICARE Regulation would result in denial of services or supplies previously covered, no action should be taken to recover payments expended for those benefits paid prior to the date of such clarification or change, unless specifically directed by TMA.

## **9.0 DOUBLE COVERAGE SITUATIONS**

A "Primary Plan," under TRICARE Law and Regulation is any other health insurance coverage the patient has, except Medicaid (Title XIX) or a supplement plan which is specifically designed to pay only TRICARE deductibles, coinsurance and other cost-shares. (See the TRICARE Reimbursement Manual (TRM), [Chapter 4](#).) Prior to payment of any claim for services or supplies rendered to any TRICARE beneficiary, regardless of eligibility status, it must be determined whether double coverage exists. If the reason for the overpayment is that another coverage plan primary to TRICARE was not considered in whole or in part in the coordination of benefits, then the following actions are required to recover the overpayment:

**9.1** If the primary plan has not made payment to the beneficiary or provider, the contractor shall attempt to recover the overpayment from the primary plan following the contractor's coordination of benefits procedures;

**9.2** If the overpayment cannot be recovered from the primary plan, or if the primary plan has made payment, the overpayment will be recovered from the party that received the erroneous payment from TRICARE.

## **10.0 THIRD PARTY RECOVERIES**

When potential recovery from or actual payment by a liable third party is discovered, the contractor shall take action under the provisions of [Section 5](#).

**4.5** Any instance where the erroneous payment was made directly to the beneficiary.

**5.0 OVERPAID PARTY IS DECEASED**

If the contractor determines that liability for an overpayment rests with a beneficiary or provider who is deceased, the contractor shall seek recoupment of the overpayment from the estate of the deceased person. The procedures described in this section shall be followed.

**6.0 GOOD FAITH PAYMENT**

**6.1** Participating providers who exercise reasonable care and precaution in identifying persons claiming to be eligible TRICARE beneficiaries and furnish otherwise-covered services and supplies to such persons in good faith, may be granted a good faith payment, although the person receiving the services and supplies is subsequently determined to be ineligible for benefits. In order to meet the requirements for a good faith payment, the participating provider must have:

- Exercised reasonable care and precaution in identifying the patient as TRICARE eligible.
- Made reasonable efforts to collect payment for the services provided from the person who erroneously claimed to be a TRICARE beneficiary.

**6.2** In order to qualify for a good faith payment, the provider must submit documentation to substantiate that he/she has met BOTH requirements. The usual evidence that a provider has exercised reasonable care and precaution in identifying the patient as TRICARE-eligible is a copy of the patient's ID card which indicates that he/she was eligible for civilian medical care at the time services were provided. Generally, the provider must have obtained the copy of the ID card when the services were provided. If the provider did not obtain a copy of the ID card, he/she will submit to the TRICARE Management Activity (TMA) Beneficiary Education and Support Division (BE&SD) an explanation of why a copy was not obtained and the reason(s) for his/her determination that the patient was eligible for TRICARE benefits.

**6.3** The documentation required to establish that a provider has made reasonable efforts to collect will vary, depending upon the facts of each case. Such documentation may include, but is not limited to, invoices or demand letters sent to the patient, and memoranda of telephone calls to the patient demanding payment. If the TRICARE beneficiary has moved and left no forwarding address, the provider must supply copies of returned letters or memoranda of unsuccessful attempts to reach the patient by telephone.

**6.4** The contractor is not authorized to determine whether a provider exercised "reasonable care" which may qualify the provider for a good faith payment; nor are they authorized to seek, invite, or encourage good faith payment requests from providers. However, should a provider initiate an inquiry regarding denial of a claim due to the patient's ineligibility, or a recoupment action in which the patient's eligibility is the issue, the contractor may advise the provider of the procedures for requesting a good faith payment.

**6.5** If the contractor has NOT paid the participating provider (i.e., the claim is denied), the contractor shall advise the provider and the patient by Explanation Of Benefits (EOB) that the claim has been denied due to the patient's ineligibility so that the provider may attempt collection from the patient in a timely manner. Occasionally, the patient may need only to update his DEERS record,

so that the denied claim may be processed and paid. Upon notification of the patient's ineligibility, the provider must attempt collection from the patient. If the provider alleges that he/she exercised reasonable care and caution in identifying the patient as TRICARE-eligible and requests a good faith payment, the contractor is responsible for advising the provider in writing within 30 days of the date of the request that documentation of his/her efforts to collect from that patient is required. The file shall be referred to TMA **BE&SD**, for consideration of the request for a good faith payment and shall include:

- Pertinent claim form(s) and EOB(s). (If the pharmacy EOB does not contain certain data elements, then a separate report is required (see [Addendum A, Figure 10.A-34](#)). If offsets have been taken, additional data elements are required as listed in [Addendum A, Figure 10.A-35](#).)
- Evidence of the patient's ineligibility.
- The provider's request for a good faith payment.
- Documentation of all contractor contacts with the provider and the patient.
- Documentation of efforts made by the provider to identify the patient as TRICARE-eligible prior to rendering service.
- Documentation of efforts to collect from the ineligible patient.

**6.6** The contractor shall notify the provider that his request has been referred to TMA **BE&SD**. If TMA grants the request for a good faith payment, the contractor shall then reprocess and pay the previously denied assigned claim and initiate recoupment action against the patient.

**6.7** If an assigned claim was paid before the contractor discovered the patient's ineligibility, the contractor shall initiate recoupment action against the participating provider, and concurrently, advise the patient of his/her ineligibility for TRICARE benefits and his/her liability for payment to the provider. If the provider alleges that he/she exercised reasonable care and precaution in identifying the patient as TRICARE-eligible, and requests a good faith payment, the file shall be referred to TMA **BE&SD**, for consideration of the request. The provider is required to supply all of the documentation outlined in [paragraph 6.2](#). If the provider's good faith payment request does not include documentation to substantiate the provider's efforts to collect from the patient, the contractor shall notify the provider in writing within 30 days of the date of the provider's request of the requirement to provide the information. Upon receipt of the requested information, the contractor shall notify the provider that his/her request has been referred to TMA **BE&SD**. The contractor shall suspend recoupment action until a response to the good faith payment request has been received from TMA **BE&SD**. If no response is received within 60 days, the contractor shall contact the Recoupment Division, TMA, to determine whether continued suspension of recoupment action is appropriate. If TMA **BE&SD** notifies the contractor that a good faith payment has been granted, the contractor shall terminate collection action against the provider, refund any monies collected from the provider, and initiate recoupment action against the ineligible patient.

**25.13** When the debtor enters into an installment repayment agreement, the offset flag shall be removed. Any suspended claims shall be processed and paid normally. If the debtor requests continuation of the offset, any amounts so collected shall be treated as an installment payment.

**25.14** Written notification of delinquency shall be sent 35 days after the established due date if an installment, or any portion thereof, remains outstanding (see [Addendum A, Figure 10.A-16](#)). If the delinquent amount is not remitted within 30 days of the initial delinquency notice, and the amount remaining due on the account is \$600 or greater, the case file, including all supporting documentation, shall be referred to the TMA OGC. If the debtor fails to bring the account current, but remits the missed installment, or a portion thereof, the contractor shall retain the case. Cases shall not be transferred to TMA until two full installment payments are past due. For example, a debtor may miss one payment entirely, but make all subsequent payments, and remain one month behind for the term of the agreement. The case would not be transferred to TMA. When a case is transferred to TMA, the contractor shall advise the debtor of the referral and shall be told that future payments should be sent to the F&AO, TMA, 16401 East Centretech Parkway, Aurora, Colorado 80011-9066 (see [Addendum A, Figure 10.A-26](#)).

## **26.0 RECOUPMENT ACTION AND THE APPEALS PROCESS**

**26.1** The determination that an overpayment was made is not, in itself, an appealable issue. When a contractor receives a request from a debtor for an administrative review, the procedures outlined in [paragraph 29.0](#) shall be followed to assure that, when appropriate, the debtor receives a Reconsideration as outlined in [Chapter 12](#).

**26.2** If a service or supply which is not a TRICARE benefit was paid in error, the reversal of the payment decision constitutes an initial adverse determination. The overpaid party may appeal if an appealable issue exists. Such appeals are subject to the requirements and time limits outlined in [Chapter 12](#). When the overpayment arises because inpatient mental health care was erroneously paid, the debtor will be advised that retroactive approval of the days paid may be requested from the TRICARE mental health review contractor. (See the TRICARE Policy Manual (TPM), [Chapter 7, Section 3.1](#).)

**26.3** Any funds recouped by offset after a reconsideration has been requested are to be identified and properly accounted. The appealing party is to be notified that the recoupment of the overpayment shall continue by offset. The contractor shall not terminate the offset action because of an appeal unless directed to do so by TMA.

**26.4** When a requirement to recoup TRICARE funds is identified in a Formal Review Decision or a Final Decision resulting from a hearing, the case shall be forwarded by TMA OGC to the appropriate contractor for development and initial recoupment action in accordance with this section. If the contractor is unsuccessful in collecting the debt, the case shall be returned to the TMA OGC in accordance with [paragraph 19.0](#).

## **27.0 OFFSET RECOUPMENT/PARTIAL PAYMENT**

**27.1** If the debtor is a hospital subject to the **Diagnosis** Related Group (DRG)-based payment system, offsets may be taken not only against claims on which payment would be issued to the debtor hospital, but also against annual payments due to debtor hospital as reimbursement for its capital and direct medical education (CAP/DME) costs. If the full amount is recouped through

offset, an adjustment claim shall be reported with the current claim or in the next payment run. If the receivable was written off, it shall be reversed. If the receivable was transferred to TMA, immediately notify the Recoupment Division, TMA OGC, telephonically and follow up by letter within two work days after the telephone call. Also, reverse the transfer transaction on the next Accounts Receivable Report.

**27.2** If a debtor has entered into an installment repayment agreement and has asked the contractor to continue to offset against future claims, the amount offset shall be applied first to interest and then to principal, as installment payments are applied. Generally, though, offset amounts shall be applied only to principal.

**27.3** When a debt has been paid either by offset, partial payment or installment payments, to within \$10.00 of the total amount due, including interest, if applicable, the contractor may consider the debt paid in full, if it is practical to do so. If the contractor chooses to consider the debt paid in full when the balance has been reduced to \$10.00 or less, the debtor shall be so advised.

## **28.0 REQUESTS FOR RELIEF OF INDEBTEDNESS**

The contractor is not authorized to compromise or to suspend or terminate collection actions on federal claims. Requests for relief based upon financial hardship shall be handled in accordance with the below paragraphs. Requests for suspension of recoupment action pending the outcome of an appeal filed in accordance with [32 CFR 199.10](#), shall be forwarded to the TMA OGC.

### **28.1 Account Balance Of Less Than \$600**

When debtors request relief from all or a portion of their indebtedness, including requests for relief from the assessment of interest, penalties, and administrative charges, the contractor shall remove the offset flag and ask the debtor to complete a Financial Affidavit (see [Addendum A, Figure 10.A-23](#) and [Figure 10.A-25](#)). The debtor will be notified that consideration cannot be given to his/her request for relief unless the completed Financial Affidavit is returned within 30 days. If the debtor fails to return the completed Financial Affidavit within 30 days, the offset flag shall again be set and recoupment action shall continue as though no request for relief had been made. When the completed Financial Affidavit is received, the contractor shall forward the affidavit, along with a copy of the demand letter(s), and the debtor's request for relief to the TMA OGC. If directed to do so by TMA, following the review of the debtor's request for relief, the contractor shall reset the offset flag and proceed with normal recoupment procedures.

### **28.2 Account Balance Of \$600 Or More**

The contractor shall remove the offset flag upon receipt of a request for relief from indebtedness and ask the debtor to complete a Financial Affidavit. The debtor will be notified that consideration cannot be given to his/her request for relief unless the completed Financial Affidavit is returned within 30 days. When the completed affidavit is received, the entire recoupment case as outlined in [paragraph 19.0](#), including the completed Financial Affidavit, shall be referred to the TMA OGC, for resolution. If the debtor fails to return the completed Financial Affidavit within 30 days, the offset flag shall again be set and recoupment action shall continue as though no request for relief had been made. This paragraph does not apply to the automatic waiver of interest on accounts paid within the first 30 days. Once a case has been established, the contractor shall stop or amend a recoupment action, as necessary, to correct a contractor error.

## Chapter 11

### Beneficiary Education And Support Division (BE&SD)

Section/Addendum	Subject/Addendum Title
1	Education Requirements
2	Government Staff And Beneficiary Education
3	TRICARE Service Centers (TSCs)
4	Beneficiary, Congressional, Media, Beneficiary Counselling and Assistance Coordinator (BCAC), Debt Collection Assistance Officer (DCAO), And Health Benefit Advisor (HBA) Relations
5	Inquiry Services Department - General
6	Correspondence Control, Processing, And Appraisal
7	Telephone Inquiries
8	Allowable Charge Reviews
9	Grievances And Grievance Processing
10	Collection Actions Against Beneficiaries
A	TRICARE Logo Figure 11.A-1 Requirements And Guidelines For The Use Of The TRICARE Logo



## Education Requirements

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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) Beneficiary Education and Support Division (BE&SD), 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. BE&SD 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 BE&SD 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 BE&SD 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/BE&SD. 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 beneficiary educational materials which may include printed and electronic media. 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. BE&SD and the TROs will review all recommendations and will prioritize products in accordance with funding availability. TMA/BE&SD 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** The MCSC shall distribute TRICARE information using effective methods that ensure timely delivery and receipt to all MHS beneficiary households in the region based on Defense Enrollment Eligibility Reporting System (DEERS) data. See Exhibit B, Contract Data Requirements List (CDRL), DD Form 1423, P050 for the Marketing and Education Plan. In addition, the MCSC shall be required to do a mailing pertaining to a benefit update, within the contract period, to all eligible beneficiary households. The MCSC shall furnish enrollment information and forms, network provider information, Health Care Finder (HCF) information, claims forms, claim completion instructions, the TRICARE Handbook, DEERS information and other informational materials upon request to beneficiaries, providers, and congressional offices. The MCSC shall establish and maintain effective communications with all beneficiaries (see [Section 4](#)).

**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. The MCSC may use any method of distribution that ensures timely receipt by all providers. Copies of TRICARE educational materials distributed to providers will be provided to the TMA Regional Director (RD), TMA BE&SD, and congressional offices. 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 a quarterly newsletter to all TRICARE Prime enrollees, including active duty personnel, dual-eligible beneficiaries, congressional offices, and Health Benefits Advisors (HBAs). The MCSC shall also distribute an annual TRICARE Standard newsletter to beneficiaries not enrolled in Prime using information contained in DEERS or provided by beneficiaries. Newsletters will generally be no more than six double-sided pages in length (8½" x 11"). The MCSC shall not modify the content or length of the beneficiary newsletter prior to distribution. The MCSC may use any method of distribution that ensures timely delivery and receipt to all recipients.

**4.4** The TDEFIC contractor shall maintain a supply of TRICARE For Life (TFL) beneficiary educational materials. The TDEFIC contractor shall provide a copy of the most recent information upon request.

## 5.0 ORDERING EDUCATION MATERIALS

Initial requests for desired educational materials shall be submitted in accordance with paragraph 2.2 to TMA BE&SD during the development of the MOU after initial award of the MCS contract. Within 30 days of the request BE&SD 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 BE&SD 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 BE&SD 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.

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## Government Staff And Beneficiary Education

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The Managed Care Support Contractor (MCSC) will conduct training for Military Health System (MHS) providers and staff regarding the TRICARE benefit. MCSCs will also develop a beneficiary education program to educate beneficiaries concerning all components of the TRICARE benefit to include the TRICARE Standard Program, TRICARE Prime, and Extra programs, and the TRICARE For Life (TFL) Program. Training materials may include a broad range of materials (slides, CDs DVDs). The Government is responsible for material development. Contractor suggestions for additional materials shall be reviewed and approved by the Government on a case-by-case basis.

### 1.0 EDUCATION REQUIREMENTS FOR GOVERNMENT PERSONNEL

**1.1** The MCSC shall conduct one three-day TRICARE training course each quarter covering all aspects of the program including, but not limited to, TRICARE, overseas, and dual-eligibles. The location of the course shall be within the region; however, the exact location will change each quarter to allow maximum participation by Government personnel who require an in-depth understanding of TRICARE to successfully accomplish their assigned duties. The contractor shall follow the Government-provided training material in delivering the course. The Government will provide all handouts for the course. Government furnished facilities may be provided if determined by the Government to be in the best interest of the Government. The Government will be responsible for registration of attendees and collection of attendee evaluations. The MCSC will provide written feedback to the Government following each course to assist the Government in providing appropriate training materials. The TRICARE Regional Office (TRO) will provide oversight of the training.

**1.2** The MCSC shall conduct three one-hour training sessions, followed by a question and answer session, for clinical and administrative personnel at each Military Treatment Facility (MTF) monthly. Training sessions will be at the date and time specified by the MTF Commander and shall correspond with the hours personnel work at the facility. The contractor shall follow the Government-provided training material in delivering the course which will cover all aspects of TRICARE including, but not limited to, TRICARE Prime, Extra, and Standard, the financial impact of MTF decisions on both the beneficiary and the MHS. The Government will provide all training materials and handouts for the course. Government-furnished facilities will be provided for the course location.

**1.3** The MCSC shall provide one one-hour briefing, followed by a question and answer session, weekly to an audience specified by the MTF Commander. Such audiences might be Ombudsmen, support groups, obstetrical patients, retiree groups, parent groups, or dual-eligibles. The contractor shall follow the Government provided training material in delivering the course. Government-furnished facilities will be provided for the course location. The MCSC shall actively announce each briefing time, location, and audience through base publications, local fraternal organizations, and flyers posted throughout the installation.

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

## Chapter 11, Section 2

### Government Staff And Beneficiary Education

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**1.4** The MCSC shall conduct three one-hour briefings, followed by a question and answer session, for military recruiters in the region, annually. Whenever possible, the briefings shall occur during the recruiters' annual regional/district conference, and cover all aspects of TRICARE. The contractor shall use the Government provided training materials (slides, notes, etc.) in delivering the course. The Government will provide all handouts for the course. Government-furnished facilities will be provided for the course location.

**1.5** The MCSC shall provide one one-hour briefing covering all aspects of TRICARE, followed by a question and answer session, annually, at each Reserve/National Guard unit listed in the web sites below. The Regional Director (RD) will provide the date and time of each briefing. The MCSC shall use the Government-provided training materials (slides, notes, etc.). Government-furnished facilities will be provided at the course location. The Government will provide all handouts for the course.

- Air National Guard: [http://www.goang.com/about/aboutang\\_locations.aspx](http://www.goang.com/about/aboutang_locations.aspx)
- Army National Guard: <http://www.arng.army.mil/tools/unit.asp>
- Navy Reserve: <http://www.navalreserve.com>
- Marine Reserves: <http://www.marforres.usmc.mil/Units>
- Air Force Reserves: <http://www.afrc.af.mil/units.htm>
- Army Reserves: <http://www.army.mil/organization/reserveunits.html>
- Coast Guard Reserves: <http://www.uscg.mil/hq/reserve/reshmpg.html>

## **2.0 BENEFICIARY SURVEYS**

In accordance with Department of Defense Instruction (DoDI) 1100.13, and Health Affairs Policy Memorandum 97-012, surveys of military members, retirees and their families must be approved and licensed through issuance of a Report Control Symbol (RCS). Contractors shall not conduct written or telephonic beneficiary surveys without the approval of the TRICARE Management Activity (TMA) Health Program Analysis and Evaluation Directorate (HPA&E). TMA has an ongoing survey research and analysis program which includes periodic population-based and encounter-based surveys of DoD beneficiaries. The surveys address beneficiary information seeking strategies and preferences, health status, use of care, satisfaction with military and civilian care, and attitudes toward TRICARE. The data are collected at the Prime Service Area (PSA) level and can be aggregated to the regional level. Regional reports containing PSA data are available through the RD. Contractors shall work with the RDs to define both their ongoing and special purpose requirements for survey data. Contractors with special needs not met by an existing instrument may submit surveys, sampling plans, and cost estimates through the RD to the TMA, HPA&E, for approval and licensing.

## **3.0 BENEFICIARY CONTACT DATA**

MCSCs shall collect and report customer service and beneficiary support workload to include categorization of the reason and volume of beneficiary inquiries received by call center and TRICARE Service Center (TSC) activities in accordance with government-directed data collection requirements contained in the contract and as directed in [Chapter 14](#).

## TRICARE Service Centers (TSCs)

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### 1.0 LOCATION AND OPERATIONS

TRICARE Service Centers (TSCs) shall be established at each Military Treatment Facility (MTF). If space provided at an MTF is not sufficient, the contractor shall be responsible for obtaining any additional space. TSCs located in an MTF shall be operated, at a minimum, Monday through Friday (except Federal holidays) during the administrative hours of the facility. The Managed Care Support Contractor (MCSC) shall staff all TSCs on a full-time basis with qualified personnel capable of performing all functions of the TSC, and be responsible for its operations. The TSC shall meet the standards in [Chapter 1, Section 3](#), as applicable. The contractor shall provide all furniture, equipment, supplies, telephone services, etc., required at each TSC regardless of where it is located.

### 2.0 TSC FUNCTIONS

**2.1** The contractor shall establish TSCs to provide all Military Health System (MHS) beneficiaries with information and services as specified below. The contractor shall ensure eligibility for care and enrollment status of beneficiaries before making any arrangements for medical services. TSCs shall have an interface with the automated claims processing and enrollment systems to support the functions of the TSC No Later Than (NLT) 30 calendar days prior to the start of the health care delivery.

**2.2** The contractor shall establish TSCs that provide all MHS beneficiaries with enrollment information, access to and referral for care, information on the Point of Service (POS) option, information (including on-line access to the claims processing system for information about the status of a claim), assist beneficiaries with claim problems when the MCSC is responsible for processing the claim and continuity-of-care services to all MHS beneficiaries including, but not limited to, active duty personnel, dependents of active duty personnel, retirees and their dependents, survivors, Medicare-eligible beneficiaries and all other categories of individuals eligible to receive MHS services. Based on the Memorandum of Understanding (MOU) provisions between the MTF Commander and the MCSC, the MCSC shall ensure effective operation of the TSCs to reflect the provisions in [Chapter 15, Section 1, paragraph 1.0](#). TSCs shall have a fully operational, on-line interface with the automated claims processing and enrollment systems to support the functions of the TSC NLT 30 calendar days prior to the start of the health care delivery and shall maintain that interface through the life of the contract. The activities of the TSC shall include:

#### 2.2.1 MHS Beneficiary Information

TSCs shall provide personal assistance to all MHS beneficiaries seeking information about TRICARE Prime, TRICARE Extra, TRICARE Standard and TRICARE For Life (TFL). The MCSC shall ensure that the TSCs are supplied with enrollment and educational information for TRICARE Prime, Extra, and Standard, dual-eligible program and claims submission information, Civilian Health and

Medical Program of the Department of Veteran Affairs (CHAMPVA) TRICARE dental programs and all other relevant materials. Through the TSCs, the MCSC shall establish mechanisms to advise beneficiaries of care options, including the POS option, and services offered.

### 2.2.2 Continuity Of Care

TSCs shall act as the focal point for providing information, referral, and assistance to beneficiaries seeking access to TRICARE services. The TSCs shall maintain day-to-day liaison with MTF officials to promote MTF optimization and ensure effective performance of the access, referral, information, and continuity of care functions.

### 2.2.3 Enrollment

TSCs shall provide personal assistance to eligible beneficiaries electing to enroll or disenroll, and permanently assigned active duty personnel enrolling in TRICARE Prime. The TSC shall provide assistance to all MHS beneficiaries, including active duty, Medicare eligibles, and others, in understanding program requirements, by answering questions, adhering to MTF Commanders' and Regional Directors' (RDs') determinations for Primary Care Manager (PCM) assignment, and following grievance and inquiry procedures in accordance with this chapter.

2.2.4 TSCs shall maintain up-to-date lists of the providers in the contractor's network. MTF commanders, RDs, and MHS beneficiaries shall be granted access to these lists on an as-needed basis.

2.2.5 TSCs shall provide lists of Direct Care (DC) PCMs to RDs and MHS beneficiaries when required for PCM selection, if these lists are provided to the TSC by the MTF.

2.2.6 TSCs shall assist all TRICARE beneficiaries with all claims issues when the MCSC is responsible for processing the claim. When the MCSC is not responsible for processing the claim, the TSC shall assist the beneficiary in identifying and contacting the organization that is responsible for processing the claim.

2.2.7 If requested by the MTF Commander, the contractor shall place a suggestion box in the TSC at a location recommended by the MTF Commander. Copies of the suggestions or comments received in the suggestion box shall be furnished to the MTF Commander when requested.

### 2.2.8 TRICARE Dental Program (TDP) Information

2.2.8.1 TSCs shall provide information on eligibility for the TDP and on how to obtain dental information from the TDP contractor. Active duty members and their families shall be informed of their possible eligibility, handed a TDP brochure containing enrollment and coverage details, and provided the following:

**The TDP is for active duty families, Selected Reserve and IRR members, and their family members**

If you are interested in enrolling your dependents in the TDP, please contact United Concordia Companies, Inc. (UCCI), to receive information on what dental benefits are covered, procedures for enrolling your family, and the amount of the enrollment fees. The Health Benefit Advisor (HBA) can also assist you with

## Beneficiary, Congressional, Media, Beneficiary Counselling and Assistance Coordinator (BCAC), Debt Collection Assistance Officer (DCAO), And Health Benefit Advisor (HBA) Relations

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### 1.0 GENERAL

In a service relations program, the contractor's primary responsibilities are to the beneficiaries and the providers. However, in meeting these responsibilities, it is frequently necessary to respond to Congressional Offices or to Beneficiary Counselling and Assistance Coordinators (BCACs), Debt Collection and Assistance Officer (DCAO), and Health Benefit Advisors (HBAs) who are intervening on behalf of a beneficiary or provider. To facilitate handling of these contacts, the contractor should establish a working relationship with the Congressional delegations in each state and with the BCACs, DCAOs, and HBAs in the Region. These individuals can often assist in resolving questions/problems of the beneficiary and provider population.

### 2.0 BENEFICIARY RELATIONS

The contractor will be invited to attend and participate in beneficiary meetings, such as the retired military associations. These meetings provide opportunity for the contractor to make presentations and distribute educational materials to the beneficiaries.

### 3.0 CONGRESSIONAL AND HBA RELATIONS

The contractor is responsible for performance of the following minimum functions in carrying out a Congressional and HBA relations programs within the region.

#### 3.1 Establish Communications

**3.1.1** The contractor shall establish and maintain effective communication with the Congressional office staffs, BCACs, DCAOs, and HBAs in the Region. To do this, the contractor shall establish procedures and provide staffing to perform all necessary functions.

**3.1.2** The contractor shall provide written notification of the contractor's point(s) of contact [name(s), address(es), e-mail addresses and phone number(s)] to all congressional offices and BCACs, DCAOs, and HBAs serving the region. The contractor shall provide separate telephone numbers (lines) reserved exclusively for congressional offices and BCACs, DCAOs, and HBAs. This service is not required to be toll-free; however, the contractor shall provide sufficient telephone lines and TRICARE-dedicated staff to meet the requirements in [Chapter 1, Section 3](#). In addition, when it is appropriate because of the volume or character of Congressional office inquiries received, a contractor representative may visit a Congressional office to resolve problems and/or

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educate the staff about TRICARE operations and requirements. In most MTF Prime Service Areas (PSAs), it is expected that the contractor's TRICARE Service Center (TSC) staff will have regular, if not daily, interface with the BCACs, DCAOs, and HBAs. In other areas, the contractor shall develop a program of regular BCAC, DCAO, and HBA contact which includes a contractor representative meeting with the BCACs, DCAOs, and/or HBAs at least semi-annually. When serious problems or other needs arise, more frequent contact will be required.

#### 4.0 SPECIAL BCAC, DCAO, HBA MEETINGS

TMA conducts workshops with HBAs in various locations throughout the year. The contractor shall provide representation to participate in the workshops where BCACs, DCAOs, and HBAs from the contractor's region will be present in significant numbers. TMA will provide at least 30 calendar days notice of such a requirement. TMA will also outline the expected nature of contractor's participation. If a contractor has a specific problem or issue which should be addressed at an BCAC, DCAO, and HBA meeting, TMA should be notified at least 21 days prior to the scheduled meeting.

#### 5.0 MEDIA RELATIONS

Media relations programs implemented by the Government and the Managed Care Support Contractor (MCSC) on behalf of the Government will have three objectives: educate beneficiaries about changes to their TRICARE benefit, respond to media queries quickly and accurately; and inform the American public about Government activities related to the TRICARE program. The MCSCs will conduct a media-relations program in accordance with Department of Defense (DoD) guidelines and guidance provided by TMA/**Beneficiary Education and Support Division (BE&SD)**. The MCSC will provide regular feedback to TMA **BE&SD** regarding their media activities, including coordination of proposed responses to media queries for sensitive and controversial issues. The MCSC will keep TMA **BE&SD** and TRICARE Regional Office (TRO) leadership aware of public and beneficiary perceptions regarding TRICARE policies and procedures, and advise TMA on proposed communication strategies for responding to these issues. All published materials will communicate consistent TRICARE program messages with one voice and tone. MCSCs will perform the following in their media relations program:

**5.1** Establish and maintain effective working relationships with members of the regional and local news media.

**5.1.1** Contractors are encouraged to work directly with the news media to provide information on new programs, changes to the benefit, and other "good news" stories.

**5.1.2** Contractors will also be expected to respond to media questions about contractor roles, responsibilities and actions on behalf of the Government in support of the TRICARE program.

**5.1.3** Contractors must work closely with the Government to ensure that information provided to the media is consistent and accurate.

**5.1.3.1** Contractors should coordinate all proposed media activities including new releases, press conferences and other media events with TMA prior to release of the information whenever feasible.

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**5.1.3.2** When immediate action is required, contractors will follow-up all media contacts by sending copies of information provided to the media and a summary of any discussions to **BE&SD**.

**5.1.4** Contractors shall speak only on issues for which they have direct responsibility and shall not speculate on issues beyond the scope of the support they are providing to the Government.

**5.2** Share information, including news releases, fact sheets, talking points, communications plans, and public affairs guidance with TMA/**BE&SD** to ensure TMA is aware of pending news stories and the information provided to the media.

**5.3** Assist TMA **BE&SD** in planning, designing, and implementing a comprehensive communications program that incorporates diverse functions and issues, serves numerous distinct and specialized audiences and responds rapidly, in crisis conditions to changing demands.

**5.4** Work with TMA to ensure beneficiaries receive unified, timely, accurate, consistent, and effective products and tools that improve their access, understanding, and appreciation of TRICARE.

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## Inquiry Services Department - General

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### 1.0 INQUIRY SERVICE DEPARTMENT OBJECTIVES

Contractors shall implement an inquiry processing service which ensures that all inquiries received from TRICARE beneficiaries, providers, and other interested parties are processed in a timely and consistent manner and that information delivered about the TRICARE program is accurate. The services department shall be able to assist in settling TRICARE claims and provide program information whether the inquiry is by telephone, letter, electronic media, or walk-in. For inquiries regarding active duty claims, contractors shall follow the procedures as outlined in the [Chapter 17](#).

### 2.0 WRITTEN INQUIRIES

The contractor shall process both routine and priority correspondence in accordance with the standards and requirements set forth in [Chapter 1, Section 3](#).

### 3.0 TELEPHONES

The contractor shall provide trained personnel to answer all TRICARE inquiries [beneficiaries, Regional Directors (RDs), providers, Assistant Secretary of Defense (Health Affairs) (ASD(HA)), TRICARE Management Activity (TMA), Beneficiary Counselling and Assistance Coordinators (BCACs), Debt Collection and Assistance Officer (DCAO), Health Benefit Advisors (HBAs), and congressional offices]. TRICARE has established the TRICARE Information Service (TIS), reachable by a series of 1-800-XXXX telephone numbers. The TIS will refer incoming calls to the appropriate contractor for action. The Managed Care Support Contractor (MCSC) and TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) contractor and the TRICARE Pharmacy (TPharm) contractor shall provide the Procuring Contracting Officer (PCO) with the single telephone number to which these calls shall be routed No Later Than (NLT) 150 calendar days prior to the start of services.

### 4.0 WALK-IN INQUIRIES

The contractor shall provide for appropriate space and trained staff to enable it to handle walk-in inquiries promptly and accurately. The facility shall include a reception area to accommodate persons visiting its offices about TRICARE matters. The work area shall provide sufficient privacy to reasonably prevent violation of the Privacy Act or Health Insurance Portability and Accountability Act (HIPAA). The contractor staff shall be trained to meet with, and properly respond to, all visitors giving prompt, accurate answers to their concerns. Because personal interviews are difficult to monitor for quality of the contact, only the most skilled persons should be assigned.

## **5.0 TRAINING OF SERVICE REPRESENTATIVES**

All representatives must be knowledgeable with a high level of communication skills. Online access to claims history and all other necessary information shall be provided. Service representatives must be thoroughly trained in the areas outlined in [Chapter 1](#). Special emphasis should be placed on medical terminology, program benefit policies (including both TRICARE Standard, Extra, and Prime) and how the programs are applied in processing, Privacy Act and Freedom of Information Act (FOIA) requirements, contractor claims processing system capabilities, and training in the identification and reporting of potential fraud and abuse situations. All personnel shall receive communications training including how to listen for content, ensure customer courtesy and effectively manage time.

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## Correspondence Control, Processing, And Appraisal

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### 1.0 GENERAL

The contractor shall provide timely, accurate answers to all TRICARE inquiries. Written inquiries received shall be sorted and categorized as defined in [paragraph 3.0](#). For standards, refer to [Chapter 1, Section 3](#). On all outgoing correspondence from the contractor to the beneficiary, if the SSN is used it shall be limited to the last four digits.

### 1.1 Correspondence Receipt And Control

The contractor shall establish and maintain an automated control system for routine and priority correspondence, appeals, and grievances which meets the requirements of [Chapter 1, Section 3](#); [Chapters 11](#); and [12](#). The contractor shall capture and retain needed data for input to workload and cycle time aging reports.

### 1.2 Availability Of information

Information required for appropriate responses to inquiries, must be retrievable from the contractor's internal records as specified in [Chapter 2, Section 1](#).

### 2.0 CONTROL

Correspondence shall be controlled and stamped with the actual date of receipt in the contractor's custody. The control system shall be automated unless the contractor receives approval for another system which will produce comparable results. When appropriate, contractor must be able to associate incoming correspondence with prior inquiries. All correspondence or other documents received or generated in the services department shall be filed in accordance with [Chapter 2, Section 1](#). If correspondence is answered by telephone, a record of the conversation shall be filed with the inquiry.

### 3.0 CATEGORIES OF CORRESPONDENCE

All incoming correspondence shall be separated into the following categories for reporting purposes:

- Appeals
- Grievances
- Priority correspondence
- Routine inquiries
- Allowable Charge Complaints

#### **4.0 ROUTINE CORRESPONDENCE**

**4.1** Responses may be provided by telephone, form letter, preprinted information, or individual letter as appropriate. A copy of the response shall be filed with the inquiry. The text of written responses shall be typed. On form letters or preprinted information, the address may be neatly handwritten, if the contractor chooses. In situations of potential fraud or abuse, a referral to the contractor's Program Integrity Unit shall be completed and a copy of the referral filed with the correspondence. For beneficiary and provider services standards, see [Chapter 1, Section 3](#).

**4.2** The contractor shall develop inquiries that do not contain enough information to identify the specific concern, using the quickest and most cost effective method for acquiring the information. Telephone contact is recommended. After a reasonable effort has been made to acquire the missing information, the contractor shall notify the correspondent that a response is not possible without the requested information. The contractor may then close the item for reporting purposes.

**4.3** Correspondence status inquiries, such as "tracer" claims from providers or beneficiaries and provider and beneficiary letters inquiring about the status of a claim, may be closed without a written response if the claim was processed within five calendar days prior to receipt of the inquiry. The day that the determination was made that the inquiry may be closed without a written response is the day the inquiry is to be closed for correspondence cycle time purposes. Otherwise, "tracer" claims, usually submitted by providers, are to be researched to determine whether the initial claim was received. If the initial claim was received and processed to completion, the contractor shall advise the provider of the date processed and the amount of payment, if any, or reason for denial. If the initial claim was not received, the contractor shall indicate this on the claim and submit the claim for normal processing, advising the provider of this action.

#### **5.0 PRIORITY CORRESPONDENCE**

**5.1** Priority written correspondence is correspondence received from members of the U.S. Congress, the Office of the Assistant Secretary of Defense (Health Affairs) (OASD(HA)), TRICARE Management Activity (TMA), a Regional Director's (RD's) office and such other classes as may be designated as "priority" by the Contracting Officer (CO). Inquiries from the Surgeons General, Flag Officers, and state officials, such as insurance commissioners, are considered priority correspondence.

**5.2** The contractor shall forward all Congressional inquiries involving Defense Enrollment Eligibility Reporting System (DEERS) to the DEERS Research and Analysis Section, Defense Manpower Data Center (DMDC)/DEERS, 400 Gigling Road, Seaside, California 93955-6771, including any claim information required for that organization to respond to the inquiry. A notification shall be sent to the Congressional office informing it that the letter has been forwarded to the DMDC Support Office (DSO).

**5.3** For priority written inquiry standards, refer to [Chapter 1, Section 3](#). The MCSC will forward all copies of Congressional correspondence to TMA including the correspondence from the Congressional office and the MCSC response.

## Telephone Inquiries

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### 1.0 TELEPHONE SYSTEM

**1.1** The contractor shall provide an incoming telephone inquiry system. All telephones must be staffed and able to respond in a manner that meets performance standards throughout the entire period. A recorded message indicating normal business hours shall be used on the telephone lines after hours. Calls will be handled in the order they are received. The phone number(s) shall be published on the Explanation of Benefits (EOB) and otherwise be made known to beneficiaries, providers, Beneficiary Counselling and Assistance Coordinators (BCACs), Debt Collection and Assistance Officer (DCAO), Health Benefit Advisors (HBAs), and Congressional offices.

**1.2** The telephone system must include a 24-hour, seven days a week, nationally accessible service, for all Military Health System (MHS) beneficiaries, including beneficiaries traveling in the contractor's region, seeking information and/or assistance in locating a network provider, to include behavioral health providers willing to accept TRICARE. Callers seeking this information must have the ability to speak with live personnel. These personnel shall be able to enter authorizations for urgent care for beneficiaries traveling outside of their Prime Service Area (PSA).

### 2.0 RESPONSIVENESS

Telephone inquiries shall be answered according to the standards in [Chapter 1, Section 3](#). Contractors may respond to telephone inquiries by letter if they cannot contact the caller by phone or if a complex explanation is required. The contractor staff shall be trained to respond in the most appropriate, accurate manner. Telephone inquiries reporting a potential fraud or abuse situation shall be documented and referred to the contractor's Program Integrity Unit.

### 3.0 REQUIREMENTS

There should be no differentiation in the service provided whether the call originates locally or through the toll-free lines. The contractor shall provide the availability of telephone contact as a service to all TRICARE inquiries (active duty personnel, TRICARE beneficiaries, dual-eligible beneficiaries, Regional Directors (RDs), providers, Assistant Secretary of Defense (Health Affairs) (ASD(HA)), TRICARE Management Activity (TMA), BCACs, DCAOs, HBAs, and Congressional offices). At a minimum, the telephone system shall be fully staffed and service shall be continuous during normal business hours which are defined as 8:00 a.m. through 6:00 p.m. (except weekends and holidays) in all time zones within the region. All customer service provided by telephone shall be without long distance charges to the beneficiary. Telephone service is intended to assist the public in securing answers to various TRICARE questions including, but not limited to:

**3.1** General program information;

**3.2** Specific information regarding claims in process and claims completed, including explanations of the methods and specific facts employed in making reasonable charge and medical necessity determinations, and information regarding types of medical services submitted (The contractor shall transfer out-of-jurisdiction calls requiring the assistance of another contractor. The contractor shall answer program information and network provider availability/assistance calls without regard to jurisdiction.);

**3.3** When the inquiry concerns questions about Defense Enrollment Eligibility Reporting System (DEERS) or DEERS eligibility, the contractor shall refer the caller to the Defense Manpower Data Center (DMDC) Beneficiary Telephone Center, 6:00 a.m. to 3:30 p.m. Pacific Time, toll-free 1-800-538-9552, TTY/TDD 1-866-363-2883. These numbers cannot be used by the TSC or other service provider; they are only for the beneficiary's use.

**3.4** Additional information needed to have a claim processed;

**3.5** Information about review and appeal rights and the actions required by the beneficiary or provider to use these rights.

**3.6** Information about and procedures for the TRICARE Program.

**3.7** Information concerning benefit authorization requirements and procedures for obtaining authorizations. Provisions must be included to allow the transfer of calls to the authorizing organization (within the contractor's organization, to include subcontractor) without disconnecting the call.

### **3.8 Telephone Standards**

Refer to [Chapter 1, Section 3, paragraph 3.4](#).

### **3.9 Toll-Free Telephone Service**

Toll-free service can be provided by a number of means available from local telephone companies. These include, but are not limited to: Wide Area Telephone Service (WATS), and Foreign Exchange (FX) lines. The contractor is not restricted to the use of any long distance carrier and may change companies at its discretion to improve the efficiency and cost effectiveness of the toll-free service. Should changes in long distance carriers occur, these changes must be transparent to MHS beneficiaries and providers. The Procuring Contracting Officer (PCO) shall be notified of any proposed change in companies at least 30 calendar days prior to the actual change of companies. The contractor shall advertise the toll-free service using all available media including the EOB; newsletters; telephone directories published by the contractor, military organizations, etc. and other appropriate sources.

### **3.10 Telephone Monitoring Equipment**

The contractor or telephone company with which the contractor does business shall have telephone equipment that is programmed to measure and record response time and determine whether standards are always met. The Managed Care Support Contractor (MCSC) will provide to TMA **Beneficiary Education and Support Division (BE&SD)** and the TRICARE Regional Offices (TROs) the opportunity to provide real-time monitoring of call center operations. The equipment shall

provide machine-generated counts to:

### **3.10.1 Measure Busy Signal Level**

“Busy signal level” is defined as the percentage of time a caller receives a busy signal. The busy signal rate shall be expressed as a percentage, which is to be determined as follows: divide the number of calls answered by the contractor by the number of calls reaching and attempting to reach the contractor.

### **3.10.2 Measure Call Volumes And Handling Times**

Contractors shall measure the number of calls received each month and the time elapsing between acknowledgment and handling by a telephone representative or Automated Response Unit (ARU). Measures shall include all calls that are directly answered by an individual or ARU (no waiting time). The on-hold time period begins when the telephone call is acknowledged and does not include the ring time.

## **3.11 Additional Equipment Requirements**

The contractor shall furnish the following:

**3.11.1** Access to a CRT for each telephone representative to retrieve or provide the information required in [paragraphs 3.0](#) through [3.7](#). The Computer Remote Terminal (CRT) shall be located to allow the telephone representatives to research data without leaving their work stations.

**3.11.2** Outgoing lines sufficient to allow call backs.

**3.11.3** Hard copy management reports regarding All Trunks Busy (ATB) data and the waiting time measurements. The hard copy management reports shall also include the total number of calls received, the number where all questions presented were answered at the time of the call, the number fully answered within 10 calendar days, the number fully answered within 20 calendar days, and the percentage of each.

**3.11.4** A supervisor’s console to monitor telephone representatives’ telephone calls for accuracy, responsiveness, clarity, and tone.

**3.11.5** Automatic call distributors and ARUs with after hours message recorders, an automated, interactive, 24-hour call-handling system designed to ensure maximum access to the toll-free lines. This system shall provide automated responses to requests for general program information and to beneficiary requests for claims status.

## **4.0 REPORTS**

Telephone activity shall be reported in accordance with contract requirements.

**5.0 TELEPHONE APPRAISAL SYSTEM**

The contractor shall establish a monitoring system or other methods to ensure quality of performance.

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## Allowable Charge Reviews

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### 1.0 GENERAL

Beneficiaries and providers have the right to question the amount allowed for services received or rendered for non-network care. Network providers should have complaint procedures included in their contracts or the administrative procedures established with the TRICARE contractor. When a complaint is received, the accuracy of the application of the reimbursement methodology, including the procedure code and the profile development must be verified. The amount of the allowance is not an appealable issue under the appeals procedures and the program.

### 2.0 ALLOWABLE CHARGE REVIEW CRITERIA

#### 2.1 Requirements

The allowable charge inquiry must be received or postmarked within 90 days from the date of the Explanation Of Benefits (EOB) or it may be denied for lack of timeliness. If the inquiry is in writing and the issue is not clearly a question of allowable charge, any doubt must be resolved in favor of handling the case as an appeal under [Chapter 12](#). The contractor shall respond only to a person entitled to the information; i.e., beneficiary, parent/guardian, participating provider, other TRICARE contractors, or TRICARE Management Activity (TMA). Allowable charge complaints shall be reported on the workload report as required by the contract.

#### 2.2 Allowable Charge Complaint Procedures

An allowable charge complaint need not be submitted in writing. Oral inquiries or complaints shall be documented on a contact report, by contractor staff. The handling requirements for timeliness of contractor processing are the same as for routine or priority correspondence. Occasionally the allowable charge complaint or inquiry will be sent directly to TMA instead of the contractor. When this occurs, the complaint/inquiry will be forwarded to the contractor for response. Upon receipt of an allowable charge complaint, the contractor shall recover the claim and all related documents necessary to completely review the case and establish accuracy of processing. The following checklist is suggested:

**2.2.1** Was the correct procedure code used?

**2.2.2** Were there any clerical errors, such as wrong type of service code, which may have caused the difference?

**2.2.3** Did the case go to medical review?

**2.2.4** Was all needed medical documentation present to make a completely accurate determination?

**2.2.5** Should the case be further documented and referred to medical review?

**2.2.6** Was the profiled fee calculated correctly?

**Note:** Contractors need not routinely validate the fee calculation; however, if the difference between billed and allowed is 20% or more, the dollar value of the difference is significant and all other factors appear to be correct, there is reason to question the validity of the fee.

### **2.3 Responses To Allowable Charge Complaints**

A written response to allowable charge complaints is preferred, but the inquiry can be handled by documented telephone call, as may other correspondence. If the complaining party indicates dissatisfaction with the contractor's oral explanation of an adverse determination, the contractor will send a detailed letter advising of the results. The beneficiary or provider must be offered a written response in all cases.

#### **2.3.1 Adverse Determination**

If the processing and payment were correct, the inquirer shall be told of the outcome and advised of the methodology for determining allowable charges. The explanation shall clearly indicate that the determination was based on the information presented and, if more complex procedures were involved or if the case was unusually complex, whether additional information could change the determination. If such information is available to the inquirer, it should be submitted to the contractor for further review. If, after the contractor's review, it is determined that the original amount is still correct, the inquirer shall be informed that this is the final determination.

#### **2.3.2 Additional Payment Due**

If it is found that an error has occurred, or if added information is secured which changes the determination, an adjustment shall be made. The notice of the determination shall explain the reason for the adjustment. Adjustments shall be prepared in accordance with instructions in [Chapter 10](#).

### **3.0 EXCESS CHARGES BILLED IN PARTICIPATING PROVIDER CLAIM CASES**

If an allowable charge inquiry/complaint indicates a participating provider is improperly billing for more than the allowable charge, refer to [Chapter 13](#).

### **4.0 CHAMPUS MAXIMUM ALLOWABLE CHARGE SYSTEM**

**4.1** For allowable charge complaints involving reimbursement based on the CHAMPUS Maximum Allowable Charge (CMAC) System, the contractor shall have no responsibility for determining whether or not the profiled fee for any given Medicare locality was calculated correctly. Once the contractor verifies that the correct procedure code was used, no data entry errors were made (including determination of where the service was rendered), and that referral to

second level or medical director review was appropriate, the contractor shall respond to the inquiry stating that the payment calculation was correctly computed.

**4.2** If it is determined that an error was made by the contractor in calculating the correct payment, the contractor shall follow the procedures in this section.

**4.3** In the event TMA determines that an error was made in the basic CMAC calculations, the contractor will receive a letter from TMA with the corrected CMAC. The contractor shall replace the incorrect CMAC with the corrected CMAC as soon as possible, but No Later Than (NLT) 10 working days after receipt of the TMA letter. Contractors are not required to adjust all the claims processed with the incorrect CMACs; however, contractors shall adjust any claims which were processed using the incorrect CMAC when a provider or beneficiary requests that adjustment.

## **5.0 DIAGNOSIS RELATED GROUP (DRG) REVIEWS**

The request from a hospital for reclassification of a claim to a higher DRG must be received or postmarked within 60 days from the date of the EOB; otherwise, the request will be denied for lack of timeliness. The contractor review is the final determination; there is no further review.

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## Grievances And Grievance Processing

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### 1.0 GRIEVANCE PROCESSING JURISDICTION

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

### 2.0 GRIEVANCE SYSTEM

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

### 3.0 CONTRACTOR RESPONSIBILITIES

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

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

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

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

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

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

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

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

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

- END -

## Collection Actions Against Beneficiaries

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### 1.0 GENERAL

**1.1** No patient, family member or sponsor shall be subjected to ongoing collection action undertaken by or on behalf of a provider of services or supplies, as a result of the inappropriate non-payment of claims for services which should have been covered under TRICARE. When the Government becomes aware that such collection action has been initiated, it will intervene on behalf of the party against whom the collection action has been taken.

**1.2** While the Government will assist in the resolution of collection matters, the ultimate responsibility for resolving collection actions lies with the patient, family member, or sponsor. The Government will not provide legal representation to resolve these issues and will not pay attorneys' fees, court costs, collection agency fees, accrued interest, late charges, etc. TRICARE can only assume responsibility for collection assistance for medically necessary supplies and services as authorized for coverage under the TRICARE regulation.

### 2.0 DEBT COLLECTION ASSISTANCE INTERVENTION

Upon notification of a problem, Department of Defense (DoD) will investigate and, when appropriate, resolve and/or assist in the clarification of collection issues for TRICARE beneficiaries.

### 3.0 CONTRACTOR RESPONSIBILITIES

#### 3.1 Research Assistance

The contractor shall provide immediate assistance to the Government in support of the debt collection assistance function. In addition to identifying specific underpayments, the contractor shall also:

**3.1.1** Designate specific individuals and provide resources to work collection issues with Government representatives during normal weekday business hours.

**3.1.2** Provide Web-site access and/or e-mail addresses, mailing addresses, fax numbers and direct phone number(s) of specialized collections research and support staff to the Government.

**3.1.3** Meet required response time for problem resolution (Standard: 85% within 10 days, 100% within 30 days). Resolution is the completion of research by the Managed Care Support Contractor (MCSC) (and/or their subcontractor(s)) to define the course of actions that have taken place on the claims that have gone to collection, to correct previous erroneous actions, if any, by the MCSC or its subcontractors, and to define clearly the remaining liability, if any, which is the responsibility of the patient. The date of resolution is the date a final, case-specific response is furnished to the Government. The response shall include all the information listed in [paragraph 3.1.6](#). If applicable,

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the response to the DCAO should note that a check is being issued to the beneficiary or provider on a priority basis, and the approximate date payment is expected.

**3.1.4** Maintain records and processing statistics on collection activity. The records to be maintained shall include a detailed chronological record of all actions taken, including names and telephone numbers of all parties contacted in the course of the actions taken, as well as copies of all correspondence sent and received.

**3.1.5** When violation of the participation agreement or balance billing is not at issue, issue letters to providers and conduct provider education when the provider was at fault.

**3.1.6** The contractor shall furnish reports of all completed collection cases.

**3.1.7** In newsletters and other materials, publicize and educate beneficiaries and providers on the Debt Collection Assistance Program. This would include informing providers of the availability of the contractor's support services to assist in resolution of claims problems, and encouraging providers to contact the contractor's priority unit for assistance prior to initiating any collection action against beneficiaries. If the contractor participates in beneficiary, sponsor or provider training, workshops or briefings at Military Treatment Facilities (MTFs) or elsewhere in the Region in accordance with specific regional requirements, the Debt Collection Assistance Program should also be covered.

**3.2 Expedited Payment**

All requests for expedited payment will be coordinated through the TRICARE contractor for the region. When research reveals a processing error by the contractor or subcontractor, any additional payment due shall be processed on an expedited basis, and the MCSC's response to the Government shall reflect an expected date of payment.

**3.3 Referrals to Program Integrity, TMA**

When it has been determined that balance billing or violation of the participation agreement is at issue, the matter will continue to be handled in accordance with the existing program integrity guidelines contained in [Chapter 13, Section 6](#).

- END -

## TRICARE Logo

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**FIGURE 11.A-1 REQUIREMENTS AND GUIDELINES FOR THE USE OF THE TRICARE LOGO**



TRICARE Brand. TRICARE® is a registered trademark of the Department of Defense (DoD). Any reproduction of its trademarks and/or service mark must be in full compliance with the requirements set forth in the TRICARE® Brand Style Guide, a copy of which is available on the TMA web site at <http://www.tricare.mil/styleguide>, and all applicable statutes and DoD regulations. The TRICARE Brand includes all TMA marks using the word TRICARE, with or without a design element like the one shown above. The TRICARE Brand also includes, but is not limited to, TRICARE University, the names of TMA programs such as "TRICARE For Life" and "TRICARE Prime," and all internet domain names used by TMA or its contractors that contain the word TRICARE.

- END -



## 6.6 Hold Harmless

**6.6.1** Hold harmless provisions are applied only to care provided by a network provider. In applicable cases, the contractor and the TQMC shall include a statement explaining hold harmless, including how the provision is waived, the beneficiary's right to a refund, the method by which a beneficiary can request a refund, and must provide information regarding from what entity a refund can be requested. (See [Chapter 5, Section 1, paragraph 2.5.](#))

**6.6.2** Suggested wording for inclusion in a reconsideration determination in which a provider is a network provider is:

"If you decide to proceed with the service or it has already been provided, and the service is provided by a network provider who was aware of your TRICARE eligibility, you may be held harmless from financial liability despite the service having been determined to be non-covered by TRICARE. A network provider cannot bill you for non-covered care unless you are informed in advance that the care will not be covered by TRICARE and you waive your right to be held harmless by agreeing in advance (which agreement is evidenced in writing) to pay for the specific non-covered care. If the service has already been provided when you receive this letter and it was provided by a network provider who was aware of your TRICARE eligibility, and if there was no such agreement and you have paid for the care, you may seek a refund for the amount you paid. This can be done by requesting a refund from (**insert contractor name and address**).

Include documentation of your payment for the care, by writing to the above address. If you have not paid for the care and have not signed such an agreement, and a network provider is seeking payment for the care, please notify the TRICARE Management Activity, Beneficiary **Education and Support Division (BE&SD)**, 7700 Arlington Boulevard, Suite 5101, Falls Church, Virginia 22042-5101.

Under hold harmless provisions, the beneficiary has no financial liability and, therefore, has no further appeal rights. If, however, you agree(d) in advance to waive your right to be held harmless, you will be financially liable and the appeal rights outlined below would apply. Similarly, the appeal rights outlined below apply if you have not yet received the care or if you received the care from a non-network provider and there is \$50.00 or more in dispute."

## 6.7 Point Of Service (POS)

**6.7.1** The POS option is available to TRICARE Prime beneficiaries who seek or receive non-emergency specialty or inpatient care, either within or outside the network which is neither provided by the beneficiary's PCM or referred by the PCM, nor authorized by the contractor. The contractor and the TQMC shall provide beneficiaries who enroll in TRICARE Prime full and fair disclosure of any restrictions on freedom of choice that may be applicable to enrollees, including the POS option. Therefore, the contractor and the TQMC must explain the right of the beneficiary to exercise the POS option and its effect on the payment of benefits for services determined to be

medically necessary (additional information about the POS option can be found in the TRM, [Chapter 2, Section 3](#)).

**6.7.2** Suggested language to be included in a reconsideration determination where the beneficiary has been identified as a TRICARE Prime enrollee is:

“Should you, as a TRICARE Prime enrollee, elect to proceed with this service and the service is provided by a non-network provider, and provided the service is found upon appeal to have been medically necessary, benefits will be payable under the deductible and cost-share amounts for Point-of-Service claims and your out-of-pocket expenses will be higher than they would be had you received the service from a network provider. No more than 50% of the allowable charge can be paid by the Government for care provided under the Point-of-Service option.”

## **6.8 Appeal Rights**

The contractor and the TQMC shall state whether further appeal rights are available if the determination is less than fully favorable.

### **6.8.1 Medical Necessity Contractor Reconsideration Determinations**

If the contractor reconsideration determination is less than fully favorable, and \$50 or more remains in dispute, the contractor shall include a statement explaining the right of the beneficiary (or representative) and the non-network participating provider to request an appeal to the TQMC for a second reconsideration. Time frames to file an appeal of the contractor reconsideration determination are as follows:

#### **6.8.1.1 Expedited Preadmission/Preprocedure Reconsiderations**

The beneficiary shall file the appeal request with the TQMC within three calendar days after the date of receipt of the initial reconsideration determination. The date of receipt of the appeal request by the TQMC shall be considered to be five calendar days after the date of mailing, unless the receipt date is documented. A request for reconsideration filed with the TQMC by the beneficiary more than three calendar days after the date of receipt but within 90 calendar days from the date of the initial reconsideration determination will be addressed as a nonexpedited reconsideration.

#### **6.8.1.2 Nonexpedited Reconsiderations**

The beneficiary or non-network participating provider shall file the appeal request with the TQMC within 90 calendar days after the date of the initial reconsideration determination.

**Note:** Refer to [Section 4, paragraph 2.6.2](#) for the appeal process in concurrent review cases.

### 6.8.2 Factual Reconsideration Determination

If the reconsideration is less than fully favorable and \$50 or more remains in dispute, the contractor shall include a statement explaining the rights of the beneficiary (or representative) and the non-network participating provider to request a formal review with TMA. A request for formal review must be postmarked or received by TMA within 60 calendar days from the date of the notice of the reconsideration determination issued by the contractor.

### 6.8.3 Reconsideration Determinations Issued By The TQMC

If the reconsideration determination issued by the TQMC is less than fully favorable and \$300 or more remains in dispute, the contractor shall include a statement explaining the right of the beneficiary (or representative) and the non-network participating provider to file a request for hearing with TMA. A request for hearing must be postmarked or received by TMA within 60 calendar days from the date of the notice on the reconsideration determination issued by the TQMC. Refer to [paragraph 7.2](#) regarding hearings in preadmission/preprocedure cases in which the requested service(s) have not commenced.

### 6.8.4 When the Amount Required to File an Appeal Remains in Dispute

The following wording is suggested if the amount required to file an appeal remains in dispute. (See [Section 2, paragraph 4.0](#) for required amount in dispute):

#### 6.8.4.1 Nonexpedited Reconsideration Determination

"An appropriate appealing party (i.e., (1) the TRICARE beneficiary, (2) the non-network participating provider of care or (3) a provider of care who has been denied approval under TRICARE), or the appointed representative of an appropriate appealing party, has the right to request a **(insert level of appeal)**. The request must be in writing, be signed, and postmarked or received by **(insert the TQMC name, postal address, e-mail address, and fax number or the Appeals and Hearings Division, TMA, 16401 East Centretech Parkway, Aurora, Colorado 80011-9066)**, within **(insert number of calendar or working)** days from the date of this decision and must include a copy of this reconsideration determination. For the purposes of TRICARE, a postmark is a cancellation mark issued by the United States Postal Service.

Additional documentation in support of the appeal may be submitted. However, because a request for **(insert level of appeal)** must be postmarked or received within **(insert number)** days from the date of the reconsideration determination, a request for **(insert level of appeal)** should not be delayed pending the acquisition of any additional documentation. If additional documentation is to be submitted at a later date, the letter requesting the **(insert level of appeal)** must include a statement that additional documentation will be submitted and the expected date of submission.

Upon receiving your request, all TRICARE claims related to the entire course of treatment will be reviewed."

**6.8.4.2 Expedited Preadmission/Preprocedure Reconsideration Determination (include in addition to the suggested wording above)**

"The TRICARE beneficiary, or the appointed representative of the beneficiary, has the alternative of requesting an expedited reconsideration. The request must be in writing, be signed and must be received by **(insert the TQMC name, postal address, e-mail address, and fax number)** within three working days after the receipt of this denial determination, and must include a copy of this denial determination. A request for an expedited reconsideration filed after the three day appeal filing deadline will be accepted as a nonexpedited request for reconsideration. It is recommended that any additional documentation you may wish to submit be submitted with the request for expedited reconsideration. Upon receiving your request, all TRICARE claims related to the entire course of treatment will be reviewed."

**6.8.5 Amount In Dispute Less Than The Amount Required To File An Appeal**

For those cases in which the amount in dispute is less than the amount required to file an appeal (refer to [Section 2, paragraph 4.0](#) for Required Amount in Dispute), the contractor or the TQMC shall notify the appealing party or representative that the reconsideration determination is final and no further administrative appeal is available. The following is suggested wording:

"Because the amount in dispute is less than **(insert required amount in dispute)**, this reconsideration determination is final and there are no further appeal rights available."

**7.0 EFFECT OF THE RECONSIDERATION DETERMINATION**

**7.1** The reconsideration determination is final and binding upon all parties unless:

**7.1.1** The amount in dispute meets the jurisdictional requirements required to file an appeal (refer to [Section 2, paragraphs 3.3](#) and [4.0](#) regarding requirements for an amount in dispute), appeal rights were offered in the notice of denial at the reconsideration (or second reconsideration) level, and a request for a second reconsideration, formal review, or hearing, as applicable, is either postmarked or received by the appeal filing deadline, or

**7.1.2** The contractor's reconsideration (or TQMC's second reconsideration) decision is reopened and revised by the contractor or the TQMC, either on its own motion or at the request of a party, within one year from the date of the reconsidered determination, or

**7.1.3** The contractor's reconsideration (or the TQMC's second reconsideration) is reopened and revised by the contractor or the TQMC, after one year but within four years, because: new and material evidence is received; a clerical error in the reconsideration determination is discovered; the contractor or the TQMC erred in an interpretation or application of TRICARE coverage policy; or an error is apparent on the face of the evidence upon which the reconsideration (or second reconsideration) determination was based, or

**7.1.4** The contractor's reconsideration (or the TQMC's second reconsideration) is reopened and revised by the contractor or the TQMC at any time, if the reconsideration (or second reconsideration) determination was obtained through fraud or an abusive practice, e.g., describing services in such a way that a wrong conclusion is reached; or

**7.1.5** The contractor's reconsideration (or the TQMC's second reconsideration) is reversed upon appeal at a hearing in accordance with the provisions of [32 CFR 199.10](#) and [199.15](#).

**7.1.5.1** Beneficiaries may appeal an TQMC reconsideration determination to TMA and obtain a hearing on such appeal to the extent allowed under the procedures in [32 CFR 199.10\(d\)](#).

**7.1.5.2** A non-network participating provider may appeal an TQMC reconsideration determination to TMA and obtain a hearing on such appeal to the extent allowed under the procedures in [32 CFR 199.10\(d\)](#). The issue in a hearing requested by a provider is limited to waiver of liability (i.e., whether the provider knew or could reasonably have been expected to know that the services were excludable) (refer to [Section 4, paragraph 4.0](#)). Because waiver of liability applies only to services retrospectively determined to be potentially excludable, waiver of liability will not apply in concurrent review or preadmission/preprocedure cases (i.e., non-network participating providers may request hearings only in cases involving retrospective determinations with the issue being limited to waiver of liability.)

**7.2** Further appeal of a preadmission/preprocedure denial to the hearing level is not permitted unless the requested services have commenced. An appeal to a hearing where the services have not commenced is not allowed because there would not be an adequate remedy should the hearing final decision hold in favor of the beneficiary. This is because the issue at hearing would be whether the medical documentation at the time of the request for preadmission/preprocedure demonstrated medical necessity for the services requested. A final decision issued as a result of the hearing process (which may take several months to complete) holding that the beneficiary met the requirements for preadmission/preprocedure on the date the preadmission/preprocedure request was made could not be implemented as the circumstances that warranted the services at the time of the initial request would unquestionably have changed.

## **8.0 CASES RETURNED WITHOUT TMA REVIEW**

At the discretion of TMA, certain cases appealed may be returned to the contractor for processing without the issuance of a formal review or hearing decision. These cases will normally involve instances in which a processing error has resulted in a denial or partial denial of a claim; instances in which the contractor has failed to obtain additional documentation as required by [paragraph 4.3](#); instances in which the contractor has failed to address the entire EOC; instances in which the contractor has erroneously identified a medical necessity issue as a factual issue and visa-versa; instances in which the contractor has failed to complete the Appeal Summary Log; and instances in which the contractor has failed to offer appropriate appeal rights. Also, TMA, in doing normal development associated with the appeal process, may obtain information that resolves the issues without further review by TMA. If the case is returned for reprocessing, for record purposes the case will be treated as a new request for reconsideration (i.e., [Chapter 1, Section 3, paragraph 4.0](#), will apply and the returned case will be reported for workload purposes). Development for additional documentation, if necessary, will be performed as it would in any reconsideration case. The contractor shall issue a revised reconsideration determination based on the merits of the claim. If applicable, additional appeal rights shall be offered by the contractor.

## **9.0 RECORD OF RECONSIDERATION**

The contractor shall ensure maintenance of records incorporating the following requirements:

**9.1** The contractor shall maintain the record of its reconsideration determinations in accordance with the requirements of [Chapter 2, Section 2, paragraph 1.19](#).

**9.2** The record of reconsideration shall be assembled and maintained in the format prescribed by [paragraph 4.5.3](#).

## **10.0 CONTRACTOR PARTICIPATION IN THE FORMAL REVIEW AND HEARING**

**10.1** Contractor participation in the formal review and hearing is limited to submission of written documentation to TMA to be considered in the adjudication of the appeal. TMA will notify the contractor, by requesting the contractor's appeal file, when a request for formal review or hearing is received. The contractor shall advise TMA within 10 calendar days of receiving notification that a formal review or hearing request has been received, that it intends to participate in the formal review or hearing through submission of additional documentation. The additional documentation shall be received by TMA within 20 calendar days following the notice to the contractor of the receipt of the formal review or hearing request.

**10.2** The contractor may appear at the hearing as a witness and offer testimony in such capacity. TMA will notify the contractor when a request for hearing is received by requesting the contractor's appeal file. The contractor shall advise TMA, within 10 calendar days of receiving notification that a hearing request has been received, that it intends to appear at the hearing as a witness. If the contractor has advised TMA that it intends to appear at the hearing as a witness, TMA will advise the contractor of the time and place of the hearing.

**10.3** If, after receiving notice from TMA that a formal review or hearing request has been submitted, the contractor and the TQMC receive additional claims or documentation related to the formal review or hearing, the contractor and the TQMC shall notify TMA of the receipt of the additional claims or documentation and submit copies of the claims or documentation to TMA, as well as copies of any written response the contractor or TQMC may have issued resulting from the receipt of additional claims or documentation.

- END -

former ADSMs, with certain service-related conditions, beyond the TAMP coverage period.

### **2.5.2 Prerequisites For TCSRC**

In accordance with the NDAA for FY 2008, a member, who is eligible for care under the TAMP, and who has a medical (as defined in [32 CFR 199.2](#)) or adjunctive dental condition believed to be related to their service on active duty may receive extended transitional care for that condition. The diagnosis determination must include the following criteria:

**2.5.2.1** To be service-related; and

**2.5.2.2** To have been first discovered/diagnosed by the member's civilian or TRICARE health care practitioner during the TAMP period and validated by a DoD physician; and

**2.5.2.3** The medical condition requires treatment and can be resolved within 180 days, as determined by a DoD physician, from the date the condition is validated by the DoD physician.

- The period of coverage for the TCSRC shall be no more than 180 days from the date the diagnosed condition is validated by a DoD physician. If a medical condition is identified during the TAMP coverage period, but not validated by a DoD physician until a date after the TAMP coverage period, the start date will be the date that the condition was validated by a DoD physician.
- Service members who are discovered to have a service-related condition, which can not be resolved within the 180 day transitional care period, should be referred by MMSO to the former member's service or to the Veterans Administration (VA) for a determination of eligibility for government provided care.
- Care is authorized for the service-related condition for 180 days from the date the DoD physician validates the service-related condition. For example a service-related condition validated on day 90 of TAMP will result in the following time lines: Care under TAMP for other than the service-related condition terminates on day 180 after the beginning of TAMP coverage. Care for the service-related condition terminates on day 270 in this example (180 days from the day the service-related condition is validated by a DoD physician).

### **2.5.3 Eligibility**

**2.5.3.1** The eligible pool of beneficiaries are former ADSMs who are within their 180 day TAMP coverage period, regardless of where they currently reside.

**2.5.3.2** A DoD physician must determine that the condition meets the criteria in [paragraph 2.5.2](#). Final validation of the condition must be made by the DoD Physician associated with MMSO. If the determination is made that the member is eligible for this program, the former member shall be entitled to receive medical and adjunctive dental care for that condition, and that condition only, as if they were still on active duty. Enrollment into this program does not affect the eligibility requirements for any other TRICARE program for the former service member or their family members.

**2.5.3.3** Enrollment in the TCSRC includes limited eligibility for MTF Pharmacy, Retail Pharmacy, and TRICARE Mail Order Pharmacy (TMOP) benefits.

#### **2.5.4 Implementation Steps, Processing For MMSO, And Contractor Requirements And Responsibilities**

The processes and requirements for a member with a possible Section 1637 condition are spelled out in [paragraphs 2.5.4.1](#) through [2.5.4.7](#). These steps, requirements, and responsibilities are applicable to MMSO, the MCSCs, TRICARE civilian providers, and the Armed Forces, and are provided to make each aware of the steps, processes, and responsibilities/requirements of each organization.

**2.5.4.1** TMA **Beneficiary Education and Support Division (BE&SD)** will educate beneficiaries on the Section 1637 benefit. Contractors will collaborate with **BE&SD** in the development of materials that support both beneficiary and provider education.

**2.5.4.2** A former ADSM on TAMP that believes he/she has a service-related condition which may qualify them for the TCSRC program is to be referred to MMSO for instructions on how to apply for the benefit.

**2.5.4.3** MMSO will determine if further clinical evaluation/testing of the former ADSM is needed to validate that the member has a qualifying condition for enrollment into the Section 1637 program. If further clinical evaluation/testing is needed, MMSO will follow existing "defer to network" referral processes and the MCSC will execute a referral and authorization to support health care delivery for the area in which the member resides. Based on the member's residential address, the MCSC will locate the proper health care delivery site. If a DoD MTF is within the one hour drive time Access To Care (ATC) standards and the MTF has the capabilities, the MTF is to receive the referral request for consideration. If there is no MTF or the MTF does not have the capabilities, then the MCSC should ascertain if a DVA medical facility (as a network provider) is within ATC standards and the facility has the capabilities. If neither of the above are available, then the MCSC shall locate a civilian provider that has both the capability and capacity to accept this referral request within the prescribed ATC standards. The MCSC will execute an active provider locator process (Health Care Finder (HCF)) to support the member's need for this referral request. MMSO's "defer to network" request will be acted on by the MCSC under the normal "urgent/72 hour" requirement. The MCSC will inform the member of the appropriate delivery site and provider contact information for the member to make the appointment. If this care is obtained in the civilian sector or a VA medical facility, the contractor shall pay these claims in the same manner as other active duty claims. The MCSC will instruct the accepting provider to return the results of the encounter to MMSO within 48 hours of the encounter. Once any additional information is received, the DoD physician associated with MMSO will make the determination of eligibility for the Section 1637 program. The eligibility determination for coverage under the Section 1637 benefit will be made within 30 calendar days of receiving the member's request, inclusive of the time required to obtain additional information. If the condition does not meet the criteria for enrollment into the Section 1637 program, but the former ADSM is otherwise eligible for TRICARE benefits, they may continue to receive care for the condition, following existing TRICARE guidelines. The former ADSM may appeal the decision of the DoD Physician in writing to MMSO within 30 calendar days of receipt of the denial by the DoD physician. MMSO will issue a final determination within 30 calendar days of receipt of the appeal. If MMSO determines the condition should be covered under the Section 1637 benefit, coverage will begin on the date MMSO renders the final determination.

## 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.
- **Beneficiary Education and Support Division (BE&SD)** 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.

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

Chapter 18, Section 3

Department Of Defense (DoD) In-Utero Fetal Surgical Repair Of Myelomeningocele Clinical Trial  
Demonstration

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**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.

## Transition

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### 1.0 CONTRACT TRANSITION-IN

#### 1.1 Start-Up Plan

This comprehensive plan shall be submitted electronically, in Microsoft® (MS) Project files, to the Procuring Contracting Officer (PCO) and the Contracting Officer's Representative (COR) No Later Than (NLT) 10 calendar days following contract award. The plans shall address all events and milestones that need to occur for each functional area described in the contract to enable the start of service performance under this contract. Within 15 calendar days following the interface meetings, the incoming contractor shall submit to the TRICARE Management Activity (TMA) a revised start-up plan for approval which incorporates the results of the Transition Specifications and Interface meetings. The final start-up plan will be incorporated into the contract at no cost to the Government.

#### 1.2 Transitions Specifications Meetings

The incoming and outgoing contractors shall attend a two to four day meeting with TMA at the TMA office in Aurora, Colorado, within 15 calendar days following contract award. This meeting is for the purpose of developing a schedule 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 contractor shall arrange meetings with Government and external agencies to establish all systems interfaces necessary to meet the requirements of this contract, including, but not limited to the Defense Eligibility Enrollment System (DEERS), the Medicare Coordination of Benefits Contractor (COBC), Military Health System (MHS) Information Assurance (IA) Certification and Accreditation Team, and TMA **Beneficiary Education and Support Division (BE&SD)**. TMA representatives shall be included in these meetings and all plans developed shall be submitted to the TMA PCO and the 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 services delivery under this contract, 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

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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 DEERS. All systems and telecommunications necessary to perform benchmarking testing must be operational at the start of benchmark testing, as outlined in [paragraph 3.0](#). 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 delivery under this contract.

## **2.2 Medicare Crossover Claims**

NLT 60 calendar days prior to the start of the service delivery in any region, the contractor shall have an established contract with the COBC for receipt of TRICARE crossover claims for all dual eligible beneficiaries for implementation when the outgoing contractor terminates claims processing. NLT 60 days prior to the start of services delivery, the contractor shall demonstrate to TMA successful receipt and testing of electronic claims batches from the COBC for accurate processing of dual eligible claims, including claims for services covered by TRICARE but not covered by Medicare.

**2.2.1** Sixty (60) calendar days prior to the start of services delivery in any region, the contractor shall have executed a Memorandum of Understanding (MOU) with all TRICARE MCSCs. The MOU shall include, but not limited to provider file update coordination, beneficiary history transfers, customer service coordination and marketing/education coordination. 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.

**2.2.2** MOU With Communications and Customer Service Directorate. Within 60 calendar days of contract award, the contractor shall meet with and establish a MOU with the TMA Communications and Customer Service Directorate. The MOU shall include, but not limited to, the review and approval process for education materials, the identification of desired education materials required by either TMA or the contractor, the process for requesting additional educational materials, and the ordering and bulk shipment of materials. The MOU shall be effective within 30 days of the meeting between TMA/BE&SD and the contractor. The content of the MOU will be coordinated with the Contracting Officer (CO) and the COR.

## **2.3 Claims Processing System And Operations**

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

### **2.3.1 Contractor File Conversions And Testing**

**2.3.1.1** The contractor shall perform initial conversion and testing of all Automated Data Processing (ADP) files (e.g., provider files, pricing files, and beneficiary history and deductible files) No Later Than (NLT) 30 calendar days following receipt of the files from the outgoing MCSC and incoming MCSC(s). All ADP file conversions shall be fully tested and operational for the Benchmark (see [paragraph 3.0](#)). Integration testing will be conducted to validate the contractor's internal

interfaces to each of the TRICARE MHS Systems. This testing will verify the contractor's system integration, functionality, and implementation process. The incoming contractor shall be responsible for the preparation and completion of Integration Testing prior to the start of Benchmark Testing.

**2.3.1.2** TMA Test Managers will work with the contractor to plan, execute and evaluate the Integration Testing efforts. The contractor shall identify a primary and a back-up Testing Coordinator to work with the TMA Test Managers. The Testing Coordinator is responsible for contractor testing preparations, coordination of tests, identification of issues and their resolution, and verification of test results. A web application will be available for use by contractor Test Coordinators to report and track issues and problems identified during integration testing.

### **2.3.2 Receipt Of Outgoing MCSC's Weekly Shipment Of History Updates And Dual Operations**

**2.3.2.1** Beginning with the 120th calendar day prior to the start of services delivery and continuing after the start of services delivery until all pertinent claims received by the outgoing contractor have been processed, the contractor shall convert the weekly shipments of the beneficiary history and deductible file updates from the outgoing contractor(s) within two work days following receipt. These files shall be validated by the incoming contractor before use. Tests for claims, update of catastrophic cap, and duplicate claims shall be performed within two workdays following conversion. Any issues identified by the incoming contractor shall be resolved with the outgoing contractor and the TMA COR shall be kept informed of all issues identified within two work days and the problem resolution. Following the start of services delivery, these files shall be loaded to history and used for claims processing on the first processing cycle following the check for duplicate **claims**.

**2.3.2.2** During the period after the start of services delivery when the incoming contractor and the outgoing contractor are processing claims, both contractors shall maintain close interface on history update exchanges and provider file maintenance. During the first 60 calendar days of dual operations, the contractors shall exchange beneficiary history updates with each contractor's claims processing cycle run. Thereafter, the exchange shall not be less than twice per week until the end of dual processing.

### **2.3.3 Installation And Operation Of The DCS**

The contractor shall have purchased, installed, configured, and connected the personal computers and printers required to operate the DCS NLT 60 days prior to the start of the services delivery. See [Chapter 9](#), for hardware, software, printer, configuration and communications requirements and contractor installation responsibilities. Approximately 30-45 days prior to services delivery, TMA will provide and install the DCS application software on the contractor designated personal computers and provide on-site training for users of the DCS in accordance with [Chapter 9](#). Following the start of services delivery, the DCS will begin displaying identified potential duplicate claim sets for which the contractor has responsibility. The contractor shall begin using the DCS to resolve potential duplicate claim sets in accordance with [Chapter 9](#) and the transition plan requirements.

## **2.4 Contractor Weekly Status Reporting**

The contractor shall submit a weekly status report of phase-in and operational activities and inventories to TMA beginning the 20th calendar day following "Notice of Award" by TMA through the 180th calendar day after the start of services delivery (or as directed by the PCO based on the status of the transition and other operational factors). The status report will address only those items identified as being key to the success of the transition as identified in the Transition Specifications Meeting or in the contractor's start-up plan.

## **2.5 Public Notification Program - Provider And Congressional Mailing**

The contractor shall prepare a mailing to all Congressional offices within the region being transitioned by the 45th calendar day prior to the start of services delivery according to the specifications of the official transition schedule. The proposed mailing shall be submitted to the PCO and the COR for review, and the TMA BE&SD for approval NLT 90 calendar days prior to the start of services. The mailing shall discuss any unique processing requirements of the contractor and any other needed information dictated by the official transition schedule.

## **3.0 INSTRUCTIONS FOR BENCHMARK TESTING**

### **3.1 General**

**3.1.1** Prior to the start of services delivery, the contractor shall demonstrate the ability of its staff and its automated eligibility checking, and claims processing systems to accurately process TRICARE claims in accordance with current requirements, including receipt and processing of Medicare cross-over claims. This will be accomplished through a comprehensive Benchmark Test. The Benchmark Test is administered by the contractor under the oversight of TMA and must be completed NLT 60 days prior to the start of services delivery under this contract.

**3.1.2** A benchmark shall consist of up to 1,000 claims, testing a multitude of claim conditions, including TRICARE covered and non-covered services, certified and non-certified providers, eligible and non-eligible beneficiaries. This benchmark may require up to 17 consecutive calendar days at the contractor's site.

**3.1.3** A benchmark test is comprised of one or more cycles or batches of claims. When more than one cycle is used, each cycle may be submitted on consecutive days. Each cycle after the initial one will include new test claims, as well as claims not completed during preceding cycles. All aspects of claims processing may be tested, e.g., receiving and sending electronic transactions, provider file development and maintenance including interface with the National Provider System when implemented, screening, coding, data entry, editing, pricing, data management, data linking, record building, access control, etc.

**3.1.4** The contractor shall demonstrate its ability to conduct eligibility checking, and claims processing functions to include: claims control and development, accessing and updating DEERS for eligibility status, calculating cost-shares and deductibles, querying and updating internal and external family and patient deductible and cost-share files on the Catastrophic Cap and Deductible Database (CCDD), submitting and modifying provider and pricing records, applying allowable charge parameters, performing duplicate checking, applying prepayment utilization review criteria, adjusting previously processed claims, demonstrating recoupment and offset procedures

**5.5.3** If the change from a QLE results in a decrease in the premium, the contractor shall retain any overpaid amount and apply it to subsequent bills or electronic payments until all of the overpayment is exhausted.

## **5.6 Terminations and Premium Adjustments**

The contractor shall initiate the process to refund any premium amounts applied for coverage after the date of termination as specified in [paragraph 4.4](#).

## **5.7 Online Transactions**

In addition to requirements specified in [paragraph 5.0](#) and its subordinate paragraphs, the contractor may provide online capability for TRS members/survivors to conduct business related to premium collection and other applicable administrative services through secure access to the contractor's web site.

## **6.0 CLAIMS PROCESSING**

**6.1** The contractor shall process TRS claims under established TRICARE Standard and TRICARE Extra ADFM cost-sharing rules and guidance. Normal TRICARE Other Health Insurance (OHI) processing rules apply to TRS.

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

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

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

**6.5** Medicare is the primary payer for TRICARE beneficiaries who have Medicare eligibility. Claims under the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) will be adjudicated under the rules set forth in [Chapter 20, Section 3](#). The Managed Care Support Contractors (MCSCs) shall follow procedures established in the TRICARE Reimbursement Manual (TRM), [Chapter 4, Section 4](#) regarding dual eligibles' claims processing.

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

**6.7** If at anytime the contractor discovers that the Selected Reserve member may be eligible for or enrolled in the FEHBP, the contractor shall report the discovery to the appropriate TRICARE RD or

their designee or TAO Director NLT one business day after discovery. As applicable, the contractor shall follow [paragraph 4.4.1](#) and its subordinate paragraphs for loss of TRS eligibility. If any other actions are to be taken by the contractor as a result of this discovery, the TRICARE RD or their designee or TAO Director will send instructions to the contractor.

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

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

### **7.1 Customer Education**

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

**7.1.2** Upon start of coverage under TRS the contractor shall mail one copy of the TRS Handbook to each new TRS member/survivor with TRS member-only coverage and one copy to the household of each TRS member/survivor with TRS member and family coverage. The contractor shall send additional handbooks upon request, such as when survivors or TRS members and covered family members live in different locations (split coverage).

### **7.2 Customer Service**

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

## **8.0 ANALYSIS AND REPORTING**

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

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

### **9.1 Claims Reporting**

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

### **9.2 Fiduciary Responsibilities**

**9.2.1** The contractor shall act as a fiduciary for all funds acquired from TRS premium collections, which are government property. The contractor shall develop strict funds control processes for its collection, retention and transfer of premium funds to the government. All

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

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

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

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

**6.6** Medicare is the primary payer for TRICARE beneficiaries who have Medicare eligibility. Claims under the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) will be adjudicated under the rules set forth in the [Chapter 20, Section 3](#). The MCSCs shall follow procedures established in the TRICARE Reimbursement Manual (TRM) ([Chapter 4, Section 4](#)) regarding dual-eligibles' claims processing.

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

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

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

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

### **7.1 Customer Education**

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

**7.1.2** Upon start of coverage under TRR each contractor shall mail one copy of the TRR handbook to each TRR member/survivor with TRR member-only coverage and one copy to the household of each TRR member/survivor with TRR member-and-family coverage. The member/survivor's servicing contractor shall send additional handbooks upon request, such as when covered family members live in different locations (split locations).

## **7.2 Customer Service**

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

## **8.0 ANALYSIS AND REPORTING**

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

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

### **9.1 Claims Reporting**

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

### **9.2 Fiduciary Responsibilities**

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

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

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

## General

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### 1.0 GENERAL

The TRICARE Pharmacy (TPharm) Benefits Program offers worldwide services through:

- Direct Care (DC) pharmacies located at Military Treatment Facilities (MTFs);
- Retail network pharmacies;
- A Mail Order Pharmacy (MOP) program including specialty pharmacy services; and
- Retail non-network pharmacies.

The requirements/guidelines in this chapter apply only to the TPharm contractor.

### 2.0 ELIGIBILITY

**2.1** The TPharm Benefits Program is available to all TRICARE eligible beneficiaries, including Uniformed Service members, TRICARE Prime Remote (TPR) enrollees, TRICARE Dual Eligibles, and TRICARE Reserve Select (TRS) members. Eligible beneficiaries need not enroll in order to use the pharmacy program. The contractor will use the Defense Enrollment Eligibility Reporting System (DEERS) to verify TRICARE eligibility prior to dispensing pharmaceuticals (or paying any claim) for all beneficiaries.

**2.2** Foreign Force Members (FFMs) and their dependents from countries that are party to a North Atlantic Treaty Organization (NATO), Status of Forces Agreement (SOFA), or Partnership For Peace (PFP) SOFA are eligible to receive pharmaceuticals or Durable Medical Equipment (DME) dispensed through retail pharmacies subject to the same rules regarding payment as are applicable to U.S. active duty members and dependents of active duty members using the TRICARE Standard/CHAMPUS program. Refer to [www.tricare.mil/foreignforces/index.cfm](http://www.tricare.mil/foreignforces/index.cfm) to verify coverage.

**2.3** Guard or service members who are injured or become ill while serving on active duty or performing official drills with their unit may be eligible for continued care/treatment associated with the specific episode of care once their active duty or drill status has terminated.

Documentation from Military Medical Support Office (MMSO) will serve as proof of eligibility and pharmaceutical claims will be processed for reimbursement. MMSO, per [Chapter 17, Section 2, paragraph 1.2](#), has authority to approve claims for drugs not covered under standard benefit guidelines.

### 3.0 APPLICABILITY OF TRICARE REQUIREMENTS

Unless waived or superseded by the provisions of this chapter or the contract, all normal TRICARE requirements set forth in the TRICARE Operations Manual (TOM), TRICARE Policy Manual (TPM), TRICARE Reimbursement Manual (TRM), and TRICARE Systems Manual (TSM) apply. Sections or language in these Manuals that obviously have no direct application to the pharmacy contractor

do not apply (e.g., requirements related to enrolling beneficiaries in TRICARE Prime, requirements related to medical benefit determinations, etc.). The requirements in the following TOM chapters **do not** apply to the pharmacy contractor:

- [Chapter 4](#), Provider Certification and Credentialing;
- [Chapter 5](#), Network Development;
- [Chapter 6](#), Enrollment;
- [Chapter 7](#), Utilization and Quality Management;
- [Chapter 9](#), TRICARE Duplicate Claims System (DCS) - TED Version;
- [Chapter 11](#), Beneficiary **Education** and **Support Division (BE&SD)**;
- [Chapter 14](#), Audits, Inspections and Reports;
- [Chapter 15](#), Regional Director (RD)/MTF and Contractor Interfaces;
- [Chapter 16](#), TRICARE Prime Remote (TPR) Program;
- [Chapter 17](#), Supplemental Health Care Program (SHCP);
- [Chapter 20](#), TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC);
- [Chapter 21](#), TRICARE Alaska; and
- [Chapter 22](#), TRICARE Reserve Select (TRS)

#### **4.0 PERFORMANCE/PROCESSING STANDARDS**

Performance standards for the TPharm Benefits Program are located in Section C of the contract. Additionally, the contractor shall comply with the TRICARE Encounter Data (TED) timeliness and TED accuracy standards included in [Chapter 1, Section 3](#).

#### **5.0 SPECIALTY PHARMACEUTICALS**

Specialty pharmaceuticals typically covered by the pharmacy contract are listed in [Addendum A](#). Products may be added or removed as necessary.

- END -

## Transition

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### 1.0 CONTRACT PHASE-IN

#### 1.1 Start-Up Plan

The contractor shall submit a Start-Up Plan No Later Than (NLT) 10 calendar days following contract award. This comprehensive plan shall be submitted electronically, in Microsoft® (MS) Project format, to the Procuring Contracting Officer (PCO) and Contracting Officer's Representative (COR). The plan shall address all events and milestones that need to occur for each functional area described in the contract to enable the start of service performance under this contract. Within 15 calendar days following the Transition Specifications and Interface meetings, the incoming contractor shall submit to the PCO and COR a revised Start-Up Plan which incorporates the results of the Transition Specifications and Interface meetings, as necessary. After the PCO approves the revised Start-Up Plan, it will be incorporated into the contract at no cost to the Government.

#### 1.2 Transition Specifications Meeting

The contractor shall attend a two to four day meeting with Department of Defense (DoD)/ TRICARE Management Activity (TMA) representatives at a Government-specified location, within 15 calendar days following contract award. This meeting is for the purpose of discussing start-up requirements, and for developing a schedule for phase-in activities. TMA will notify the contractor as to the exact date and place 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.

The transition specifications meeting will include a meeting with the outgoing pharmacy contractor. A Memorandum of Understanding (MOU) will be developed (between the incoming and outgoing contractors) that addresses coordination of phase-in/phase-out activities. Specific activities to be addressed at the meeting include, but are not limited to:

**1.2.1** The contractor shall coordinate with the outgoing contractor to perform an electronic transfer of beneficiary mail order and open refill history to the extent allowed by applicable state and federal requirements and laws. The contractor shall demonstrate its ability to receive these files NLT 60 calendar days prior to the start of Option Period 1.

**1.2.2** The contractor shall make arrangements with the outgoing contractor to ensure any Mail Order Pharmacy (MOP) prescription orders received by the outgoing contractor after the start of Option Period 1 are promptly forwarded to the incoming contractor. This requirement is valid for a period of 180 days after the start of mail order services. Overnight shipping shall be used, at the incoming contractor's expense, to forward the orders. The incoming contractor shall ensure that notification of the change of contractor is sent with the dispensed prescription to the beneficiary for those prescriptions that were forwarded from the outgoing contractor.

**1.2.3** The contractor shall coordinate with the outgoing contractor the transfer of any beneficiary/claims history files, including a schedule that addresses initial shipments and updates as necessary. The incoming contractor shall perform initial conversion and testing of any electronic files NLT 30 calendar days following receipt of the files from the outgoing contractor.

**1.2.4** The contractor shall coordinate with the outgoing contractor to establish time frames for the transfer of any open/pending prior authorization requests and medical necessity reviews.

### **1.3 Interface Meetings**

**1.3.1** Within 30 calendar days from contract award, the contractor shall arrange meetings with Government and external agencies to establish all systems interfaces necessary to meeting the requirements of the contract. These meetings shall be scheduled with, but not limited to, the Defense Manpower Data Center (DMDC), Pharmacy Data Transaction Service (PDTs), Military Health System (MHS) Defense Information Assurance Certification and Accreditation Process (DIACAP) Team, and TMA **Beneficiary Education and Support Division (BE&SD)**. The meeting with DMDC shall be a technical specifications meeting regarding Defense Enrollment Eligibility Reporting System (DEERS) applications and interfaces. TMA/DoD representatives shall be included in these meetings and all plans developed shall be submitted to the PCO and COR within 10 calendar days after the meeting for final approval.

**1.3.2** The contractor is required to attend and participate (by telephone) in Systems Integration meetings during contract start-up. The purpose of these meetings is to address all phases of systems interface implementation and start-up, including testing and problem resolution. The meetings, scheduled and hosted by TMA, will be held at least weekly during the transition period, and will continue after contract start-up until all system integration related issues are resolved.

## **2.0 START-UP REQUIREMENTS**

### **2.1 Systems Development**

**2.1.1** NLT 60 calendar days prior to the initiation of services under the contract, the processing systems and the telecommunications interconnections between these systems shall be reviewed by 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 the contract. This includes telecommunications links with TMA, DEERS, and PDTs. This review is in addition to benchmark testing as outlined in [paragraph 3.0](#) (all systems necessary for benchmark testing must be operational at the start of benchmark testing). The contractor shall effect any modifications required by TMA prior to the initiation of services under this contract. The contractor shall be notified of any such required modifications by the PCO. The contractor will attend and participate in weekly Systems Integration meetings (see [paragraph 1.3.1](#)).

**2.1.2** NLT 30 calendar days prior to the start of services, the incoming contractor shall demonstrate to TMA successful implementation of all web-based capabilities as required in the contract.

## Chapter 24

### TRICARE Overseas Program (TOP)

Section/Addendum	Subject/Addendum Title
1	Administration
2	Records Management
3	Financial Administration
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Chapter 24, TRICARE Overseas Program (TOP)

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30	Figures Figure 24.30-1 Overseas Pharmacy Provider Notice Letter (Sample) Figure 24.30-2 TOP Contractor Provider Certification Request Letter Figure 24.30-3 Attestation

**6.30** The TOP contractor shall establish Utilization Management (UM) high dollar/frequency thresholds in accordance with [Section 6](#).

**6.31** Claims either denied as “beneficiary not eligible” or “found to be not eligible on DEERS” may be processed as a “good faith payment” when received from the TMA Beneficiary **Education and Support Division (BE&SD)**. The TAO Director shall work with the TOP contractor on claims issues related to good faith payment documentation (e.g., a completed claim form and other documentation as required by [Chapter 10, Sections 3 and 4](#)).

**6.32** The provisions of [Chapter 8, Section 6, paragraph 10.0](#) shall apply to the TOP.

**6.33** The Claims Auditing Software requirements outlined in the TRM, [Chapter 1, Section 3](#) do not apply to TOP claims; however, the TOP contractor shall implement an internal process for identifying upcoding, unbundling, etc. on coded claims.

## **7.0 APPLICATION OF DEDUCTIBLE AND COST-SHARING**

Application of TOP deductible and cost-sharing procedures shall follow the guidelines outlined in [Chapter 8, Section 7](#).

## **8.0 EOB VOUCHERS**

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

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

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

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

**8.1.4** TOP EOB for overseas enrolled ADSM claims shall be annotated “ACTIVE DUTY”

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

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

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

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

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

## **9.0 DUPLICATE PAYMENT PREVENTION.**

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

**9.2** The TOP contractor shall ensure that business processes are established which require appropriate system and/or supervisory controls to prevent erroneous manual overrides when reviewing potential duplicate payments.

## **10.0 DOUBLE COVERAGE**

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

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

**10.3** Overseas insurance plans such as German Statutory Health Insurance, Japanese National Insurance (JNI), and Australian Medicare, etc., are considered OHI. National Health Insurance (NHI) plans do not always provide EOBs to assist in the adjudication of TRICARE claims. If a beneficiary has attempted unsuccessfully to obtain an EOB from their NHI plan, they may submit a beneficiary attestation and an itemized claim checklist (approved by TMA) with their claim. The TOP contractor shall waive the requirement for an EOB from the NHI plan when accompanied by the TMA-approved documentation.

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

## **11.0 THIRD PARTY LIABILITY (TPL)**

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

## **12.0 REIMBURSEMENT/PAYMENT OF OVERSEAS CLAIMS**

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

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

## Beneficiary Education And Support Division (BE&SD)

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### 1.0 GENERAL

**1.1** All TRICARE requirements regarding BE&SD shall apply to the TRICARE Overseas Program (TOP) unless specifically changed, waived, or superseded by the provisions of this section; the TRICARE Policy Manual (TPM), [Chapter 12](#); or the TRICARE contract for health care support services outside the 50 United States and the District of Columbia (hereinafter referred to as the "TOP contract"). See [Chapter 11](#) for additional instructions.

**1.2** Per Department of Defense Instruction (DoDI 6010.21 ("TRICARE Marketing Policy") dated December 18, 2001, TRICARE marketing materials developed by contractors must be coordinated with appropriate Regional Director (RD) and approved by TRICARE Management Activity (TMA). For the TOP contract, this coordination includes the TRICARE Area Office (TAO) Directors. Coordination of local administrative changes is at the local discretion of Military Treatment Facilities (MTFs).

### 2.0 TRICARE SERVICE CENTERS (TSCs)

**2.1** The provisions of [Chapter 11, Section 3](#) are applicable to the TOP, except that TOP TSCs are jointly staffed by MTF personnel and TOP contractor personnel.

**2.2** The requirement for full-time staffing as described in [Chapter 11, Section 3, paragraph 1.0](#) is applicable to the Beneficiary Service Representatives (BSRs) in the TSCs. The TOP contractor shall implement appropriate business processes to provide full-time TSC coverage if the assigned BSR(s) are unavailable due to planned or unplanned absences (e.g., illness, leave, personal emergencies, etc.) for more than two consecutive business days. Local processes for managing short-term BSR absences (up to two consecutive business days) shall be addressed in the Memorandum of Understanding (MOU) between the affected MTF commander(s) and the TOP contractor.

### 3.0 HEALTH CARE FINDER (HCF) SERVICES

**3.1** TOP HCF functions are performed by TOP contractor personnel located in the TSCs or in contractor-operated call center(s). The contractor shall offer call center operations to support HCF services via toll-free lines 24 hours per day, seven days per week, 365 days per year.

**Note:** The contractor must also offer claims assistance via toll-free lines seven days per week, 365 days per year, between the hours of 2:00 AM and 7:00 PM Central Standard Time (CST). These service hours for claims assistance apply even if claims assistance is provided via the contractor's call center(s).

**3.1.1** HCFs (including MTF/contractor personnel and call centers) are responsible for facilitating access to host nation provider care (including, but not limited to primary care, specialty care, mental health care, ancillary services, Durable Medical Equipment (DME), and pharmacy

services), and for authorizing certain health care services. Additionally, HCFs shall inform beneficiaries of access mechanisms, referral procedures, and rules regarding use of host nation TOP network/non-network providers. They shall also improve patient continuity of care by establishing mechanisms to facilitate necessary consultations, follow-up appointments and the sharing of medical records. TOP HCFs will serve all Military Health System (MHS) beneficiaries in the region, regardless of their enrollment status. This includes dual-eligible beneficiaries and beneficiaries residing or enrolled in the 50 United States and the District of Columbia who may require assistance when accessing care in an overseas location.

**3.1.2** For MTF enrollees, the specialty care referral process includes a covered benefit review; entering appropriate authorizations into the contractor's system; locating a qualified network or non-network host nation provider to provide the care on a cashless, claimless basis; providing the beneficiary with a written care authorization and the host nation provider's information; and assisting the beneficiary with establishing an appointment with the host nation provider (upon beneficiary request). The contractor shall also provide information to MTF personnel regarding the status of specialty care referrals and shall work cooperatively with the MTF to assist in obtaining consult results from host nation providers; however, the contractor is not responsible for tracking receipt of consult results.

**3.1.3** For TOP Prime Remote enrollees, the specialty care referral process includes a medical necessity review; a covered benefit review; entering appropriate authorizations into the contractor's system; locating a qualified network or non-network host nation provider to provide the care on a cashless, claimless basis; providing the beneficiary with a written care authorization and the host nation provider's information; and assisting the beneficiary with establishing an appointment with the host nation provider (upon beneficiary request). This process is also applicable to Active Duty Service Members (ADSMs) who are on Temporary Additional Duty/ Temporary Duty (TAD/TDY), in an authorized leave status, or deployed/deployed on liberty in a remote overseas location, and to TRICARE Prime/TRICARE Prime Remote (TPR) enrollees who require urgent specialty care while traveling outside the 50 United States and the District of Columbia.

**3.1.4** Beneficiaries enrolled to the Uniformed Services Family Health Plan (USFHP) and the Continued Health Care Benefit Program (CHCBP) must follow the requirements of those programs when obtaining overseas care.

**3.2** The TOP HCF is responsible for the following functions:

**3.2.1 Referral Assistance for TOP Beneficiaries**

The TOP contractor (working in concert with the MTF Commander) is required to ensure optimal use of MTFs and to foster coordination of all care delivered in the civilian sector and care referred to and from the MTF. The TOP HCF is the primary mechanism for achieving these objectives. The referral services of the TOP HCF are primarily to ensure access to care for enrolled beneficiaries, but the TOP HCF is also available to assist non-enrollees in finding network/non-network host nation providers. For TOP Prime/TOP Prime Remote enrollees, the referral is generally initiated by the beneficiary's Primary Care Manager (PCM). The PCM or beneficiary contacts the TOP HCF for assistance in locating an appropriate host nation provider and to obtain authorization for the care (see [Sections 17](#) and [18](#) for additional information on HCF referral assistance).

### **3.2.2 Referral Assistance for Beneficiaries Enrolled or Residing in the 50 United States and the District of Columbia**

The TOP contractor shall provide referral assistance for TRICARE Prime/TPR enrollees who require urgent or emergent health care while traveling outside the 50 United States and the District of Columbia. These referrals will generally be initiated by the beneficiary, a host nation provider, or an overseas MTF provider. Emergency care never requires preauthorization; however, ADFMs enrolled to TRICARE Prime/TPR may receive urgent and emergency health care services in locations outside the 50 United States and the District of Columbia (to include emergency medical evacuation per Section 7) on a cashless, claimless basis if the care is coordinated in advance with the TOP contractor. The TOP contractor shall implement guarantee of payment or other business processes to ensure that ADFMs enrolled to TRICARE Prime/TPR may receive urgent or emergency medical services on a cashless, claimless basis upon beneficiary request.

### **3.2.3 Authorizations**

The TOP HCF will authorize care for TPR enrollees; for ADSMs who are on TAD/TDY, in an authorized leave status, or deployed, deployed on liberty in a remote overseas location, and for TRICARE Prime/TPR enrollees who require urgent or emergent health care while traveling outside the 50 United States and the District of Columbia. The contractor shall also ensure that MTF-issued authorizations are entered into all applicable contractor systems. Non-emergent specialty health care received from a host nation provider must be authorized if benefits are to be paid as TOP Prime/TPR.

**3.2.4** Care subject to a PCM referral/authorization/Non-Availability Statement (NAS) may receive a clinical review and authorization by the HCF or other designee. An NAS is needed for non-emergency inpatient mental health care when the beneficiary resides within an overseas MTF enrollment area (defined as a 40-mile radius or a one hour drive time from the MTF).

**3.2.5** If an ADFM TOP Prime/TOP Prime Remote enrollee receives care that was not authorized, the care may be covered under the TOP Point of Service (POS) option, with POS deductibles and cost-shares. POS provisions also apply to TRICARE Prime/TPR enrollees who receive non-emergency care outside the 50 United States and the District of Columbia without obtaining prior authorization from the TOP contractor. The care must also be otherwise coverable under TRICARE or the claim shall be denied.

**3.2.6** ADSM care that was not referred and authorized may be denied unless it is retroactively authorized by the appropriate service or TAO personnel. POS does not apply to ADSMs.

## **4.0 CUSTOMER SERVICE RESPONSIBILITIES**

TOP customer support shall be provided to TOP RD and TAO staffs, TOP host nation providers, TOP beneficiaries, designated Point of Contacts (POCs), TOP MTF staffs including Health Benefit Advisors (HBAs)/Beneficiary Counseling and Assistance Coordinators (BCACs)/Debt Collection Assistance Officers (DCAOs), stateside TRICARE Regional Offices (TROs), stateside Managed Care Support Contractors (MCSCs), stateside TRICARE beneficiaries traveling overseas, claims processing

contractors, and TMA. TOP contractor customer support service shall include the following:

**4.1** The TOP contractor shall secure at a minimum one dedicated post office box for the receipt of all claims and correspondence from foreign locations per overseas region.

**4.2** The TOP contractor shall identify a specific individual and an alternate to assist the TOP RD, TAO Directors, TMA, BCACs and stateside claims processing contractors with the resolution of TOP issues. Issues which cannot be successfully resolved shall be referred to the TOP Contracting Officer's Representative (COR).

**4.3** The TOP contractor shall identify a specific individual and an alternate to assist DCAOs with the resolution of TOP beneficiary debt collection issues.

**4.4** The TOP contractor shall be responsible for establishing and operating a dedicated TRICARE overseas claims/correspondence processing department with a dedicated staff. This department and staff shall be under the direction of a supervisor, who shall function as the contractor's POC for TRICARE overseas claims and related operational and support services. The contractor's department for TRICARE overseas claims shall include at a minimum the following functions/requirements:

**4.4.1** The TOP contractor shall provide toll-free telephone service for claims assistance to TOP beneficiaries and providers seven days a week, 365 days a year, between the hours of 2:00 AM and 7:00 PM CST. Toll-free services must be available from any stateside or overseas location.

**4.4.2** The TOP contractor shall have the ability to translate claims submitted in a foreign language and write in German, Italian, Japanese, Korean, Tagalog (Filipino) and Spanish, or shall have the ability to obtain such translation or writing.

**4.4.3** The TOP contractor shall provide on-line read only access to their claims processing system to the TOP RD, each TOP TAO Director, and the TMA technical representative for TOP claims.

**4.4.4** The TOP contractor shall provide a secure, user-friendly internet portal for receipt of customer claims status inquiries and access to claims status information (to include the ability to view and print Explanation of Benefits (EOBs)).

**4.4.5** The TOP contractor is required to provide, upon TMA or TAO Director request, documentation of claims for auditing purposes.

**4.5** The TOP contractor is required to assist traveling TOP beneficiaries to ensure beneficiary access/receipt of urgent or emergent care in the 50 United States and the District of Columbia. The contractor shall also assist beneficiaries residing or enrolled in the United States or the District of Columbia who require urgent or emergent care while traveling overseas. ADFMs who are enrolled to TRICARE Prime or TPR may receive emergency medical services in locations outside the 50 United States and the District of Columbia (to include emergency medical evacuation) on a cashless, claimless basis if the care is coordinated in advance with the TOP contractor.

**4.6** The contractor shall refer beneficiary, provider, HBAs, and congressional inquiries not related to claims status to TMA Chief, **BE&SD**.

## 5.0 BENEFICIARY SERVICES

**5.1** The TOP contractor shall achieve the highest level of beneficiary satisfaction possible in the overseas environment. This shall be accomplished by developing qualified host nation provider networks (complemented by non-network host nation providers as necessary), ensuring timely access to host nation care, providing TOP information/education/training to beneficiaries and host nation providers, and processing claims in a timely, accurate manner.

**5.2** In addition to the beneficiary education requirements outlined in [Chapter 11, Sections 1 and 2](#), the TOP contractor may be required to conduct beneficiary education/enrollment activities for arriving/deploying units in accordance with the enrollment protocols established in the Memorandum of Understanding (MOU) between the TOP contractor and the MTFs.

**5.3** In addition to the requirements outlined in [Chapter 11, Section 2](#), all beneficiary satisfaction activities (including beneficiary surveys conducted in accordance with [Chapter 11, Section 2](#)) shall be coordinated with the three TAOs to achieve a coordinated, uniform approach to Department of Defense (DoD) customer services overseas.

**5.4** The TOP contractor shall maintain up-to-date lists of host nation network providers, and shall make this information available at all TOP TSCs and via web-based access. Web-based network provider listings shall include information regarding authorization requirements that are applicable to TOP enrollees.

**5.5** The TOP contractor's beneficiary education plan shall address their process for educating TOP beneficiaries regarding care received in the 50 United States and the District of Columbia. At a minimum, this process shall include information regarding referrals/authorizations while stateside, TOP POS policy, and the recommended process for accessing care while stateside. TOP beneficiaries traveling stateside shall be encouraged to utilize MTF care whenever possible. If MTF care is not available, beneficiaries should be encouraged to seek care from a network provider before obtaining care from a non-network provider.

**5.6** The requirement for a quarterly three-day TRICARE training course, as outlined in [Chapter 11, Section 2, paragraph 1.1](#), is superseded for the TOP contractor by a requirement for a total of nine three-day TRICARE training courses per contract option period (two per option period within the TRICARE Eurasia-Africa area; two within the TRICARE Pacific area; two within the TRICARE Latin America/Canada (TLAC) area; and three additional courses that may occur in any stateside or overseas location at the direction of the Contracting Officer (CO)).

**Note:** Only the frequency requirements of [Chapter 11, Section 2, paragraph 1.1](#) are superseded; all other requirements of the referenced paragraph apply to the TOP contractor.

**5.7** The requirement for mailing TRICARE handbooks, as outlined in [Chapter 11, Section 1, paragraph 4.1](#), is superseded for the TOP contractor by a requirement for "on-demand" processes for distributing TRICARE handbooks upon beneficiary request (including, at a minimum, web-based requests, telephone requests, and on-site requests at a TSC).

## **6.0 PROVIDER SERVICES**

**6.1** The TOP contractor shall ensure that all host nation network providers and their support staff have sufficient understanding of the applicable TRICARE program requirements, policies, and procedures to allow them to carry out the requirements of this contract in an efficient and effective manner that promotes beneficiary satisfaction.

**6.2** The TOP contractor shall have the responsibility for developing and delivering TRICARE Program information to host nation providers. The contractor shall determine the requirements for printed products and will develop and deliver these products after obtaining approval from the government. The information in these products will generally be determined by the contractor based on their understanding of the needs of their network providers; however, the government may mandate the inclusion of certain topics or information.

**6.3** Provider education materials shall include information regarding claims processing procedures, claims submission deadlines, and normal claims processing time lines.

**6.4** The government shall ensure provider satisfaction with contractor-provided information by conducting random satisfaction surveys of select network providers.

## **7.0 GRIEVANCES AND GRIEVANCE PROCESSING**

The TOP contractor shall process all grievances related to contractor personnel or contractor actions. The contractor shall also process all grievances related to network or non-network host nation providers or institutions, with a copy provided to the TMA COR and the appropriate TAO.

- END -

report the discovery to the appropriate waiver approval authority NLT one business day after discovery. Claims may be pended or held until a final decision is reached. As applicable, the contractor shall follow [paragraph 4.3](#) and its subordinate paragraphs for loss of TYA eligibility.

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

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

### **7.1 Customer Education**

**7.1.1** Materials (i.e., public notices, flyers, informational brochures, web site, etc.) will be developed and distributed centrally by Department of Defense (DoD), TRICARE Management Activity (TMA), Office of **BE&SD**. The contractor shall distribute all informational materials associated with the TYA program to the same extent and through the same means as other TRICARE materials are distributed. Copies of TYA informational materials may be obtained through the usual TMA **BE&SD** process.

**7.1.2** Upon start of coverage under TYA, the DMDC-generated enrollment letter will include information on how purchasers can obtain TYA and other TRICARE plan materials over the internet or how to request fulfillment materials from the contractor. The servicing contractor shall send fulfillment materials only upon request.

### **7.2 Customer Service**

The contractor shall provide all customer service support to young adult dependents in a manner equivalent to that provided to other TRICARE beneficiaries.

## **8.0 ANALYSIS AND REPORTING**

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

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

### **9.1 Claims Reporting**

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

### **9.2 Fiduciary Responsibilities**

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

**9.2.2** Premiums shall be deposited into a non-interest bearing account to collect and disburse TYA premiums. The contractor shall deposit TYA premium collections to the established account within one business day of receipt. A separate bank account is not required; however, individual line item reporting for the TYA program is required.

**9.2.3** The contractor shall wire-transfer the premium collections, net of refund payments, monthly to a specified government account as directed by the TMA Contract Resource Management (CRM) Finance And Accounting Office (F&AO). The government will provide the contractor with information for this government account. The contractor shall notify the TMA CRM F&AO, by e-mail, within one business day of the deposit, specifying the date and amount of the deposit as well as its purpose (i.e., TYA premiums).

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

**9.2.5** The contractor shall electronically submit monthly reports of premium activity supporting the wire transfer of dollars as described in the Contract Data Requirements List (CDRL) DD Form 1423.

## **10.0 CHCBP TO TYA PROCEDURES**

Young adult dependents who qualify for TYA coverage and were previously or are currently enrolled in the CHCBP may elect to purchase TYA.

### **10.1 Enrollment Procedures**

Enrollment actions must be coordinated between the CHCBP contractor and the TYA enrolling contractor. The CHCBP contractor will provide contact information to the enrolling contractors to coordinate CHCBP to TYA enrollments.

#### **10.1.1 CHCBP Coverage Was Terminated More Than 30 Days Before Receipt of TYA Application and Young Adult Dependent Is Not Eligible for Continuation or Retroactive TYA Coverage**

The enrolling contractor will validate in DEERS that the CHCBP enrollment was terminated more than 30 days from the date of the TYA application. The TYA enrolling contractor will process the TYA application according to [paragraph 4.1.2](#).

#### **10.1.2 Currently Enrolled in CHCBP or TYA Application Received Within 30 Days of Termination of CHCBP Coverage**

Upon receipt of a properly completed TYA application for someone currently enrolled in or within 30 days of termination of CHCBP coverage, the enrolling contractor will request the CHCBP contractor to disenroll the young adult dependent from CHCBP with an effective date one day prior to the requested start date. The CHCBP contractor will terminate the CHCBP coverage based on the TYA effective date or the CHCBP paid-through date, whichever is earlier. The CHCBP contractor will recalculate the amount of premiums required for the remaining CHCBP coverage, and refund any overpayment of CHCBP premiums. The refund shall include an explanation that the refund amount represents a refund of CHCBP premiums as a result of the TYA enrollment and how

**3.10.4** Once an application has been fully processed, the contractor shall issue a letter to the applicant confirming CHCBP coverage (including the dates of coverage) within 10 business days. The letter shall advise the beneficiary of the requirements that must be met for continued coverage in the program, including information regarding future contractor billings and premium payments that the beneficiary will be required to make. The contractor shall also issue either a CHCBP coverage policy or such other sufficient written information regarding the CHCBP for beneficiaries' reference should they have any questions regarding benefits and program requirements.

### **3.11 Coverage and Renewals**

**3.11.1** The contractor shall mail initial premium renewal notices to beneficiaries no later than 30 days before the expiration of the coverage. The beneficiary's coverage in CHCBP is based on the documentation that the applicant submits to verify eligibility, therefore, the contractor shall not routinely query DEERS for renewal coverages and quarterly billings. Absent information or evidence to the contrary, the contractor shall assume that the individual continues to meet the requirements for CHCBP. Renewal notices shall clearly specify the premium amount due, the date by which the premium must be received, and the mailing address to which the premium payment must be sent. Renewal notices shall specify that failure to submit the premium due will result in denial of continued coverage and termination from the program.

**3.11.2** The contractor shall provide a 30 calendar day grace period following the premium due date in which the beneficiary may submit his/her premium and continue benefits with no break in coverage. If the premium is not received following the initial renewal notice to the beneficiary requesting premium for the next quarter, the contractor shall issue a second renewal notice to the beneficiary within 10 business days of the start of the grace period. The second renewal notice shall indicate that this is the second and final billing notice and that if payment is not received by the due date specified in the notice, that CHCBP coverage will be terminated as of that date. The notice shall also advise the beneficiary that if coverage is terminated due to nonpayment of premium, that he/she will be permanently locked-out of CHCBP.

**3.11.3** If the premium is not received by the end of the grace period, the contractor shall terminate the beneficiary's coverage in CHCBP and mail a letter to the beneficiary confirming the termination within 10 business days, to include the effective date and basis for the termination. The contractor shall enter all CHCBP terminations into DEERS.

**3.11.4** Beneficiaries who desire to voluntarily withdraw from the CHCBP prior to the end of their paid up period shall send a written request to the contractor. Beneficiaries who voluntarily disenroll from the CHCBP are not permitted to re-enroll until they gain and then once again lose TRICARE eligibility. Refund of unused premiums is only allowed for items covered in [paragraph 3.8](#).

**3.11.5** Following a beneficiary's termination from the CHCBP, except for those who have re-established TRICARE coverage, the contractor shall issue a Certificate of Creditable Coverage (CoCC) to the beneficiary within 10 business days from the termination date and upon request up to 24 months after the termination date. No later than four months prior to the start work date of the contract, the government will furnish the contractor with a sample of the format for the CoCCs.

**3.11.6** In preparing and mailing all written notices and correspondence to applicants and beneficiaries, the contractor shall use the most current address on file or available.

### **3.12 CHCBP Coverage Data and Report**

The contractor shall maintain systems and databases to collect, track and process applications and to report monthly coverage information to the government as well as any ad hoc reports that may be requested regarding CHCBP coverage. The contractor shall have the capability to retroactively retrieve pertinent coverage information on any individual who has been accepted or denied coverage in the program, to include the basis for such denials.

### **4.0 PROGRAM MATERIALS**

All informational materials, booklets, brochures, and other public material are subject to review and approval by the TMA **Beneficiary Education and Support Division (BE&SD)** prior to finalizing the material, and all must contain the contractor's name, mailing address, toll-free telephone number and web site.

### **5.0 INQUIRIES AND CUSTOMER SERVICE FUNCTIONS**

The contractor shall respond to CHCBP inquiries from any geographic area, to include locations outside the 50 United States and the District of Columbia. The contractor shall provide timely, accurate and thorough responses to the inquiries it receives from any source, e.g., prospective applicants, beneficiaries, providers, other contractors, government officials, etc. in accordance with [Chapter 1, Section 3, paragraph 3.0](#).

### **6.0 FIDUCIARY RESPONSIBILITIES**

**6.1** The contractor shall act as a fiduciary for all funds acquired from CHCBP premium collections, which are government property. The contractor shall develop strict funds control processes for its collection, retention and transfer of CHCBP premiums to the government. The contractor shall follow the requirements in [Chapter 3](#).

**6.2** The contractor shall maintain a system for tracking and reporting premiums and beneficiaries/policy holders. The system is subject to government review and approval.

**6.3** By the 10th calendar day of the month following the activity, the contractor shall submit the following reports: CHCBP Workload Report, CHCBP Monthly Enrollee Premiums Report, CHCBP Adjusted Premiums Report, CHCBP Enrollment Data Report, and CHCBP Premiums Summary Report as described in the DD Form 1423, Contract Data Requirements List (CDRL), and submit per [Chapter 14, Section 2](#).

### **7.0 DEERS**

Refer to the DEERS instructions in the TSM for additional DEERS requirements related to CHCBP.

### **8.0 REPORTING RESPONSIBILITIES**

In addition to the written monthly reports, the CHCBP contractor may be required to produce CHCBP ad hoc reports as requested by the government. The data elements or information for such reports would be limited to that information that the CHCBP contractor has collected or should

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### Appendix A

#### Acronyms And Abbreviations

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ARVC	Arrhythmogenic Right Ventricular Cardiomyopathy
ASA	Adjusted Standardized Amount American Society of Anesthesiologists
ASAP	Automated Standard Application for Payment
ASC	Accredited Standards Committee Ambulatory Surgical Center
ASCA	Administrative Simplification Compliance Act
ASCUS	Atypical Squamous Cells of Undetermined Significance
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
ATA	American Telemedicine Association
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
BC	Birth Center
BCaBA	Board Certified Assistant Behavior Analyst
BCABA	Board Certified Associate Behavior Analyst
BCAC	Beneficiary Counseling and Assistance Coordinator
BCBA	Board Certified Behavior Analyst
BCBS	Blue Cross [and] Blue Shield
BCBSA	Blue Cross [and] Blue Shield Association
BCC	Biostatistics Center
<b>BE&amp;SD</b>	<b>Beneficiary Education and Support Division</b>
BH	Behavioral Health
BI	Background Investigation
<b>BIA</b>	<b>Bureau of Indian Affairs</b>
BIPA	Benefits Improvement Protection Act
BL	Black Lung
BLS	Basic Life Support

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#### Acronyms And Abbreviations

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BMI	Body Mass Index
BMT	Bone Marrow Transplantation
BNAF	Budget Neutrality Adjustment Factor
BOS	Bronchiolitis Obliterans Syndrome
BP	Behavioral Plan
BPC	Beneficiary Publication Committee
BRAC	Base Realignment and Closure
BRCA	BReast CAncer (genetic testing)
BRCA1/2	BReast CAncer Gene 1/2
BS	Bachelor of Science
BSGI	Breast-Specific Gamma Imaging
BSID	Bayley Scales of Infant Development
BSR	Beneficiary Service Representative
BWE	Beneficiary Web Enrollment
C&A	Certification and Accreditation
C&P	Compensation and Pension
C/S	Client/Server
CA	Care Authorization
CA/NAS	Care Authorization/Non-Availability Statement
CABG	Coronary Artery Bypass Graft
CAC	Common Access Card
CACREP	Council for Accreditation of Counseling and Related Educational Programs
CAD	Coronary Artery Disease
CAF	Central Adjudication Facility
CAH	Critical Access Hospital
CAMBHC	Comprehensive Accreditation Manual for Behavioral Health Care
CAP	Competitive Acquisition Program
CAP/DME	Capital and Direct Medical Education
CAPD	Continuous Ambulatory Peritoneal Dialysis
CAPP	Controlled Access Protection Profile
CAQH	Council for Affordable Quality Health
CAS	Carotid Artery Stenosis
CAT	Computerized Axial Tomography
CB	Consolidated Billing
CBC	Cypher Block Chaining
CBE	Clinical Breast Examination
CBHCO	Community-Based Health Care Organizations
CBP	Competitive Bidding Program
CBSA	Core Based Statistical Area
CC	Common Criteria Convenience Clinic Criminal Control (Act)

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CPI	Consumer Price Index
CPI-U	Consumer Price Index - Urban (Wage Earner)
CPNS	Certified Psychiatric Nurse Specialists
CPR	CAC PIN Reset
CPT	Chest Physiotherapy Current Procedural Terminology
CPT-4	Current Procedural Terminology, 4th Edition
CQM	Clinical Quality Management
CQMP	Clinical Quality Management Program
CQMP AR	Clinical Quality Management Program Annual Report
CQS	Clinical Quality Studies
CRM	Contract Resource Management (Directorate)
CRNA	Certified Registered Nurse Anesthetist
CRS	Cytoreductive Surgery
CRSC	Combat-Related Special Compensation
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
CTA	<b>Composite Tissue Allotransplantation</b> Computerized Tomography Angiography
CTC	Computed Tomographic Colonography
CTCL	Cutaneous T-Cell Lymphoma
CTEP	Cancer Therapy Evaluation Program
CTX	Corporate Trade Exchange
CUC	Chronic Ulcerative Colitis
CVAC	CHAMPVA Center
CVS	Contractor Verification System
CY	Calendar Year
DAA	Designated Approving Authority
DAO	Defense Attache Offices
DBA	Doing Business As
DBN	DoD Benefits Number
DC	Direct Care
DCAA	Defense Contract Audit Agency
DCAO	Debt Collection Assistance Officer

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DCID	Director of Central Intelligence Directive
DCII	Defense Clearance and Investigation Index
DCIS	Defense Criminal Investigating Service Ductal Carcinoma In Situ
DCN	Document Control Number
DCP	Data Collection Period
DCPE	Disability Compensation and Pension Examination
DCR	Developed Character Reference
DCS	Duplicate Claims System
DCSI	Defense Central Security Index
DCWS	DEERS Claims Web Service
DD (Form)	Department of Defense (Form)
DDAS	DCII Disclosure Accounting System
<b>DDD</b>	<b>Degenerative Disc Disease</b>
DDP	Dependent Dental Plan
DDS	DEERS Dependent Suffix
DE	Durable Equipment
DECC	Defense Enterprise Computing Center
DED	Dedicated Emergency Department
DEERS	Defense Enrollment Eligibility Reporting System
DELM	Digital Epiluminescence Microscopy
DENC	Detailed Explanation of Non-Concurrence
DepSecDef	Deputy Secretary of Defense
DES	Data Encryption Standard Disability Evaluation System
DFAS	Defense Finance and Accounting Service
DG	Diagnostic Group
DGH	Denver General Hospital
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
DLI	Donor Lymphocyte Infusion

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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
DOC	Dynamic Orthotic Cranioplasty (Band)
DoD	Department of Defense
DoD AI	Department of Defense Administrative Instruction
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DoDIG	Department of Defense Inspector General
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
DPPO	Designated Provider Program Office
DRA	Deficit Reduction Act
DREZ	Dorsal Root Entry Zone
DRG	Diagnosis Related Group
DRPO	DEERS RAPIDS Program Office
DRS	Decompression Reduction Stabilization
DSAA	Defense Security Assistance Agency
DSC	DMDC Support Center
DSCC	Data and Study Coordinating Center

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#### Acronyms And Abbreviations

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DS Logon	DoD Self-Service Logon
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSM-III	Diagnostic and Statistical Manual of Mental Disorders, Third Edition
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition
DSMC	Data and Safety Monitoring Committee
DSMO	Designated Standards Maintenance Organization
DSMT	Diabetes Self-Management Training
DSO	DMDC Support Office
DSPOC	Dental Service Point of Contact
DSU	Data Sending Unit
DTF	Dental Treatment Facility
DTM	Directive-Type Memorandum
DTR	Derived Test Requirements
DTRO	Director, TRICARE Regional Office
DUA	Data Use Agreement
DVA	Department of Veterans Affairs
DVAHCF	Department of Veterans Affairs Health Care Finder
DVD	Digital Video Disc
DWR	DSO Web Request
Dx	Diagnosis
DXA	Dual Energy X-Ray Absorptiometry
E-ID	Early Identification
E-NAS	Electronic Non-Availability Statement
e-QIP	Electronic Questionnaires for Investigations Processing
E&M	Evaluation & Management
E2R	Enrollment Eligibility Reconciliation
EAL	Common Criteria Evaluation Assurance Level
EAP	Employee-Assistance Program Ethandamine phosphate
EBC	Enrollment Based Capitation
ECA	External Certification Authority
ECAS	European Cardiac Arrhythmia Society
ECG	Electrocardiogram
ECHO	Extended Care Health Option
ECT	Electroconvulsive Therapy
ED	Emergency Department
EDC	Error Detection Code
EDI	Electronic Data Information Electronic Data Interchange
EDIPI	Electronic Data Interchange Person Identifier
EDIPN	Electronic Data Interchange Person Number
EDI_PN	Electronic Data Interchange Patient Number

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EEG	Electroencephalogram
EEPROM	Erasable Programmable Read-Only Memory
EFM	Electronic Fetal Monitoring
EFMP	Exceptional Family Member Program
EFP	Environmental 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
EHRA	European Heart Rhythm Association
EIA	Educational Interventions for Autism Spectrum Disorders
EID	Early Identification Enrollment Information for Dental
EIDS	Executive Information and Decision Support
EIN	Employer Identification Number
EIP	External Infusion Pump
EKG	Electrocardiogram
ELN	Element Locator Number
ELISA	Enzyme-Linked Immunoabsorbent Assay
E/M	Evaluation and Management
EMC	Electronic Media Claim Enrollment Management Contractor
EMDR	Eye Movement Desensitization and Reprocessing
EMG	Electromyogram
EMTALA	Emergency Medical Treatment & Active Labor Act
ENTNAC	Entrance National Agency Check
EOB	Explanation of Benefits
EOBs	Explanations of Benefits
EOC	Episode of Care
EOE	Evoked Otoacoustic Emission
EOG	Electro-oculogram
EOMB	Explanation of Medicare Benefits
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

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EST	Eastern Standard Time
ESWT	Extracorporeal Shock Wave Therapy
ET	Eastern Time
ETIN	Electronic Transmitter Identification Number
EWPS	Enterprise Wide Provider System
EWRAS	Enterprise Wide Referral and Authorization System
F&AO	Finance and Accounting Office(r)
FAI	Femoroacetabular Impingement
FAP	Familial Adenomatous Polyposis
FAR	Federal Acquisition Regulations
FASB	Federal Accounting Standards Board
FBI	Federal Bureau of Investigation
FCC	Federal Communications Commission
FCCA	Federal Claims Collection Act
FDA	Food and Drug Administration
FDB	First Data Bank
FDL	Fixed Dollar Loss
Fed	Federal Reserve Bank
FEHBP	Federal Employee Health Benefit Program
FEL	Familial Erythrophagocytic Lymphohistiocytosis
FEV <sub>1</sub>	Forced Expiratory Volume
FFM	Foreign Force Member
FHL	Familial Hemophagocytic Lymphohistiocytosis
FI	Fiscal Intermediary
FIPS	Federal Information Processing Standards (or System)
FIPS PUB	FIPS Publication
FISH	Fluorescence In Situ Hybridization
FISMA	Federal Information Security Management Act
FL	Form Locator
FMCRA	Federal Medical Care Recovery Act
FMRI	Functional Magnetic Resonance Imaging
FOBT	Fecal Occult Blood Testing
FOC	Full Operational Capability
FOIA	Freedom of Information Act
FPO	Fleet Post Office
FQHC	Federally Qualified Health Center
FR	Federal Register Frozen Records
FRC	Federal Records Center
FSO	Facility Security Officer
FTE	Full Time Equivalent
FTP	File Transfer Protocol

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FX	Foreign Exchange (lines)
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GAO	General Accounting Office
GBL	Government Bill of Lading
GDC	Guglielmi Detachable Coil
GFE	Government Furnished Equipment
GHP	Group Health Plan
GHz	Gigahertz
GIFT	Gamete Intrafallopian Transfer
GIQD	Government Inquiry of DEERS
GP	General Practitioner
GPCI	Geographic Practice Cost Index
H/E	Health and Environment
HAC	Health Administration Center Hospital Acquired Condition
HAVEN	Home Assessment Validation and Entry
HBA	Health Benefits Advisor
HBO	Hyperbaric Oxygen Therapy
HCC	Health Care Coverage
HCDP	Health Care Delivery Program
HCF	Health Care Finder
HCFA	Health Care Financing Administration
HCG	Human Chorionic Gonadotropin
HCIL	Health Care Information Line
HCM	Hypertrophic Cardiomyopathy
HCO	Healthcare Operations Division
HCP	Health Care Provider
HCPC	Healthcare Common Procedure Code (formerly HCFA Common Procedure Code)
HCPCS	Healthcare Common Procedure Coding System (formerly Healthcare Common Procedure Coding System)
HCPR	Health Care Provider Record
HCSR	Health Care Service Record
HDC	High Dose Chemotherapy
HDC/SCR	High Dose Chemotherapy with Stem Cell Rescue
HDGC	Hereditary Diffuse Gastric Cancer
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

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

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IAVM	Information Assurance Vulnerability Management
IAW	In accordance with
IBD	Inflammatory Bowel Disease
IC	Individual Consideration Integrated Circuit
ICASS	International Cooperative Administrative Support Services
ICD	Implantable Cardioverter Defibrillator
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICF	Intermediate Care Facility
ICMP	Individual Case Management Program
ICMP-PEC	Individual Case Management Program For Persons With Extraordinary Conditions
ICN	Internal Control Number
ICSP	Individual Corporate Services Provider
ID	Identification Identifier
IDB	Intradiscal Biacuplasty
IDD	Internal or Intervertebral Disc Decompression
IDE	Investigational Device Exemption Investigational Device
IDEA	Individuals with Disabilities Education Act
IDES	Integrated Disability Evaluation System
IDET	Intradiscal Electrothermal Therapy
IDME	Indirect Medical Education
IdP	Identity Protection
IDTA	Intradiscal Thermal Annuloplasty
IE	Interface Engine Internet Explorer
IEA	Intradiscal Electrothermal Annuloplasty
IEP	Individualized Educational Program
IFR	Interim Final Rule
IFSP	Individualized Family Service Plan
IG	Implementation Guidance
IgA	Immunoglobulin A
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 Instant Message/Messaging Intramuscular
IMRT	Intensity Modulated Radiation Therapy
IND	Investigational New Drugs

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INR	International Normalized Ratio Intramuscular International Normalized Ratio
INS	Immigration and Naturalization Service
IOC	Initial Operational Capability
IOD	Interface Operational Description
IOLs	Intraocular Lenses
IOM	Internet Only Manual
IOP	Intraocular Pressure
IORT	Intra-Operative Radiation Therapy
IP	Inpatient
IPC	Information Processing Center (outdated term, see SMC)
IPHC	Intraperitoneal Hyperthermic Chemotherapy
IPN	Intraperitoneal Nutrition
IPP	In-Person Proofing
IPPS	Inpatient Prospective Payment System
IPS	Individual Pricing Summary
IPSEC	Secure Internet Protocol
IQ	Intelligence Quotient
IQM	Internal Quality Management
IRB	Institutional Review Board
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
JC	Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations (JCAHO))
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCIH	Joint Committee on Infant Hearing
JCOS	Joint Chiefs of Staff
JFTR	Joint Federal Travel Regulations
JNI	Japanese National Insurance
JTF-GNO	Joint Task Force for Global Network Operations
JUSDAC	Joint Uniformed Services Dental Advisory Committee <sup>7</sup>
JUSMAC	Joint Uniformed Services Medical Advisory Committee
JUSPAC	Joint Uniformed Services Personnel Advisory Committee

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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
LCIS	Lobular Carcinoma In Situ
LDL	Low Density Lipoprotein
LDLT	Living Donor Liver Transplantation
LDR	Low Dose Rate
<b>LGS</b>	<b>Lennox-Gastaut Syndrome</b>
LLLT	Low Level Laser Therapy
LNT	Lexical Neighborhood Test
LOC	Letter of Consent
LOD	Letter of Denial/Revocation Line of Duty
LOI	Letter of Intent
LOS	Length-of-Stay
LOT	Life Orientation Test
LPN	Licensed Practical Nurse
LSIL	Low-grade Squamous Intraepithelial Lesion
LSN	Location Storage Number
LTC	Long-Term Care
LUPA	Low Utilization Payment Adjustment
LV	Left Ventricle [Ventricular]
LVEF	Left Ventricular Ejection Fraction
LVN	Licensed Vocational Nurse
LVRS	Lung Volume Reduction Surgery
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
MBI	Molecular Breast Imaging
MCIO	Military Criminal Investigation Organization
MCS	Managed Care Support
MCSC	Managed Care Support Contractor
MCSS	Managed Care Support Services
MCTDP	Myelomeningocele Clinical Trial Demonstration Protocol
MD	Doctor of Medicine

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MDI	Mental Developmental Index Multiple Daily Injection
MDQC	Mail Delivery Quality Code
MDR	MHS Data Repository
MDS	Minimum Data Set
MEB	Medical Evaluation Board
MEC	Marketing and Education Committee
MEI	Medicare Economic Index
MEPS	Military Entrance Processing Station
MEPRS	Medical Expense Performance Reporting System
MET	Microcurrent Electrical Therapy
MFCC	Marriage and Family Counseling Center
MGCRB	Medicare Geographic Classification Review Board
MGIB	Montgomery GI Bill
MH	Mental Health
MHO	Medical Holdover
MHS	Military Health System
MHSO	Managing Health Services Organization
MHSS	Military Health Services System
MI	Myocardial Infarction
MI&L	Manpower, Installations, and Logistics
MIA	Missing In Action
MIAP	Multi-Host Internet Access Portal
MIDCAB	Minimally Invasive Direct Coronary Artery Bypass
<b>mild®</b>	<b>Minimally Invasive Lumbar Decompression</b>
MIRE	Monochromatic Infrared Energy
MLNT	Multisyllabic Lexical Neighborhood Test
MMA	Medicare Modernization Act
MMEA	Medicare and Medicaid Extenders Act (of 2010)
MMP	Medical Management Program
MMSO	Military Medical Support Office
MMWR	Morbidity and Mortality Weekly Report
MNR	Medical Necessity Report
MOA	Memorandum of Agreement
MOH	Medal Of Honor
MOMS	Management of Myelomeningocele Study
MOP	Mail Order Pharmacy
MOU	Memorandum of Understanding
MPI	Master Patient Index
MR	Magnetic Resonance Medical Review Mentally Retarded
MRA	Magnetic Resonance Angiography

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MRHFP	Medicare Rural Hospital Flexibility Program
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
MUE	Medically Unlikely Edits
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
NACLCL	National Agency Check with Law Enforcement and Credit
NADFM	Non-Active Duty Family Member
NARA	National Archives and Records Administration
NAS	Naval Air Station Non-Availability Statement
NATO	North Atlantic Treaty Organization
NAVMED	Naval Medical (Form)
NBCC	National Board of Certified Counselors
NCCI	National Correct Coding Initiatives
NCE	National Counselor Examination
NCF	National Conversion Factor
NCI	National Cancer Institute
NCMHCE	National Clinical Mental Health Counselor Examination
NCPAP	Nasal Continuous Positive Airway Pressure
NCPDP	National Council of Prescription Drug Program
NCQA	National Committee for Quality Assurance
NCVHS	National Committee on Vital and Health Statistics
NDAA	National Defense Authorization Act
NDC	National Drug Code
NDMS	National Disaster Medical System

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NED	National Enrollment Database
NETT	National Emphysema Treatment Trial
NF	Nursing Facility
NG	National Guard
NGPL	No Government Pay List
NHLBI	National Heart, Lung and Blood Institute
NHSC	National Health Service Corps
NICHD	National Institute of Child Health and Human Development
NIH	National Institutes of Health
NII	Networks and Information Integration
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
NMA	Non-Medical Attendant
NMES	Neuromuscular Electrical Stimulation
NMOP	National Mail Order Pharmacy
NMR	Nuclear Magnetic Resonance
NMT	Nurse Massage Therapist
NOAA	National Oceanic and Atmospheric Administration
NoPP	Notice of Private Practices
NOSCASTC	National Operating Standard Cost as a Share of Total Costs
NP	Nurse Practitioner
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPR	Notice of Program Reimbursement
NPS	Naval Postgraduate School
NPWT	Negative Pressure Wound Therapy
NQF	National Quality Forum
NRC	Nuclear Regulatory Commission
NRS	Non-Routine [Medical] Supply
NSDSMEP	National Standards for Diabetes Self-Management Education Programs
NSF	Non-Sufficient Funds
NTIS	National Technical Information Service
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claims Committee
O/ATIC	Operations/Advanced Technology Integration Center
OA	Office of Administration
OAE	Otoacoustic Emissions
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)

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OASD (H&E)	Office of the Assistant Secretary of Defense (Health and Environment)
OASD (MI&L)	Office of the Assistant Secretary of Defense (Manpower, Installations, and Logistics)
OASIS	Outcome and Assessment Information Set
OB/GYN	Obstetrician/Gynecologist
OBRA	Omnibus Budget Reconciliation Act
OCE	Outpatient Code Editor
OCHAMPUS	Office of Civilian Health and Medical Program of the Uniformed Services
OCMO	Office of the Chief Medical Officer
OCONUS	Outside of the Continental United States
OCR	Office of Civil Rights
OCSP	Organizational Corporate Services Provider
OCT	Optical Coherence Tomograph
OD	Optical Disk
OF	Optional Form
OGC	Office of General Counsel
OGC-AC	Office of General Counsel-Appeals, Hearings & Claims Collection Division
OGP	Other Government Program
OHI	Other Health Insurance
OHS	Office of Homeland Security
OIG	Office of Inspector General
OMB	Office of Management and Budget
OP/NSP	Operation/Non-Surgical Procedure
OPD	Outpatient Department
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
OR	Operating Room
OSA	Obstructive Sleep Apnea
OSAS	Obstructive Sleep Apnea Syndrome
OSD	Office of the Secretary of Defense
OSHA	Occupational Safety and Health Act
OSS	Office of Strategic Services
OT	Occupational Therapy (Therapist)
OTC	Over-The-Counter
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 <sub>2</sub>	Partial Pressure of Carbon Dioxide
PAO <sub>2</sub>	Partial Pressure of Oxygen

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PAK	Pancreas After Kidney (transplant)
PAP	Papanicolaou
PAT	Performance Assessment Tracking
PatID	Patient Identifier
PAVM	Pulmonary Arteriovenous Malformation
PBM	Pharmacy Benefit Manager
PC	Peritoneal Carcinomatosis Personal Computer Professional Component
PCA	Patient Controlled Analgesia
PCDIS	Purchased Care Detail Information System
PCI	Percutaneous Coronary Intervention
PCM	Primary Care Manager
PCMBN	PCM By Name
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
PCSIB	Purchased Care Systems Integration Branch
PD	Passport Division
PDA	Patent Ductus Arteriosus Personal Digital Assistant
PDD	Percutaneous (or Plasma) Disc Decompression
PDDBI	Pervasive Developmental Disorders Behavior Inventory
PDDNOS	Pervasive Developmental Disorder Not Otherwise Specified
PDF	Portable Document Format
PDI	Potentially Disqualifying Information
PDQ	Physicians's Data Query
PDR	Person Data Repository
PDS	Person Demographics Service
PDTS	Pharmacy Data Transaction System
PDX	Principal Diagnosis
PE	Physical Examination
PEC	Pharmacoeconomic Center
PEP	Partial Episode Payment
PEPR	Patient Encounter Processing and Reporting
PERMS	Provider Education and Relations Management System
PET	Positron Emission Tomography
PFCRA	Program Fraud Civil Remedies Act
PFP	Partnership For Peace

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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
PIRFT	Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)
PIT	PCM Information Transfer
PIV	Personal Identity Verification
PK	Public Key
PKE	Public Key Enabling
PKI	Public Key Infrastructure
PKU	Phenylketonuria
PLS	Preschool Language Scales
PM-DRG	Pediatric Modified-Diagnosis Related Group
PMPM	Per Member Per Month
PMR	Percutaneous Myocardial Laser Revascularization
PNET	Primitive Neuroectodermal Tumors
PNT	Policy Notification Transaction
POA	Power of Attorney Present On Admission
POA&M	Plan of Action and Milestones
POC	Pharmacy Operations Center Plan of Care Point of Contact
POL	May 1996 TRICARE/CHAMPUS Policy Manual 6010.47-M
POS	Point of Sale (Pharmacy only) Point of Service Public Official's Statement
POV	Privately Owned Vehicle
PPACA	Patient Protection and Affordable Care Act
PPD	Per Patient Day
PPN	Preferred Provider Network
PPO	Preferred Provider Organization
PPP	Purchasing Power Parity

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PPS	Prospective Payment System Ports, Protocols and Services
PPSM	Ports, Protocols, and Service Management
PPV	Pneumococcal Polysaccharide Vaccine
PQI	Potential Quality Indicator Potential Quality Issue
PR	Periodic Reinvestigation
PRC	Program Review Committee
PRFA	Percutaneous Radiofrequency Ablation
PRG	Peer Review Group
PRO	Peer Review Organization
ProDUR	Prospective Drug Utilization Review
PROM	Programmable Read-Only Memory
PRP	Personnel Reliability Program
PRPP	Pharmacy Redesign Pilot Project
PSA	Prime Service Area Physician Scarcity Area
PSAB	Personnel Security Appeals Board
PSCT	Peripheral Stem Cell Transplantation
PSD	Personnel Security Division
PSG	Polysomnography
PSI	Personnel Security Investigation
PST	Pacific Standard Time
PT	Pacific Time Physical Therapist Physical Therapy Prothrombin Time
PTA	Pancreas Transplant Alone Percutaneous Transluminal Angioplasty
PTC	Processed To Completion
PTCA	Percutaneous Transluminal Coronary Angioplasty
PTK	Phototherapeutic Keratectomy
PTNS	Posterior Tibial Nerve Stimulation
PTSD	Post-Traumatic Stress Disorder
PVCs	Premature Ventricular Contractions
QA	Quality Assurance
QC	Quality Control
QI	Quality Improvement Quality Issue
QII	Quality Improvement Initiative
QIO	Quality Improvement Organization
QIP	Quality Improvement Program
QLE	Qualifying Life Event

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QM	Quality Management
QUIG	Quality Indicator Group
RA	Radiofrequency Annuloplasty Remittance Advice
RADDP	Remote Active Duty Dental Program
RAM	Random Access Memory
RAP	Request for Anticipated Payment
RAPIDS	Real-Time Automated Personnel Identification System
RC	Reserve Component
RCC	Recurring Credit/Debit Charge Renal Cell Carcinoma
RCCPDS	Reserve Component Common Personnel Data System
RCN	Recoupment Case Number Refund Control Number
RCS	Report Control Symbol
RD	Regional Director Registered Dietitian
RDBMS	Relational Database Management System
RDDDB	Reportable Disease Database
REM	Rapid Eye Movement
RF	Radiofrequency
RFA	Radiofrequency Ablation
RFI	Request For Information
RFP	Request For Proposal
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RhoGAM	RRho (D) Immune Globulin
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 OASIS Verification
RPM	Record Processing Mode
RRA	Regional Review Authority
RTC	Residential Treatment Center
rTMS	Repetitive Transcranial Magnetic Stimulation
RUG	Resource Utilization Group

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RV	Residual Volume Right Ventricle [Ventricular]
RVU	Relative Value Unit
SAAR	System Authorization Access Request
SAD	Seasonal Affective Disorder
SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier
SAFE	Sexual Assault Forensic Examination
SAO	Security Assistant Organizations
SAP	Special Access Program
SAPR	Sexual Assault Prevention and Response
SAS	Sensory Afferent Stimulation
SAT	Service Assist Team
SBCC	Service Branch Classification Code
SBI	Special Background Investigation
SCA	Service Contract Act
SCH	Sole Community Hospital
SCHIP	State Children's Health Insurance Program
SCI	Sensitive Compartmented Information Spinal Cord Injury
SCIC	Significant Change in Condition
SCOO	Special Contracts and Operations Office
SCR	Stem Cell Rescue
S/D	Security Division
SD (Form)	Secretary of Defense (Form)
SEP	Sensory Evoked Potentials
SES	Senior Executive Service
SelRes	Selected Reserve
SF	Standard Form
SFTP	Secure File Transfer Protocol
SGDs	Speech Generating Devices
SHCP	Supplemental Health Care Program
SI	Sensitive Information Small Intestine (transplant) Special Indicator (code) Status Indicator
SIDS	Sudden Infant Death Syndrome
SIF	Source Input Format
SII	Special Investigative Inquiry
SI/L	Small Intestine-Live (transplant)
SIOP-ESI	Single Integrated Operational plan-Extremely Sensitive Information
SIP	System Identification Profile
SIT	Standard Insurance Table
SMC	System Management Center

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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
SSDI	Social Security Disability Insurance
SSL	Secure Socket Layer
SSM	Site Security Manager
SSN	Social Security Number
SSO	Short-Stay Outlier
ST	Speech Therapy
STF	Specialized Treatment Facility
STS	Specialized Treatment Services
STSF	Specialized Treatment Service Facility
SUBID	Sub-Identifier
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
TAR	Total Ankle Replacement
TARO	TRICARE Alaska Regional Office
TB	Tuberculosis
TBD	To Be Determined

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TBE	Tick Borne Encephalitis
TBI	Traumatic Brain Injury
TC	Technical Component
TCMHC	TRICARE Certified Mental Health Counselor
TCP/IP	Transmission Control Protocol/Internet Protocol
TCSRC	Transitional Care for Service-Related Conditions
TDD	Targeted Disc Decompression
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Program/Plan
TDY	Temporary Duty
TED	TRICARE Encounter Data
TEE	Transesophageal Echocardiograph [Echocardiography]
TEFRA	Tax Equity and Fiscal Responsibility Act
TEOB	TRICARE Explanation of Benefits
TEPRC	TRICARE Encounter Pricing (Record)
TEPRV	TRICARE Encounter Provider (Record)
TET	Tubal Embryo Transfer
TF	Transfer Factor
TFL	TRICARE For Life
TFMDP	TRICARE (Active Duty) Family Member Dental Plan
TGRO	TRICARE Global Remote Overseas
TGROHC	TGRO Host Country
TIFF	Tagged Imaged File Format
TIL	Tumor-Infiltrating Lymphocytes
TIMPO	Tri-Service Information Management Program Office
TIN	Taxpayer Identification Number
TIP	Thermal Intradiscal Procedure
TIPS	Transjugular Intrahepatic Portosystemic Shunt
TIS	TRICARE Information Service
TLAC	TRICARE Latin America/Canada
TLC	Total Lung Capacity
TMA	TRICARE Management Activity
TMA-A	TRICARE Management Activity - Aurora
TMAC	TRICARE Maximum Allowable Charge
TMCPA	Temporary Military Contingency Payment Adjustment
TMH	Telemental Health
TMI&S	Technology Management Integration & Standards
TMOP	TRICARE Mail Order Pharmacy
TMR	Transmyocardial Revascularization
TMS	Transcranial Magnetic Stimulation
TNEX	TRICARE Next Generation (MHS Systems)
TNP	Topical Negative Pressure

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TOB	Type of Bill
TOE	Target of Evaluation
TOL	TRICARE Online
TOM	August 2002 TRICARE Operations Manual 6010.51-M February 2008 TRICARE Operations Manual 6010.56-M
TOP	TRICARE Overseas Program
TOPO	TRICARE Overseas Program Office
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
TRIAP	TRICARE Assistance Program
TRM	August 2002 TRICARE Reimbursement Manual 6010.55-M February 2008 TRICARE Reimbursement Manual 6010.58-M
TRO	TRICARE Regional Office
TRO-N	TRICARE Regional Office-North
TRO-S	TRICARE Regional Office-South
TRO-W	TRICARE Regional Office-West
TRPB	TRICARE Retail Pharmacy Benefits
TRR	TRICARE Retired Reserve
TRRx	TRICARE Retail Pharmacy
TRS	TRICARE Reserve Select
TRSA	TRICARE Reserve Select Application
TSC	TRICARE Service Center
TSF	Target of Evaluation Security Functions
TSM	August 2002 TRICARE Systems Manual 7950.1-M February 2008 TRICARE Systems Manual 7950.2-M
TSP	Target of Evaluation Security Policy
TSR	TRICARE Select Reserve
TSRDP	TRICARE Select Reserve Dental Program
TSRx	TRICARE Senior Pharmacy
TSS	TRICARE Senior Supplement

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TSSD	TRICARE Senior Supplement Demonstration
TTOP	TRICARE Transitional Outpatient Payment
TTPA	Temporary Transitional Payment Adjustment
TTY	Teletypewriter
TUNA	Transurethral Needle Ablation
TYA	TRICARE Young Adult
UAE	Uterine Artery Embolization
UARS	Upper Airway Resistance Syndrome
UB	Uniform Bill
UBO	Uniform Business Office
UCBT	Umbilical Cord Blood Stem Cell Transplantation
UCC	Uniform Commercial Code Urgent Care Center
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
UPPP	Uvulopalatopharyngoplasty
URFS	Unremarried Former Spouse
URL	Universal Resource Locator
US	Ultrasound 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

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USPHS	United States Public Health Service
USPS	United States Postal Service
USPSTF	U.S. Preventive Services Task Force
USS	United Seaman's Service
USTF	Uniformed Services Treatment Facility
UV	Ultraviolet
VA	Veterans Affairs (hospital) Veterans Administration
VAC	Vacuum-Assisted Closure
VAD	Ventricular Assist Device
VAMC	VA Medical Center
VATS	Video-Assisted Thoroscopic Surgery
VAX-D	Vertebral Axial Decompression
VD	Venereal Disease
VO	Verifying Office (Official)
VPN	Virtual Private Network
VPOC	Verification Point of Contact
VRDX	Reason Visit Diagnosis
VSAM	Virtual Storage Access Method
VSD	Ventricular Septal Defect
WAC	Wholesale Acquisition Cost
WAN	Wide Area Network
WATS	Wide Area Telephone Service
WC	Worker's Compensation
WebDOES	Web DEERS Online Enrollment System (application)
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
WWW	World Wide Web
X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome
XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer
2D	Two Dimensional
3D	Three Dimensional

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