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**CHANGE 119
6010.57-M
OCTOBER 23, 2014**

**PUBLICATIONS SYSTEM CHANGE TRANSMITTAL
FOR
TRICARE POLICY MANUAL (TPM), FEBRUARY 2008**

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

**CHANGE TITLE: NATIONAL DEFENSE AUTHORIZATION ACT FISCAL YEAR 2011, SECTION 724,
TRICARE CERTIFIED MENTAL HEALTH COUNSELORS**

CONREQ: 16959

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change defines TRICARE Certified Mental Health Counselors (TCMHC) for purposes of reimbursement; continues services of TCMHCs and Supervised Mental Health Counselors under the Basic Program Benefits; extends the time frame for mental health counselors to meet the requirements to be considered a TCMHC; and expands the supervision requirements of the TCMHC; and adds a Contract Data Requirements List.

EFFECTIVE DATE: August 18, 2014.

IMPLEMENTATION DATE: November 24, 2014.

This change is made in conjunction with Feb 2008 TOM, Change No. 133, Feb 2008 TRM, Change No. 105, and Feb 2008 TSM, Change No. 69.

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

CHANGE 119
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TRICARE Policy Manual 6010.57-M, February 1, 2008

Chapter 1, Section 1.2

Exclusions

1.1.18 Services and supplies provided under circumstances or in geographic locations requiring a Non-Availability Statement (NAS), when such a statement was not obtained. (See [Section 6.1](#).)

1.1.19 Services or supplies which require preauthorization if preauthorization was not obtained. Services and supplies which were not provided according to the terms of the preauthorization. An exception to the requirement for preauthorization may be granted if the services otherwise would be payable except for the failure to obtain preauthorization.

1.1.20 Psychoanalysis or psychotherapy provided to a beneficiary or any member of the immediate family that is credited towards earning a degree or furtherance of the education or training of a beneficiary or sponsor, regardless of diagnosis or symptoms that may be present.

1.1.21 Inpatient stays primarily to control or detain a runaway child, whether or not admission is to an authorized institution.

1.1.22 Services or supplies, including inpatient stays, directed or agreed to by a court or other governmental agency. However, those services and supplies (including inpatient stays) that otherwise are medically or psychologically necessary for the diagnosis or treatment of a covered condition and that otherwise meet all TRICARE requirements for coverage are not excluded.

1.1.23 Services and supplies required as a result of occupational disease or injury for which any benefits are payable under a worker's compensation or similar law, whether or not such benefits have been applied for or paid; except if benefits provided under such laws are exhausted.

1.1.24 Services and supplies in connection with cosmetic, reconstructive, or plastic surgery except as specifically provided in [32 CFR 199.4\(e\)\(8\)](#) (see [Chapter 4, Section 2.1](#)).

1.1.25 Surgery performed primarily for psychological reasons (such as psychogenic) (see [Chapter 4, Section 2.1](#)).

1.1.26 Electrolysis (see [Chapter 4, Section 2.1](#)).

1.1.27 Dental care or oral surgery, except as specifically provided in [32 CFR 199.4\(e\)\(10\)](#) (see [Chapter 4, Section 7.1](#) and [Chapter 8, Section 13.1](#)).

1.1.28 Services and supplies related to obesity or weight reduction whether surgical or nonsurgical; wiring of the jaw or any procedure of similar purposes; regardless of the circumstances under which performed; except that benefits may be provided for the gastric bypass, gastric stapling, or gastroplasty procedures in connection with morbid obesity as provided in [32 CFR 199.4\(e\)\(15\)](#) (see [Chapter 4, Section 13.2](#) and [Chapter 8, Section 7.2](#)).

1.1.29 Services and supplies related to transsexualism or such other conditions as gender dysphoria (including, but not limited, to intersex surgery, psychotherapy, and prescription drugs), except as specifically provided in [32 CFR 199.4\(e\)\(7\)](#) (see [Chapter 4, Sections 15.1, 16.1, 17.1](#), and [Chapter 7, Section 1.1](#)).

1.1.30 Sex therapy, sexual advice, sexual counseling, sex behavior modification, psychotherapy for mental disorders involving sexual deviations (i.e., transvestic fetishism), or other similar services, and any supplies provided in connection with therapy for sexual dysfunctions or inadequacies (see

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Chapter 1, Section 1.2

Exclusions

[Chapter 4, Section 15.1](#) and [Chapter 7, Section 1.1](#)).

1.1.31 Removal of corns or calluses or trimming of toenails and other routine podiatry services, except those required as a result of a diagnosed systemic medical disease affecting the lower limbs, such as severe diabetes (see [Chapter 8, Section 1.1](#)).

1.1.32 Treatment of dyslexia.

1.1.33 Surgery to reverse surgical sterilization procedures (see [Chapter 4, Sections 15.1](#) and [17.1](#) and [Chapter 7, Section 2.3](#)).

1.1.34 Noncoital reproductive procedures including artificial insemination, In Vitro Fertilization (IVF), gamete intrafallopian transfer and all other such assistive reproductive technologies. Services and supplies related to artificial insemination (including semen donors and semen banks), IVF, gamete intrafallopian transfer and all other noncoital reproductive technologies (see [Chapter 4, Sections 17.1, 18.1](#) and [Chapter 7, Section 2.3](#)).

1.1.35 Nonprescription contraceptives (see [Chapter 4, Section 17.1](#) and [Chapter 7, Section 2.3](#)).

1.1.36 Diagnostic tests to establish paternity of a child; or tests to determine sex of an unborn child (see [Chapter 4, Section 18.2](#) and [Chapter 5, Section 2.1](#)).

1.1.37 Preventive care, such as routine annual, or employment-requested physical examinations; routine screening procedures; immunizations; except as provided in the Clinical Preventive Services policy (see [Chapter 7, Sections 2.1, 2.2, 2.5, and 2.6](#)).

1.1.38 Services of chiropractors and naturopaths whether or not such services would be eligible for benefits if rendered by an authorized provider (see [Chapter 7, Section 18.5](#)).

1.1.39 Counseling services that are not medically necessary in the treatment of a diagnosed medical condition. For example, educational counseling, vocational counseling, and counseling for socioeconomic purposes, stress management, life-style modification, etc. Services provided by a certified marriage and family therapist, pastoral counselor or supervised mental health counselor in the treatment of a mental disorder are covered only as specifically provided in [32 CFR 199.6](#). Services provided by alcoholism rehabilitation counselors are covered only when rendered in a TRICARE-authorized treatment setting and only when the cost of those services is included in the facility's TRICARE-determined allowable cost rate.

Note: See [Chapter 8, Section 7.1](#) for policy on Nutritional Therapy. Diabetes Self-Management Training (DSMT) is covered (see [Chapter 8, Section 8.1](#)).

1.1.40 Acupuncture, whether used as a therapeutic agent or as an anesthetic.

1.1.41 Hair transplants, wigs (also referred to as cranial prosthesis), or hairpieces, except as allowed in accordance with section 744 of the DoD Appropriations Act for 1981 (see [Chapter 4, Section 2.1](#) and [Chapter 8, Section 12.1](#)).

1.1.42 Self-help, academic education or vocational training services and supplies, unless the provisions of [32 CFR 199.4\(b\)\(1\)\(v\)](#) relating to general or special education, apply.

Substance Use Disorders

Issue Date: June 26, 1995

Authority: [32 CFR 199.4\(c\)\(3\)\(ix\)\(A\)](#), [\(e\)\(4\)](#), and [\(h\)](#)

1.0 DESCRIPTION

Complication of alcohol and/or drug use or dependency and detoxification.

2.0 POLICY

Coverage may be extended for the treatment of substance use disorders including detoxification, rehabilitation, and outpatient care provided in authorized Substance Use Disorder Rehabilitation Facilities (SUDRFs) in accordance with the [paragraph 3.0](#).

3.0 POLICY CONSIDERATIONS

3.1 Emergency And Inpatient Hospital Services

3.1.1 Emergency and inpatient hospital services are covered when medically necessary for the active medical treatment of the acute phases of substance use withdrawal (detoxification), for stabilization, and for treatment of medical complications of substance use disorders.

3.1.2 Emergency and inpatient hospital services are considered medically necessary only when the patient's condition is such that the personnel and facilities of a hospital are required.

3.1.3 Stays provided for substance use disorder rehabilitation in a hospital-based facility are covered when provided as outlined in [paragraph 3.2](#).

3.1.4 Inpatient hospital services are subject to the provisions regarding the limit on inpatient mental health services.

3.1.5 Inpatient hospital services are subject to the statutory requirement for preauthorization.

3.2 Authorized Substance Use Disorder Treatment

3.2.1 Only those services provided by an authorized institutional providers are covered. Such a provider must be either an authorized hospital, or an organized substance use disorder treatment program in an authorized freestanding or hospital-based SUDRF.

3.2.2 A qualified mental health provider (physicians, clinical psychologists, Clinical Social Workers (CSWs), and psychiatric nurse specialists) shall prescribe the particular level of treatment.

3.2.3 Each beneficiary is entitled to three substance use disorder treatment benefit periods in his or her lifetime. A waiver may be extended in accordance with the criteria in [paragraph 3.5](#).

3.2.3.1 A benefit period begins with the first date of covered treatment and ends 365 days later, regardless of the total services actually used within the benefit period.

3.2.3.2 Emergency and inpatient hospital services as described under [paragraph 3.1.1](#), do not constitute substance use treatment for the purposes of establishing the beginning of a benefit period.

3.2.3.3 Unused benefits cannot be carried over to subsequent benefit periods.

3.3 Covered Services

3.3.1 Rehabilitative care in an authorized hospital or SUDRF, whether freestanding or hospital-based, is covered on either a residential or partial care (day, evening or weekend) basis.

3.3.1.1 Residential Care is subject to the following:

3.3.1.1.1 Care must be preauthorized.

3.3.1.1.2 Coverage during a single benefit period is limited to no more than one inpatient stay (prior to October 1, 2008, exclusive of stays classified in Diagnosis Related Group (DRG) 433; and on or after October 1, 2008, exclusive of stays classified in DRG 894) in hospitals subject to DRG-based payment system or 21 days in a DRG-exempt facility for rehabilitation care, unless the limit is waived in accordance with the criteria in [paragraph 3.5](#).

3.3.1.1.3 If the patient is medically in need of chemical detoxification, but does not require the personnel or facilities of a general hospital setting, detoxification services are covered in addition to rehabilitative care, but in a DRG-exempt facility detoxification services are limited to seven days, unless the limit is waived in accordance with the criteria in [paragraph 3.5](#).

3.3.1.1.4 The medical and psychological necessity of the detoxification must be documented. Any detoxification services provided in the SUDRF must be under general medical supervision.

3.3.1.2 Partial care is subject to the following:

3.3.1.2.1 Care must be preauthorized

3.3.1.2.2 Coverage during a single benefit period is limited to 21 days unless the limit is waived in accordance with the criteria in [paragraph 3.5](#).

3.3.2 Outpatient care is subject to the following:

3.3.2.1 Outpatient care (substance use disorder) must be provided by an approved SUDRF, whether freestanding or hospital-based. Certified addiction rehabilitation counselors or certified alcohol counselors employed by **an authorized hospital or a SUDRF** may provide the care.

3.3.2.2 The SUDRF must bill for the services using the appropriate Healthcare Common Procedure Coding System (HCPCS) code. Payment is the lesser of the billed amount or the CHAMPUS Maximum Allowable Charge (CMAC).

3.3.2.3 Coverage is up to 60 visits in a benefit period unless the limit is waived in accordance with the criteria in [paragraph 3.5](#).

3.3.2.4 Outpatient care is covered in both individual and group settings, in an authorized hospital or freestanding or hospital-based SUDRF. For patients with a primary diagnosis of mental disorder (**Diagnostic and Statistical Manual of Mental Disorders** (DSM)) that coexists with an alcohol and other drug abuse disorder see [Section 3.13](#).

3.3.2.5 Opioid Replacement Treatment

Effective November 21, 2013, opioid replacement treatment is covered for the treatment of substance use disorders. Opioid replacement treatment involves the substitution of a therapeutic drug with addictive potential for a drug of addiction. Benefit limits stated in [paragraph 3.3.1.2](#) or [paragraph 3.3.2.3](#) apply unless waived in accordance with [Section 3.5](#) of this Chapter.

3.3.3 Family Therapy.

3.3.3.1 Family therapy provided on an outpatient basis by an approved SUDRF, whether freestanding or hospital-based, is covered beginning with the completion of the patient's rehabilitative care as outlined in [paragraph 3.3.1](#). The family therapy is covered for up to 15 visits in a benefit period unless the limit is waived in accordance with the criteria in [paragraph 3.5](#). Services provided on an outpatient basis will be reimbursed under the appropriate allowable charge for the procedure code(s) billed.

3.3.3.2 Family therapy must be provided by a qualified mental health provider (psychiatrists or other physicians, clinical psychologists, Certified Psychiatric Nurse Specialists (CPNS), **certified clinical social workers, TRICARE certified mental health counselors**, certified marriage and family therapists; **and** pastoral and **supervised** mental health counselors, under a physician's supervision).

3.4 Coverage Limitations

3.4.1 Detoxification. Admissions to all facilities (includes DRG and non-DRG facilities) for detoxification are covered if preauthorized as medically/psychologically necessary. Days of detoxification must be counted toward the statutory day limit, limiting care for adults (age 19 and over) to 30 days in a fiscal year or 30 days in an admission and to 45 days for children (age 18 and under).

3.4.2 Rehabilitation. Rehabilitation stays are subject to a limit of three benefit periods in a lifetime unless this limit is waived. Preadmission and continued stay authorization is required for substance use disorder detoxification and rehabilitation. Rehabilitation stays are covered if preauthorized as medically/psychologically necessary. Days of rehabilitation must be counted toward the statutory day limit, restricting care for adults (age 19 and over) to 30 days in a fiscal year or 30 days in an admission and to 45 days for children (aged 18 and under). The concept of an emergency admission does not apply to rehabilitative care.

Note: The beneficiary may have either 21 days of rehabilitation in a residential (inpatient) basis or 21 days of rehabilitation in a partial hospital setting or a combination of both, as long as the 21-day limit for the total rehabilitation period is not exceeded.

3.5 Waiver Of Benefit Limits

The specific benefit limits set forth in this section may be waived by the contractor in special cases based on a determination that all of the following criteria are met:

3.5.1 Active treatment has taken place during the period of the benefit limit and substantial progress has been made according to the plan of treatment.

3.5.2 Further progress has been delayed due to the complexity of the illness.

3.5.3 Specific evidence has been presented to explain the factors that interfered with further treatment progress during the period of the benefit limit.

3.5.4 The waiver request includes specific time frames and a specific plan of treatment which will complete the course of treatment.

3.6 Payment Responsibility

Providers may not hold patients liable for payment for services for which payment is disallowed due to the provider's failure to follow established procedures for preadmission and continued stay authorization. With respect to such services, providers may not seek payment from the patient or the patient's family, unless the patient has agreed to personally pay for the services knowing that payment would not be made. Any such effort to seek payment is a basis for termination of the provider's authorized status.

3.7 Coverage is allowed for Antabuse® in the treatment of alcoholism.

3.8 Confidentiality

Release of any patient identifying information, including that required to adjudicate a claim, must comply with the provisions of section 544 of the Public Health Service Act, as amended (42 United States Code (USC) 290dd-3), which governs the release of medical and other information from the records of patients undergoing treatment of substance use disorder. If the patient refuses to authorize the release of medical records which are, in the opinion of the contractor necessary to determine benefits on a claim for treatment of substance use disorder the claim will be denied.

4.0 EXCEPTIONS

4.1 Aversion therapy. The programmed use of physical measures, such as electric shock, alcohol or other drugs (except Antabuse®) as negative reinforcement is not covered, even if recommended by a physician. All professional and institutional charges associated with a rehabilitation treatment program that uses aversion therapy must also be denied.

Treatment Of Mental Disorders

Issue Date: December 5, 1984

Authority: [32 CFR 199.4\(c\)\(3\)\(ix\)](#)

1.0 CPT¹ PROCEDURE CODE RANGES

90801 - 90899 for care provided through December 31, 2012.

90785 - 90899 for care provided on or after January 1, 2013.

2.0 POLICY

Benefits are payable for services and supplies that are medically or psychologically necessary for the treatment of mental disorders when:

2.1 The services are rendered by persons who meet the criteria of [32 CFR 199.6](#) for their respective disciplines (whether the person is an individual professional provider or is employed by another authorized provider), and

2.2 The mental disorder is one of those listed in the current edition of the **Diagnostic and Statistical Manual of Mental Disorders** (DSM) and is of a severity not only to cause the patient distress but also to interfere with the patient's ability to carry out his or her usual activities.

3.0 POLICY CONSIDERATIONS

3.1 Professional and Institutional Providers of Mental Health Services

3.1.1 List of authorized providers. Only the types of providers listed below are considered qualified providers of mental health services. The person providing the care must meet the criteria of [32 CFR 199.6](#), whether that person is an individual, professional provider or is employed by another authorized provider.

- Psychiatrists and other physicians;
- Clinical psychologists;
- Certified psychiatric nurse specialists (CPNSs);
- **Certified** clinical social workers;
- **TRICARE certified mental health counselors**;
- Certified marriage and family therapists;
- Pastoral counselors; and
- **Supervised** mental health counselors.

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3.1.2 Professional staff of institutions providing mental health services. For those types of institutional providers that are certified by TRICARE Management Activity (TMA), reviewers may assume that all professional staff meet regulatory criteria. Any evidence to the contrary is to be brought to the attention of TMA Special Contract Operations Office (SCOO), immediately. Contractors shall notify institutional providers within their jurisdictions that payment is authorized only for professional services provided by employees meeting the program requirements. In any situation where the contractor obtains evidence that an institution is billing for professional services of unqualified staff, the case is to be submitted to the TMA Office of Program Integrity (PI).

3.2 Review of Claims for Treatment of Mental Disorders

All claims for treatment of mental disorders are subject to review in accordance with claims processing procedures contained in the TRICARE Operations Manual (TOM).

3.2.1 Psychotropic drugs. All patients receiving psychotropic drugs must be under the care of a qualified mental health provider authorized by state licensure to prescribe drugs. That provider need not be the attending provider, but there must be evidence in the treatment plan of coordination between the various providers.

3.2.2 Electroconvulsive treatment (CPT² procedure codes 90870 and 90871). Electroconvulsive treatment is covered when medically or psychologically appropriate and when rendered by qualified providers. However, the use of electric shock as negative reinforcement (aversion therapy) is excluded.

3.2.3 Ancillary therapies (no code, as separate reimbursement is not permitted). Includes art, music, dance, occupational, and other ancillary therapies, when included by the attending provider in an approved inpatient treatment plan and under the clinical supervision of a licensed doctoral level mental health professional. These ancillary therapies are not separately reimbursed professional services but are included within the institutional reimbursement.

3.2.4 Services by non-medical providers. With the exception of pastoral counselors and supervised mental health counselors, approved categories of non-medical providers may render covered services independent of physician referral and supervision. All providers, however, are expected to consult with, or refer patients to, a physician for evaluation and treatment of physical conditions that may co-exist with or contribute to a mental disorder. Failure to do so will result in denial of the non-physician provider's services on quality-of-care grounds. Questionable cases will be referred to peer review.

3.3 The first eight outpatient mental health visits per beneficiary in a fiscal year require no Primary Care Manager (PCM) or Health Care Finder (HCF) referral, nor is a preauthorization required (see [Chapter 1, Section 8.1](#) and the TOM, [Chapter 7, Section 2](#)). This applies to outpatient mental health visits identified by CPT² codes 90801 - 90857 for services provided through December 31, 2012; and, CPT² codes 90791 - 90853 for services provided on or after January 1, 2013.

4.0 EXCLUSIONS

4.1 Sexual dysfunctions, paraphilias, and gender identity disorders.

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Chapter 11

Section 1.1

Providers - General

Issue Date: January 28, 1994

Authority: [32 CFR 199.2\(b\)](#) and [32 CFR 199.6](#)

1.0 POLICY

TRICARE benefits may be allowed for the following authorized providers: (For information on authorized providers refer to [32 CFR 199.2](#) and [32 CFR 199.6](#).)

1.1 Institutional Providers

Categories of institutional providers include:

- Hospitals, acute care, general and special.
- Organ transplantation centers.
- Organ transplant consortia.
- Hospitals, psychiatric.
- Hospitals, long-term (tuberculosis, chronic care, or rehabilitation).
- Skilled Nursing Facilities (SNFs).
- Residential Treatment Centers (RTCs).
- Christian Science sanatoriums.
- Infirmaries.
- Other special institutional providers.
- Freestanding Ambulatory Surgical Centers (ASCs).
- Birthing centers.
- Psychiatric Partial Hospitalization Programs (PHPs).
- Hospice programs.
- Substance Use Disorder Rehabilitation Facilities (SUDRFs).

1.2 Individual Professional Providers

Types of professional providers include:

1.2.1 Physicians

- Doctors of Medicine (M.D.)
- Doctors of Osteopathy (D.O.)

1.2.2 Dentists

1.2.3 Other Allied Health Professionals

- Clinical psychologist.
- Doctors of Optometry.
- Doctors of Podiatry or Surgical Chiropody.
- Certified Nurse Midwives (CNMs).
- Certified Nurse Practitioners (NPs).
- Certified Clinical Social Worker (CSW).
- Certified Psychiatric Nurse Specialist (CPNS).
- Certified Physician Assistants (PAs).
- Anesthesiologist Assistant (AA).
- Certified Registered Nurse Anesthetist (CRNA).
- Other individual paramedical providers.
 - Licensed Registered Nurses (RNs).
 - Licensed registered Physical Therapists (PTs) and Occupational Therapists (OTs).
 - Audiologists.
 - Speech therapists (speech pathologists).
- Registered Dietitian (RD).
- Nutritionist.
- **TRICARE Certified Mental Health Counselor (TCMHC).**

1.2.4 Extramedical Individual Providers

- Certified marriage and family therapists.
- Pastoral counselors.
- **Supervised Mental Health Counselor (SMHC).**
- Christian Science practitioners and Christian Science nurses.

1.3 Other Providers

Categories include:

- Independent laboratory.
- Suppliers of portable x-ray services.
- Pharmacies.
- Ambulance companies.
- Medical equipment firms, medical supply firms.
- Mammography suppliers.

1.4 Extended Care Health Option (ECHO) Providers

Categories include:

- ECHO inpatient care provider.
- ECHO outpatient care provider.
- ECHO durable equipment vendor.

Physician Referral And Supervision

Issue Date: December 18, 1985

Authority: [32 CFR 199.6\(c\)\(3\)\(iii\)\(K\)](#), [\(c\)\(3\)\(iv\)](#); and 10 USC 1079(a)

1.0 ISSUE

1.1 In order to be considered for benefits on a fee-for-service basis, the services of the following individual professional providers of care may be provided only if the beneficiary/patient is referred by a physician for the treatment of a medically-diagnosed condition.

1.2 A physician must also provide continuing and ongoing oversight and supervision of the program or episode of treatment provided by the following individual providers:

- Licensed Registered Nurses (RNs).
- Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN).
- Audiologist.
- Pastoral Counselors.
- **Supervised** Mental Health Counselors.

2.0 POLICY

2.1 A physician must establish a diagnosis which, in order to be considered for benefits, must describe a covered condition. This means the physician must actually see the patient, do an evaluation and arrive at an initial diagnostic impression prior to referring the patient. Any change in the referral diagnosis must be coordinated with the referring physician.

2.2 The overall management of the patient rests with the physician and, in order to assure appropriate case management, coordination must be made with the referring physician on an ongoing basis. Physician supervision means the physician provides overall medical management of the case. The referring physician does not have to be physically located on the premises of the provider to whom the referral is made. Communication back to the referring physician is an indication of medical management.

2.3 Military physicians may refer patients to civilian providers. Because of the mobility of military physicians due to transfers, retirements and discharges, if the original referring physician has relocated, another military physician may assume responsibility for the case upon review of the military treatment facility clinical record, a narrative of the patient's present status and the proposed treatment plan.

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Physician Referral And Supervision

3.0 EXCLUSION

Any services provided prior to examination and subsequent referral by a physician.

- END -

Chapter 11

Section 3.11

Mental Health Counselor

Issue Date: February 24, 1988

Authority: [32 CFR 199.6\(c\)\(3\)\(iii\)\(N\)](#) and [\(c\)\(3\)\(iv\)\(C\)](#)

1.0 ISSUE

Mental Health Counselor.

2.0 POLICY

2.1 TRICARE Certified Mental Health Counselor (TCMHC)

For the purposes of TRICARE, a TCMHC **is an independent provider who does not require referral and oversight by a physician in order to receive reimbursement for service to a beneficiary.** A TCMHC must be licensed for independent practice in mental health counseling by the jurisdiction where practicing. In jurisdictions with two or more licenses allowing for differing scopes of independent practice, the licensed mental health counselor may only practice within the scope of licensure he or she possesses. In addition, a TCMHC is an individual who:

2.1.1 Meets all of the requirements identified in [paragraphs 2.1.1.1](#) through [2.1.1.3](#):

2.1.1.1 Has passed the National Clinical Mental Health Counselor Examination (NCMHCE) or an examination determined by the Director, TRICARE Management Activity (TMA) as equal in scope, intent, and content to the NCMHCE; and

2.1.1.2 Possesses a master's or higher-level degree from a mental health counseling program of education and training accredited for Mental Health Counseling or Clinical Mental Health Counseling by the Council for Accreditation of Counseling and Related Educational Programs (CACREP); and

2.1.1.3 Has a minimum of two years of post-master's degree supervised mental health counseling practice that includes a minimum of 3,000 hours of supervised clinical practice and 100 hours of face-to-face supervision. This supervision must be provided by mental health counselors, psychiatrists, clinical psychologists, certified clinical social workers, TCMHCs, or certified psychiatric nurse specialists who **are** licensed for independent practice in the jurisdiction where practicing and must be **practicing within the scope of their licenses.** Supervision must be conducted in a manner that is consistent with the guidelines **regarding knowledge, skills, and practice standards** for supervision of the American Mental Health Counselors Association (AMHCA).

Or

2.1.2 Has met the requirements identified in [paragraphs 2.1.2.1 or 2.1.2.2](#), **plus 2.1.2.3** at any point prior to January 1, 2017.

2.1.2.1 Possesses a master's or higher-level degree from a mental health counseling program of education and training accredited for Mental Health Counseling or Clinical Mental Health Counseling by CACREP and has passed the National Counselor Examination (NCE); **or**

2.1.2.2 Possesses a master's or higher-level degree from a mental health counseling program of education and training accredited for Mental Health Counseling or Clinical Mental Health Counseling by CACREP or from an educational institution accredited by a Regional Accrediting Organization recognized by the Council for Higher Education Accreditation and has passed the NCMHCE; **and**

2.1.2.3 Has a minimum of two years of post-master's degree supervised mental health counseling practice that includes a minimum of 3,000 hours of supervised clinical practice and 100 hours of face-to-face supervision. This supervision must be provided by mental health counselors, **psychiatrists, clinical psychologists, certified clinical social workers, TCMHCs, or certified psychiatric nurse specialists** who **are** licensed for independent practice in the jurisdiction where practicing and must be **practicing within the scope of their licenses**. **Supervision must be** conducted in a manner that is consistent with the guidelines **regarding knowledge, skills, and practice standards** for supervision of the AMHCA.

2.2 Supervised Mental Health Counselor (SMHC)

For purposes of TRICARE, an SMHC is an individual who does not meet the requirements of a certified mental health counselor, but meets the requirements identified in [paragraphs 2.2.1 through 2.2.3](#) and abides by the conditions of reimbursement identified in [paragraph 2.2.4](#).

2.2.1 Possesses a minimum of a master's degree in mental health counseling or allied mental health field from a regionally accredited institution; and

2.2.2 Has two years of post-masters experience which includes 3,000 hours of clinical work and 100 hours of face-to-face supervision; and

2.2.3 Is licensed or certified to practice as a mental health counselor by the jurisdiction where practicing; and

2.2.4 May only be reimbursed when:

2.2.4.1 The TRICARE beneficiary is referred for therapy by a physician; and

2.2.4.2 A physician is providing ongoing oversight and supervision of the therapy being provided; and

2.2.4.3 The mental health counselor certifies on each claim for reimbursement that written communication has been made or will be made to the referring physician of the results of the treatment. Such communication will be made at the end of the treatment, or more frequently, as required by the referring physician.

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2.2.4.4 The Contractor shall provide reports as described in the Contract Data Requirement List (CDRL).

- END -

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2.1.5 To meet the medical and clinical needs of patients, professional staff coverage is provided during service hours.

2.1.5.1 Physicians are available during service hours to respond to medical and psychiatric problems.

2.1.5.2 A Registered Nurse (RN) is on duty during service hours to provide psychiatric nursing care.

2.1.5.3 RNs and other treatment staff are assigned depending upon the number, location, and acuity level of the patients.

2.1.5.4 Medical and professional consultation and supervision are readily available during service hours.

2.1.5.5 The facility maintains liaison relationships with other psychiatric and human service providers for emergency services.

2.1.6 The management of medical care is vested in a physician.

2.1.6.1 A physician or psychologist member on active duty in the military medical corps or United States Public Health Services does not meet the compliance requirement.

2.1.6.2 A resident, intern, or fellow does not meet the compliance requirement.

2.1.7 Professionals who perform assessments and/or treat children and adolescents understand human growth and development and can identify age-related treatment needs.

2.1.8 The qualifications, training, and experience necessary to assume specific clinical responsibilities are specified in writing and verified prior to employment.

2.2 Staff Qualifications

2.2.1 Within the scope of its programs and services, the facility has a sufficient number of professional, administrative, and support staff to address the medical and clinical needs of patients and to coordinate the services provided.

2.2.1.1 Qualified mental health providers meet state licensure, registration, or certification requirements.

2.2.1.2 PHP staff meet the following educational and experience requirements:

2.2.1.2.1 A physician, other than a psychiatrist, has a medical or osteopathic degree from an accredited university, and is licensed by the state in which he/she is practicing;

2.2.1.2.2 A psychiatrist has a medical or osteopathic degree from an accredited university, is licensed by the state, and has completed an approved psychiatric residency;

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2.2.1.2.3 A psychologist has a doctoral degree from an accredited university, and has two years of clinically supervised experience in psychological health services, with one year postdoctoral and one year in an organized psychological services program;

2.2.1.2.4 A Certified Psychiatric Nurse Specialist (CPNS) has a master's degree from an accredited school of nursing with a specialty in psychiatric or mental health nursing, or addiction treatment. The nurse has two years of post-master's degree practice in the field of psychiatric or mental health nursing;

2.2.1.2.5 A social worker has a master's degree in social work from a graduate school accredited by the Council on Social Work Education, and has two years of post-master's degree, supervised clinical social work practice;

2.2.1.2.6 A staff nurse has a minimum of a diploma or an associate degree in nursing, and is licensed by the state in which he/she is practicing;

2.2.1.2.7 Under TRICARE, mental health professionals must meet criteria in 32 CFR 199.6 for their provider types regarding education, training, and supervised clinical experience. TRICARE Certified Mental Health Counselors and certified marriage and family therapists do not require supervision or referral of patients by TRICARE authorized physicians. Supervised Mental Health Counselors (SMHC) and pastoral counselors have master's degrees in mental health or behavioral sciences from accredited universities. SMHCs have two years (3,000 hours of clinical work and 100 hours of face-to-face supervision) of supervised, post-master's degree practice and pastoral counselors have two years (1,200 hours of approved supervision) of supervised post-master's degree practice. Both extramedical providers require supervision by qualified members of the professional staff.

2.2.1.2.8 An occupational therapist, recreational therapist, or expressive art therapist has at least a bachelor's degree from an accredited college or university, is nationally registered or certified, and is licensed or certified in his/her respective field when this is offered or required by the state where the facility is located;

2.2.1.2.9 A teacher has a bachelor's degree from an accredited university and is certified as a teacher in the respective state;

2.2.1.2.10 An addiction therapist has a master's degree in mental health or behavioral sciences from an accredited university, three years of experience in alcohol and/or drug abuse counseling;

2.2.1.2.11 An addiction counselor has a bachelor's degree from an accredited university, five years of experience in alcohol and/or drug abuse counseling, and is supervised at least weekly by a qualified member of the professional staff; and

2.2.1.2.12 Direct service staff, e.g., patient care assistants, have at least a high school diploma or equivalent. These staff offer support and assistance to patients but do not provide therapy, e.g., individual, family, couples, or group. They receive documented supervision from qualified health care professionals.

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2.2.2 PHPs that employ master's or doctoral level mental health staff who are not qualified mental health providers must have a supervision program to oversee and monitor their provision of clinical care.

2.2.2.1 All care provided is the responsibility of a licensed or certified mental health professional, as previously defined in this section.

2.2.2.2 To provide services, non-licensed clinicians:

2.2.2.2.1 Have a master's or doctoral degree from an accredited university;

2.2.2.2.2 Practice under a licensed or certified mental health professional for up to two years during which time the non-licensed clinician is actively working toward licensure or certification.

2.2.2.2.3 Meet the credential requirements of the facility to provide clinical services.

2.2.2.3 Supervision provided to non-licensed clinicians is specified in writing and meets the following requirements:

2.2.2.3.1 The supervisor is employed by the facility and provides clinical supervision only in privileged areas;

2.2.2.3.2 The supervisor meets at least weekly on an individual basis with the supervisee and provides additional on-site supervision as needed;

2.2.2.3.3 Supervisory sessions are regularly documented by the supervisor;

2.2.2.3.4 Clinical documentation meets medical records and quality assessment and improvement standards; and

2.2.2.3.5 All clinical entries by the supervisee are reviewed and countersigned by the supervisor.

2.3 Patient Rights

2.3.1 The facility protects all individual patient rights, including civil rights, under applicable federal and state laws.

2.3.1.1 Policies and procedures clearly describe the rights of the patients and the facility's methods to guarantee these rights.

2.3.1.2 Patients and families are informed of their rights in language that they understand.

2.3.1.3 All patients are treated with dignity and respect, and are afforded full protection of their basic personal and privacy rights.

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- 2.3.1.4** The facility maintains a safe environment; patients are protected from physical or emotional harm by other patients, staff, and visitors.
- 2.3.1.5** The facility protects the right of confidentiality for all patients, their families, and significant others. Personal pictures, video tapes, or audio recordings are not obtained without written consent.
- 2.3.1.6** Informed consent is obtained from the patient, family, or legal guardian authorizing emergency medical care, including surgical procedures.
- 2.3.1.7** If the patient is a minor, the parents or guardians are informed of the patients treatment progress at regular intervals.
- 2.3.1.8** The patient, family, or significant others have the right to present complaints or grievances about the facility or the care received. The facility has procedures for responding to these complaints.
- 2.3.1.9** The patient and family, when appropriate, are provided with written descriptions of the principles, methods, and interventions used in behavior management.
- 2.3.1.10** When food services are provided, patients receive adequate and nutritious meals with accommodations for special diets, and are not denied food as a method of behavioral management.
- 2.3.1.11** The patient and family, when appropriate, receive education regarding all medications prescribed, including benefits, side effects, and risks.
- 2.3.1.11.1** Patients have the right to refuse treatment and medications. If a patient or family refuses treatment, the facility makes documented, reasonable efforts to understand the issues involved and resolve the conflict. If the conflict cannot be resolved, the facility:
- 2.3.1.11.1.1** terminates treatment on reasonable notification of patient, family, or legal guardian;
or
- 2.3.1.11.1.2** seeks legal alternatives to ensure that the patient's safety and treatment needs are met.
- 2.3.1.12** Any research involving beneficiaries has prior approval and complies with the regulations protecting human subjects of the Department of Health and Human Services (45 CFR Part 46).
- 2.3.2** The facility has a written policy regarding patient abuse and neglect.
- 2.3.2.1** All facility staff, patients, and families as appropriate, are informed of the policy.
- 2.3.2.2** All incidents of suspected abuse and neglect are reported promptly to the appropriate state agencies.

2.3.3 Facility marketing and advertising meets professional standards.

2.4 Behavior Management

2.4.1 Behavior management is based on a comprehensive, written plan that describes a full range of interventions utilizing positive reinforcement methods and clear implementation guidelines.

2.4.2 Policies and procedures for behavior management are developed by the medical director, the clinical director and medical/professional staff and approved by the governing body. They are implemented on the basis of the following considerations:

2.4.2.1 Behavior management is individualized to ensure appropriate consideration of the patient's developmental level, psychological state, cognitive capacity, and other clinically relevant factors;

2.4.2.2 Time-out is a brief, voluntary separation from program, activities, or other patients, and is initiated by the patient or at the request of staff to help the patient regain self-control;

2.4.2.3 Physical holding is a brief, involuntary procedure initiated by the staff to enable a patient to regain self-control; and

2.4.2.4 Restraint or seclusion are considered extraordinary interventions to be used only by professional staff in an emergency.

2.4.2.4.1 Such interventions imply a severity of dysfunction and the need for a level of care beyond the scope of a facility.

2.4.2.4.2 A physician's order is obtained within the hour and the patient is assessed for transfer to an appropriate level of care.

2.5 Admission Process

The admission process helps the patient to fully use the medical, clinical, and program services of the facility. The patient, family and significant others as appropriate, are familiarized with the treatment program and how the PHP services address patient capabilities and medical/clinical needs.

2.5.1 Preadmission information is obtained to evaluate the medical and/or psychological necessity for admission. Recent psychiatric, psychological, and psychosocial evaluations are reviewed.

2.5.2 Written admission criteria describe the clinical circumstances under which admission to partial hospitalization is considered appropriate:

2.5.2.1 The patient is in need of crisis stabilization and treatment of partial stabilized mental health disorders;

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2.5.2.2 The patient exhibits psychiatric symptoms that cause significant impairment in day-to-day social, vocational, and/or educational functioning;

2.5.2.3 The patient is able to exhibit adequate control over his/her behavior and is judged not to be immediately dangerous to self or others;

2.5.2.4 The patient has established social supports that help to maintain him/her in the least restrictive environment;

2.5.2.5 The patient has the physical and intellectual capacity to actively participate in all aspects of the therapeutic program;

2.5.2.6 The patient has not made sufficient clinical gains within an outpatient setting, or the severity of his/her presenting symptoms is such that success in outpatient treatment is doubtful; or

2.5.2.7 The patient is ready for discharge from an inpatient setting, but is assessed as needing daily monitoring, support, and ongoing therapeutic interventions.

2.5.3 A qualified mental health professional, who meets requirements for individual professional providers and who is permitted by law and by the facility to refer patients for admission, shall render medical and/or psychological necessity determinations for admission.

2.5.4 The facility accepts only those patients who meet the conditions outlined in the admission criteria, and for whom the facility has an operational program.

2.5.5 The facility observes and maintains compliance with the conditions of licensure under which it operates, including age, sex, type, and number of patients accepted.

2.5.6 No one is denied admission on the basis of race, religion, national origin, or sexual orientation.

2.5.7 Patients and families who are not accepted for treatment are provided with alternative recommendations and referrals as needed.

2.5.7.1 Referral policies and procedures specify needs and services the facility cannot provide.

2.5.7.2 Referrals for examination, assessment, and consultation are discussed with the patient and/or family prior to admission.

2.5.8 During the admission process, the patient, family or significant others, when appropriate, are clearly apprised of the expectations for treatment and the services provided.

2.5.8.1 Written and signed documentation verifies that patients and family members understand the treatment that will be provided.

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2.5.8.2 The policies and procedures for emergency medical and psychiatric care are explained, including transfer or referral and the means of transfer, e.g., family, facility staff, or ambulance service.

2.5.9 All admissions are preauthorized by TMA.

2.6 Assessments

2.6.1 Professional staff are responsible for current assessments of all patients. Consideration is given to the fundamental clinical needs of patients including, but not limited to, their physical, psychological, social, developmental, family, educational, environmental, and recreational needs.

2.6.2 Assessments conducted within 30 days prior to admission may be used if reviewed and approved for treatment planning purposes by the responsible physician or doctoral level clinical psychologist.

2.6.2.1 A physical examination is completed by a qualified physician, qualified physician assistant, or nurse practitioner within 24 hours of admission. When the examination is conducted by a physician assistant or nurse practitioner, a physician must countersign. The physical examination includes: a complete medical history; a general physical examination; sensorimotor development and functioning; physical development; vision and hearing; immunization status; serology; urinalysis, and other routine laboratory studies as indicated; and a tuberculin test with results or a chest X-ray to rule out tuberculosis.

2.6.2.2 A mental health evaluation is completed by a qualified psychiatrist or doctoral level psychologist within 24 hours of admission. A mental health evaluation includes: reason for admission; present clinical presentation; psychosocial stressors related to the present illness; current potential risk to self or others; history of present illness; past psychiatric history; developmental assessment; presence or absence of physical disorders or conditions affecting the present illness; alcohol and drug history; the mental status examination. A diagnosis on all five axes is given, based on the current addition of the **Diagnostic and Statistical Manual of Mental Disorders** of the American Psychiatric Association (APA).

2.6.2.3 A nursing assessment is completed by a registered nurse within 24 hours of admission. The nursing assessment documents a general history of patient and family health, and includes a history of current medications, allergies, pertinent medical problems requiring nursing attention, current risk and safety factors, nutritional patterns, immunization status, and sleep patterns.

2.6.2.4 A social history is completed by a qualified mental health professional prior to the development of the master treatment plan. The social history includes: present problems; childhood and family history; current living situation; family dynamics and relationships; relationships with significant others; history of physical, sexual, and/or substance abuse; impact of any medical conditions on the patient; and the impact of financial, religious, ethnic, cultural, legal, and environmental influences upon the patient or family. The social history includes family goals and recommendations for family involvement in treatment.

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2.6.2.5 A skills assessment is completed by a licensed or certified activity, occupational, or rehabilitation therapist prior to the development of the master treatment plan. The assessment includes activity patterns prior to admission, aptitudes and/or limitations, activities of daily living, perceptual-motor skills, sensory integration factors, cognitive skills, communication skills, social interaction skills, creative abilities, vocational skills, and impact of physical limitations.

2.6.2.6 A psychological evaluation, if clinically indicated, is completed by a doctoral level licensed clinical psychologist. The psychological evaluation includes a comprehensive clinical assessment and recommendations multidisciplinary treatment plan. Testing may include: intellectual, cognitive, and perceptual functioning; stressors and coping mechanisms; neuropsychological functioning; and personality assessment. Psychological testing completed within the past 12 months may be added to the patient's clinical record if reviewed and approved by the responsible physician or clinical psychologist.

2.6.2.7 For children and adolescent patients, an educational or vocational assessment is completed by a certified teacher. The educational assessment includes an evaluation of the patient's educational history, current classroom observations, achievement testing, and identification of learning disabilities and needs. If an educational assessment has been completed within the past 12 months, it may be added to the patient's record if reviewed and approved by the facility's director of education.

2.6.2.8 A comprehensive alcohol and drug history evaluation, if clinically indicated, is completed by a qualified addiction professional. The evaluation consists of a history of substance use, including the patient's past and current use of psychoactive substances, age of onset, the duration, methods, patterns, circumstances, and consequences of use, biopsychosocial antecedents and influences, family and peer substance use patterns, and the types of, and responses to, previous substance use treatment.

2.6.2.9 Additional assessments include legal, nutritional, neuropsychological, neurological, speech, hearing and language, and any others that may be clinically indicated.

2.7 Clinical Formulation

A clinical formulation is developed on all patients by a qualified mental health provider. The clinical formulation is reviewed and approved by the responsible physician or doctoral level licensed clinical psychologist. The clinical formulation is generally organized into a Descriptive Section including the nature, severity, and precipitant of the individual's mental health disorder; an Explanatory Section including the rationale for the development and maintenance of the symptoms and dysfunctional life patterns; and the Treatment-Prognostic Section serving as the explicit blueprint governing treatment interventions and prognosis. The clinical formulation:

2.7.1 Is completed prior to the development of the master treatment plan;

2.7.2 Incorporates significant clinical interpretations from each of the multidisciplinary assessments;

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2.7.3 Identifies patient strengths and limitations, current psychosocial stressors, present level of functioning, developmental issues to be considered, degree of risk to self or others, and significant treatment issues;

2.7.4 Interrelates the assessment material and indicates the focus of treatment strategies;

2.7.5 Clearly describes the clinical problems to be addressed in treatment, including plans for discharge; and

2.7.6 Substantiates Axes I through V diagnoses, using the current **Diagnostic Statistical Manual of Mental Disorders** of the APA.

2.8 Treatment Planning

A qualified mental health care professional shall be responsible for the development, implementation, supervision, and assessment of an individualized, interdisciplinary treatment plan.

2.8.1 A comprehensive treatment plan is completed by the seventh treatment day. The comprehensive plan:

2.8.1.1 Clearly articulates the clinical problems that are the focus of treatment;

2.8.1.2 Identifies individual treatment goals that correspond to each identified problem;

2.8.1.2.1 Goals and objectives are specific outcome statements based on the anticipated response to treatment.

2.8.1.2.2 Treatment goals and clinical needs are discussed with the patient and, in the case of adolescents, with the parent and/or legal guardian.

2.8.1.3 Identifies individualized and observable or measurable objectives that represent incremental progress toward attaining goals;

2.8.1.4 Describes strategies of treatment, responsible clinicians, and related interventions that address individual needs and assist the patient in achieving identified objectives and goals;

2.8.1.5 Includes specific, individualized discharge criteria, which identify essential goals and objectives to be met prior to termination of treatment;

2.8.1.6 Identifies needed services that are not provided directly by the facility; and

2.8.1.7 For children and adolescents, as well as for adult patients as appropriate, specific goals, objectives, and treatment strategies are developed for the family.

2.8.2 The treatment plan is reviewed at least every two weeks, or when major changes occur in treatment. The results of the treatment plan review are recorded in the clinical record.

2.9 Discharge and Transition Planning

Transition planning addresses anticipated patient needs at discharge. The planning involves: determining necessary modifications in the treatment plan, facilitating the termination of treatment, and identifying resources for maintaining therapeutic stability following discharge.

2.9.1 The patient's living situation, placement needs, ongoing treatment needs, and educational/vocational needs are assessed.

2.9.2 The treatment plan includes strategies to facilitate termination and transition to outpatient care.

2.9.3 Community and therapeutic resources are identified to help the patient and family to maintain therapeutic gains.

2.10 Clinical Documentation

2.10.1 Clinical records are maintained on each patient to plan care and treatment and to provide ongoing evaluation of the patient's progress in treatment.

2.10.2 All care provided to the patient is documented in the clinical record. Each clinical record contains all pertinent clinical information and at least the following:

2.10.2.1 Demographic data, including name, date of birth, sex, next of kin, occupation (in the case of children and adolescents, occupation of parents or legal guardian, school, grade) date of initial contact, legal status, religion, current home address, telephone number, referral source, and reason for referral;

2.10.2.2 Consent forms;

2.10.2.3 Pertinent legal documents;

2.10.2.4 Reports of all assessments and clinical formulations;

2.10.2.5 Treatment plans and treatment plan reassessments;

2.10.2.6 Consultation reports;

2.10.2.7 Laboratory reports;

2.10.2.8 Doctor's orders;

2.10.2.9 Progress notes; and

2.10.2.10a Discharge summary.

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2.1.1.5.1 A physician member on active duty in the military medical corps or U.S. Public Health Services does not meet the requirement.

2.1.1.5.2 A resident or intern does not meet the requirement.

2.1.1.6 The course of treatment is prescribed and supervised by a qualified health care professional.

2.1.1.7 Professional staff who perform assessments and/or treat patients have a background in chemical dependency and, when applicable, experience in treating adolescents with substance use disorders.

2.1.1.8 The qualifications, training, and experience necessary to assume specific clinical responsibilities are specified in writing and verified prior to employment.

2.2 Staff Qualifications

2.2.1 Within the scope of its programs and services, the facility has a sufficient number of professional, administrative, and support staff to address the medical and clinical needs of patients and to coordinate the services provided.

2.2.1.1 Qualified health care professionals meet state licensure, registration, or certification requirements to practice in their respective disciplines.

2.2.1.2 Professional staff meet the following educational and experience requirements:

2.2.1.2.1 A physician, other than a psychiatrist, has a medical or osteopathic degree from an accredited university;

2.2.1.2.2 A psychiatrist has a medical or osteopathic degree from an accredited university, is licensed by the state, and has completed an approved psychiatric residency;

2.2.1.2.3 A psychologist has a doctoral degree from an accredited university, and has two years of clinically supervised experience in psychological health services, with one year postdoctoral and one year in an organized psychological services program;

2.2.1.2.4 A Certified Psychiatric Nurse Specialist (CPNS) has a master's degree from an accredited school of nursing with a specialty in psychiatric or mental health nursing, or addiction treatment. The nurse has two years of post-master's degree practice in the field of psychiatric or mental health nursing or addiction treatment;

2.2.1.2.5 A social worker has a master's degree in social work from a graduate school accredited by the Council on Social Work Education, and has two years of post-master's degree, supervised clinical social work practice;

2.2.1.2.6 A staff nurse has a minimum of a diploma or an associate degree in nursing, and is licensed by the state in which he/she is practicing;

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2.2.1.2.7 Under TRICARE, mental health professionals must meet criteria in 32 CFR 199.6 for their provider types regarding education, training, and supervised clinical experience. TRICARE Certified Mental Health Counselors and certified marriage and family therapists do not require supervision or referral of patients by TRICARE authorized physicians. Supervised Mental Health Counselors (SMHCs) and pastoral counselors have master's degrees in mental health or behavioral sciences from accredited universities. SMHCs have two years (3,000 hours of clinical work and 100 hours of face-to-face supervision) of supervised, post-master's degree practice and pastoral counselors have two years (1,200 hours of approved supervision) of supervised post-master's degree practice. Both extramedical providers require supervision by qualified members of the professional staff.

2.2.1.2.8 An occupational therapist, recreational therapist, or expressive art therapist has at least a bachelor's degree from an accredited college or university, is nationally registered or certified, and is licensed or certified in his/her respective field when this is offered or required by the state where the facility is located;

2.2.1.2.9 A teacher has a bachelor's degree from an accredited university and is certified as a teacher in the respective state;

2.2.1.2.10 An addiction therapist has a master's degree in mental health or behavioral sciences from an accredited university, three years of experience in alcohol and/or drug abuse counseling;

2.2.1.2.11 An addiction counselor has a bachelor's degree from an accredited university, five years of experience in alcohol and/or drug abuse counseling, and is supervised at least weekly by a qualified member of the professional staff; and

2.2.1.2.12 Direct service staff, e.g., patient care assistants, have at least a high school diploma or equivalent. These staff offer support and assistance to patients but do not provide therapy, e.g., individual, family, couples, or group. They receive documented supervision from qualified health care professionals.

2.2.2 Facilities that employ master's or doctoral level staff who are not qualified health care providers have a supervision program to oversee and monitor their provision of clinical care.

2.2.2.1 All care provided is the responsibility of a licensed or certified health care professional, as previously defined in this section.

2.2.2.2 To provide services, nonlicensed clinicians:

2.2.2.2.1 Have a master's or doctoral degree from an accredited university or professional education program in a health care discipline; and

2.2.2.2.2 Practice under a licensed or certified health care professional for a two-year period during which time the nonlicensed clinician is actively working toward licensure or certification.

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2.2.2.3 Supervision provided to nonlicensed clinicians is specified in writing and meets the following requirements:

2.2.2.3.1 The supervisor is employed by the facility and provides clinical supervision only in privileged areas;

2.2.2.3.2 The supervisor meets at least weekly on an individual basis the supervisee and provides additional on-site supervision as needed;

2.2.2.3.3 Supervisory sessions are regularly documented by the clinical supervisor;

2.2.2.3.4 Clinical documentation meets clinical records and quality assessment and improvement standards; and

2.2.2.3.5 All clinical entries by the supervisee are reviewed and countersigned by the supervisor.

2.3 Patient Rights

2.3.1 The facility protects all individual patient rights, including civil rights, under applicable federal and state laws.

2.3.1.1 Policies and procedures clearly describe the rights of the patients and the facility's methods to guarantee these rights.

2.3.1.2 Patients and families are informed of their rights in language that they understand.

2.3.1.3 All patients are treated with dignity and respect, and are afforded full protection of their basic personal and privacy rights. For inpatient rehabilitation facilities:

2.3.1.3.1 The right to privacy is based on individual developmental and clinical requirements;

2.3.1.3.2 Patients may contact an attorney;

2.3.1.3.3 Patients may send and receive mail without hindrance unless clinically contraindicated and restricted by a physician's or responsible clinical psychologist's order;

2.3.1.3.4 Patients may have private telephone contact with members of their immediate family or guardian unless clinically contraindicated and restricted by a physician's or responsible clinical psychologist's order;

2.3.1.3.5 Patients may have private visits with their family or guardian unless clinically contraindicated and restricted by a physician's or responsible clinical psychologist's order;

2.3.1.3.6 All orders to restrict patient rights are supported by a written justification of clinical need and are reviewed every seven days;

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- 2.3.1.3.7** Mail, telephone calls, and family visits are not restricted by treatment philosophy, level, phase, or milieu program design;
- 2.3.1.3.8** Patients are not required to dress in distinctive clothing for behavioral control purposes or as a consequence for misconduct;
- 2.3.1.3.9** Except at admission, body searches for the detection of contraband require a written physician's order. The order and the justification are documented in the clinical record; and
- 2.3.1.3.10** The facility provides opportunities for patients to attend religious services and to seek religious counsel unless clinically contraindicated.
- 2.3.1.4** The facility maintains a safe environment; patients are protected from physical or emotional harm by other patients, staff, and visitors.
- 2.3.1.5** The facility protects the right of confidentiality for all patients, their families, and significant others. Personal pictures, videotapes, or audio recordings are not obtained without written permission.
- 2.3.1.6** Informed consent is obtained from the patient, family, or legal guardian, as appropriate, authorizing emergency medical care, including surgical procedures.
- 2.3.1.7** Parents, families, legal guardians, and significant others, as appropriate, are informed of the patient's treatment progress at regular intervals.
- 2.3.1.8** The patient, family, or legal guardian have the right to present complaints or grievances about the facility or the care received. The facility has procedures for responding to these complaints.
- 2.3.1.9** When applicable, the patient and family are provided with written descriptions of the principles, methods, and interventions used in behavior management. If a level or phase system is implemented:
- 2.3.1.9.1** Level achievement is not considered to be an objective of the interdisciplinary treatment plan;
- 2.3.1.9.2** Level achievement or lack thereof does not affect the provision of therapeutic services, including passes when clinically indicated;
- 2.3.1.9.3** Level achievement or lack thereof does not negate a timely discharge once the therapeutic goals and objectives have been attained; and
- 2.3.1.9.4** The level or phase system is not used to compromise the basic rights of the patient.
- 2.3.1.10** When food services are provided, patients receive adequate and nutritious meals with accommodations for special diets, and are not denied food as a method of behavior management.

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2.3.1.11 The patient and family, when appropriate, receive education regarding all medications prescribed, including benefits, side effects, and risks.

2.3.1.12 Patients have the right to refuse treatment and medications. If a patient or family refuses treatment, the facility makes documented, reasonable efforts to understand the issues involved and resolve the conflict. If the conflict cannot be resolved the facility:

2.3.1.12.1 Terminates treatment on reasonable notification of patient, family, or legal guardian;
or

2.3.1.12.2 Seeks legal alternatives to ensure that the patient's safety and treatment needs are met.

2.3.1.13 Any research involving TRICARE beneficiaries has prior approval from TMA and complies with the regulations protecting human subjects of the Department of Health and Human Services (45 CFR 46).

2.3.2 The facility has a written policy regarding patient abuse and neglect.

2.3.2.1 All facility staff, patients, and families as appropriate, are informed of the policy.

2.3.2.2 All incidents of suspected abuse and neglect are reported promptly to the appropriate state agencies.

2.4 Behavior Management

2.4.1 Behavior management is based on a comprehensive, written plan that describes a full range of interventions utilizing positive reinforcement methods and clear implementation guidelines.

2.4.2 Policies and procedures for behavior management are developed by the medical director, the clinical director and medical/professional staff and approved by the governing body. They are implemented on the basis of the following considerations:

2.4.2.1 Behavior management is individualized to ensure appropriate consideration of the patient's developmental level, psychological state, cognitive capacity, and other clinically relevant factors;

2.4.2.2 Time-out is a brief, voluntary separation from program, activities, or other patients, and is initiated by the patient or at the request of staff to help the patient regain self-control;

2.4.2.3 Physical holding is a brief, involuntary procedure initiated by the staff to enable a patient to regain self-control; and

2.4.2.4 Restraint or seclusion are considered extraordinary interventions to be used only by professional staff in an emergency.

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2.4.2.4.1 Such interventions imply a severity of dysfunction and the need for a level of care beyond the scope of a facility.

2.4.2.4.2 A physician's order is obtained within the hour and the patient is assessed for transfer to an appropriate level of care.

2.4.2.5 If any part of a facility is locked to ensure patient safety, the rationale is based on clinical or medical needs and the security measures are consistent with the treatment philosophy, mission statement, and admission criteria.

2.5 Admission Process

The admission process helps the patient to fully use the medical, clinical, and program services of the facility. The patient, family and significant others as appropriate, are familiarized with the treatment program and how the facility addresses patient capabilities and medical/clinical needs.

2.5.1 Preadmission information is obtained to evaluate the medical and/or psychological necessity for admission. Recent psychiatric, psychological, and psychosocial evaluations are reviewed.

2.5.2 Written admission criteria describe the extent and complexity of the substance use disorders and the appropriateness of inpatient and/or partial hospitalization care.

2.5.3 Medical or psychological determinations shall be rendered by qualified mental health professionals who meet TRICARE requirements for individual professional providers and who are permitted by law and the facility to refer patients for admission.

2.5.4 The facility accepts only those patients who meet the conditions outlined in the admission criteria, and for whom the facility has an operational program.

2.5.5 The facility observes and maintains compliance with the conditions of licensure under which it operates, including age, sex, type, and number of patients accepted.

2.5.6 No one is denied admission on the basis of race, religion, national origin, or sexual orientation.

2.5.7 Patients and families who are not accepted for treatment are provided with alternative recommendations and referrals as needed.

2.5.7.1 Referral policies and procedures specify needs and services the facility cannot provide.

2.5.7.2 Referrals for examination, assessment, and consultation are discussed with the patient and/or family prior to admission.

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2.5.8 During the admission process, the patient and family are clearly apprised of the expectations for treatment and the services provided.

2.5.8.1 Written and signed documentation verifies that patients and family members understand the clinical care that will be provided.

2.5.8.2 The policies and procedures for emergency medical and psychiatric care are explained, including transfer or referral and the means of transfer, e.g., family, facility staff, or ambulance service.

2.5.9 All admissions are planned and approved by a qualified mental health provider and preauthorized by TMA.

2.6 Assessments

2.6.1 Professional staff are responsible for current addiction-focused assessments of all patients. Consideration is given to the fundamental clinical needs of patients including, but not limited to, their physical, psychological, social, developmental, family, educational, environmental, and recreational needs.

2.6.2 Assessments conducted within 30 days prior to admission may be used if reviewed and approved for treatment planning purposes by the responsible physician or doctoral level clinical psychologist. If a patient is admitted directly from acute care, the existing medical history may be incorporated into the clinical record if reviewed and approved by the responsible physician.

2.6.2.1 A medical history and assessment is completed within 24 hours of admission to inpatient rehabilitation or within three working days of admission to partial hospitalization. A physician, qualified physician assistant, or nurse practitioner completes a medical history that contains the patient's history of licit and illicit drug use; a medical history denoting physical problems associated with addictions; a physical examination sensitive to pathological substance use; serology, urinalysis, and other routine laboratory studies as indicated; and an assessment of speech, vision, and hearing. For adolescents, physical development and sensorimotor functioning are also assessed, and immunizations are reviewed and completed using the schedule recommended by the American Academy of Pediatrics. When the medical history and assessment is conducted by a physician assistant or nurse practitioner, a physician must countersign.

2.6.2.2 A nursing assessment is completed by a registered nurse. In a inpatient facility that provides detoxification services or nursing care to address physical health problems the assessment is completed on the day of admission or within three treatment days of admission to a partial hospital program. The nursing assessment defines the patient's nursing needs; emphasizes biological and cognitive dimensions of addiction; notes nutritional problems and responses associated with physical illness; and assesses for alcohol and/or other drug withdrawal using an established norm or scale.

2.6.2.3 An alcohol and drug history evaluation is conducted by a qualified health care professional within 24 hours of admission for inpatient care and by the third treatment day for partial care. The evaluation consists of a chronological history of drugs used and includes: the

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patient's age at the onset of use; the duration, methods, patterns, circumstances, and consequences of use; family and peer use of alcohol and other drugs; and the responses to previous substance use treatment.

2.6.2.4 An emotional and behavioral evaluation is completed by a qualified health care professional within three days of admission to inpatient rehabilitation and by the fifth treatment day in partial hospitalization. The evaluation documents the reason for admission; current clinical presentation; psychosocial stressors related to substance use; current potential risk to self or others; history of present illness; psychiatric, alcohol, and drug history; and a mental status examination. The evaluation includes a developmental assessment for adolescents and results in diagnoses on Axes I through V, based on the current **Diagnostic and Statistical Manual of Mental Disorders** of the American Psychiatric Association. If completed by a nonlicensed staff, the evaluation is reviewed and approved by a responsible member of the professional staff organization.

2.6.2.5 A social assessment is completed by a qualified health care professional within three days of admission to inpatient rehabilitation and by the fifth treatment day in partial hospitalization. The social assessment documents the presenting problems necessitating admission; childhood history and significant losses; sexual history and history of any physical or sexual abuse; family dynamics, including relationships with parents, siblings, and significant others; peer group relationships; current and past home situation; impact of any medical condition; impact of the patient/family's financial circumstances; and impact of religious, ethnic, and cultural influences on the patient and family.

2.6.2.6 A family assessment for adolescent patients is completed by a qualified health care professional within three days of admission to inpatient rehabilitation and by the fifth treatment day in partial hospitalization. The family assessment documents the inter-generational family structure including births, deaths, marriages, separations, and divorces; significant medical, mental health, and substance use problems among immediate and extended family members; family values, attitudes, and beliefs that have an impact on the patient's use of psychoactive substances; significant communication patterns and dynamics that have a bearing on the patient's use of substances; strategies for involving the family in treatment; and recommendations and goals for family therapy, if indicated.

2.6.2.7 A psychological evaluation is completed by a doctoral level psychologist for all adolescent patients and, when appropriate, for adult patients. The psychological evaluation is completed within five treatment day of the request and assesses intellectual, cognitive, and perceptual functioning; identifies stressors and coping mechanisms; and provides neuropsychological screening and personality assessment if clinically indicated.

2.6.2.8 A skills assessment is completed by a qualified activity therapy professional for all adolescent patients and adult patients as appropriate. The skills assessment is completed within three days of admission to inpatient rehabilitation and by the fifth treatment day in partial hospitalization. It provides data to plan therapeutic activities and assesses activity patterns prior to admission; aptitudes and/or limitations; activities of daily living; perceptual motor skills; communications skills; social interaction skills; creative abilities; and impact of physical limitations.

2.6.2.9 An educational assessment is completed by a qualified teacher for all adolescents, and for adults as appropriate within three days of admission to inpatient rehabilitation and by the fifth treatment day in partial hospitalization. It may include an evaluation of educational and vocational history; current classroom observations; achievement testing; and identification of learning disabilities. If completed within the past 12 months, the educational assessment may be added to the patient record if reviewed and approved by the facility's director of education.

2.6.2.10 Additional assessments include legal, nutritional, neuropsychological, neurological, speech, hearing and language, and any others that may be clinically indicated. Unless otherwise specified by a physician's order, these assessments are completed by qualified health care professionals within three days of admission to inpatient rehabilitation and by the fifth treatment day in partial hospitalization. If an assessment is delayed due to the patient's condition, an explanation is recorded in the clinical record.

2.7 Clinical Formulation

A clinical formulation is developed on all patients by a qualified mental health provider. The clinical formulation is reviewed and approved by the responsible physician or doctoral level licensed clinical psychologist. The clinical formulation is generally organized into a Descriptive Section including the nature, severity, and precipitant of the individual's mental health disorder; an Explanatory Section including the rationale for the development and maintenance of the symptoms and dysfunctional life patterns; and the Treatment-Prognostic Section serving as the explicit blueprint governing treatment interventions and prognosis. The clinical formulation:

2.7.1 Is completed prior to the development of the master treatment plan;

2.7.2 Incorporates significant clinical interpretations from each of the multidisciplinary assessments;

2.7.3 Identifies patient strengths and limitations, current psychosocial stressors, present level of functioning, developmental issues to be considered, degree of risk to self or others, and significant treatment issues;

2.7.4 Interrelates the assessment material and indicates the focus of treatment strategies;

2.7.5 Clearly describes the clinical problems to be addressed in treatment, including plans for discharge; and

2.7.6 Substantiates Axes I through V diagnoses, using the current **Diagnostic Statistical Manual of Mental Disorders** of the American Psychiatric Association.

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2.8 Treatment Planning

A qualified health care professional is responsible for the development, implementation, supervision, and assessment of an individualized, interdisciplinary treatment plan.

2.8.1 A preliminary treatment plan is completed within 24 hours of admission and consists, at a minimum, of a physician's admission note and orders.

2.8.2 A master treatment plan is completed within five days of admission to inpatient rehabilitation, and by the seventh treatment day for partial hospitalization. The master plan:

2.8.2.1 Clearly articulates the clinical problems that are the focus of treatment;

2.8.2.2 Identifies individual treatment goals that correspond to each identified problem;

2.8.2.2.1 Goals and objectives are specific outcome statements based on the anticipated response to treatment.

2.8.2.2.2 Treatment goals and clinical needs are discussed with the patient and, when appropriate, with the parent, family, or legal guardian.

2.8.2.3 Identifies individualized and observable or measurable objectives that represent incremental progress toward attaining goals;

2.8.2.4 Describes strategies of treatment, responsible clinicians, and interventions that address individual needs and assist the patient in achieving identified objectives and goals;

2.8.2.5 Includes specific, individualized discharge criteria, which identify essential goals and treatment objectives to be met prior to termination of treatment; and

2.8.2.6 Identifies needed services that are not provided directly by the facility.

2.8.2.7 Specifies goals, objectives, and treatment strategies for the family, if appropriate and clinically indicated.

2.8.3 The treatment plan is regularly updated for effectiveness and revised when major changes occur in treatment. Objectives and strategies are modified to reflect the patient's response or lack of response to the individualized treatment program. The results are recorded in the clinical record.

2.9 Discharge and Transition Planning

Transition planning addresses the continuing care needs of patients. It involves modifying the treatment plan to facilitate the termination of treatment and identifying resources to maintain therapeutic stability following discharge.

2.9.1 During transition planning, the living situation, ongoing treatment needs, and educational/vocational needs are assessed.

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2.9.2 The treatment plan includes strategies to facilitate termination, address temporary regression, and promote adjustment to a less intensive level of care.

2.9.3 Community and therapeutic resources are identified to help the patient and family maintain the stability achieved in treatment.

2.10 Clinical Documentation

2.10.1 Clinical records are maintained for each patient. The records serve as a basis for the planning of patient care and treatment and to provide ongoing evaluation of the individual patient's progress in treatment.

2.10.2 Each clinical record contains: essential demographic data; consent forms; clinical assessments formulations; treatment plans and updates; consultation reports; laboratory reports; doctor's orders; unusual occurrences; special behavioral interventions; progress notes; and a discharge summary.

2.10.3 Clinical records are maintained and controlled by an appropriately qualified records administrator or technician.

2.10.3.1 Written policies and procedures ensure that records are current, accurate, confidential, and safely stored.

2.10.3.2 Current records are kept in patient care areas and are immediately accessible to staff.

2.10.3.3 Policies and procedures adhere to federal guidelines for the release of confidential information specific to alcohol and other drug treatment.

2.11 Progress Notes

2.11.1 Progress notes clearly document the course of treatment for the patient and family. The entries provide information for review, analysis, and modification of the treatment plan. Progress notes include:

2.11.1.1 A description of the interventions made by the provider in accordance with the treatment plan and the patient's response in measurable, observable and/or quantifiable behavioral terms;

2.11.1.2 Interpretations of the responses to treatment;

2.11.1.3 Justification, implementation, and interpretation of the effectiveness of interventions for behavior management;

2.11.1.4 Justification for changes in medication, and a description of any side effects and adverse reactions; and

2.11.1.5 Date and length of the therapy session.

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2.11.2 All clinical entries are legible, contemporaneous, sequential, signed, and dated. At a minimum, the following are required:

2.11.2.1 During detoxification, nursing notes on each shift and physician notes daily;

2.11.2.2 A weekly nursing note on progress in treatment for inpatient rehabilitation partial hospitalization;

2.11.2.3 A weekly note by the responsible psychiatrist or doctoral level clinical psychologist and a monthly evaluation of the patient's response to all treatment provided;

2.11.2.4 Updates, at least weekly, of the interdisciplinary treatment plan and treatment plan reviews;

2.11.2.5 Weekly progress notes on group and therapeutic services;

2.11.2.6 Progress notes on individual and family therapy, within 24 hours of each session for detoxification and inpatient rehabilitation and within 48 hours for partial hospitalization; and

2.11.2.7 A discharge summary completed within fifteen days and signed by a qualified health care professional.

2.12 Therapeutic Services

2.12.1 Multidisciplinary Services are provided to address the assessed clinical needs of each patient. For adolescents, services are adapted to the individual developmental stage and comprehension level. Services that are clinically contraindicated are documented in the patient record.

2.12.1.1 Inpatient rehabilitation provides a professionally staffed seven-day-per-week therapeutic program. Services for adolescents are adapted to the individual developmental state and comprehension level. Milieu activities are incorporated with medical and nursing services; individual, group, and family therapy; addiction counseling services; health and addiction education for families and significant others; educational, physical health, dietary, pharmacy, and emergency services as appropriate; and a range of other therapies administered on an individual and/or group basis.

2.12.1.2 Partial hospitalization provides addiction counseling, medical monitoring and/or management for less than 24 hours a day. Services for adolescents are adapted to the individual developmental state and comprehension level. Milieu activities are incorporated with medical and nursing services; individual, group, and family therapy; addiction counseling services; health and addiction education for families and significant others; educational, physical health, dietary, pharmacy, and emergency services as appropriate; and a range of other therapies administered on an individual and/or group basis.

2.12.2 Psychotherapy Services Individual, group, and family therapy are provided at a frequency and intensity appropriate to the individualized clinical needs of the patient. These are

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offered as indicated in the treatment plan by qualified health care professionals who practice within the scope of their license.

2.12.3 Addiction Counseling Services Individual, group, and family addiction counseling services are offered by health care professionals to address the impact of substance use on biopsychosocial functioning.

2.12.4 Therapeutic Educational Services As appropriate, therapeutic educational services are provided or arranged to meet the specific needs of adolescent and adult patients.

2.12.4.1 When educational services are provided, the necessary resources and equipment are available to meet the specific educational needs of the patients.

2.12.4.2 The educational services sustain the educational/ intellectual development of patients and provide remedial opportunities for those who have fallen behind.

2.12.4.3 Teachers are certified by the state in which the facility is located.

2.12.4.3.1 If teachers are not certified in special education, the facility retains a special education teacher to provide consultation and supervision.

2.12.4.3.2 If the educational services not accredited by a state agency, the facility makes this clear in its policies, brochures, and applicant information.

2.12.4.3.3 If the facility's school program is accredited or approved by a state agency, applicable documentation of accreditation or approval is made available to TMA.

2.12.5 Therapeutic Activities A range of therapeutic activities are provided to help the patient meet treatment goals and develop healthy leisure and life skills.

2.12.5.1 All therapeutic activities are managed and directed by a qualified occupational therapist/recreational therapist.

2.12.5.2 The facility provides the necessary resources and equipment to support the recreational and leisure needs of the patients.

2.12.5.3 Adult and adolescent patients help plan leisure and social activities during the day, in the evening, and on the weekend.

2.13 Ancillary Services

2.13.1 Emergency Services Policies and procedures for emergency services define the facilities to be used and the qualified and responsible staff who assess the situation and arrange transfers, as indicated.

2.13.1.1 A written agreement is maintained with each facility providing emergency services.

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2.13.1.2 Appropriate information is exchanged between the referring and receiving facilities.

2.13.1.3 In accordance with written policy and legal requirements, parents, legal guardians, or significant others are notified in an emergency.

2.13.2 Physical Health Services Physical health services are available, 24 hours per day, seven days per week for inpatient programs and during hours of operation for partial programs, either directly or through contractual arrangement. The physical health services necessary for patient evaluation and treatment are provided.

2.13.2.1 Physical health services include, but are not limited to: complete medical history and physical examinations; pathology and laboratory services; vision, hearing, and dental services; and radiology services.

2.13.2.2 Contractual agreements include a description of the services provided and the reporting requirements.

2.13.3 Pharmacy Services The facility, when appropriate, provides or contracts for pharmacy services. Written policies and procedures govern the safe storage and administration of drugs and meet applicable federal, state, and local laws and regulations.

2.13.3.1 A registered pharmacist is responsible for:

2.13.3.1.1 Developing written policies and procedures that govern safe storage, preparation, distribution, and administration of drugs in accordance with applicable laws and regulations;

2.13.3.1.2 Dispensing drugs and chemicals;

2.13.3.1.3 Developing a formulary in conjunction with the medical staff;

2.13.3.1.4 Recording monthly inspections of all drug storage units, including emergency boxes, emergency carts, and stock medications; and

2.13.3.1.5 Approving a medication administration program and participating in staff development activities.

2.13.3.2 The emergency box is stocked with drugs as indicated by the attending physician's list. The pharmacist checks the emergency box monthly and after each use.

2.13.3.3 All medications administered are documented.

2.13.3.3.1 Only authorized physicians write medication orders.

2.13.3.3.2 The prescribing physician signs telephone orders within 72 hours.

2.13.3.3.3 Medications are administered by authorized physicians, registered nurses, or licensed practical nurses under the supervision of a physician or registered nurse.

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2.13.3.3.4 If self-administration of medication is ordered, the patient is supervised by a qualified staff member.

2.13.3.4 Medications prescribed in a manner not approved by the Food and Drug Administration require approval by the medical director, and are justified in the clinical record.

2.13.3.5 A qualified physician, nurse, or pharmacist informs the patient and family or legal guardian as appropriate, of the benefits, side effects, and risks associated with prescribed medications.

2.13.4 Dietary Services When provided by the facility, dietary services are under the supervision of a registered dietician. The dietician develops a diet manual and approves menus that are nutritionally and calorically adequate, taking into consideration patients' special needs.

2.13.4.1 Dietary personnel comply with federal, state, and local laws concerning food preparation and handling.

2.13.4.2 The dietary services meet all applicable local, state, and federal regulations concerning the handling, preparation, and distribution of food.

2.13.4.2.1 Supplies are clearly labeled and nonfood supplies, including cleaning materials, are stored separately.

2.13.4.2.2 Food is protected from contamination and spoilage.

2.13.4.2.3 Food preparation areas, utensils, and equipment are thoroughly cleaned and sanitized after each period of use.

2.13.4.2.4 All food items are stored above floor level in covered containers that are insect and vermin proof.

2.13.4.2.5 Perishable foods are stored at proper temperatures.

2.13.4.2.6 All reusable eating and drinking utensils are sanitized after use. Broken or chipped dishes, glasses, and cooking utensils are discarded.

2.13.4.2.7 Garbage is disposed of in a sanitary manner to prevent the transmission of disease.

2.13.4.2.8 Dining areas are attractive and clean, and the furnishings are in good repair.

3.0 PHYSICAL PLANT AND ENVIRONMENT

3.1 Physical Environment

3.1.1 The buildings and grounds of the facility are maintained, repaired, and cleaned so that they are not hazardous to the health and safety of patients, staff, and visitors.

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3.1.1.1 All space, supplies, equipment, motor vehicles, and facilities, both within and outside the facility, meet applicable federal, state, and local requirements for safety, fire, health, and sanitation.

3.1.1.2 Equipment and furnishings are of safe and sturdy construction. Furniture is comfortable, attractive, and age appropriate.

3.1.1.3 Sufficient staff and resources are provided to carry out preventive maintenance and regular housekeeping services.

3.1.1.4 Repair and replacement of broken items is done promptly.

3.1.1.5 Windows and doors used for ventilation are screened.

3.1.2 The physical environment is appropriate to the nature of the services provided and the patients served.

3.1.2.1 Indoor and outdoor areas are provided where patients can gather for reading, study, relaxation, entertainment, or recreation.

3.1.2.2 Recreational areas and equipment meet the developmental and clinical needs of the patients.

3.1.3 In an inpatient rehabilitation center, all sleeping areas meet state licensure requirements, promote comfort and dignity, and provide adequate space and privacy for the patients.

3.1.3.1 No more than four patients are housed in a sleeping room unless provisions are made for adequate privacy.

3.1.3.2 Each patient has his/her own bed consisting of a level bedstead and a clean mattress in good condition.

3.1.3.3 All mattresses are fire retardant and have water repellent covers or protectors.

3.1.3.4 Linens, blankets, pillows, and towels are furnished by the facility. Linens and towels are changed at least weekly.

3.1.3.5 Sleeping rooms have windows or skylights.

3.1.4 The facility makes appropriate provisions for personal hygiene.

3.1.4.1 All toilets have secured seats, are kept clean, are in good working order, and have partitions and doors.

3.1.4.2 All bathtub and shower areas are appropriately partitioned for privacy.

3.1.4.3 Bathrooms are cleaned thoroughly each day.

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3.1.4.4 Toothbrushes, toothpaste, soap, and other items of personal hygiene are provided if necessary.

3.1.4.5 Nondistorting mirrors are furnished in each bathroom.

3.1.5 Separate areas and adequate space are provided for therapeutic services including educational, rehabilitative, and vocational services.

3.1.6 A comprehensive smoking policy is established for patients, staff, and visitors.

3.2 Physical Plant Safety

3.2.1 The facility is of permanent construction and maintained in a manner that protects the lives and safety of patients, staff, and visitors.

3.2.2 The facility complies with all applicable building codes, fire, health and safety laws, ordinances, and regulations in the state in which it is located. Current inspection reports are retained for TMA review.

3.2.2.1 The fire inspection meets or exceeds the regulations set by the local fire marshal (as governed by local ordinances), and may never be less than those regulations set by the state fire marshal.

3.2.2.2 Buildings in which patients are housed overnight or receive treatment are in compliance with the appropriate provisions of the **Life Safety Code of the National Fire Protection Association** or equivalent protection is provided and documented.

3.2.2.3 The health inspection meets or exceeds the regulations set by the local health ordinances (where applicable) but may never be less than those regulations set by the state health department.

3.2.2.4 Levels of lighting are maintained throughout the facility that are appropriate for the purpose of the designated area.

3.2.3 The number, type, capacity, and location of fire extinguishers and/or smoke detectors comply with all applicable local or state fire regulations. All staff are instructed in the use of fire extinguishers. Fire extinguishers are inspected and serviced as required.

3.2.4 All fire safety systems are kept in good operating condition. Fire safety systems are inspected regularly and records are kept on file. An electronic fire alarm system automatically notifies the fire department. If such a system is not available, an alternative method is implemented.

3.2.5 Regular safety inspections are conducted by a safety committee. The personnel responsible for safety evaluations receive appropriate training. Monthly safety inspections are documented and maintained on file.

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3.2.6 Specific safety measures are provided for areas of the facility that present unusual hazards to patients, staff, or visitors. Special consideration is given to building and campus features that may cause harm such as “invisible glass doors” and recreation equipment. All stairways have handrails.

3.3 Disaster Planning

3.3.1 The facility has written plans and policies for taking care of casualties arising from internal and external disasters. The plans are rehearsed at least every six months.

3.3.2 The facility is prepared to handle internal and external disasters such as explosions, fires, or tornadoes. The plan incorporates evacuation procedures approved by qualified fire, safety, and other appropriate experts.

3.3.3 The plans for internal and external disasters include instructions on the use of alarm and smoke detection systems, methods of fire containment, plans for notifying appropriate personnel, and posted evacuation routes.

3.3.4 Disaster plans are made available to all facility personnel, and evacuation routes are posted in appropriate areas within the facility.

3.3.5 Records are maintained regarding the disaster training offered to employees.

3.3.6 Regular fire drills are conducted for each shift and on each patient unit. At least one drill is conducted monthly.

3.3.7 An evaluation of all drills concerning internal and external disasters is made at least every six months.

4.0 EVALUATION SYSTEM

4.1 Evaluation Activities

4.1.1 The facility has a written plan of evaluation to examine the overall quality of patient care and services. Evaluation activities include, but are not limited to, quality assessment and improvement, utilization review, patient records, drug utilization review, risk management, infection control, safety, and facility evaluation.

4.1.2 The system of evaluation meets guidelines set forth by accrediting bodies, such as the Joint Commission or CARF, and regulatory agencies of local, state, and federal government.

4.2 Quality Assessment and Improvement

4.2.1 The facility has a program that monitors the quality, appropriateness, and effectiveness of the care, treatment, and services provided for patients and their families.

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4.2.2 Quality assessment and improvement activities include, but are not limited to, clinical peer review, outcome studies, incident reporting, and the attainment of programmatic, clinical, and administrative goals.

4.2.2.1 The evaluation system involves all of the disciplines, services, and programs of the facility, including administrative and support staff activities.

4.2.2.2 The evaluation system identifies opportunities for improving the effectiveness and efficiency of patient care.

4.2.3 The quality monitoring process uses explicit clinical indicators, i.e., well-defined, measurable variables related to the provision and outcome of patient care.

4.2.3.1 The clinical indicators identify high-volume, high-risk, and problem-prone areas of clinical practice.

4.2.3.2 The clinical indicators focus on structural, process, and outcome measures.

4.2.3.3 Each clinical indicator requires the establishment of a threshold to determine when a problem or opportunity to improve care exists.

4.2.4 The clinical director, in consultation with the medical director and professional staff organization, is responsible for developing and implementing quality assessment and improvement activities throughout the facility. A similar methodology is applied to services, departments, disciplines, programs, and patient populations.

4.3 Utilization Review

4.3.1 Utilization review activities include, but are not limited to, concurrent and retrospective studies examining the distribution of services as well as the clinical necessity of treatment.

4.3.2 The written utilization review process identifies the appropriateness of admission, continued stay, and timeliness of discharge as part of the effort to provide quality patient care in a cost-effective manner.

4.3.3 The utilization review process identifies the under-utilization, over-utilization, and inefficient use of the facility's resources, both concurrently and retrospectively.

4.3.4 A conflict-of-interest policy applies to all staff involved in the utilization review process.

4.3.5 A confidentiality policy protects both the patients and clinical staff involved in the utilization review activity and maintains the confidentiality of the findings and recommendations.

4.3.6 The source of payment is not used as the basis for determining patient reviews.

4.3.7 Review information is reported to the relevant departments, services, and disciplines for further recommendations and corrective actions as appropriate.

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4.3.8 The findings of the utilization review process are used as a basis for revising the plan of operation, including a review of staff qualifications and staff composition.

4.3.9 The CEO is responsible for the utilization review process.

4.4 Patient Records

4.4.1 The facility monitors and evaluates the completeness of patient records, including timeliness of entries, appropriate signatures, the pertinence of clinical entries particularly with regard to regular recording of progress/non-progress in treatment plan.

4.4.2 Qualified health care professionals review a representative sample of patient records on a monthly basis.

4.4.3 Conclusions, recommendations, actions taken, and the results of actions are monitored and reported.

4.5 Drug Utilization Review

4.5.1 The facility establishes objective criteria for monitoring and evaluating the prophylactic, therapeutic, and empiric use of drugs.

4.5.2 The monitoring of drug usage ensures that medications are administered appropriately, safely, and effectively.

4.5.3 Data are collected on the drugs most frequently prescribed, those prescribed for other than FDA-approved use, and those with known or suspected adverse reactions or interactions with other drugs.

4.5.4 The review process involves physicians, nurses, pharmacists, administrative and management staff, and other personnel as needed.

4.5.5 Minutes document the classes of drugs reviewed, the findings, conclusions, recommendations, and actions taken.

4.5.6 The results of drug evaluations are disseminated to nursing and medical staff, and are incorporated into other data in the evaluation system involving practice patterns, clinical performance, and staff competence.

4.6 Risk Management

4.6.1 A risk management program is implemented to prevent and control risks to patients and staff, and to minimize costs to the facility associated with patient care and safety.

4.6.2 Risk management activities are coordinated with other evaluation programs including safety monitoring, utilization review, infection control, drug utilization review, and patient record reviews.

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4.6.3 The risk management findings are reviewed quarterly to identify clinical problems or opportunities to improve patient care.

4.6.3.1 Minutes are maintained that include conclusions, recommendations, and the corrective action(s) taken to reduce patient/staff risk and cost.

4.6.3.2 The findings related to risk management are included in the facility evaluation.

4.6.3.3 A summary report is submitted to the governing body indicating the findings and results of risk management activities.

4.7 Infection Control

4.7.1 The facility implements policies and procedures for the surveillance, prevention, and control of infections.

4.7.2 A qualified staff person is assigned responsibility for the management of infection surveillance, prevention, and control.

4.7.3 All staff involved in direct patient care and patient care support are involved in infection control activities.

4.7.3.1 Training is provided for all new employees on infection control, personal hygiene, and their responsibility to prevent and control infection.

4.7.3.2 Education on the prevention and control of infection is provided at least annually for staff in all the departments, services, and programs involved in patient care.

4.7.4 Records and reports of actual and potential infections among patients and staff are documented. Patterns and trends are monitored through the use of aggregated data.

4.8 Safety

The facility implements a safety monitoring system as described below:

4.8.1 An incident reporting system reviews all accidents, injuries, and safety hazards. Incidents are investigated and evaluated, and follow-up actions are documented and tracked.

4.8.2 Disaster training, safety orientation, and continuing safety education are monitored through a review of reports and an evaluation of drills.

4.8.3 A continuous safety surveillance system exists that detects and reports safety hazards related to patients, staff, or visitors.

4.8.4 A multidisciplinary safety committee evaluates the safety monitoring activities, with the authority to take action when conditions pose a threat to people, equipment, or buildings.

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4.9 Facility Evaluation

4.9.1 The CEO and other administrative staff develop a strategic plan with specific goals and objectives to evaluate the various functions of the facility.

4.9.2 The annual goals and objectives for each program component or service are related to the patient population served.

4.9.3 The strategies to meet the objectives are defined.

4.9.4 The criteria by which the programs and services are to be evaluated are specified.

4.9.5 The programs, services, and organization are evaluated annually.

4.9.5.1 An explanation is given of any variance or failure to meet the goals and objectives.

4.9.5.2 The findings of this evaluation are documented and reported to the governing body.

- END -

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Standards For Residential Treatment Centers (RTCs) Serving Children And Adolescents

2.1.3 Clinicians providing individual, group, and family therapy meet TRICARE requirements for professional providers of care, and operate within the scope of their license.

2.1.4 To meet the identified medical and clinical needs of patients, on-site professional staff coverage is provided 24 hours a day, seven days per week.

2.1.4.1 Physicians are available 24 hours a day, seven days per week to respond to medical and psychiatric problems.

2.1.4.2 A registered nurse (RN) is on duty every shift to plan, assign, supervise, and evaluate nursing care.

2.1.4.3 RNs and other treatment staff are assigned depending upon the number, location, and acuity level of the patients.

2.1.4.4 Medical and professional consultation and supervision are readily available during service hours.

2.1.4.5 Liaison relationships are maintained with other psychiatric and human service providers for emergency services.

2.1.5 The authority for medical management of care is vested in a physician. A psychiatrist is actively involved in developing and implementing individualized treatment.

2.1.5.1 A physician member of the active duty military medical corps or the United States Public Health Service does not meet this requirement.

2.1.5.2 A resident or intern does not meet this requirement.

2.1.6 The authority for planning, developing, implementing, and monitoring of all clinical activities is vested in a psychiatrist or doctoral level psychologist.

2.1.7 Professionals who perform assessments and/or treat children and adolescents understand human growth and development and can identify age-related treatment needs.

2.1.8 The qualifications, training, and experience necessary to assume specific clinical responsibilities are specified in writing and verified prior to employment.

2.2 Staff Qualifications

2.2.1 Within the scope of its programs and services, the facility has a sufficient number of professional, administrative, and support staff to address the medical and clinical needs of patients and to coordinate the services provided. Qualified mental health providers meet state licensure, registration, or certification requirements in their respective disciplines.

2.2.1.1 RTC staff meet the following educational and experience requirements:

2.2.1.1.1 A physician, other than a psychiatrist, has a medical or osteopathic degree from an accredited university, and is licensed by the state in which he/she is practicing;

2.2.1.1.2 A psychiatrist has a medical or osteopathic degree from an accredited university, is licensed by the state, and has completed an approved psychiatric residency;

2.2.1.1.3 A psychologist has a doctoral degree from an accredited university, and has two years of clinically supervised experience in psychological health services, with one year postdoctoral and one year in an organized psychological services program;

2.2.1.1.4 A Certified Psychiatric Nurse Specialist (CPNS) has a master's degree from an accredited school of nursing with a specialty in psychiatric or mental health nursing, or addiction treatment. The nurse has two years of post-master's degree practice in the field of psychiatric or mental health nursing;

2.2.1.1.5 A social worker has a master's degree in social work from a graduate school accredited by the Council on Social Work Education, and has two years of post-master's degree, supervised clinical social work practice;

2.2.1.1.6 A staff nurse has a minimum of a diploma or an associate degree in nursing, and is licensed by the state in which he/she is practicing;

2.2.1.1.7 Under TRICARE, mental health professionals must meet criteria in 32 CFR 199.6 for their provider types regarding education, training, and supervised clinical experience. TRICARE Certified Mental Health Counselors and certified marriage and family therapists do not require supervision or referral of patients by TRICARE authorized physicians. Supervised Mental Health Counselors (SMHC) and pastoral counselors have master's degrees in mental health or behavioral sciences from accredited universities. SMHCs have two years (3,000 hours of clinical work and 100 hours of face-to-face supervision) of supervised, post-master's degree practice and pastoral counselors have two years (1,200 hours of approved supervision) of supervised post-master's degree practice. Both extramedical providers require supervision by qualified members of the professional staff.

2.2.1.1.8 An occupational therapist, recreational therapist, or expressive art therapist has at least a bachelor's degree from an accredited college or university, is nationally registered or certified, and is licensed or certified in his/her respective field when this is offered or required by the state where the facility is located;

2.2.1.1.9 A teacher has a bachelor's degree from an accredited university and is certified as a teacher in the respective state;

2.2.1.1.10 An addiction therapist has a master's degree in mental health or behavioral sciences from an accredited university, and three years of experience in alcohol/drug abuse counseling;

2.2.1.1.11 An addiction counselor has a bachelor's degree from an accredited university, five years of experience in alcohol and/or drug abuse counseling, and is supervised at least weekly by a qualified member of the professional staff; and

2.2.1.1.12 Direct service staff, e.g., patient care assistants, have at least a high school diploma or equivalent. These staff offer support and assistance to patients but do not provide therapy, e.g., individual, family, couples, or group. They receive documented supervision from qualified health care professionals.

2.2.2 RTCs that employ master's or doctoral level staff who are not qualified mental health providers have a supervision program to oversee and monitor their provision of clinical care.

2.2.2.1 All care provided is the responsibility of a licensed or certified mental health professional, as previously defined in this section.

2.2.2.2 To provide services, nonlicensed clinicians:

2.2.2.2.1 Have a master's or doctoral degree in a mental health discipline;

2.2.2.2.2 Practice under a licensed or certified mental health professional for up to two years during which time the nonlicensed clinician is actively working toward licensure or certification; and

2.2.2.2.3 Meet the credential requirements of the facility to provide clinical services;

2.2.2.3 Supervision provided to nonlicensed clinicians is specified in writing and meets the following requirements:

2.2.2.3.1 The supervisor is employed by the facility and provides clinical supervision only in privileged areas;

2.2.2.3.2 The supervisor meets at least weekly on an individual basis with the supervisee and provides additional on-site supervision as needed;

2.2.2.3.3 Supervisory sessions are regularly documented by the clinical supervisor;

2.2.2.3.4 Clinical documentation meets clinical records and quality assessment and improvement standards; and

2.2.2.3.5 All clinical entries by the supervisee are reviewed and countersigned by the supervisor.

2.3 Patient Rights

2.3.1 The facility protects all individual patient rights, including civil rights, under applicable federal and state laws.

2.3.1.1 Policies and procedures clearly describe the rights of the patients and the facility's methods to guarantee these rights.

2.3.1.2 Patients and families are informed of their rights in language that is easily understood.

2.3.1.3 All patients are treated with dignity and respect, and are afforded full protection of their basic personal and privacy rights.

2.3.1.3.1 The right to privacy is based on individual developmental and clinical requirements.

2.3.1.3.2 Patients may contact an attorney.

- 2.3.1.3.3** Patients may send and receive mail without hindrance unless clinically contraindicated and restricted by the responsible physician's or clinical psychologist's order.
- 2.3.1.3.4** Patients may have private telephone contact with members of their immediate family or guardian unless clinically contraindicated and restricted by the responsible physician's or clinical psychologist's order.
- 2.3.1.3.5** Patients may have private visits with their family or guardian unless clinically contraindicated and restricted by the responsible physician's or clinical psychologist's order.
- 2.3.1.3.6** All orders to restrict patient rights are supported by a written justification of clinical need and are reviewed every seven days.
- 2.3.1.3.7** Mail, telephone calls, and family visits are not restricted by treatment philosophy, level, phase, or milieu program design.
- 2.3.1.3.8** Patients are not required to dress in distinctive clothing for behavioral control purposes or as a consequence for misconduct.
- 2.3.1.3.9** Except at admission, body searches for the detection of contraband require a written physician's order. The order and the justification are documented in the clinical record.
- 2.3.1.3.10** The facility provides opportunities for patients to attend religious services and to seek religious counsel unless clinically contraindicated.
- 2.3.1.4** The facility maintains a safe environment; patients are protected from physical or emotional harm by other patients, staff, and visitors.
- 2.3.1.5** The facility protects the right of confidentiality for all patients, their families, and significant others. Personal pictures, videotapes, or audio recordings are not obtained without written permission.
- 2.3.1.6** Informed consent is obtained from the patient, family, or legal guardian authorizing emergency medical care, including surgical procedures.
- 2.3.1.7** Parents or guardians are informed of the patient's treatment progress at regular intervals, and at least monthly.
- 2.3.1.8** The patient, family, or legal guardian have the right to present complaints or grievances about the facility or the care received. The facility has procedures for responding to these complaints.
- 2.3.1.9** The patient and family are provided with written descriptions of the principles, methods, and interventions used in behavior management. If a level or phase system is implemented:
- 2.3.1.9.1** Level achievement is not considered to be an objective of the interdisciplinary treatment plan;

2.3.1.9.2 Level achievement or lack thereof does not affect the provision of therapeutic services, including passes when clinically indicated;

2.3.1.9.3 Level achievement or lack thereof does not negate a timely discharge once the therapeutic goals and objectives have been attained; and

2.3.1.9.4 The level or phase system is not used to compromise the basic rights of the patient.

2.3.1.10 When food services are provided, patients receive adequate and nutritious meals with accommodations for special diets, and are not denied food as a method of behavior management.

2.3.1.11 The patient and family receive education regarding all medications prescribed, including benefits, side effects, and risks.

2.3.1.12 Patients have the right to refuse treatment and medications. If a patient or family refuses treatment, the facility:

2.3.1.12.1 Makes documented, reasonable efforts to understand the issues involved and resolve the conflict. If the issue cannot be resolved, the facility:

2.3.1.12.1.1 Terminates treatment on reasonable notification of patient, family, or legal guardian; or

2.3.1.12.1.2 Seeks legal alternatives to ensure that the patient's safety and treatment needs are met.

2.3.1.13 Any research involving TRICARE beneficiaries has prior approval from TMA and complies with the regulations protecting human subjects of the Department of Health and Human Services (45 CFR 46).

2.3.2 The facility has a written policy regarding patient abuse and neglect.

2.3.2.1 All facility staff, patients, and families as appropriate, are informed of the policy.

2.3.2.2 All incidents of suspected abuse and neglect are reported promptly to the appropriate state agencies.

2.3.3 Facility marketing and advertising meets professional standards.

2.4 Behavior Management

2.4.1 Behavior management is based on a comprehensive, written plan that describes a full range of interventions using positive reinforcement methods and clear implementation guidelines.

2.4.2 Policies and procedures for behavior management are developed by the medical director or clinical director and medical/professional staff and approved by the governing body. They are implemented on the basis of the following considerations:

2.4.2.1 Behavior management is individualized to ensure appropriate consideration of the patient's developmental level, psychological state, cognitive capacity, and other clinically relevant factors.

2.4.2.2 Time-out is a brief, voluntary separation from program, activities, or other patients, and is initiated by the patient or at the request of staff to help the patient regain self-control.

2.4.2.3 Physical holding is a brief, involuntary procedure that is initiated by trained staff to help the patient regain self-control.

2.4.2.4 Restraint is the use of physical holds or mechanical devices which inhibit the voluntary movement of the whole or a portion of the patient's body.

2.4.2.5 Seclusion is the restriction or confinement of a patient to a room or other area until released with a staff member's approval or assistance.

2.4.2.6 If any part of a facility is locked to ensure patient safety, the rationale is based on clinical or medical needs and the security measures are consistent with the treatment philosophy, mission statement, and admission criteria.

2.4.3 Restraint and seclusion are considered extraordinary interventions to be used only by professional staff in an emergency, after less restrictive methods have been attempted unsuccessfully.

2.4.3.1 A psychiatrist conducts an assessment of the patient providing the rationale and clinical justification for the intervention.

2.4.3.2 The psychiatrist evaluates the appropriateness of the patient's continued treatment at the residential level of care.

2.4.3.3 The assessment and justification for the use of restraint or seclusion are documented in the clinical record for each episode and include the consideration of less restrictive interventions.

2.4.3.4 Each written order for restraint or seclusion is time limited, and does not exceed four hours. PRN orders are not used.

2.4.3.5 Restraint or seclusion is not used as a punishment, or for staff convenience.

2.4.3.6 All restraint or seclusion incidents are reported daily to the medical director or physician designee.

2.4.4 Only trained and clinically privileged RNs or qualified mental health professionals may implement seclusion and restraint procedures in an emergency situation.

2.4.4.1 The psychiatrist is provided with a clear assessment of the patient's current condition.

2.4.4.2 The psychiatrist writes or gives a telephone order within 30 minutes of implementation.

2.4.4.2.1 The psychiatrist's written order and clinical assessment are entered into the clinical record within 24 hours of the telephone order.

2.4.4.2.2 Seclusion or restraint procedures exceeding eight hours require continued authorization by the medical director or physician designee.

2.4.4.2.3 If seclusion or restraint procedures exceed 24 hours, the patient is assessed by the medical director to determine the appropriateness of treatment at the residential level of care.

2.4.4.2.4 An RN or qualified mental health professional may release a patient from seclusion or restraint prior to the time specified. The assessment and rationale for ending the procedure is documented in the clinical record.

2.4.4.3 Appropriate attention is given to patients in seclusion or restraint. Observations occur at least every 15 minutes and care is regularly documented in the clinical record.

2.4.4.3.1 Observations by an RN or a qualified mental health professional occur every hour with documentation of the appropriateness of continuing or discontinuing use.

2.4.4.3.2 Documented care includes, at a minimum, rest room breaks every two hours, fluids every hour, and regularly scheduled meals and snacks.

2.4.4.3.3 For mechanically restrained patients, range of motion and circulation checks are done every hour, and vital sign monitoring occurs every two hours.

2.4.5 The facility maintains an aggregate log on the use of special treatment procedures including the patient's name, date of the occurrence, type of intervention used, and the duration of the intervention.

2.4.6 On a daily basis, the medical director or clinical director reviews all incidents involving time-outs, physical holds, restraints, and seclusions, and investigates unusual or unwarranted patterns of use.

2.5 Admission Process

The admission process helps the patient to fully use the medical, clinical, and program services of the RTC. The patient, family and significant others as appropriate, are familiarized with the treatment program and how the facility addresses patient capabilities and medical/clinical needs.

2.5.1 Preadmission information is obtained to evaluate the medical and/or psychological necessity for admission. Recent psychiatric, psychological, and psychosocial evaluations are reviewed.

2.5.2 Written admission criteria describe the extent and complexity of the disorders appropriate for residential treatment.

2.5.3 A qualified mental health professional, who meets TRICARE requirements for individual professional providers and who is permitted by law and by the facility to refer patients for admission, shall render medical and/or psychological necessity determinations for admission.

2.5.4 The facility accepts only those patients who meet the conditions outlined in the admission criteria, and for whom the RTC has an operational program.

2.5.5 The facility observes and maintains compliance with the conditions of licensure under which it operates, including age, sex, type, and number of patients accepted.

2.5.6 No one is denied admission on the basis of race, religion, national origin, or sexual orientation.

2.5.7 Patients and families who are not accepted for treatment are provided with alternative recommendations and referrals as needed.

2.5.7.1 Referral policies and procedures include statements about the special needs and services the facility cannot provide.

2.5.7.2 Referrals for examination, assessment, and consultation are discussed with the patient and family prior to admission.

2.5.8 During the admission process, the patient and family are clearly apprised of the expectations for treatment and the services provided.

2.5.8.1 Written and signed documentation verifies that patients and family members understand the clinical care that will be provided.

2.5.8.2 The policies and procedures for emergency medical or psychiatric care are explained, including transfer or referral and the means of transfer, e.g., family, facility staff, or ambulance service.

2.5.9 All admissions are planned and approved by a qualified mental health professional, who meets TRICARE requirements as an individual professional providers and is permitted by law and by the facility to refer patients for admission.

2.5.10 All admissions are preauthorized by TMA.

2.6 Assessments

2.6.1 Professional staff are responsible for current assessments of all patients. Consideration is given to the fundamental clinical needs of patients including, but not limited to their physical, psychological, social, spiritual, developmental, family, educational, environmental, and recreational needs.

2.6.2 All required clinical assessments are completed prior to the development of the master treatment plan. Assessments conducted within 30 days prior to admission may be used if reviewed and approved for treatment planning by the responsible psychiatrist.

2.6.2.1 A physical examination is completed on all patients by a qualified physician, qualified physician assistant, or nurse practitioner within 24 hours of admission. When the physical examination is completed by a physician assistant or nurse practitioner, a physician must countersign. The physical examination includes: a complete medical history; a general physical examination; sensorimotor development and functioning; physical development; vision and hearing; immunization status; serology, urinalysis, and other routine laboratory studies as indicated; and a tuberculin test with results or a chest X-ray to rule out tuberculosis. A physical examination is conducted every 12 months, or sooner if indicated.

2.6.2.2 A mental health assessment is completed on all patients by a qualified psychiatrist or doctoral level psychologist within 24 hours of admission. The psychiatric evaluation includes: the reason for admission; current clinical presentation; psychosocial stressors related to the present illness; current potential risk to self or others; history of present illness; past psychiatric history; developmental assessment; presence or absence of physical disorders or conditions affecting the presenting illness; alcohol and drug history; and mental status examination. A diagnosis on all five axes is given, based on the current edition of the **Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association**. A repeat psychiatric evaluation is conducted every six months, or sooner if indicated.

2.6.2.3 A nursing assessment is completed on all patients by a registered nurse within 24 hours of admission. The nursing assessment documents a general history of the patient's and family's health and includes a history of current medications, allergies, pertinent medical problems requiring nursing attention, current risk and safety factors, nutritional patterns, immunization status, and sleep patterns.

2.6.3 A social history is completed on all patients by a qualified mental health professional. The social history includes: presenting problems; developmental history; history of significant losses; physical or sexual abuse; family substance abuse; family constellation; parents' military service history; family dynamics and relationships; peer group influences; physical description of current and past home environment; impact of any medical conditions upon the patient; and the impact of financial, religious, ethnic, and cultural influences upon the patient or family. Goals and recommendations for family involvement in treatment are also indicated. A social history completed within the past 12 months may be included in the patient's clinical record if reviewed and approved by the responsible psychiatrist or qualified mental health professional.

2.6.4 A psychological evaluation is completed by a doctoral level licensed clinical psychologist. The psychological evaluation includes a comprehensive clinical assessment and recommendations for the multidisciplinary treatment plan. Testing may include: intellectual, cognitive, and perceptual functioning; stressors and coping mechanisms; neuropsychological functioning; and personality assessment. Psychological testing completed within the past 12 months may be included in the patient's clinical record if reviewed and approved by the responsible physician or clinical psychologist. The psychological evaluation is repeated every 12 months, or sooner if indicated.

2.6.5 A skills assessment is completed on all patients by a licensed or certified activity, occupational, or rehabilitation therapist. The assessment includes activity patterns prior to admission, aptitudes and/or limitations, activities of daily living, perceptual-motor skills, sensory integration factors, cognitive skills, communication skills, social interaction skills, creative abilities, vocational skills, and the impact of physical limitations. The skills assessment is repeated every 12 months, or sooner if indicated.

2.6.6 An educational assessment is completed on all patients by a certified teacher. The educational assessment includes an evaluation of the patient's educational history, current classroom observations, achievement testing, and identification of learning disabilities and needs. An educational assessment completed within the past 12 months may be included in the patient's clinical record if reviewed and approved by the facility's director of education.

2.6.7 Additional assessments may include, as appropriate, speech, hearing and language evaluations, neuropsychological evaluations, neurological evaluations, vocational assessments, nutritional assessments, legal assessments, and other assessments that are clinically indicated.

2.7 Clinical Formulation

A clinical formulation is developed on all patients by a qualified mental health provider. The clinical formulation is reviewed and approved by the responsible physician or doctoral level licensed clinical psychologist. The clinical formulation is generally organized into a Descriptive Section including the nature, severity, and precipitant of the individual's mental health disorder; an Explanatory Section including the rationale for the development and maintenance of the symptoms and dysfunctional life patterns; and the Treatment-Prognostic Section serving as the explicit blueprint governing treatment interventions and prognosis. The clinical formulation:

2.7.1 Is completed prior to the development of the master treatment plan;

2.7.2 Incorporates significant clinical interpretations from each of the multidisciplinary assessments;

2.7.3 Identifies patient strengths and limitations, current psychosocial stressors, present level of functioning, developmental issues to be considered, degree of risk to self or others, and significant treatment issues;

2.7.4 Interrelates the assessment material and indicates the focus of treatment strategies;

2.7.5 Clearly describes the clinical problems to be addressed in treatment, including plans for discharge; and

2.7.6 Substantiates Axes I through V diagnoses, using the current **Diagnostic Statistical Manual of Mental Disorders of the American Psychiatric Association**.

2.8 Treatment Planning

A qualified mental health professional shall be responsible for the development, implementation, supervision, and assessment of an individualized, interdisciplinary treatment plan.

2.8.1 A preliminary treatment plan is completed within 24 hours of admission and consists, at a minimum, of a physician's admission note and orders.

2.8.2 A comprehensive treatment plan is completed within 10 days of admission to the RTC. The comprehensive treatment plan:

2.8.2.1 Clearly articulates the clinical problems that are the focus of treatment;

2.8.2.2 Identifies individual treatment goals that correspond to each identified problem;

2.8.2.2.1 Goals are specific outcome statements based on the anticipated response to treatment.

2.8.2.2.2 Treatment goals and clinical needs are discussed with the patient and family.

2.8.2.3 Identifies individualized and observable or measurable objectives that represent incremental progress toward attaining goals;

2.8.2.4 Describes strategies of treatment, responsible clinicians, and interventions that address individual needs and assist the patient in achieving identified objectives and goals;

2.8.2.5 Includes specific, individualized discharge criteria, which identify essential goals and objectives to be met prior to termination of treatment;

2.8.2.6 Identifies needed services that are not provided directly by the facility; and

2.8.2.7 Specifies goals, objectives, and treatment strategies for the family. If geographically distant family therapy is indicated:

2.8.2.7.1 A therapist is identified to provide family therapy on behalf of the facility.

2.8.2.7.2 A designated staff member serves as a liaison with the therapist to ensure treatment coordination.

2.8.2.7.3 The therapist provides the facility with a monthly report regarding patient/family progress in treatment.

2.8.3 The treatment plan is reviewed for effectiveness and revised at least every 30 days, or when major changes occur in treatment. Objectives and strategies are modified to reflect the patient's response or lack of response to the individualized treatment program. The results are recorded in the clinical record.

2.9 Discharge And Transition Planning

Discharge and transition planning is based upon the anticipated needs of the patient at the time of discharge. The planning involves: determining necessary modifications in the treatment plan, facilitating the termination of treatment, and identifying resources to maintain therapeutic stability following discharge.

2.9.1 During the treatment planning process, the patient's living situation, ongoing treatment needs, and educational and/or vocational needs are assessed.

2.9.2 The treatment plan is modified to anticipate termination, address the temporary regression of the patient, and facilitate re-entry into the home environment or a less intensive level of care.

2.9.3 Community and therapeutic resources are identified to help the patient and family to maintain previous therapeutic gains.

2.9.4 If the patient is not returning home, the RTC is responsible for facilitating alternative discharge plans.

2.10 Clinical Documentation

Clinical records are maintained on each patient to plan care and treatment and to provide ongoing evaluation of the patient's progress. All care is documented and each clinical record contains at least the following:

2.10.1 Demographic data, including the patient's name, date of birth, sex, next of kin, occupation of parents or guardian, school and grade, date of initial contact, legal status, legal documents, religion, current home address, telephone number of the family, source of referral, and reason for referral;

2.10.2 Other information, including consent forms and pertinent legal documents; reports of all assessments and clinical formulation; treatment plans and treatment plan reassessments; consultation and laboratory reports; physician orders; progress notes; and a discharge summary.

2.11 Progress Notes

2.11.1 Progress notes clearly document the course of treatment for the patient and family. The entries provide information for review, analysis, and modification of the treatment plan. Progress notes include:

2.11.1.1 A description of the interventions made by the provider in accordance with the treatment plan and the patient's response in measurable, observable and/or quantifiable behavioral terms;

2.11.1.2 Interpretations of the responses to treatment;

2.11.1.3 Justification, implementation, and interpretation of the effectiveness of interventions for behavior management;

2.11.1.4 Justification for changes in medication, and a description of any side effects and adverse reactions; and

2.11.1.5 Date and length of the therapy session.

2.11.2 All clinical entries are legible, contemporaneous, sequential, signed, and dated. At a minimum, the following are required:

2.11.2.1 A weekly note by a registered nurse evaluating the patient's progress in treatment;

2.11.2.2 A weekly note by the responsible psychiatrist or doctoral level clinical psychologist and a monthly evaluation of the patient's response to all treatment provided;

2.11.2.3 The interdisciplinary treatment plan and monthly treatment plan reviews;

2.11.2.4 Progress notes on individual therapy within 24 hours of each session including the name of the clinician providing the therapy, when it was provided, and the duration of the session;

2.11.2.5 Weekly progress notes on group and therapeutic activity services;

2.11.2.6 Progress notes on family therapy including the name of the person providing the therapy, when it was provided, and the duration of the session after each contact; and

2.11.2.7 A discharge summary including a plan for continuing care is entered in the record within 15 days following discharge.

2.12 Therapeutic Services

2.12.1 A range of therapeutic services are provided to address the assessed clinical needs of patients. These include, at a minimum: psychotherapy; educational services; therapeutic activities; and physical health, dietary, emergency, pharmacy, and other services as clinically indicated. Cognitive, behavioral, and other therapies are administered on an individual and group basis. A seven-day-a-week program integrates milieu activities and clinical services. Services that are clinically contraindicated are documented in the clinical record.

2.12.2 Psychotherapy Services Individual, group, and family psychotherapy are provided to all patients. The type of psychotherapy and its primary purpose is included in each patient's treatment plan.

2.12.2.1 Individual psychotherapy is provided by a privileged qualified mental health provider, practicing within the scope of his/her license or by a practitioner under the supervision of a licensed mental health provider, as discussed in [paragraph 2.2](#) and is offered as indicated in the treatment plan.

2.12.2.2 Group psychotherapy is provided by a privileged qualified mental health provider, practicing within the scope of his/her license or by a practitioner under the supervision of a licensed mental health provider, as discussed in [paragraph 2.2](#) and is offered as indicated in the treatment plan.

2.12.2.3 Family psychotherapy is provided by a privileged qualified mental health provider, practicing within the scope of his/her license or by a practitioner under the supervision of a licensed mental health provider as discussed in [paragraph 2.2](#) and is offered as indicated in the treatment plan.

2.12.2.3.1 If geographically distant family therapy is required, the facility makes arrangements to engage a qualified therapist who provides the psychotherapy.

2.12.2.3.2 Telephone contacts with the family or guardian do not meet the compliance requirement of this standard.

2.12.3 Therapeutic Activities A range of therapeutic activities are offered to help the patient meet the goals of the treatment plan.

2.12.3.1 The activities program is directed and staffed by a licensed, registered, or certified activity therapist.

2.12.3.2 The facility provides the staff and resources necessary to support the program.

2.12.3.2.1 A structured skills program is provided for all patients.

2.12.3.2.2 A leisure and social program is provided. Patients participate in the planning and scheduling of daytime, evening, and weekend activities.

2.12.3.2.3 If indicated by the skills assessment, the patient receives a vocational assessment and the necessary vocational training.

2.12.3.2.4 If the facility has an organized vocational training program, the program is state certified and staffed by qualified vocational teachers.

2.12.4 Therapeutic Educational Services Therapeutic educational services appropriate to the patient's educational and therapeutic needs are provided or arranged.

2.12.4.1 If the facility provides educational services, the necessary resources and equipment are available to meet the educational needs of children and adolescents.

2.12.4.2 Each patient receives a complete educational assessment. The results of the assessment are incorporated into the clinical formulation and the interdisciplinary treatment plan.

2.12.4.3 The therapeutic educational services are integrated into the individual treatment plan, coordinated with the milieu program, and documented in the clinical record.

2.12.4.4 Educational services are provided by qualified teachers. Teachers have a bachelor's degree from an accredited university and are certified by the state in which the facility is located.

2.12.4.4.1 If the teachers are not certified in special education, the facility retains a special education teacher to provide consultation and supervision.

2.12.4.4.2 If the therapeutic school program is not accredited by a state agency, the facility makes this information clear in its policies, brochures, and information given to all applicants.

2.12.4.4.3 If the facility has a school program accredited or approved by a state agency, documentation of this accreditation or approval is made available to TMA for review.

2.12.4.5 Local schools may be used by patients for the transitional phase of treatment. This transition is individualized, coordinated with the school, and progress is documented.

2.13 Ancillary Services

2.13.1 Emergency Services Policies and procedures for emergency services define the facilities to be used and the qualified and responsible staff who assess the situation and arrange transfers, as indicated.

2.13.1.1 A written agreement is maintained with each facility providing emergency services.

2.13.1.2 Appropriate information is exchanged between the referring and receiving facilities.

2.13.1.3 In accordance with written policy and legal requirements, parents, legal guardians, or significant others are notified in an emergency.

2.13.2 Physical Health Services Physical health services are available 24 hours per day, seven days per week, either directly or through contractual arrangement. The physical health services necessary for patient evaluation and treatment are provided.

2.13.2.1 Physical health services include, but are not limited to: complete medical history and physical examinations; pathology and laboratory services; vision, hearing, and dental services; and radiology services.

2.13.2.2 Contractual agreements include a description of the services provided and the reporting requirements.

2.13.3 Pharmacy Services The facility provides, or contracts for, all pharmacy services. Written policies and procedures govern the safe storage and administration of drugs and meet applicable federal, state, and local laws and regulations.

2.13.3.1 A registered pharmacist is responsible for:

2.13.3.1.1 Developing written policies and procedures that govern safe storage, preparation, distribution, and administration of drugs in accordance with applicable laws and regulations;

2.13.3.1.2 Dispensing drugs and chemicals;

2.13.3.1.3 Developing a formulary in conjunction with the medical staff;

2.13.3.1.4 Recording monthly inspections of all drug storage units, including emergency boxes, emergency carts, and stock medications; and

2.13.3.1.5 Approving a medication administration program and participating in staff development activities.

2.13.3.2 The emergency box is stocked with drugs as indicated by the attending physician's list. The pharmacist checks the emergency box monthly and after each use.

2.13.3.3 All medications administered are documented.

2.13.3.3.1 Only authorized physicians write medication orders.

2.13.3.3.2 The prescribing physician signs telephone orders within 72 hours.

2.13.3.3.3 Medications are administered by authorized physicians, registered nurses, or licensed practical nurses under the supervision of a physician or registered nurse.

2.13.3.3.4 If self-administration of medication is ordered, the patient is supervised by a qualified staff member.

2.13.3.4 Medications prescribed in a manner not approved by the Food and Drug Administration require approval by the medical director, and are justified in the clinical record.

2.13.3.5 A qualified physician, nurse, or pharmacist informs the patient and family or legal guardian as appropriate, of the benefits, side effects, and risks associated with prescribed medications.

2.13.4 Dietary Services Dietary services are under the supervision of a registered dietician. The dietician develops a diet manual and approves menus that are nutritionally and calorically adequate, taking into consideration patients' special needs.

2.13.4.1 Dietary personnel comply with federal, state, and local laws concerning food preparation and handling.

2.13.4.2 The dietary services meet all applicable local, state, and federal regulations concerning the handling, preparation, and distribution of food.

2.13.4.2.1 Supplies are clearly labeled and nonfood supplies, including cleaning materials, are stored separately.

2.13.4.2.2 Food is protected from contamination and spoilage.

2.13.4.2.3 Food preparation areas, utensils, and equipment are thoroughly cleaned and sanitized after each period of use.

2.13.4.2.4 All food items are stored above floor level in covered containers that are insect and vermin proof.

2.13.4.2.5 Perishable foods are stored at proper temperatures.

2.13.4.2.6 All reusable eating and drinking utensils are sanitized after use. Broken or chipped dishes, glasses, and cooking utensils are discarded.

2.13.4.2.7 Garbage is disposed of in a sanitary manner to prevent the transmission of disease.

2.13.4.2.8 Dining areas are attractive and clean, and the furnishings are in good repair.

3.0 PHYSICAL PLANT AND ENVIRONMENT

3.1 Physical Environment

3.1.1 The buildings and grounds of the facility are maintained, repaired, and cleaned so that they are not hazardous to the health and safety of the patients, staff, and visitors.

3.1.1.1 All space, supplies, equipment, motor vehicles, and facilities, both within and outside the facility, meet applicable federal, state, and local requirements for safety, fire, health, and sanitation.

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Standards For Residential Treatment Centers (RTCs) Serving Children And Adolescents

3.1.1.2 Equipment and furnishings are of safe and sturdy construction. Furniture is comfortable, attractive, and age appropriate.

3.1.1.3 Sufficient staff and resources are provided to carry out preventive maintenance and regular housekeeping services.

3.1.1.4 Repair and replacement of broken items is done promptly.

3.1.1.5 Windows and doors used for ventilation are screened.

3.1.1.6 Sleeping rooms have windows or skylights.

3.1.2 The physical environment is appropriate to the nature of the services provided and the patients served.

3.1.2.1 Indoor and outdoor areas are provided where patients can gather for reading, study, relaxation, entertainment, or recreation.

3.1.2.2 Recreational areas and equipment meet the developmental and clinical needs of the patients.

3.1.2.3 Resources such as toys, books, and games are age appropriate and accessible.

3.1.3 All sleeping areas meet state licensure requirements, promote comfort and dignity, and provide adequate space and privacy for the patients.

3.1.3.1 No more than four patients are housed in a sleeping room unless provisions are made for adequate privacy.

3.1.3.2 Each patient has his/her own bed consisting of a level bedstead and a clean mattress in good condition.

3.1.3.3 All mattresses are fire retardant and have water repellent covers or protectors.

3.1.3.4 Linens, blankets, pillows, and towels are furnished by the facility. Linens and towels are changed at least weekly.

3.1.4 Storage areas are provided for each patient's clothing and personal possessions.

3.1.4.1 Adequate, secure personal storage space is available to each patient.

3.1.4.2 Storage space is accessible and within easy reach.

3.1.5 The facility makes appropriate provisions for personal hygiene.

3.1.5.1 All toilets have secured seats, are kept clean, are in good working order, and have partitions and doors.

3.1.5.2 All bathtub and shower areas are appropriately partitioned for privacy.

3.1.5.3 Bathrooms are cleaned thoroughly each day.

3.1.5.4 Toothbrushes, toothpaste, soap, and other items of personal hygiene are provided if necessary.

3.1.5.5 Nondistorting mirrors are furnished in each bathroom.

3.1.6 Separate areas and adequate space are provided for therapeutic services including educational, rehabilitative, and vocational services.

3.1.7 A comprehensive smoking policy is established for patients, staff, and visitors.

3.2 Physical Plant Safety

3.2.1 The facility is of permanent construction and maintained in a manner that protects the lives and safety of patients, staff, and visitors.

3.2.2 The facility complies with all applicable building codes, fire, health and safety laws, ordinances, and regulations in the state in which it is located. Current inspection reports are retained for TMA review.

3.2.2.1 The fire inspection meets or exceeds the regulations set by the local fire marshal (as governed by local ordinances), and may never be less than those regulations set by the state fire marshal.

3.2.2.2 Buildings in which patients are housed overnight or receive treatment are in compliance with the appropriate provisions of the **Life Safety Code of the National Fire Protection Association** or equivalent protection is provided and documented.

3.2.2.3 The health inspection meets or exceeds the regulations set by the local health ordinances (where applicable) but may never be less than those regulations set by the state health department.

3.2.2.4 Levels of lighting are maintained throughout the facility that are appropriate for the purpose of the designated area.

3.2.3 The number, type, capacity, and location of fire extinguishers and/or smoke detectors comply with all applicable local or state fire regulations. All staff are instructed in the use of fire extinguishers. Fire extinguishers are inspected and serviced as required.

3.2.4 All fire safety systems are kept in good operating condition. Fire safety systems are inspected regularly and records are kept on file. An electronic fire alarm system automatically notifies the fire department. If such a system is not available, an alternative method is implemented.

3.2.5 Regular safety inspections are conducted by a safety committee. The personnel responsible for safety evaluations receive appropriate training. Monthly safety inspections are documented and maintained on file.

3.2.6 Specific safety measures are provided for areas of the facility that present unusual hazards to patients, staff, or visitors. Special consideration is given to building and campus features that may cause harm such as “invisible glass doors” and recreation equipment. All stairways have handrails.

3.3 Disaster Planning

3.3.1 The facility has written plans and policies for taking care of casualties arising from internal and external disasters. The plans are rehearsed at least every six months.

3.3.2 The facility is prepared to handle internal and external disasters such as explosions, fires, or tornadoes. The plan incorporates evacuation procedures approved by qualified fire, safety, and other appropriate experts.

3.3.3 The plans for internal and external disasters include instructions on the use of alarm and smoke detection systems, methods of fire containment, plans for notifying appropriate personnel, and posted evacuation routes.

3.3.4 Disaster plans are made available to all facility personnel, and evacuation routes are posted in appropriate areas within the facility.

3.3.5 Records are maintained regarding the disaster training offered to employees.

3.3.6 Regular fire drills are conducted for each shift and on each patient unit. At least one drill is conducted monthly.

3.3.7 An evaluation of all drills concerning internal and external disasters is made at least every six months.

4.0 EVALUATION SYSTEM

4.1 Evaluation Activities

4.1.1 The facility has a written plan of evaluation to examine the overall quality of patient care and services. Evaluation activities include, but are not limited to, quality assessment and improvement, utilization review, patient records, drug utilization review, risk management, infection control, safety, and facility evaluation.

4.1.2 The system of evaluation meets guidelines set forth by accrediting bodies, such as the Joint Commission, and regulatory agencies of local, state, and federal government.

4.2 Quality Assessment and Improvement

4.2.1 The facility has a program that monitors the quality, appropriateness, and effectiveness of the care, treatment, and services provided for patients and their families.

4.2.2 Quality assessment and improvement activities include, but are not limited to, clinical peer review, outcome studies, incident reporting, and the attainment of programmatic, clinical, and administrative goals.

4.2.2.1 The evaluation system involves all of the disciplines, services, and programs of the facility, including administrative and support staff activities.

4.2.2.2 The evaluation system identifies opportunities for improving the effectiveness and efficiency of patient care.

4.2.3 The quality monitoring process uses explicit clinical indicators, i.e., well-defined, measurable variables related to the provision and outcome of patient care.

4.2.3.1 The clinical indicators identify high-volume, high-risk, and problem-prone areas of clinical practice.

4.2.3.2 The clinical indicators focus on structural, process, and outcome measures.

4.2.3.3 Each clinical indicator requires the establishment of a threshold to determine when a problem or opportunity to improve care exists.

4.2.4 The clinical director, in consultation with the medical director and the medical and professional staff organization, is responsible for developing and implementing quality assessment and improvement activities throughout the facility. A similar methodology is applied to services, departments, disciplines, programs, and patient populations.

4.3 Utilization Review

4.3.1 The RTC shall implement a utilization review process, pursuant to a written plan approved by the professional staff, the administration, and the governing body.

4.3.2 Utilization review activities include, but are not limited to, concurrent and retrospective studies examining the distribution of services as well as the clinical necessity of treatment.

4.3.3 The utilization review process identifies the appropriateness of admission, continued stay, and timeliness of discharge as part of the effort to provide quality patient care in a cost-effective manner.

4.3.4 The utilization review process identifies the under-utilization, over-utilization, and inefficient use of the facility's resources, both concurrently and retrospectively.

4.3.5 A conflict-of-interest policy applies to all staff involved in the utilization review process.

4.3.6 A confidentiality policy protects both the patients and clinical staff involved in the utilization review activity and maintains the confidentiality of the findings and recommendations.

4.3.7 The source of payment is not used as the basis for determining patient reviews.

4.3.8 Review information is reported to the applicable departments, services, and disciplines for further recommendations and corrective actions as appropriate.

4.3.9 The findings of the utilization review process are used as a basis for revising the plan of operation, including a review of staff qualifications and staff composition.

4.3.10 The CEO is responsible for the development and implementation of the utilization review process.

4.4 Patient Records

4.4.1 Clinical records are maintained and controlled by an appropriately qualified records administrator or technician.

4.4.1.1 Written policies and procedures ensure that records are current, accurate, confidential, and safely stored.

4.4.1.2 Current records are kept in patient care areas and are immediately accessible to staff.

4.4.1.3 Policies and procedures adhere to federal guidelines for the release of confidential information specific to residential treatment.

4.4.2 The facility monitors and evaluates the completeness of patient records, including timeliness of entries, appropriate signatures, and the pertinence of clinical entries, particularly with regard to the regular recording of progress/non-progress in treatment.

4.4.3 Qualified health care professionals review a representative sample of patient records on a monthly basis.

4.4.4 Conclusions, recommendations, actions taken, and the results of actions are monitored and reported.

4.5 Drug Utilization Review

4.5.1 The facility establishes objective criteria for monitoring and evaluating the prophylactic, therapeutic, and empiric use of drugs.

4.5.2 The monitoring of drug usage ensures that medications are administered appropriately, safely, and effectively.

4.5.3 Data are collected on the drugs most frequently prescribed, those prescribed for other than FDA-approved use, and those with known or suspected adverse reactions or interactions with other drugs.

4.5.4 The review process involves physicians, nurses, pharmacists, administrative and management staff, and other personnel as needed.

4.5.5 Minutes document the classes of drugs reviewed, and the findings, conclusions, recommendations, and actions taken.

4.5.6 The results of drug evaluations are disseminated to nursing and medical staff, and are incorporated into other data in the evaluation system involving practice patterns, clinical performance, and staff competence.

4.5.7 The medical or professional staff is responsible for the drug utilization review process.

4.6 Risk Management

4.6.1 A risk management program is implemented to prevent and control risks to patients and staff, and to minimize costs to the facility associated with patient care and safety.

4.6.2 Risk management activities are coordinated with other evaluation programs including safety monitoring, utilization review, infection control, drug utilization review, and patient record reviews.

4.6.3 The risk management findings are reviewed quarterly to identify clinical problems or opportunities to improve patient care.

4.6.3.1 Minutes are maintained that include conclusions, recommendations, and the corrective action(s) taken to reduce patient/staff risk and cost.

4.6.3.2 The findings related to risk management are included in the facility evaluation.

4.6.3.3 A summary report is submitted to the governing body indicating the findings and results of risk management activities.

4.7 Infection Control

4.7.1 The facility implements policies and procedures for the surveillance, prevention, and control of infections.

4.7.2 A qualified staff person is assigned responsibility for the management of infection surveillance, prevention, and control.

4.7.3 All staff involved in direct patient care and patient care support are involved in infection control activities.

4.7.3.1 Training is provided for all new employees on infection control, personal hygiene, and their responsibility to prevent and control infection.

4.7.3.2 Education on the prevention and control of infection is provided at least annually for staff in all the departments, services, and programs involved in patient care.

4.7.4 Records and reports of actual and potential infections among patients and staff are documented. Patterns and trends are monitored through the use of aggregated data.

4.8 Safety

The facility implements a safety monitoring system as described below:

4.8.1 An incident reporting system reviews all accidents, injuries, and safety hazards. Incidents are investigated and evaluated, and follow-up actions are documented and tracked.

4.8.2 Disaster training, safety orientation, and continuing safety education are monitored through a review of reports and an evaluation of drills.

Acronyms And Abbreviations

AA	Anesthesiologist Assistant
AA&E	Arms, Ammunition and Explosives
AAA	Abdominal Aortic Aneurysm
AAAHC	Accreditation Association for Ambulatory Health Care, Inc.
AAFES	Army/Air Force Exchange Service
AAMFT	American Association for Marriage and Family Therapy
AAP	American Academy of Pediatrics
AAPC	American Association of Pastoral Counselors
AARF	Account Authorization Request Form
AATD	Access and Authentication Technology Division
ABA	American Banking Association Applied Behavior Analysis
ABMT	Autologous Bone Marrow Transplant
ABPM	Ambulatory Blood Pressure Monitoring
ABR	Auditory Brainstem Response
AC	Active Component
ACA	Affordable Care Act
ACD	Augmentative Communication Devices
ACE	Angiotensin-Converting Enzyme
ACH	Automated Clearing House
ACI	Autologous Chondrocyte Implantation
ACIP	Advisory Committee on Immunization Practices
ACO	Administrative Contracting Officer
ACOG	American College of Obstetricians and Gynecologists
ACOR	Administrative Contracting Officer's Representative
ACP	American College of Physicians
ACS	American Cancer Society
ACSC	Ambulatory Care Sensitive Condition
ACSP	Autism Demonstration Corporate Services Provider
ACTUR	Automated Central Tumor Registry
AD	Active Duty
ADA	American Dental Association American Diabetes Association Americans with Disabilities Act
ADAMHA	Alcohol, Drug Abuse, And Mental Health Administration

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Appendix A

Acronyms And Abbreviations

ADAMHRA	Alcohol, Drug Abuse, And Mental Health Reorganization Act
ADCP	Active Duty Claims Program
ADD	Active Duty Dependent
ADDP	Active Duty Dental Program
ADFM	Active Duty Family Member
ADH	Atypical Ductal Hyperplasia
ADL	Activities of Daily Living
ADP	Automated Data Processing
ADSM	Active Duty Service Member
AF	Atrial Fibrillation
AFAP	Attenuated Familial Adenomatous Polyposis
AFB	Air Force Base
AFOSI	Air Force Office of Special Investigations
AFS	Ambulance Fee Schedule
AGR	Active Guard/Reserve
AHA	American Hospital Association
AHLTA	Armed Forces Health Longitudinal Technology Application
AHRQ	Agency for Healthcare Research and Quality
AI	Administrative Instruction
AIDS	Acquired Immune Deficiency Syndrome
AIF	Ambulance Inflation Factor
AIIM	Association for Information and Image Management
AIS	Ambulatory Infusion Suite Automated Information Systems
AIX	Advanced IBM Unix
AJ	Administrative Judge
ALA	Annual Letter of Assurance
ALB	All Lines Busy
ALH	Atypical Lobular Hyperplasia
ALL	Acute Lymphocytic Leukemia
ALOS	Average Length-of-Stay
ALS	Action Lead Sheet Advanced Life Support
ALT	Autolymphocyte Therapy
AM&S	Acquisition Management and Support (Directorate)
AMA	Against Medical Advice American Medical Association
AMCB	American Midwifery Certification Board
AMH	Accreditation Manual for Hospitals
AMHCA	American Mental Health Counselor Association
ANCC	American Nurses Credentialing Center
AML	Acute Myelogenous [Myeloid] Leukemia
ANSI	American National Standards Institute

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Acronyms And Abbreviations

AOA	American Osteopathic Association
APA	American Psychiatric Association American Podiatry Association
APC	Adenomatous Polyposis Coli Ambulatory Payment Classification
API	Application Program Interface
APN	Assigned Provider Number
APO	Army Post Office
ARB	Angiotensin Receptor Blocker
ARCIS	Archives and Records Centers Information System
ART	Assisted Reproductive Technology
ARU	Automated Response Unit
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
ASRM	American Society for Reproductive Medicine
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
BAA	Business Associate Agreement
BACB	Behavioral Analyst Certification Board
BART	BRACAnalysis Large Rearrangement Test
BBA	Balanced Budget Act
BBP	Bloodborne Pathogen
BBRA	Balanced Budget Refinement Act

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Acronyms And Abbreviations

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
BCBA-D	Board Certified Behavior Analyst - Doctoral
BCBS	Blue Cross [and] Blue Shield
BCBSA	Blue Cross [and] Blue Shield Association
BCC	Biostatistics Center
BE&SD	Beneficiary Education and Support Division
BH	Behavioral Health
BI	Background Investigation
BIA	Bureau of Indian Affairs
BIPA	Benefits Improvement Protection Act
BL	Black Lung
BLS	Basic Life Support
BMI	Body Mass Index
BMT	Bone Marrow Transplantation
BNAF	Budget Neutrality Adjustment Factor
BOS	Bronchiolitis Obliterans Syndrome
BP	Behavioral Plan
PPPV	Benign Paroxysmal Positional Vertigo
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

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Acronyms And Abbreviations

CAMBHC	Comprehensive Accreditation Manual for Behavioral Health Care
CAP	Competitive Acquisition Program
CAP/DME	Capital and Direct Medical Education
CAPD	Continuous Ambulatory Peritoneal Dialysis
CAPP	Controlled Access Protection Profile
CAQH	Council for Affordable Quality Health
CARC	Claim Adjustment Reason Code
CAS	Carotid Artery Stenosis
CAT	Computerized Axial Tomography
CB	Consolidated Billing
CBC	Cypher Block Chaining
CBE	Clinical Breast Examination
CBHCO	Community-Based Health Care Organizations
CBL	Commercial Bill of Lading
CBP	Competitive Bidding Program
CBSA	Core Based Statistical Area
CC	Common Criteria Convenience Clinic Criminal Control (Act)
CC&D	Catastrophic Cap and Deductible
CCCT	Clomiphene Citrate Challenge Test
CCD	Corporate Credit or Debit
CCDD	Catastrophic Cap and Deductible Data
CCEP	Comprehensive Clinical Evaluation Program
CCN	Case Control Number
CCPD	Continuous Cycling Peritoneal Dialysis
CCR	Cost-To-Charge Ratio
CCTP	Custodial Care Transitional Policy
CD	Compact 9Disc
CDC	Centers for Disease Control and Prevention
CDCF	Central Deductible and Catastrophic Cap File
CDD	Childhood Disintegrative Disorder
CDH	Congenital Diaphragmatic Hernia
CD-I	Compact Disc- Interactive
CDR	Clinical Data Repository
CDRL	Contract Data Requirements List
CD-ROM	Compact Disc - Read Only Memory
CDT	Current Dental Terminology
CEA	Carotid Endarterectomy
CEIS	Corporate Executive Information System
CEO	Chief Executive Officer
CEOB	CHAMPUS Explanation of Benefits

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Acronyms And Abbreviations

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

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Acronyms And Abbreviations

CO	Contracting Officer
COB	Close of Business Coordination of Benefits
COBC	Coordination of Benefits Contractor
COBRA	Consolidated Omnibus Budget Reconciliation Act
CoCC	Certificate of Creditable Coverage
COCO	Contractor Owned-Contractor Operated
COE	Common Operating Environment
CONUS	Continental United States
COO	Chief Operating Officer
COOP	Continuity of Operations Plan
COPA	Council on Postsecondary Accreditation
COPD	Chronic Obstructive Pulmonary Disease
COR	Contracting Officer's Representative
CORE	Committee on Operating Rules for Information Exchange
CORF	Comprehensive Outpatient Rehabilitation Facility
CORPA	Commission on Recognition of Postsecondary Accreditation
COTS	Commercial-off-the-shelf
CP	Cerebral Palsy
CPA	Certified Public Accountant
CPE	Contract Performance Evaluation
CPI	Consumer Price Index
CPI-U	Consumer Price Index - Urban (Wage Earner)
CPNS	Certified Psychiatric Nurse Specialists
CPR	CAC PIN Reset
CPT	Chest Physiotherapy Current Procedural Terminology
CPT-4	Current Procedural Terminology, 4th Edition
CQM	Clinical Quality Management
CQMP	Clinical Quality Management Program
CQMP AR	Clinical Quality Management Program Annual Report
CQS	Clinical Quality Studies
CRM	Contract Resource Management (Directorate)
CRNA	Certified Registered Nurse Anesthetist
CRP	Canalith Repositioning Procedure
CRS	Cytoreductive Surgery
CRSC	Combat-Related Special Compensation
CRT	Computer Remote Terminal
CSA	Clinical Support Agreement
CSE	Communications Security Establishment (of the Government of Canada)
CSP	Corporate Service Provider Critical Security Parameter
CST	Central Standard Time

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

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

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

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DTRO	Director, TRICARE Regional Office
DUA	Data Use Agreement
DVA	Department of Veterans Affairs
DVAHCF	Department of Veterans Affairs Health Care Finder
DVD	Digital Versatile Disc (formerly Digital Video Disc)
DVD-R	Digital Versatile Disc-Recordable
DWR	DSO Web Request
Dx	Diagnosis
DXA	Dual Energy X-Ray Absorptiometry
E-ID	Early Identification
E-NAS	Electronic Non-Availability Statement
e-QIP	Electronic Questionnaires for Investigations Processing
E&M	Evaluation & Management
E2R	Enrollment Eligibility Reconciliation
EACH	Essential Access Community Hospital
EAL	Common Criteria Evaluation Assurance Level
EAP	Employee-Assistance Program Ethandamine phosphate
EBC	Enrollment Based Capitation
ECA	External Certification Authority
ECAS	European Cardiac Arrhythmia Society
ECG	Electrocardiogram
ECHO	Extended Care Health Option
ECT	Electroconvulsive Therapy
ED	Emergency Department
EDC	Error Detection Code
EDI	Electronic Data Information Electronic Data Interchange
EDIPI	Electronic Data Interchange Person Identifier
EDIPN	Electronic Data Interchange Person Number
EDI_PN	Electronic Data Interchange Patient Number
EEG	Electroencephalogram
EEPROM	Erasable Programmable Read-Only Memory
EFM	Electronic Fetal Monitoring
EFMP	Exceptional Family Member Program
EFP	Environmental Failure Protection
eFRC	Electronic Federal Records Center
EFT	Electronic Funds Transfer Environmental Failure Testing
EGHP	Employer Group Health Plan
E/HPC	Enrollment/Health Plan Code
EHHC	ECHO Home Health Care Extended Care Health Option Home Health Care

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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
EOP	Explanation of Payment
ePHI	electronic Protected Health Information
EPO	Erythropoietin Exclusive Provider Organization
EPR	EIA Program Report
EPROM	Erasable Programmable Read-Only Memory
ER	Emergency Room
ERA	Electronic Remittance Advice
ERISA	Employee Retirement Income and Security Act of 1974
ESRD	End Stage Renal Disease
EST	Eastern Standard Time
ESWT	Extracorporeal Shock Wave Therapy
ET	Eastern Time
ETIN	Electronic Transmitter Identification Number
EWPS	Enterprise Wide Provider System
EWRAS	Enterprise Wide Referral and Authorization System
F&AO	Finance and Accounting Office(r)
FAI	Femoroacetabular Impingement
FAP	Familial Adenomatous Polyposis

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FAR	Federal Acquisition Regulations
FASB	Federal Accounting Standards Board
FBI	Federal Bureau of Investigation
FCC	Federal Communications Commission
FCCA	Federal Claims Collection Act
FDA	Food and Drug Administration
FDB	First Data Bank
FDL	Fixed Dollar Loss
Fed	Federal Reserve Bank
FEHBP	Federal Employee Health Benefit Program
FEL	Familial Erythrophagocytic Lymphohistiocytosis
FEV ₁	Forced Expiratory Volume
FFM	Foreign Force Member
FHL	Familial Hemophagocytic Lymphohistiocytosis
FI	Fiscal Intermediary
FIPS	Federal Information Processing Standards (or System)
FIPS PUB	FIPS Publication
FISH	Fluorescence In Situ Hybridization
FISMA	Federal Information Security Management Act
FL	Form Locator
FMCRA	Federal Medical Care Recovery Act
FMRI	Functional Magnetic Resonance Imaging
FOBT	Fecal Occult Blood Testing
FOC	Full Operational Capability
FOIA	Freedom of Information Act
FOUO	For Official Use Only
FPO	Fleet Post Office
FQHC	Federally Qualified Health Center
FR	Federal Register Frozen Records
FRC	Federal Records Center
FSH	Follicle Stimulating Hormone
FSO	Facility Security Officer
FTC	Federal Trade Commission
FTE	Full Time Equivalent
FTP	File Transfer Protocol
FX	Foreign Exchange (lines)
FY	Fiscal Year
GAAP	Generally Accepted Accounting Principles
GAF	Geographic Adjustment Factor
GAO	General Accounting Office
GDC	Guglielmi Detachable Coil

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GFE	Government Furnished Equipment
GHP	Group Health Plan
GHz	Gigahertz
GIFT	Gamete Intrafallopian Transfer
GIQD	Government Inquiry of DEERS
GP	General Practitioner
GPCI	Geographic Practice Cost Index
GTMCPA	General Temporary Military Contingency Payment Adjustment
H/E	Health and Environment
HAC	Health Administration Center Hospital Acquired Condition
HAVEN	Home Assessment Validation and Entry
HBA	Health Benefits Advisor
HBO	Hyperbaric Oxygen Therapy
HCC	Health Care Coverage
HCDP	Health Care Delivery Program
HCF	Health Care Finder
HCFA	Health Care Financing Administration
HCG	Human Chorionic Gonadotropin
HCIL	Health Care Information Line
HCM	Hypertrophic Cardiomyopathy
HCO	Healthcare Operations Division
HCP	Health Care Provider
HCPC	Healthcare Common Procedure Code (formerly HCFA Common Procedure Code)
HCPCS	Healthcare Common Procedure Coding System (formerly HCFA 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
HDE	Humanitarian Device Exemption
HDGC	Hereditary Diffuse Gastric Cancer
HDL	Hardware Description Language
HDR	High Dose Radiation
HEAR	Health Enrollment Assessment Review
HEDIS	Health Plan Employer Data and Information Set
HepB-Hib	Hepatitis B and Hemophilus influenza B
HH	Home Health
HHA	Home Health Agency
HHA PPS	Home Health Agency Prospective Payment System
HHC	Home Health Care
HHC/CM	Home Health Care/Case Management

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HHRG	Home Health Resource Group
HHS	Health and Human Services
HI	Health Insurance
HIAA	Health Insurance Association of America
HIC	Health Insurance Carrier
HICN	Health Insurance Claim Number
HINN	Hospital-Issued Notice Of Noncoverage
HINT	Hearing in Noise Test
HIPAA	Health Insurance Portability and Accountability Act (of 1996)
HIPEC	Hyperthermic Intraperitoneal Chemotherapy
HIPPS	Health Insurance Prospective Payment System
HIQH	Health Insurance Query for Health Agency
HITECH	Health Information Technology for Economic and Clinical Health
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
IAVM	Information Assurance Vulnerability Management

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IAW	In accordance with
IBD	Inflammatory Bowel Disease
IC	Individual Consideration Integrated Circuit
ICASS	International Cooperative Administrative Support Services
ICD	Implantable Cardioverter Defibrillator
ICD-9-CM	International Classification of Diseases, 9th Revision, Clinical Modification
ICD-10-CM	International Classification of Diseases, 10th Revision, Clinical Modification
ICD-10-PCS	International Classification of Diseases, 10th Revision, Procedure Coding System
ICF	Intermediate Care Facility
ICMP	Individual Case Management Program
ICMP-PEC	Individual Case Management Program For Persons With Extraordinary Conditions
ICN	Internal Control Number
ICSP	Individual Corporate Services Provider
ID	Identification Identifier
IDB	Intradiscal Biacuplasty
IDD	Internal or Intervertebral Disc Decompression
IDE	Investigational Device Exemption Investigational Device
IDEA	Individuals with Disabilities Education Act
IDES	Integrated Disability Evaluation System
IDET	Intradiscal Electrothermal Therapy
IDME	Indirect Medical Education
IdP	Identity Protection
IDTA	Intradiscal Thermal Annuloplasty
IE	Interface Engine Internet Explorer
IEA	Intradiscal Electrothermal Annuloplasty
IEP	Individualized Educational Program
IFC	Interim Final Rule with comment
IFR	Interim Final Rule
IFSP	Individualized Family Service Plan
IG	Implementation Guidance
IgA	Immunoglobulin A
IGCE	Independent Government Cost Estimate
IHC	Immunohistochemistry
IHI	Institute for Healthcare Improvement
IHS	Indian Health Service
IIHI	Individually Identifiable Health Information
IIP	Implantable Infusion Pump

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IM	Information Management Instant Message/Messaging Intramuscular
IMRT	Intensity Modulated Radiation Therapy
IND	Investigational New Drugs
INR	International Normalized Ratio Intramuscular International Normalized Ratio
INS	Immigration and Naturalization Service
IOC	Initial Operational Capability
IOD	Interface Operational Description
IOLs	Intraocular Lenses
IOM	Internet Only Manual
IOP	Intraocular Pressure
IORT	Intra-Operative Radiation Therapy
IP	Inpatient
IPC	Information Processing Center (outdated term, see SMC)
IPHC	Intraperitoneal Hyperthermic Chemotherapy
IPN	Intraperitoneal Nutrition
IPP	In-Person Proofing
IPPS	Inpatient Prospective Payment System
IPS	Individual Pricing Summary
IPSEC	Secure Internet Protocol
IQ	Intelligence Quotient
IQM	Internal Quality Management
IRB	Institutional Review Board
IRF	Inpatient Rehabilitation Facility
IRR	Individual Ready Reserve
IRS	Internal Revenue Service
IRTS	Integration and Runtime Specification
IS	Information System
ISN	Investigation Schedule Notice
ISO	International Standard Organization
ISP	Internet Service Provider
IT	Information Technology
ITSEC	Information Technology Security Evaluation Criteria
IV	Initialization Vector Intravenous
IVD	In Vitro Diagnostic Ischemic Vascular Disease
IVF	In Vitro Fertilization
JC	Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations (JCAHO))
JCAHO	Joint Commission on Accreditation of Healthcare Organizations

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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
JUSMAC	Joint Uniformed Services Medical Advisory Committee
JUSPAC	Joint Uniformed Services Personnel Advisory Committee
KB	Knowledge Base
KO	Contracting Officer
LAA	Limited Access Authorization
LAC	Local Agency Check
LAK	Lymphokine-Activated Killer
LAN	Local Area Network
LASER	Light Amplification by Stimulated Emission of Radiation
LCD	Local Coverage Determination
LCF	Long-term Care Facility
LCIS	Lobular Carcinoma In Situ
LDL	Low Density Lipoprotein
LDLT	Living Donor Liver Transplantation
LDR	Low Dose Rate
LDT	Laboratory Developed Test
LGS	Lennox-Gastaut Syndrome
LH	Luteinizing Hormone
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
LVSD	Left Ventricular Systolic Dysfunction

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MAC	Maximum Allowable Charge Maximum Allowable Cost
MAC III	Mission Assurance Category III
MAID	Maximum Allowable Inpatient Day
MAP	MYH-Associated Polyposis
MB&RB	Medical Benefits and Reimbursement Branch
MBI	Molecular Breast Imaging
MCIO	Military Criminal Investigation Organization
MCS	Managed Care Support
MCSC	Managed Care Support Contractor
MCSS	Managed Care Support Services
MCTDP	Myelomeningocele Clinical Trial Demonstration Protocol
MD	Doctor of Medicine
MDI	Mental Developmental Index Multiple Daily Injection
MDR	MHS Data Repository
MDS	Minimum Data Set
MEB	Medical Evaluation Board
MEC	Marketing and Education Committee
MEI	Medicare Economic Index
MEPS	Military Entrance Processing Station
MEPRS	Medical Expense Performance Reporting System
MESA	Microsurgical Epididymal Sperm Aspiration
MET	Microcurrent Electrical Therapy
MFCC	Marriage and Family Counseling Center
MGCRB	Medicare Geographic Classification Review Board
MGIB	Montgomery GI Bill
MH	Mental Health
MHCC	Maryland Health Care Commission
MHO	Medical Holdover
MHS	Military Health System
MHSO	Managing Health Services Organization
MHSS	Military Health Services System
MI	Myocardial Infarction
MI&L	Manpower, Installations, and Logistics
MIA	Missing In Action
MIAP	Multi-Host Internet Access Portal
MIDCAB	Minimally Invasive Direct Coronary Artery Bypass
mild®	Minimally Invasive Lumbar Decompression
MIRE	Monochromatic Infrared Energy
MLNT	Multisyllabic Lexical Neighborhood Test
MMA	Medicare Modernization Act

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MMEA	Medicare and Medicaid Extenders Act (of 2010)
MMP	Medical Management Program
MMPCMHP	Maryland Multi-Payer Patient-Centered Medical Home Program
MMPP	Maryland Multi-Payer Patient
MMR	Mismatch Repair
MMWR	Morbidity and Mortality Weekly Report
MNR	Medical Necessity Report
MOA	Memorandum of Agreement
MOH	Medal Of Honor
MOMS	Management of Myelomeningocele Study
MOP	Mail Order Pharmacy
MOU	Memorandum of Understanding
MPI	Master Patient Index
MR	Magnetic Resonance Medical Review Mentally Retarded
MRA	Magnetic Resonance Angiography
MRHFP	Medicare Rural Hospital Flexibility Program
MRI	Magnetic Resonance Imaging
MRPU	Medical Retention Processing Unit
MRS	Magnetic Resonance Spectroscopy
MS	Microsoft® Multiple Sclerosis
MSA	Metropolitan Statistical Area
MSC	Military Sealift Command
MSI	Microsatellite Instability
MSIE	Microsoft® Internet Explorer
MSP	Medicare Secondary Payer
MSS	Medical Social Services
MST	Mountain Standard Time
MSUD	Maple Syrup Urine Disease
MSW	Masters of Social Work Medical Social Worker
MT	Mountain Time
MTF	Military Treatment Facility
MUE	Medically Unlikely Edits
MV	Multivisceral (transplant)
MVS	Multiple Virtual Storage
MWR	Morale, Welfare, and Recreation
MYH	mutY homolog
N/A	Not Applicable
N/D	No Default
NAC	National Agency Check

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NACHA	National Automated Clearing House Association
NACI	National Agency Check Plus Written Inquiries
NACLC	National Agency Check with Law Enforcement and Credit
NADFM	Non-Active Duty Family Member
NARA	National Archives and Records Administration
NAS	Naval Air Station
	Non-Availability Statement
NATO	North Atlantic Treaty Organization
NAVMED	Naval Medical (Form)
NBCC	National Board of Certified Counselors
NCCI	National Correct Coding Initiatives
NCCN	National Comprehensive Cancer Network
NCD	National Coverage Determination
NCE	National Counselor Examination
NCF	National Conversion Factor
NCI	National Cancer Institute
NCMHCE	National Clinical Mental Health Counselor Examination
NCPAP	Nasal Continuous Positive Airway Pressure
NCPDP	National Council of Prescription Drug Program
NCQA	National Committee for Quality Assurance
NCVHS	National Committee on Vital and Health Statistics
NDAA	National Defense Authorization Act
NDC	National Drug Code
NDMS	National Disaster Medical System
NED	National Enrollment Database
NETT	National Emphysema Treatment Trial
NF	Nursing Facility
NG	National Guard
NGPL	No Government Pay List
NHLBI	National Heart, Lung and Blood Institute
NHSC	National Health Service Corps
NICHD	National Institute of Child Health and Human Development
NIH	National Institutes of Health
NII	Networks and Information Integration
NIPRNET	Nonsecure Internet Protocol Router Network
NIS	Naval Investigative Service
NISPOM	National Industrial Security Program Operating Manual
NIST	National Institute of Standards and Technology
NLDA	Nursery and Labor/Delivery Adjustment
NLT	No Later Than
NMA	Non-Medical Attendant
NMES	Neuromuscular Electrical Stimulation

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NMOP	National Mail Order Pharmacy
NMR	Nuclear Magnetic Resonance
NMT	Nurse Massage Therapist
NOAA	National Oceanic and Atmospheric Administration
NoPP	Notice of Private Practices
NOSCASTC	National Operating Standard Cost as a Share of Total Costs
NP	Nurse Practitioner
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPR	Notice of Program Reimbursement
NPS	Naval Postgraduate School
NPWT	Negative Pressure Wound Therapy
NQF	National Quality Forum
NRC	Nuclear Regulatory Commission
NRS	Non-Routine [Medical] Supply
NSDSMEP	National Standards for Diabetes Self-Management Education Programs
NSF	Non-Sufficient Funds
NTIS	National Technical Information Service
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claims Committee
O/ATIC	Operations/Advanced Technology Integration Center
OA	Office of Administration
OAE	Otoacoustic Emissions
OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)
OASD (H&E)	Office of the Assistant Secretary of Defense (Health and Environment)
OASD (MI&L)	Office of the Assistant Secretary of Defense (Manpower, Installations, and Logistics)
OASIS	Outcome and Assessment Information Set
OB/GYN	Obstetrician/Gynecologist
OBRA	Omnibus Budget Reconciliation Act
OCE	Outpatient Code Editor
OCHAMPUS	Office of Civilian Health and Medical Program of the Uniformed Services
OCMO	Office of the Chief Medical Officer
OCONUS	Outside of the Continental United States
OCR	Office for Civil Rights Optical Character Recognition
OCSP	Organizational Corporate Services Provider
OCT	Optical Coherence Tomograph
OD	Optical Disk
OF	Optional Form
OGC	Office of General Counsel

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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
OTCD	Ornithine Transcarbamylase Deficiency
OUSD	Office of the Undersecretary of Defense
OUSD (P&R)	Office of the Undersecretary of Defense (Personnel and Readiness)
P/O	Prosthetic and Orthotics
P&CL	Privacy & Civil Liberties [Office]
P&T	Pharmacy And Therapeutics (Committee)
PA	Physician Assistant
PACAB	Port Access Coronary Artery Bypass
PACO ₂	Partial Pressure of Carbon Dioxide
PAO ₂	Partial Pressure of Oxygen
PAK	Pancreas After Kidney (transplant)
PAP	Papanicolaou
PAS	Privacy Act Statement
PAT	Performance Assessment Tracking
PATH Intl	Professional Association of Therapeutic Horsemanship International
PatID	Patient Identifier
PAVM	Pulmonary Arteriovenous Malformation
PBM	Pharmacy Benefit Manager
PBT	Proton Beam Therapy
PC	Peritoneal Carcinomatosis Personal Computer Professional Component
PCA	Patient Controlled Analgesia
PCDIS	Purchased Care Detail Information System

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PCI	Percutaneous Coronary Intervention
PCM	Primary Care Manager
PCMBN	PCM By Name
PCMH	Patient-Centered Medical Home
PCMRA	PCM Research Application
PCMRS	PCM Panel Reassignment (Application) PCM Reassignment System
PCO	Procurement (Procuring) Contracting Officer
PCP	Primary Care Physician Primary Care Provider
PCS	Pelvic Congestion Syndrome Permanent Change of Station
PCSIB	Purchased Care Systems Integration Branch
PD	Passport Division
PDA	Patent Ductus Arteriosus Personal Digital Assistant
PDD	Percutaneous (or Plasma) Disc Decompression
PDDBI	Pervasive Developmental Disorders Behavior Inventory
PDDNOS	Pervasive Developmental Disorder Not Otherwise Specified
PDF	Portable Document Format
PDI	Potentially Disqualifying Information
PDQ	Physicians's Data Query
PDR	Person Data Repository
PDS	Person Demographics Service
PDTS	Pharmacy Data Transaction System
PDX	Principal Diagnosis
PE	Physical Examination
PEC	Pharmacoeconomic Center
PEP	Partial Episode Payment
PEPR	Patient Encounter Processing and Reporting
PERMS	Provider Education and Relations Management System
PESA	Percutaneous Epididymal Sperm Aspiration
PET	Positron Emission Tomography
PFCRA	Program Fraud Civil Remedies Act
PFP	Partnership For Peace
PFPWD	Program for Persons with Disabilities
PGD	Preimplantation Genetic Diagnosis
Phen-Fen	Pondimin and Redux
PHI	Protected Health Information
PHIMT	Protected Health Information Management Tool
PHP	Partial Hospitalization Program
PHS	Public Health Service
PI	Program Integrity (Office)

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PIA	Privacy Impact Assessment (Online)
PIC	Personnel Investigation Center
PIE	Pulsed Irrigation Evacuation
PII	Personally Identifiable Information
PIN	Personnel Identification Number
PIP	Personal Injury Protection Personnel Identity Protection
PIRFT	Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)
PIT	PCM Information Transfer
PIV	Personal Identity Verification
PK	Public Key
PKE	Public Key Enabling
PKI	Public Key Infrastructure
PKU	Phenylketonuria
PLS	Preschool Language Scales
PM-DRG	Pediatric Modified-Diagnosis Related Group
PMPM	Per Member Per Month
PMR	Percutaneous Myocardial Laser Revascularization
PNET	Primitive Neuroectodermal Tumors
PNT	Policy Notification Transaction
POA	Power of Attorney Present On Admission
POA&M	Plan of Action and Milestones
POC	Pharmacy Operations Center Plan of Care Point of Contact
POL	May 1996 TRICARE/CHAMPUS Policy Manual 6010.47-M
POS	Point of Sale (Pharmacy only) Point of Service Public Official's Statement
POV	Privately Owned Vehicle
PPACA	Patient Protection and Affordable Care Act
PPC-PCMH	Physician Practice Connections Patient-Centered Medical Home
PPD	Per Patient Day
PPN	Preferred Provider Network
PPO	Preferred Provider Organization
PPP	Purchasing Power Parity
PPS	Prospective Payment System Ports, Protocols and Services
PPSM	Ports, Protocols, and Service Management
PPV	Pneumococcal Polysaccharide Vaccine
PQI	Potential Quality Indicator Potential Quality Issue

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PR	Periodic Reinvestigation
PRC	Program Review Committee
PRFA	Percutaneous Radiofrequency Ablation
PRG	Peer Review Group
PRO	Peer Review Organization
ProDUR	Prospective Drug Utilization Review
PROM	Programmable Read-Only Memory
PRP	Personnel Reliability Program
PRPP	Pharmacy Redesign Pilot Project
PSA	Prime Service Area Physician Scarcity Area
PSAB	Personnel Security Appeals Board
PSCT	Peripheral Stem Cell Transplantation
PSD	Personnel Security Division
PSF	Provider Specific File
PSG	Polysomnography
PSI	Personnel Security Investigation
PST	Pacific Standard Time
PT	Pacific Time Physical Therapist Physical Therapy Prothrombin Time
PTA	Pancreas Transplant Alone Percutaneous Transluminal Angioplasty
PTC	Processed To Completion
PTCA	Percutaneous Transluminal Coronary Angioplasty
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
QM	Quality Management
QUIG	Quality Indicator Group
RA	Radiofrequency Annuloplasty Remittance Advice
RADDP	Remote Active Duty Dental Program

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RAM	Random Access Memory
RAP	Request for Anticipated Payment
RAPIDS	Real-Time Automated Personnel Identification System
RARC	Remittance Advice Remark Code
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
RIA	Radioimmunoassay
RM	Records Management
RN	Registered Nurse
RNG	Random Number Generator
RO	Regional Office
ROC	Resumption of Care
ROFR	Right of First Refusal
ROM	Read-Only Memory Rough Order of Magnitude
ROMF	Record Object Metadata File
ROT	Read-Only Table
ROTC	Reserved Officer Training Corps
ROVER	RHHI OASIS Verification
RPM	Record Processing Mode
RRA	Regional Review Authority
RRS	Records Retention Schedule
RTC	Residential Treatment Center
rTMS	Repetitive Transcranial Magnetic Stimulation
RUG	Resource Utilization Group

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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
SAMHSA	Substance Abuse and Mental Health Services Administration
SAO	Security Assistant Organizations
SAP	Special Access Program
SAPR	Sexual Assault Prevention and Response
SAS	Sensory Afferent Stimulation
SAT	Service Assist Team
SAVR	Surgical Aortic Valve Replacement
SBCC	Service Branch Classification Code
SBI	Special Background Investigation
SCA	Service Contract Act
SCH	Sole Community Hospital
SCHIP	State Children's Health Insurance Program
SCI	Sensitive Compartmented Information Spinal Cord Injury
SCIC	Significant Change in Condition
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

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SIRT	Selective Internal Radiation Therapy
SIT	Standard Insurance Table
SLP	Speech-Language Pathology
SMC	System Management Center
SMHC	Supervised Mental Health Counselor
SN	Skilled Nursing
SNF	Skilled Nursing Facility
SNS	Sacral Nerve Root Stimulation
SOC	Start of Care
SOFA	Status Of Forces Agreement
SOIC	Senior Officer of the Intelligence Community
SON	Submitting Office Number
SOR	Statement of Reasons System of Records
SORN	System of Records Notice
SPA	Simple Power Analysis
SPC	Special Processing Code
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

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T-3	TRICARE Third Generation
TAD	Temporary Additional Duty
TAFIM	Technical Architecture Framework for Information Management
TAH	Total Artificial Heart
TAMP	Transitional Assistance Management Program
TAO	TRICARE Alaska Office TRICARE Area Office
TAR	Total Ankle Replacement
TARO	TRICARE Alaska Regional Office
TAVR	Transcatheter Aortic Valve Replacement
TB	Tuberculosis
TBD	To Be Determined
TBE	Tick Borne Encephalitis
TBI	Traumatic Brain Injury
TC	Technical Component
TCMHC	TRICARE Certified Mental Health Counselor
TCP/IP	Transmission Control Protocol/Internet Protocol
TCSRC	Transitional Care for Service-Related Conditions
TDD	Targeted Disc Decompression
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Program/Plan
TDR	Total Disc Replacement
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

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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
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)
TPSA	Transitional Prime Service Area
TQMC	TRICARE Quality Monitoring Contractor
TRDP	TRICARE Retiree Dental Program
TRI	TED Record Indicator
TRIAP	TRICARE Assistance Program
TRIP	Temporary Records Information Portal
TRM	August 2002 TRICARE Reimbursement Manual 6010.55-M February 2008 TRICARE Reimbursement Manual 6010.58-M
TRO	TRICARE Regional Office
TRO-N	TRICARE Regional Office-North
TRO-S	TRICARE Regional Office-South

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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
TSSD	TRICARE Senior Supplement Demonstration
TTOP	TRICARE Transitional Outpatient Payment
TTPA	Temporary Transitional Payment Adjustment
TTY	Teletypewriter
TUNA	Transurethral Needle Ablation
TYA	TRICARE Young Adult
UAE	Uterine Artery Embolization
UARS	Upper Airway Resistance Syndrome
UB	Uniform Bill
UBO	Uniform Business Office
UCBT	Umbilical Cord Blood Stem Cell Transplantation
UCC	Uniform Commercial Code Urgent Care Center
UCSF	University of California San Francisco
UIC	Unit Identification Code
UIN	Unit Identifier Number
UM	Utilization Management
UMO	Utilization Management Organization
UMP	User Maintenance Portal
UPIN	Unique Physician Identification Number
UPPP	Uvulopalatopharyngoplasty
URFS	Unremarried Former Spouse
URL	Universal Resource Locator
US	Ultrasound United States
US-CERT	United States-Computer Emergency Readiness Team
USA	United States of America
USACID	United States Army Criminal Investigation Division

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USAF	United States Air Force
USAO	United States Attorneys' Office
USC	United States Code
USCG	United States Coast Guard
USCO	Uniformed Services Claim Office
USD	Undersecretary of Defense
USD (P&R)	Undersecretary of Defense (Personnel and Readiness)
USDI	Undersecretary of Defense for Intelligence
USFHP	Uniformed Services Family Health Plan
USHBP	Uniformed Services Health Benefit Plan
USMC	United States Marine Corps
USMTF	Uniformed Services Medical Treatment Facility
USN	United States Navy
USPDI	United States Pharmacopoeia Drug Information
USPHS	United States Public Health Service
USPS	United States Postal Service
USPSTF	U.S. Preventive Services Task Force
USS	United Seaman's Service
USTF	Uniformed Services Treatment Facility
UV	Ultraviolet
VA	Veterans Affairs (hospital) Veterans Administration
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
WHS	Washington Headquarters Services
WIC	Women, Infants, and Children (Program)

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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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