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TRICARE
MANAGEMENT ACTIVITY

MB&RB

**CHANGE 25
6010.57-M
JANUARY 13, 2010**

**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: PARTIAL HOSPITALIZATION POLICIES

CONREQ: 14885

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change provides that TRICARE's approval of a hospital as an authorized provider is sufficient for its psychiatric Partial Hospitalization Program (PHP) to also be considered an authorized TRICARE provider. Separate TRICARE certification of hospital-based psychiatric PHPs is no longer required; however, freestanding PHPs must continue to obtain separate TRICARE certification to be considered authorized providers.

EFFECTIVE DATE: November 30, 2009.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Feb 2008 TRM, Change No. 25.


**John A. D'Alessandro
Chief, Medical Benefits and
Reimbursement Branch**

**ATTACHMENT(S): 77 PAGE(S)
DISTRIBUTION: 6010.57-M**

**CHANGE 25
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Chapter 11

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Psychiatric Partial Hospitalization Program (PHP) Certification Standards

Issue Date: July 14, 1993

Authority: [32 CFR 199.6\(b\)\(4\)\(xii\)](#)

1.0 ISSUE

Psychiatric Partial Hospitalization Program (PHP) Certification Standards.

2.0 DESCRIPTION

A psychiatric PHP is a treatment setting capable of providing an interdisciplinary program of medical therapeutic services at least three hours per day, five days per week, which may embrace day, evening, night and weekend treatment programs which employ an integrated, comprehensive and complementary schedule of recognized treatment approaches. Partial hospitalization is an appropriate setting for crisis stabilization, treatment of partially stabilized mental health disorders, and a transition from an inpatient program when medically necessary. A full day program consists of 6 hours or more and a half-day program consists of three to five hours.

3.0 POLICY

3.1 Psychiatric PHPs must be either a distinct part of an otherwise authorized institutional provider or a freestanding program. The treatment program must be under the general direction of a psychiatrist employed by the PHP to ensure medication and physical needs of all the patients are considered. The primary or attending provider must be an authorized mental health provider, operating within the scope of his/her license. These categories include physicians, clinical psychologists, Certified Psychiatric Nurse Specialists (CPNSs), Clinical Social Workers (CSWs), marriage and family counselors, pastoral counselors and mental health counselors.

3.2 Certification:

3.2.1 Hospital-Based PHPs. When a hospital is a TRICARE authorized provider, the hospital's PHP also shall be considered a TRICARE authorized provider. Effective on or after November 30, 2009, separate TRICARE certification of a hospital-based PHPs is no longer required.

3.2.2 Freestanding PHPs, and prior to November 30, 2009, hospital-based PHPs, must be certified and enter into a participation agreement with TRICARE and obtain the required preauthorization prior to admitting patients. Applications for freestanding PHPs may be obtained from the TRICARE Quality Monitoring Contractor (TQMC).

3.3 In addition, in order for a **freestanding** psychiatric PHP to be authorized, the PHP shall comply with the following requirements:

3.3.1 The PHP shall comply with Standards for Psychiatric PHPs and Facilities.

3.3.2 The PHP shall be currently accredited by the Joint Commission (JC) under the **Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC)**.

3.3.3 The PHP shall be licensed as a PHP to provide PHP services within the applicable jurisdiction in which it operates.

3.3.4 The PHP shall accept the allowable PHP rate, as provided in [32 CFR 199.14\(a\)\(2\)\(ix\)](#), for freestanding PHPs and the TRICARE Reimbursement Manual (TRM), [Chapter 13, Section 2, paragraph 3.7](#) for hospital-based PHPs as payment in full for services provided.

3.3.5 The PHP shall comply with all requirements of this section applicable to institutional providers generally concerning preauthorization, concurrent care review, claims processing, beneficiary liability, double coverage, utilization and quality review and other matters.

3.3.6 The PHP must be fully operational and treating patients for a period of at least six months (with at least 30% minimum patient census) before an application for approval may be submitted to the TQMC. The PHP shall not be considered an authorized provider nor may any benefits be paid to the facility for any services provided prior to the date the facility is approved by the Director, TRICARE Management Activity (TMA), or designee.

3.3.7 All diagnostic and therapeutic mental health services must be provided by an authorized mental health provider. This includes all psychotherapy (individual, group, family or conjoint, psychoanalysis, collateral), psychological testing and assessment. [Exception: PHPs that employ individuals with master's or doctoral level degrees in a mental health discipline who do not meet the licensure, certification and experience requirements for a qualified mental health provider but are actively working toward licensure or certification, may provide services within the all-inclusive per diem rate but the individual must work under the clinical supervision of a fully qualified mental health provider employed by the PHP.] All other program services shall be provided by trained, licensed staff.

3.3.8 The PHP shall ensure the provision of an active family therapy treatment component which assures that each patient and family participate at least weekly in family therapy provided by the institution and rendered by an authorized mental health provider. There is no acceptable substitute for family therapy. Family therapy is an integral part of the treatment of children and adolescents and must be included in all mental health treatment plans. If the family is not in the area, the patient is probably not a candidate for partial care as individuals in this program return to their home setting daily, and effective family interaction is essential. If the family or patient is not cooperative in participating in family therapy, they may not be viable candidates for a partial program. By accepting a child or adolescent under the age of 21 for admission, a partial program is acknowledging that it can provide the specific treatment appropriate to that individual's needs and is responsible for taking only those individuals whom it feels it can help through the development of an appropriate treatment program designed to encompass family therapy and maximize the patient's ability to function in one or more major life activities. The requirement for family therapy is not considered met by telephonic therapy or multifamily group therapy. If family therapy is

clinically contraindicated, an exception to this requirement may be granted by the applicable TRICARE contractor.

3.3.9 The PHP must have a written agreement with at least one backup authorized hospital which specifies that the hospital will accept any and all beneficiaries transferred for emergency mental health or medical/surgical care. The PHP must have a written emergency transport agreement with at least one ambulance company which specifies the estimated transport time to each backup hospital.

3.3.10 Social services required. The facility must provide an active social services component which assures the patient appropriate living arrangements after treatment hours, transportation to and from the facility, arrangement of community based support services, referral of suspected child abuse to the appropriate state agencies, and effective after care arrangements, at a minimum.

3.3.11 Educational services required. Programs treating children and adolescents must ensure the provision of a state certified educational component which assures that patients do not fall behind in educational placement while receiving partial hospital treatment. The cost of educational services will not be funded separately from the per diem rate. The hours devoted to education do not count toward the therapeutic half or full day program.

3.3.12 The PHP shall enter into a participation agreement with the Director, TMA. The agreement shall include, but shall not be limited to, the following provisions:

3.3.12.1 The PHP agrees not to bill the beneficiary for services in excess of the cost-share for services for which payment is disallowed for failure to comply with requirements for preauthorization or concurrent care review or for days on which less than **three** hours were provided in the PHP.

3.3.12.2 The PHP agrees not to bill the beneficiary for services excluded on the basis of the following provisions: [32 CFR 199.4\(g\)\(1\)](#) (not medically necessary), [\(g\)\(3\)](#) (inappropriate level of care) or [\(g\)\(7\)](#)(custodial care), unless the beneficiary has agreed in writing to pay for the care, knowing the specific care in question had been determined noncovered. (A general statement signed at admission as to financial liability does not fulfill this requirement.)

3.3.12.3 The PHP agrees to accept the determined per diem amount, and to bill for and collect the patient's cost-share, both of which shall be considered as payment in full for all mental health services provided.

- END -

Chapter 11

Section 2.6

Psychiatric Partial Hospitalization Program (PHP) Certification Process **Before November 30, 2009, And Thereafter, For Only Freestanding PHPs**

Issue Date: July 14, 1993

Authority: [32 CFR 199.6\(b\)\(4\)\(xii\)\(A\)](#) and [\(b\)\(4\)\(xii\)\(E\)](#)

1.0 ISSUE

Process for **Freestanding** Psychiatric Partial Hospitalization Program (PHP) Certification.

2.0 DESCRIPTION

A psychiatric PHPs is a treatment setting capable of providing an interdisciplinary program of medical therapeutic services at least three hours per day, five days per week, which may embrace day, evening, night and weekend treatment programs which employ an integrated, comprehensive and complementary schedule of recognized treatment approaches. Partial hospitalization is a time-limited, ambulatory, active treatment program that offers therapeutically intensive, coordinated, and structured clinical services within a stable therapeutic environment. Partial hospitalization is an appropriate setting for crisis stabilization, treatment of partially stabilized mental health disorders, and a transition from an inpatient program when medically necessary to avoid a serious deterioration in functioning.

3.0 POLICY

3.1 **Freestanding** PHPs must enter into a participation agreement, and be accredited and in substantial compliance with the **Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC)** of the Joint Commission (JC). **This also applies to hospital-based PHPs providing care before November 30, 2009.**

3.2 A complete application for certification as an authorized **freestanding** psychiatric PHP consists of an application and agreement signed and dated by the Chief Executive Officer (CEO) of the program.

4.0 EFFECTIVE DATE

September 29, 1993.

- END -

Standards For Psychiatric Partial Hospitalization Programs (PHPs) Before November 30, 2009, And Thereafter Only Freestanding PHPs

1.0 ORGANIZATION AND ADMINISTRATION

1.1 Definition

Partial hospitalization is a time-limited, ambulatory, active treatment that offers therapeutically intensive, coordinated, and structured clinical services within a stable therapeutic milieu. Psychiatric Partial Hospitalization Programs (PHPs) may be either freestanding or part of a broader mental health or medical system. For purposes of this Addendum, a "facility" refers to a freestanding PHP and hospital-based PHPs before November 30, 2009. Nevertheless, a partial hospital should be conceived as a separate, identifiable, organized unit.

PHPs serve patients who exhibit psychiatric symptoms, disturbances of conduct, and decompensating conditions affecting their mental health. The emotional/behavioral problems exhibited must be manageable outside an inpatient environment. Patients suitable for partial hospitalization should present no imminent harm to themselves or others; have a community based network of support; and have a consistent place of residence.

A PHP is capable of providing an interdisciplinary program of medical and therapeutic services a minimum of three hours per day, five days per week. Full-day, half-day, evening, and weekend programs may be included. Coordinated, intensive comprehensive treatment is provided. A PHP may be appropriate for crisis stabilization and transition from an inpatient program when medically necessary.

Crisis management is available 24 hours a day, seven days a week. PHPs have a written agreement with at least one authorized hospital to provide emergency mental health and medical/surgical care.

1.2 Eligibility

1.2.1 To be eligible for certification, the facility is required to be licensed and fully operational for a period of at least six months, with a minimum patient census of at least 30% of bed capacity.

1.2.2 The facility is currently accredited by the Joint Commission (JC) under the current edition of the **Manual for Mental Health, Chemical Dependency, and Mental Retardation/Developmental Disabilities Services**.

1.2.3 The facility has a written participation agreement with TRICARE Management Activity (TMA). The PHP is not an authorized provider and benefits are not paid for services provided until

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the date upon which a participation agreement is signed by the Deputy Director, TMA, or a designee. Retroactive approval is not given.

1.2.4 Where different certification, accreditation, or licensing standards exist, the more exacting standard applies. Regulations take precedence over standards and standards take precedence over participation agreements.

1.3 Governing Body

1.3.1 A governing body is responsible for the policies, bylaws, and activities of the facility. If the PHP is owned by a partnership or single owner, the partners or single owner is regarded as the governing body.

1.3.2 The governing body or Chief Executive Officer (CEO) provides written notification to TMA of any significant changes in: CEO; medical director or clinical director; purpose or philosophy; volume of services; licensure, certification, or accreditation status by a state, local agency, or national organization; and location. The written notice must be submitted 30 days prior to the proposed changes.

1.3.3 The governing body provides leadership and sufficient resources to ensure that appropriate and adequate services are delivered to all patients. To accomplish this, the governing body:

1.3.3.1 Specifies the qualifications, authority, and responsibilities of its members;

1.3.3.2 Establishes bylaws, rules, regulations, policies, and procedures in accordance with legal requirements and standards;

1.3.3.3 Conducts regular meetings and maintains minutes of all deliberations and actions;

1.3.3.4 Conducts business based upon its rules, regulations, and defined responsibilities;

1.3.3.5 Establishes a mission statement that provides the basis for strategic planning;

1.3.3.6 Adopts a plan of operation consistent with the mission statement with goals and objectives that reflect the long-range direction of the facility;

1.3.3.7 Appoints a CEO to implement policies and procedures and oversee the day-to-day operation of the facility;

1.3.3.8 Appoints a medical director to oversee the medical care provided in the facility and a clinical director to oversee the clinical program;

1.3.3.9 Authorizes the establishment of a medical or professional staff organization to oversee and direct patient care services;

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- 1.3.3.10** Establishes bylaws, rules, and regulations to govern the activities of the medical or professional staff organization;
 - 1.3.3.11** Ensures that sufficient clinical staff are available to provide necessary and appropriate patient care services;
 - 1.3.3.12** Ensures that sufficient administrative and support staff are available to maintain the administrative, health, and safety aspects of the facility;
 - 1.3.3.13** Oversees the system of financial management and accountability;
 - 1.3.3.14** Ensures that the physical, financial, and staffing resources of the facility are adequately insured;
 - 1.3.3.15** Approves the initiation, expansion, or modification of programs, services, and resources; and
 - 1.3.3.16** Evaluates the performance of the CEO, clinical director and medical director on an annual basis, using specific performance criteria.
- 1.3.4** The governing body is responsible for the continuing development and improvement of patient care. The governing body:
- 1.3.4.1** Reviews, and as necessary, revises and updates the plan of operation on at least an annual basis;
 - 1.3.4.2** Approves all policy changes for the facility as documented in the minutes of the governing body meetings;
 - 1.3.4.3** Appoints members to the medical or professional staff and grants clinical privileges on the basis of verified expertise and practice;
 - 1.3.4.4** Reappoints medical or professional staff and renews clinical privileges on the basis of continued competence, adherence to staff rules and regulations, and quality-of-care reviews;
 - 1.3.4.5** Approves a system to ensure that direct care staff are supervised by a qualified health care professional;
 - 1.3.4.6** Approves a system of quality assessment and improvement which evaluates the efficiency, appropriateness, and effectiveness of programs and services provided;
 - 1.3.4.7** Approves admission criteria that clearly confirm the medical and/or psychological necessity for treatment at the partial hospitalization level of care;
 - 1.3.4.8** Reviews reports from various evaluation activities to determine that identified problems are appropriately addressed and that care is improved;

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1.3.4.9 Ensures that the facility maintains continued compliance with state-licensing regulations and national accreditation standards; and

1.3.4.10 Establishes an organizational structure to facilitate communication between the CEO, clinical director, medical director, administrative staff, medical or professional staff, and the governing body.

1.3.5 If a business relationship exists between a governing body member and the facility, a conflict-of-interest policy defines the member's authority, responsibilities, and restrictions.

1.3.6 Orientation and continuing-education programs are provided to members of the governing body to enhance their awareness of the facility and its services.

1.3.7 The governing body conducts an annual review of its documented performance in meeting its purposes, responsibilities, goals, and objectives.

1.4 Chief Executive Officer (CEO)

1.4.1 The CEO is appointed by the governing body and meets the following minimum qualifications:

1.4.1.1 Has a master's degree in business administration, public health, hospital administration, behavioral science, or health care; or

1.4.1.2 Meets similar educational requirements prescribed by TMA; and

1.4.1.3 Has five years of administrative experience in the field of mental health.

1.4.2 The CEO assumes overall administrative responsibility for the operation of the facility according to governing body policies.

1.4.3 The CEO plans, develops, and implements programs and services, recruits and directs staff, and ensures the appropriate utilization of resources. The CEO:

1.4.3.1 Implements an organizational structure that facilitates communication, delineates responsibility, and specifies lines of clinical and administrative supervision;

1.4.3.2 Prepares a manual of policies and procedures which is reviewed annually and revised as necessary;

1.4.3.3 Develops a strategic plan that specifies long- and short-term goals and objectives. The plan is evaluated annually and the results reported to the governing body;

1.4.3.4 Ensures the development of an effective evaluation program to analyze and report patterns and trends in clinical performance and service delivery; and

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1.4.3.5 Prepares detailed reports for the governing body regarding the facility's operations and pertinent findings related to the quality of patient care.

1.4.4 The CEO, along with the medical director and clinical director, establishes a plan of operation that is approved by the governing body, reviewed annually, and revised as necessary. The plan provides an overview of service delivery and differentiates between adolescent and adult programs. The plan describes the:

1.4.4.1 Theoretical orientation of the PHP;

1.4.4.2 Clinical characteristics of the population served;

1.4.4.3 Admission, continued-stay, and discharge criteria;

1.4.4.4 Process for determining the eligibility and medical necessity for admission;

1.4.4.5 Interdisciplinary treatment planning, review, and revision processes;

1.4.4.6 Specific services provided;

1.4.4.7 Therapeutic modalities offered;

1.4.4.8 Outside resources providing services that are not available within the facility;

1.4.4.9 Qualifications of staff for each service and therapeutic modality;

1.4.4.10 Responsibilities of each professional discipline and their relationships with each other;

1.4.4.11 Supervision provided to staff who are not eligible to practice independently;

1.4.4.12 Methods to involve family members; and

1.4.4.13 Processes for transition, discharge, and follow-up care.

1.5 Clinical Director

1.5.1 The clinical director is appointed by the governing body and meets the following qualifications:

1.5.1.1 Is a psychiatrist or doctoral level clinical psychologist who meets applicable requirements for individual professional providers and is licensed to practice in the state where the facility is located; and

1.5.1.2 Possesses requisite experience, credentials applicable under state practice and licensing laws appropriate to the professional discipline; and

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1.5.1.3 Has a minimum of five years' clinical experience in the treatment of mental disorders specific to the ages and disabilities of the population served.

1.5.2 The clinical director is responsible for:

1.5.2.1 Overseeing the clinical program;

1.5.2.2 Participating in the planning, development, and implementation of programs and services;

1.5.2.3 Serving as a liaison to the medical or professional staff to ensure that matters of clinical importance are conveyed to the CEO and the governing body;

1.5.2.4 Developing, in conjunction with the medical director, medical and professional staff, the behavior management plan;

1.5.2.5 Submitting regular reports to the governing body about clinical affairs, including unusual occurrences;

1.5.2.6 Developing and implementing a peer review system that monitors professional practice; and

1.5.2.7 Developing, in consultation with the medical director, medical and professional staff, an effective quality assessment and improvement program.

1.6 Medical Director

1.6.1 The medical director is appointed by the governing body and meets the following qualifications:

1.6.1.1 Is a graduate of an accredited school of medicine or osteopathy who is licensed to practice medicine in the state where the facility is located; and

1.6.1.2 Has completed an approved residency in psychiatry and has a minimum of five years' clinical experience in treating mental disorders specific to the ages and disabilities of the population served.

1.6.2 The medical director is responsible for:

1.6.2.1 Overseeing all the medical care provided;

1.6.2.2 Participating in the planning, development, and implementation of programs and services;

1.6.2.3 Serving as a liaison to the medical or professional staff to ensure that matters of medical importance are conveyed to the CEO and the governing body;

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1.6.2.4 Developing, in conjunction with the clinical director, medical and professional staff, the behavior management plan;

1.6.2.5 Submitting regular reports to the governing body about medical affairs, including unusual occurrences;

1.6.2.6 Developing and implementing a peer review system that monitors professional practice; and

1.6.2.7 Developing, in consultation with the clinical director, medical and professional staff, an effective quality assessment and improvement program.

1.6.3 If qualified, the medical director may also serve as the clinical director.

1.7 Medical or Professional Staff Organization

The medical or professional staff organization is established by the governing body. The organized staff is accountable for patient care and is responsible for:

1.7.1 Making recommendations to the governing body concerning appointments and reappointments to the medical or professional staff;

1.7.2 Determining the specific clinical privileges that may be granted and the training and experience required for each;

1.7.3 Defining clinical privileges based upon the services provided and the ages, disabilities, and clinical needs of the patients served; e.g., specialty groups for trauma victims;

1.7.4 Maintaining rules and regulations that support the goals and objectives of the PHP;

1.7.5 Ensuring the ethical conduct of individual staff members;

1.7.6 Establishing position requirements and verifying the qualifications of all staff providing direct patient care;

1.7.7 Implementing a system to evaluate the performance and current competence of its members; and

1.7.8 Overseeing the patient care responsibilities of staff who are not members of the medical or professional staff.

1.8 Personnel Policies and Records

1.8.1 The facility maintains written personnel policies, updated job descriptions, and comprehensive personnel records.

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1.8.2 Job descriptions for full-time, part-time and contracted employees are criteria-based and clearly contain:

- 1.8.2.1** Position title, required education and training, prior work experience, and other qualifications;
- 1.8.2.2** lines of supervision, responsibility, authority, and communication;
- 1.8.2.3** Duties and responsibilities corresponding to education, training, and experience; and
- 1.8.2.4** Annual performance appraisals with objective evaluation criteria, ratings, and comments.

1.8.3 Individual personnel records contain:

- 1.8.3.1** Application for employment;
- 1.8.3.2** Verification of the qualifications for the position;
- 1.8.3.3** Criteria-based job description;
- 1.8.3.4** Pre-employment reference checks;
- 1.8.3.5** Signed acknowledgment that the employee understands policies on patient abuse and neglect and confidentiality;
- 1.8.3.6** Pre-employment health examinations to ensure that all employees are able, physically and mentally, to perform their duties;
- 1.8.3.7** Annual performance appraisals;
- 1.8.3.8** Documented attendance at educational and training programs, including orientation and in-service courses;
- 1.8.3.9** Any complaints, allegations, inquiries or findings of patient abuse or neglect; and
- 1.8.3.10** Warnings or disciplinary actions.

1.9 Staff Development

The facility provides appropriate training and development programs for administrative, professional, support, and direct care staff.

1.9.1 Orientation and training programs are relevant to the care and treatment of PHP patients. The programs are specific to the skills, responsibilities, and duties of the staff.

1.9.2 Instruction in life safety, disaster planning, and fire safety including the proper use of fire extinguishers, is provided at orientation and annually thereafter.

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1.9.3 Instruction in cardiopulmonary resuscitation is required to maintain current certification.

1.9.4 All direct care staff receive relevant in-service education in emergency first aid, human growth and development, behavioral management, clinical observation, and clinical record documentation.

1.9.5 Staff training and development activities are provided by individuals who are qualified by education, training, and experience.

1.9.6 Staff training and development programs are influenced by the results of evaluation activities and are documented on a regular basis.

1.10 Fiscal Accountability

The facility maintains complete and accurate financial records of income and disbursements which are open to inspection upon reasonable notice by the United States Government or its authorized agents. The facility:

1.10.1 Has a schedule of public rates and charges for all services provided, and makes this available to all referral sources and families;

1.10.2 Has an independent audit performed at least annually; and

1.10.3 Maintains insurance coverage on all buildings, equipment, physical resources, and vehicles. Adequate comprehensive liability insurance protects patients, staff, and visitors.

1.11 Designated Teaching Facilities

1.11.1 Students, residents, interns, or fellows providing direct clinical care are under the supervision of a qualified staff member approved by an accredited university or medical school.

1.11.2 The teaching program is approved by the Deputy Director, TMA or a designee. To be an approved teaching program the facility has:

1.11.2.1 A written contract or letter of agreement between the accredited university and the governing body. The contract or letter of agreement designates:

1.11.2.1.1 The qualified health care professional providing supervision;

1.11.2.1.2 The nature and extent of supervision required; and

1.11.2.1.3 The supervisor's medical and legal responsibilities for all clinical care provided by the student, resident, intern, or fellow.

1.11.2.2 A description of the training program within the plan of operation, specifying the assignments, supervision, and documentation required;

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1.11.2.3 A medical or professional staff organization to recommend the privileges granted, under supervision, to students, interns, residents, or fellows; and

1.11.2.4 A medical director or clinical director as appropriate to oversee the training program and provide regular reports to the governing body.

1.12 Emergency Reports and Records

1.12.1 The facility notifies TMA of any serious occurrence involving beneficiaries.

1.12.1.1 Reportable occurrences include life-threatening accidents, a patient death, patient disappearances, suicide attempts, cruel or abusive treatment, physical or sexual abuse, or any equally dangerous situation.

1.12.1.2 The occurrence is reported by telephone to the Deputy Director, TMA or a designee, on the next business day; a full written account is sent within seven days.

1.12.1.3 The occurrence and contact with TMA are documented in the patient's clinical record.

1.12.1.4 Notification is provided to the next of kin or legal guardian and, if required by state or commonwealth law, the appropriate legal authorities.

1.12.2 Any disaster or emergency situation, natural or man made, such as fire or severe weather, is reported by telephone within 72 hours, followed by a written report within seven days, to TMA.

1.12.3 All of the facility financial and clinical records are available for review by TMA during announced or unannounced on-site reviews and inspections. The on-site review includes an examination of any clinical records, regardless of the source of payment.

2.0 TREATMENT SERVICES

2.1 Staff Composition

A written plan defines the number and composition of staff required to meet the medical and clinical needs of patients.

2.1.1 Staffing patterns are based upon the characteristics and special needs of the population served, the patient census, and the type(s) and intensity of services required.

2.1.2 Sufficient full-time professional staff provide clinical assessments, active therapeutic interventions, and ongoing program evaluation.

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

2.1.4 A professional staff member is on-site during service hours to supervise and direct the milieu.

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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 A professional counselor, marriage and family counselor, or pastoral counselor has a master's degree in mental health or behavioral sciences from an accredited university, has two years of supervised, post-master's degree practice;

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 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.

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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.

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.

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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.

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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;

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;

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- 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.
- 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.

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;

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

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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.

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 At a minimum, the following assessments and documentation are required:

2.11.2.1 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;

2.11.2.2 A nursing note by a registered nurse evaluating the patient's progress every 10 visits;

2.11.2.3 Progress notes on individual and family therapy sessions, to be written within 48 hours of each session;

2.11.2.4 Weekly progress notes on group therapy, therapeutic activities, educational, vocational, and ancillary services;

2.11.2.5 A review of the interdisciplinary treatment plan at least every two weeks; and

2.11.2.6 A discharge summary completed within two weeks and signed by a qualified mental health provider.

2.12 Therapeutic Services

2.12.1 The facility provides therapeutic services that include, but are not limited to, clinical therapies, psychoeducational groups, focus groups, and therapeutic activities. Services are adapted to the ages, disabilities, individual developmental stages, and comprehensive levels of the patients.

2.12.2 All PHP patients are provided with individual, group, and family therapy as indicated in the treatment plan. These clinical therapies are provided by or under the supervision of qualified mental health professions practicing within the scope of their licenses and clinical privileges.

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Unless clinically contraindicated and waived by TMA or designee, each patient and family, when appropriate, participate at least weekly in family therapy with a qualified mental health provider.

2.12.3 The facility provides or makes arrangements for educational services that meet the special needs of children, adolescents, and adult patients.

2.12.3.1 When the facility provides educational services, the services:

2.12.3.1.1 Are provided by qualified and certified teachers;

2.12.3.1.2 Sustain the educational/ intellectual development and, when indicated provide remedial opportunities;

2.12.3.1.3 Integrate elements from the individual treatment plan and are coordinated with other services;

2.12.3.1.4 Are documented regularly in the clinical record; and

2.12.3.1.5 Are accredited or approved by a state agency. If the school program is not accredited as part of the local school system, the facility makes this clear in its policies, brochures, and applicant information.

2.12.3.2 When the facility does not provide educational services, it ensures that patients do no fall behind academically while receiving partial hospital treatment.

2.12.4 The facility offers a range of therapeutic activities which are provided by qualified activity therapy professionals.

2.12.4.1 The therapeutic activity services is supervised by a qualified activity therapy professional.

2.12.4.2 The facility provides the necessary resources to support therapeutic activities for both full-day and half-day programs.

2.13 Ancillary Services

2.13.1 Emergency Services

The facility has policies and procedures for emergency services that identify the facilities to be used and the staff qualified and responsible for assessing the situation and arranging transfers, when indicated.

2.13.1.1 The facility has a written agreement with at least one backup authorized hospital to accept patients for emergency mental health or medical/surgical care.

2.13.1.2 The facility has a written emergency transportation agreement with at least one ambulance company, which specifies the estimated time to reach each backup hospital.

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

2.13.1.4 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

The facility makes available during service hours, either directly or through contractual arrangement, the physical health services necessary for patient evaluation and treatment.

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

When appropriate, 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 Monthly inspections are made of all drug storage areas, including emergency boxes, emergency carts, and stock medications.

2.13.3.2 Medication orders are written only by authorized physicians and are an integral part of the patient's treatment plan. Monitoring verifies effectiveness of the medicine.

2.13.3.3 Medications are administered by registered nurses or by licensed practical nurses supervised a physician or registered nurse. All medications administered are documented.

2.13.3.4 If the self-administration of medication is ordered, the administration of that medication is supervised and documented by qualified, licensed staff member.

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

2.13.3.6 When medications are prescribed in a manner that is not approved by the Food and Drug Administration, their use requires approval by the medical director and special justification in the clinical record.

2.13.3.7 A medication administration training program is provided for the nursing staff members authorized to administer drugs.

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2.13.4 Dietary Services

The facility meets all applicable federal, state, and local rules and regulations regarding the safe storage, handling, preparation, and distribution of food.

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

2.13.4.2 Food is protected from contamination and spoilage.

2.13.4.3 Food preparation areas, utensils, and equipment are thoroughly cleaned and sanitized after use.

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

2.13.4.5 Perishable foods are stored at proper temperatures.

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

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

2.13.4.8 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.

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 furniture are of safe and sturdy construction and are not hazardous for patients and staff. Furniture is comfortable, attractive, and age appropriate.

3.1.1.3 The facility has sufficient staff to carry out preventive maintenance and regular housekeeping services.

3.1.1.4 Repairs to, or replacement of, broken items are made promptly.

3.1.1.5 Windows and doors used for ventilation are screened.

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

3.1.2.1 Adequate space is provided for patient activities.

3.1.2.2 Recreational areas and equipment are available to, and consistent with, the ages of the patients and their developmental and clinical needs.

3.1.3 Privacy is provided for personal hygiene.

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

3.1.3.2 Bathrooms are thoroughly cleaned each day.

3.1.3.3 Good-quality mirrors are furnished in each bathroom.

3.1.4 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 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.

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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 JC, 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 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 process will be pursuant to a written plan.

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.

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- 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 relevant 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 utilization review process.

4.4 Patient Records

- 4.4.1** To ensure proper maintenance and control of clinical records, the facility provides or contracts for the services of a registered record administration or accredited record technician who supervises records and maintains their quality.
 - 4.4.1.1** Written policies and procedures concerning records maintenance ensure that records are current, accurate, and confidential.
 - 4.4.1.2** Policies and procedures describe methods to lock, store, and safeguard records.
 - 4.4.1.3** Current records are kept in patient care areas and are immediately accessible to staff.
 - 4.4.1.4** Policies and procedures reflect federal confidentiality guidelines for the release of confidential information.
- 4.4.2** The facility monitors and evaluates the completeness of patient records, including timeliness of entries, appropriate signatures, the pertinence of clinical entries.
- 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.

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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.

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.

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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

4.8.1 The facility implements a safety monitoring system as described below:

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

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

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

4.8.1.4 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.

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 PHP.

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 -

Participation Agreement For Freestanding Psychiatric Partial Hospitalization Program (PHP) Services

CORPORATE NAME: _____

DBA: _____
(If different from corporate name)

LOCATION: _____

MAILING ADDRESS: _____
(If different from location)

TELEPHONE: _____

PROVIDER EIN NO: _____

U. S. Department of Defense
TRICARE Management Activity
16401 East Centretch Parkway
Aurora, Colorado 80011-9066

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**PARTICIPATION AGREEMENT FOR FREESTANDING PSYCHIATRIC
PARTIAL HOSPITALIZATION PROGRAM**

FACILITY NAME:

LOCATION:

TELEPHONE:

PROVIDER EIN:

U. S. Department of Defense
TRICARE Management Activity
16401 East Centretch Parkway
Aurora, Colorado 80011-9066

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ARTICLE 1

RECITALS

1.1 IDENTIFICATION OF PARTIES

This Participation Agreement is between the United States of America through the Department of Defense, TRICARE Management Activity (hereinafter TMA), a field activity of the Office of the Secretary of Defense, the administering activity for the TRICARE Management Activity (hereinafter TMA) and _____ (hereinafter designated the PHP).

1.2 AUTHORITY FOR PARTIAL HOSPITAL CARE

The implementing regulations for TMA, 32 Code of Federal Regulations (CFR), Part 199, provides for cost-sharing of partial hospital care under certain conditions.

1.3 PURPOSE OF PARTICIPATION AGREEMENT

It is the purpose of this participation agreement to recognize the undersigned PHP as an authorized provider of partial hospital care, subject to the terms and conditions of this agreement, and applicable federal law and regulation.

ARTICLE 2

DEFINITIONS

2.1 AUTHORIZED TMA REPRESENTATIVES

The authorized representative(s) of the Deputy Director, TMA, may include, but are not limited to, TMA staff, Department of Defense personnel, and contractors, such as private sector accounting/audit firm(s) and/or utilization review and survey firm(s). Authorized representatives will be specifically designated as such.

2.2 BILLING NUMBER

The billing number for all partial hospitalization services is the PHP's employer's identification number (EIN). This number must be used until the provider is officially notified by TMA or a designee of a change. The PHP's billing number is shown on the face sheet of this agreement.

2.3 ADMISSION AND DISCHARGE

(a) An admission occurs upon the formal acceptance by the PHP of a beneficiary for the purpose of participating in the therapeutic program with the registration and assignment of a patient number or designation.

(b) A discharge occurs at the time that the PHP formally releases the patient from partial hospitalization status; or when the patient is admitted to another level of care.

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2.4 MENTAL DISORDER

As defined in the [32 CFR 199.2](#), for the purposes of the payment of benefits, a mental disorder is a nervous or mental condition that involves a clinically significant behavioral or psychological syndrome or pattern that is associated with a painful symptom, such as distress, and that impairs a patient's ability to function in one or more major life activities. Additionally, the mental disorder must be one of those conditions listed in the current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

2.5 PARTIAL HOSPITALIZATION

As defined by [32 CFR 199.2\(b\)](#), partial hospitalization is a treatment setting capable of providing an interdisciplinary program of medical therapeutic services at least three hours per day, five days per week, which may embrace day, evening, night, and weekend treatment programs which employ an integrated, comprehensive and complementary schedule of recognized treatment approaches. Partial hospitalization is a time-limited, ambulatory, active treatment program that offers therapeutically intensive, coordinated, and structured clinical services within a stable therapeutic environment. Psychiatric partial hospitalization is an appropriate setting for crisis stabilization, treatment of partially stabilized mental health disorders, and transition from an inpatient program when medically necessary. Such programs must enter into a participation agreement with TRICARE, and be accredited and in substantial compliance with the **Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC)** of the Joint Commission (JC).

ARTICLE 3

PERFORMANCE PROVISIONS

3.1 GENERAL AGREEMENT

(a) The PHP agrees to render partial hospitalization services to eligible beneficiaries in need of such services, in accordance with this participation agreement and the 32 CFR 199. These services shall include board, patient assessment, psychological testing, treatment services, social services, educational services, family therapy, and such other services as are required by the 32 CFR 199.

(b) The PHP agrees that all certifications and information provided to the Deputy Director, TMA incident to the process of obtaining and retaining authorized provider status is accurate and that it has no material errors or omissions. In the case of any misrepresentations, whether by inaccurate information being provided or material facts withheld, authorized provider status will be denied or terminated, and the PHP will be ineligible for consideration for authorized provider status for a two year period. Termination of authorized PHP status will be pursuant to [Article 13](#) of this agreement.

(c) The PHP shall not be considered an authorized provider nor may any benefits be paid to the PHP for any services provided prior to the date the PHP is approved by the Deputy Director, TMA, or a designee as evidenced by signature on the participation agreement.

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3.2 LIMIT ON RATE BILLED

(a) The PHP agrees to limit charges for services to beneficiaries to the rate set forth in this agreement.

(b) The PHP agrees to charge only for services to beneficiaries that qualify within the limits of law, regulation, and this agreement.

3.3 ACCREDITATION AND STANDARDS

The PHP hereby agrees to:

(a) Comply with the Standards for Psychiatric Partial Hospitalization Programs, as promulgated by the Deputy Director, TMA.

(b) Be licensed to provide PHP services within the applicable jurisdiction in which it operates.

(c) Be specifically accredited by and remain in compliance with standards issued by the **JC** under the **Accreditation Manual for Mental Health, Chemical Dependency, and Mental Retardation/Developmental Disabilities Services** (formerly the **Consolidated Standards Manual**).

(d) Accept the allowable partial hospitalization program rate, as provided in **32 CFR 199.14(a)(2)(ix)**, as payment in full for services provided.

(e) Comply with all requirements of **32 CFR 199.4** applicable to institutional providers generally concerning preauthorization, concurrent care review, claims processing, beneficiary liability, double coverage, utilization and quality review, and other matters.

(f) Be fully operational and treating patients for a period of at least six months (with at least 30% minimum patient census) before an application for approval may be submitted.

(g) Ensure that all mental health services are provided by qualified mental health providers who meet the requirements for individual professional providers. (Exception: PHPs that employ individuals with master's or doctoral level degrees in a mental health discipline who do not meet the licensure, certification, and experience requirements for a qualified mental health provider but are actively working toward licensure or certification, may provide mental health services within the per diem rate but the individual must work under the direct clinical supervision of a fully qualified mental health provider employed by the PHP.) All other program services will be provided by trained, licensed staff.

(h) Ensure the provision of an active family therapy component which ensures that each patient and family participate at least weekly in family therapy provided by the institution and rendered by an authorized mental health provider.

(i) Have a written agreement with at least one backup authorized hospital which specifies that the hospital will accept any and all beneficiaries transferred for emergency mental health or medical/surgical care. The PHP must have a written emergency transport agreement with at least one ambulance company which specifies the estimated transport time to each backup hospital.

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(j) Not bill the beneficiary for services in excess of the cost-share or services for which payment is disallowed for failure to comply with requirements for preauthorization.

(k) Not bill the beneficiary for services excluded on the basis of 32 CFR 199.4(g)(1) (not medically necessary), (g)(3) (inappropriate level of care) or (g)(7) (custodial care), unless the beneficiary has agreed in writing to pay for the care, knowing the specific care in question has been determined as noncovered. (A general statement signed at admission as to financial liability does not fill this requirement.)

(l) Prior to the initiation of this agreement, and annually thereafter, conduct a self-assessment of its compliance with the **Standards for Psychiatric Partial Hospitalization Programs**, and notify the Deputy Director, TMA, of any matter regarding which the facility is not in compliance with such standards.

3.4 QUALITY OF CARE

(a) The PHP shall assure that any and all eligible beneficiaries receive partial hospitalization services which comply with standards in Article 3.3 and the **Standards for Psychiatric Partial Hospitalization Programs**.

(b) The PHP shall provide partial hospitalization services in the same manner to beneficiaries as it provides to all patients to whom it renders services.

(c) The PHP shall not discriminate against beneficiaries in any manner including admission practices or provisions of special or limited treatment.

3.5 BILLING FORM

The PHP shall use the Centers for Medicare and Medicaid Services (CMS) 1450 UB-04 billing form (or subsequent editions). PHPs shall identify PHP care on the billing form in the remarks block by stating "PHP care".

3.6 COMPLIANCE WITH TMA UTILIZATION REVIEW ACTIVITIES

Under the terms of this agreement, the PHP shall:

(a) Appoint a single individual within the facility to serve as the point of contact for conducting utilization review activities with TMA or its designee. This individual must have a clinical background and be capable of directly responding to questions from professionally qualified reviewers. The PHP will inform TMA in writing of the designated individual.

(b) Obtain precertification for all care to be rendered to a beneficiary within the PHP.

(c) Promptly provide medical records and other documentation required in support of the utilization review process upon request by TMA or its designee. Confidentiality considerations are not valid reasons for refusal to submit medical records on any beneficiary. Failure to comply with documentation requirements will usually result in denial of certification of care.

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(d) Maintain medical records, including progress notes, clinical formulation, and the master treatment plan in compliance with standards and regulations.

3.7 PROFESSIONAL STAFF ORGANIZATION

The PHP shall follow a medical model for all services and shall vest ultimate authority for planning, developing, implementing, and monitoring all clinical activities patient care in a psychiatrist or licensed doctoral-level psychologist. The management of medical care will be vested in a physician. Clinicians providing individual, group, and family therapy meet the requirements as qualified mental health providers as defined in [32 CFR 199.6](#), and operate within the scope of their licenses.

3.8 PROFESSIONAL STAFF QUALIFICATIONS

(a) The PHP shall comply with requirements for professional staff qualifications stated in the **Standards for Psychiatric Partial Hospitalization Programs**.

(b) The Chief Executive Officer (CEO) shall have five years' administrative experience and, effective October 1, 1997, shall possess a master's degree in business administration, nursing, social work, or psychology, or meet similar educational requirements as prescribed by the Deputy Director, TMA.

ARTICLE 4

PAYMENT PROVISIONS

4.1 RATE STRUCTURE: DETERMINATION OF RATE

The TRICARE rate is the per diem rate that TRICARE will authorize for all mental health services rendered to a patient and the patient's family as part of the total treatment plan submitted by a approved PHP, and approved by TMA or a designee. The per diem rate will be as specified in [32 CFR 199.14\(a\)\(2\)\(ix\)\(C\)](#); for any full day partial hospitalization program (minimum of 6 hours), the maximum per diem payment is 40% of the average inpatient per diem amount per case paid to both high and low volume psychiatric hospitals and units (as defined in [32 CFR 199.14\(a\)\(2\)](#)) by Federal census region during Fiscal Year 1990. A partial hospitalization program of less than 6 hours (with a minimum of 3 hours) will be paid a per diem rate of 75% of the rate for full-day program.

4.2 PHP SERVICES INCLUDED IN PER DIEM PAYMENT

The per diem payment amount must be accepted as payment in full for all institutional services provided, including board, patient assessment, treatment services (with the exception of the five psychotherapy sessions per week which may be allowed separately for individual or family psychotherapy when provided and billed by an authorized professional provider who is not employed by or under contract with the PHP), routine nursing services, educational services, ancillary services (including art, music, dance, occupational, recreational, and other such therapies), psychological testing and assessments, social services, overhead and any other services for which the customary practice among similar providers is included as part of institutional charges. Non-mental-health-related medical services may be separately allowed when provided and billed by an

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authorized independent professional provider not employed by or under contract with the PHP. This includes ambulance services when medically necessary for emergency transportation. Note: The PHP may not enforce or control separate billing for professional services.

4.3 OTHER PAYMENT REQUIREMENTS

No payment is due for leave days, for days in which treatment is not provided, for days on which the patient is absent from treatment (whether excused or unexcused), or for days in which the duration of the program services was less than three hours. Hours devoted to education do not count toward the therapeutic half or full day program and TRICARE will not separately reimburse educational services (see Article 5.2).

4.4 PREREQUISITES FOR PAYMENT

Provided that there shall first have been a submission of claims in accordance with procedures, the PHP shall be paid based upon the allowance of the rate determined in accordance with the prevailing 32 CFR 199.14 (see Article 4.1), and contingent upon certain conditions provided in the 32 CFR 199, the **Standards for Psychiatric Partial Hospitalization Programs**, and in particular the following:

(a) The patient seeking admission is suffering from a mental disorder which meets the diagnostic criteria of the current edition of the current edition of the **Diagnostic and Statistical Manual of the American Psychiatric Association** and meets the TRICARE definition of a mental disorder.

(b) The patient meets the criteria for admission to a PHP issued by the Deputy Director, TMA.

(c) A qualified mental health professional who meets requirements for individual professional providers and who is permitted by law and by the PHP recommends that the patient be admitted to the PHP.

(d) A qualified mental health professional with admitting privileges who meets the requirements for individual professional providers will be responsible for the development, supervision, implementation, and assessment of a written, individualized, interdisciplinary clinical formulation and plan of treatment.

(e) All services are provided by or under the supervision of an authorized mental health provider (see Article 3.3(g)).

(f) The Deputy Director, TMA, or a designee has precertified all care rendered to the patient.

(g) The patient meets eligibility requirements for coverage.

4.5 DETERMINED RATE AS PAYMENT IN FULL

(a) The PHP agrees to accept the rate determined pursuant to the 32 CFR 199.14 (see Article 4.1) as the total charge for services furnished by the PHP to beneficiaries. The PHP agrees to accept the rate even if it is less than the billed amount, and also agrees to accept the amount paid, combined with the cost-share amount and deductible, if any, paid by or on behalf of the

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beneficiary, as full payment for the PHP services. The PHP agrees to make no attempt to collect from the beneficiary or beneficiary's family, except as provided in Article 4.6(a), amounts for PHP services in excess of the rate.

(b) The PHP agrees to submit all claims as a participating provider. TMA agrees to make payment of the determined rate directly to the PHP for any care authorized under this agreement.

(c) The PHP agrees to submit claims for services provided to beneficiaries at least every 30 days (except to the extent delay is necessitated by efforts to first collect from other health insurance). If claims are not submitted at least every 30 days, the PHP agrees not to bill the beneficiary or the beneficiary's family for any amounts disallowed.

4.6 TRICARE AS SECONDARY PAYOR

(a) The PHP is subject to the provisions of 10 United States Code (USC) Section 1079 (j)(1). The PHP must submit claims first to all other insurance plans and/or medical service or health plans under which the beneficiary has coverage prior to submitting a claim to TRICARE.

(b) Failure to collect first from primary health insurers and/or sponsoring agencies is a violation of this agreement, may result in denial or reduction of payment, and may result in a false claim against the United States. It may also result in termination of this agreement by TMA pursuant to [Article 8](#).

4.7 COLLECTION OF COST-SHARE

(a) The PHP agrees to collect from the beneficiary or the parents or guardian of the beneficiary only those amounts applicable to the patient's cost-share (copayment) as defined in [32 CFR 199.4](#), and services and supplies which are not a benefit.

(b) The PHP's failure to collect or to make diligent effort to collect the beneficiary's cost-share (copayment) as determined by policy is a violation of this agreement, may result in denial or reduction of payment, and may result in a false claim against the United States. It may also result in termination by TMA of this agreement pursuant to [Article 13](#).

4.8 BENEFICIARY RIGHTS

If the PHP fails to abide by the terms of this participation agreement and TMA or its designee either denies the claim or claims and/or terminates the agreement as a result, the PHP agrees to forego its rights, if any, to pursue the amounts not paid by TRICARE from the beneficiary or the beneficiary's family.

ARTICLE 5

EDUCATIONAL SERVICES

5.1 EDUCATIONAL SERVICES REQUIRED

Programs treating children and adolescents must ensure the provision of a state certified educational component which assures that the patients do not fall behind in educational placement while receiving partial hospital treatment.

5.2 REIMBURSEMENT OF EDUCATIONAL SERVICES

Any charges for educational services are included in the per diem payment. TRICARE will not separately reimburse educational services. The hours devoted to education do not count toward the therapeutic half or full day program.

ARTICLE 6

RECORDS AND AUDIT PROVISIONS

6.1 ON-SITE AND OFF-SITE REVIEWS/AUDITS

The PHP grants the Deputy Director, TMA [or authorized representative(s)], the right to conduct on-site or off-site reviews or accounting audits with full access to patients and records. The audits may be conducted on a scheduled or unscheduled (unannounced) basis. This right to audit/review includes, but is not limited to, the right to:

(a) Examine fiscal and all other records of the PHP which would confirm compliance with this agreement and designation as an authorized PHP provider.

(b) Conduct audits of PHP records including clinical, financial, and census records to determine the nature of the services being provided, and the basis for charges and claims against the United States for services provided to beneficiaries. The Deputy Director, TMA, or a designee shall have full access to records of both TRICARE and non-TRICARE patients.

(c) Examine reports of evaluations and inspections conducted by federal, state, local government, and private agencies and organizations.

(d) Conduct on-site inspections of the facilities of the PHP and interview employees, members of the staff, contractors, board members, volunteers, and patients, as may be required.

(e) Release copies of final review reports (including reports of on-site reviews) under the Freedom of Information Act.

6.2 RIGHT TO UNANNOUNCED INSPECTION OF RECORDS

(a) TMA and its authorized agents shall have the authority to visit and inspect the PHP at all reasonable times on an unannounced basis.

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(b) The PHP's records shall be available and open for review by TMA during normal working hours, from 8 a.m. to 5 p.m., Monday through Friday, on an unannounced basis.

6.3 CERTIFIED COST REPORTS

Upon request, the PHP shall furnish TMA or a designee the audited cost reports certified by an independent auditing agency.

6.4 RECORDS REQUESTED BY TMA

Upon request, the PHP shall furnish TMA or a designee such records, including medical records and patient census records, that would allow TMA or a designee to determine the quality and cost-effectiveness of care rendered.

6.5 FAILURE TO COMPLY

Failure to allow audits/reviews and/or to provide records constitutes a material breach of this agreement. It may result in denial or reduction of payment, termination of this agreement pursuant to [Article 13](#), and any other appropriate action by TMA.

ARTICLE 7

NONDISCRIMINATION

7.1 COMPLIANCE

The PHP agrees to comply with provisions of section 504 of the Rehabilitation Act of 1973 (Public Law 93-112; as amended) regarding nondiscrimination on basis of handicap, Title VI of the Civil Rights Act of 1964 (Public Law 88-352), and with the Americans With Disabilities Act of 1990 (Public Law 101-336), as well as all regulations implementing these Acts.

ARTICLE 8

AMENDMENT

8.1 AMENDMENT BY TMA

(a) The Deputy Director, TMA, or designee may amend the terms of this participation agreement by giving 120 days' notice in writing of the amendment(s) except amendments to the 32 CFR 199, which shall be considered effective as of the effective date of the regulation change and do not require a formal amendment of this agreement to be effective. When changes or modifications to this agreement result from amendments to the 32 CFR 199 through rulemaking procedures, the Deputy Director, TMA, or designee, is not required to give 120 days' written notice. Amendments to this agreement resulting from amendments to the 32 CFR 199 shall become effective on the date the regulation amendment is effective or the date this agreement is amended, whichever date is earlier.

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(b) The PHP, if it concludes it does not wish to accept the proposed amendment(s), including any amendment resulting from amendment(s) to the 32 CFR 199 accomplished through rulemaking procedures, may terminate its participation as provided for in Article 13.3. However, if the PHP's notice of intent to terminate its participation is not given at least 60 days prior to the effective date of the proposed amendment(s), then the proposed amendment(s) shall be incorporated into this agreement for PHP care furnished between the effective date of the amendment(s) and the effective date of termination of this agreement.

ARTICLE 9

TRANSFER OF OWNERSHIP

9.1 ASSIGNMENT BARRED

This agreement is nonassignable.

9.2 AGREEMENT ENDS

(a) Unless otherwise extended as specified in Article 9.3(c) below, this agreement ends as of 12:01 am on the date that transfer of ownership occurs.

(b) Change of Ownership is defined as follows:

(1) The change in an owner(s) that has/have 50% or more ownership constitutes change of ownership.

(2) The merger of the PHP corporation (for-profit or not-for-profit) into another corporation, or the consolidation of two or more corporations, resulting in the creation of a new corporation, constitutes change of ownership. The transfer of corporate stock or the merger of another corporation into the PHP corporation, however, does not constitute change of ownership. The transfer of title to property of the PHP corporation to another corporation(s), and the use of that property for the rendering of partial hospital care by the corporation(s) receiving it is essential for a change of ownership.

(3) The lease of all or part of an PHP or a change in the PHP's lessee constitutes change of ownership.

9.3 NEW AGREEMENT REQUIRED

(a) If there is a change of ownership of a PHP as specified in Article 9.2(b), then the new owner, in order to be an authorized partial hospital program, must enter into a new agreement with TMA. The new owner is subject to any existing plan of correction, expiration date, applicable health and safety standards, ownership and financial interest disclosure requirements and any other provisions and requirements of this agreement.

(b) A PHP contemplating or negotiating a change in ownership must notify TMA in writing at least 30 days prior to the effective date of the change. At the discretion of the Deputy Director, TMA, or a designee, this agreement may remain in effect until a new participation agreement can

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be signed to provide continuity of coverage for beneficiaries. A PHP that has provided the required 30 days' advance notification of a change of ownership may seek an extension of this agreement's effect for a period not to exceed 180 days from the date of the transfer of ownership. Failure to provide 30 days' advance notification of a change of ownership will result in a denial of a request for an extension of this agreement and termination of this agreement upon transfer of ownership as specified in Article 9.2(a).

(c) Prior to a transfer of ownership of a PHP, the new owners may petition TMA in writing for a new participation agreement. The new owners must document that all required licenses and accreditations have been maintained, and must provide documentation regarding any program changes. Before a new participation agreement is executed, the Deputy Director, TMA, or a designee will review the PHP to ensure that it is in compliance with 32 CFR 199.

ARTICLE 10

REPORTS

10.1 INCIDENT REPORTS

Any serious occurrence involving a beneficiary, outside the normal routine of the partial hospitalization program, shall be reported to TMA, Benefits Management Division, and/or a designee, as follows:

(a) An incident of a life-threatening accident, patient death, patient disappearance, suicide attempt, incident of cruel or abusive treatment, or any equally dangerous situation involving a beneficiary, shall be reported by telephone on the next business day with a full written report within seven days.

(b) The incident and the following report shall be documented in the patient's clinical record.

(c) Notification shall be provided, if appropriate, to the parents, legal guardian, or legal authorities.

(d) When a beneficiary is absent without leave and is not located within 24 hours, the incident shall be reported by telephone to TMA, on the next business day. If the patient is not located within three days, a written report of the incident is made to TMA within seven days.

10.2 DISASTER OR EMERGENCY REPORTS

Any disaster or emergency situation, natural or man-made, such as fire or severe weather, shall be reported telephonically within 72 hours, followed by a comprehensive written report within seven days to TMA.

10.3 REPORTS OF PHP CHANGES

The governing body or the administrator of the PHP shall submit in writing to TMA any proposed significant changes within the PHP no later than 30 days prior to the actual date of change; failure to report such changes may lead to termination of this agreement. A report shall be

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made concerning the following items:

- (a) Any change in administrator or primary professional staff.
- (b) Any change in purpose, philosophy or any addition or deletion of services or programs. This includes capacity or hours of operation.
- (c) Any licensure, certification, accreditation or approval status change by a state agency or national organization.
- (d) Any anticipated change in location or anticipated closure.
- (e) Any suspension of operations for 24 hours or more.

ARTICLE 11

GENERAL ACCOUNTING OFFICE

11.1 RIGHT TO CONDUCT AUDIT

The PHP grants the United States General Accounting Office the right to conduct audits.

ARTICLE 12

APPEALS

12.1 APPEAL ACTIONS

Appeals of TMA actions under this agreement, to the extent they are allowable, will be pursuant to the [32 CFR 199.10](#) and [32 CFR 199.15](#).

ARTICLE 13

TERMINATION AND AMENDMENT

13.1 TERMINATION OF AGREEMENT BY TMA

The Deputy Director, TMA, or a designee, may terminate this agreement in accordance with procedures for termination of institutional providers as specified in [32 CFR 199.9](#).

13.2 BASIS FOR TERMINATION OF AGREEMENT BY TMA

(a) In addition to any authority under the [32 CFR 199.9](#) to terminate or exclude a provider, the Deputy Director, TMA or a designee may terminate this agreement upon 30 days' written notice, for cause, if the PHP:

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(1) Is not in compliance with the requirements of the Dependents Medical Care Act, as amended (10 USC 1071 et seq), the 32 CFR 199, the **Standards for Psychiatric Partial Hospitalization Programs**, or with performance provisions stated in [Article 3](#) of this participation agreement.

(2) Fails to comply with payment provisions set forth in [Article 4](#) of this participation agreement.

(3) Fails to allow audits/reviews and/or to provide records as required by [Article 6](#) of this participation agreement.

(4) Fails to comply with nondiscrimination provisions of [Article 7](#) of this participation agreement.

(5) Changes ownership as set forth in [Article 9](#) of this participation agreement.

(6) Fails to provide incident reports, disaster or emergency reports, or reports of PHP changes as set forth in [Article 10](#) of this participation agreement.

(7) Initiates a program change without written approval by TMA or a designee; program changes include but are not limited to: changes in the physical location; population served; number of beds; type of license; expansion of program(s); or development of new program(s).

(8) Does not admit a beneficiary during any period of 24 months.

(9) Suspends operations for a period of 120 days or more.

(10) Is determined to be involved in provider fraud or abuse, as established by [32 CFR 199.9](#). This includes the submission of falsified or altered claims or medical records which misrepresent the type, frequency, or duration of services or supplies.

(b) The Deputy Director of TMA may terminate this agreement without prior notice in the event that the PHP's failure to comply with the **Standards for Psychiatric Partial Hospital Programs** presents an immediate danger to life, health or safety.

13.3 TERMINATION OF AGREEMENT BY THE PHP

The PHP may terminate this agreement by giving the Deputy Director, TMA, or designee, written notice of such intent to terminate. The effective date of a voluntary termination under this article shall be 60 days from the date of notification of intent to terminate or, upon written request, as agreed between the PHP and TMA.

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ARTICLE 14

RECOUPMENT

14.1 RECOUPMENT

TMA shall have the authority to suspend claims processing or seek recoupment of claims previously paid as specified under the provisions of the Federal Claims Collection Act (31 USC 3701 et seq), the Federal Medical Care Recovery Act (42 USC 2651-2653) and [32 CFR 199.14](#).

ARTICLE 15

ORDER OF PRECEDENCE

15.1 ORDER OF PRECEDENCE

If there is any conflict between this agreement and any Federal statute or regulation including the 32 CFR 199, the statute or regulation controls.

ARTICLE 16

DURATION

16.1 DURATION

This agreement shall remain in effect until the expiration date specified in Article [18.1](#) unless terminated earlier by TMA or the PHP under [Article 13](#). TMA may extend this agreement for 60 days beyond the established date if necessary to facilitate a new agreement.

16.2 REAPPLICATION

The PHP must reapply to TMA at least 90 days prior to the expiration date of this agreement if it wishes to continue as an authorized PHP. Failure to reapply will result in the automatic termination of this agreement on the date specified in Article [18.1](#).

ARTICLE 17

EFFECTIVE DATE

17.1 EFFECTIVE DATE

(a) This participation agreement will be effective on the date signed by the Deputy Director, TMA, or a designee.

(b) This agreement must be signed by the President or CEO of the PHP.

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ARTICLE 18

AUTHORIZED PROVIDER

18.1 PROVIDER STATUS

On the effective date of the agreement, TMA recognizes the PHP as an authorized provider for the purpose of providing psychiatric partial hospitalization care to eligible beneficiaries within the framework of the program(s) identified below.

PSYCHIATRIC PARTIAL HOSPITALIZATION PROGRAM NAME(S)	CAPACITY	AGE RANGE	DAYS OF OPERATION	HALF-DAY (HD) FULL-DAY (FD)

Partial Hospitalization Facility Name

Expiration Date

TRICARE Management Activity

By: Signature

By: Signature

Name and Title

Name and Title

Executed on: _____

Executed on: _____

- END -

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Appendix A

Acronyms And Abbreviations

ASC	Accredited Standards Committee Ambulatory Surgical Center
ASCA	Administrative Simplification Compliance Act
ASCUS	Atypical Squamous Cells of Undetermined Significance
ASD	Assistant Secretary of Defense Atrial Septal Defect Autism Spectrum Disorder
ASD(C3I)	Assistant Secretary of Defense for Command, Control, Communications, and Intelligence
ASD(HA)	Assistant Secretary of Defense (Health Affairs)
ASD (MRA&L)	Assistant Secretary of Defense for Manpower, Reserve Affairs, and Logistics
ASP	Average Sale Price
ATA	American Telemedicine Association
ATB	All Trunks Busy
ATO	Approval to Operate
AVM	Arteriovenous Malformation
AWOL	Absent Without Leave
AWP	Average Wholesale Price
B&PS	Benefits and Provider Services
B2B	Business to Business
BACB	Behavioral Analyst Certification Board
BBA	Balanced Budget Act
BBP	Bloodborne Pathogen
BBRA	Balanced Budget Refinement Act
BC	Birth Center
BCABA	Board Certified Associate Behavior Analyst
BCAC	Beneficiary Counseling and Assistance Coordinator
BCBA	Board Certified Behavior Analyst
BCBS	Blue Cross [and] Blue Shield
BCBSA	Blue Cross [and] Blue Shield Association
BCC	Biostatistics Center
BI	Background Investigation
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
BP	Behavioral Plan
BPC	Beneficiary Publication Committee
BPS	Beneficiary and Provider Services
BRAC	Base Realignment and Closure
BRCA	BRest CAncer

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BS	Bachelor of Science
BSID	Bayley Scales of Infant Development
BSR	Beneficiary Service Representative
BWE	Beneficiary Web Enrollment
C&A	Certification and Accreditation
C&CS	Communications and Customer Service
C/S	Client/Server
CA	Care Authorization
CA/NAS	Care Authorization/Non-Availability Statement
CABG	Coronary Artery Bypass Graft
CAC	Common Access Card
CAD	Coronary Artery Disease
CAF	Central Adjudication Facility
CAH	Critical Access Hospital
CAMBHC	Comprehensive Accreditation Manual for Behavioral Health Care
CAP	Competitive Acquisition Program
CAP/DME	Capital and Direct Medical Education
CAPD	Continuous Ambulatory Peritoneal Dialysis
CAPP	Controlled Access Protection Profile
CAS	Carotid Artery Stenosis
CAT	Computerized Axial Tomography
CB	Consolidated Billing
CBC	Cypher Block Chaining
CBHCO	Community-Based Health Care Organizations
CBSA	Core Based Statistical Area
CC	Common Criteria Criminal Control (Act)
CC&D	Catastrophic Cap and Deductible
CCDD	Catastrophic Cap and Deductible Data
CCEP	Comprehensive Clinical Evaluation Program
CCMHC	Certified Clinical Mental Health Counselor
CCN	Case Control Number
CCPD	Continuous Cycling Peritoneal Dialysis
CCR	Cost-To-Charge Ratio
CCTP	Custodial Care Transitional Policy
CD	Compact Disc
CDC	Centers for Disease Control and Prevention
CDCF	Central Deductible and Catastrophic Cap File
CDD	Childhood Disintegrative Disorder
CDH	Congenital Diaphragmatic Hernia
CD-I	Compact Disc- Interactive
CDR	Clinical Data Repository

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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
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
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
CMS	Centers for Medicare and Medicaid Services
CMVP	Cryptographic Module Validation Program

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CNM	Certified Nurse Midwife
CNS	Central Nervous System Clinical Nurse Specialist
CO	Contracting Officer
COB	Close of Business Coordination of Benefits
COBC	Coordination of Benefits Contractor
COBRA	Consolidated Omnibus Budget Reconciliation Act
CoCC	Certificate of Creditable Coverage
COCO	Contractor Owned-Contractor Operated
COE	Common Operating Environment
CONUS	Continental United States
COO	Chief Operating Officer
COOP	Continuity of Operations Plan
COPA	Council on Postsecondary Accreditation
COPD	Chronic Obstructive Pulmonary Disease
COR	Contracting Officer's Representative
CORF	Comprehensive Outpatient Rehabilitation Facility
CORPA	Commission on Recognition of Postsecondary Accreditation
COTS	Commercial-off-the-shelf
CPA	Certified Public Accountant
CPE	Contract Performance Evaluation
CPI	Consumer Price Index
CPI-U	Consumer Price Index - Urban (Wage Earner)
CPNS	Certified Psychiatric Nurse Specialists
CPR	CAC PIN Reset
CPT	Chest Physiotherapy Current Procedural Terminology
CPT-4	Current Procedural Terminology, 4th Edition
CQMP	Clinical Quality Management Program
CQMP AR	Clinical Quality Management Program Annual Report
CQS	Clinical Quality Studies
CRM	Contract Resource Management (Directorate)
CRNA	Certified Registered Nurse Anesthetist
CRT	Computer Remote Terminal
CSA	Clinical Support Agreement
CSE	Communications Security Establishment (of the Government of Canada)
CSP	Corporate Service Provider Critical Security Parameter
CST	Central Standard Time
CSU	Channel Sending Unit
CSV	Comma-Separated Value
CSW	Clinical Social Worker

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IQM	Internal Quality Management
IRB	Institutional Review Board
IRR	Individual Ready Reserve
IRS	Internal Revenue Service
IRTS	Integration and Runtime Specification
IS	Information System
ISN	Investigation Schedule Notice
ISO	International Standard Organization
ISP	Internet Service Provider
IT	Information Technology
ITSEC	Information Technology Security Evaluation Criteria
IV	Initialization Vector Intravenous
IVF	In Vitro Fertilization
JC	Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations (JCAHO))
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCOS	Joint Chiefs of Staff
JFTR	Joint Federal Travel Regulations
JNI	Japanese National Insurance
JTF-GNO	Joint Task Force for Global Network Operations
JUSDAC	Joint Uniformed Services Dental Advisory Committee
JUSMAC	Joint Uniformed Services Medical Advisory Committee
JUSPAC	Joint Uniformed Services Personnel Advisory Committee
KB	Knowledge Base
KO	Contracting Officer
LAA	Limited Access Authorization
LAC	Local Agency Check
LAK	Lymphokine-Activated Killer
LAN	Local Area Network
LASER	Light Amplification by Stimulated Emission of Radiation
LCF	Long-term Care Facility
LDL	Low Density Lipoprotein
LDLT	Living Donor Liver Transplantation
LDR	Low Dose Rate
LLLT	Low Level Laser Therapy
LNT	Lexical Neighborhood Test
LOC	Letter of Consent
LOD	Letter of Denial/Revocation
LOI	Letter of Intent
LOS	Length-of-Stay
LOT	Life Orientation Test

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LPN	Licensed Practical Nurse
LSIL	Low-grade Squamous Intraepithelial Lesion
LSN	Location Storage Number
LTC	Long-Term Care
LUPA	Low Utilization Payment Adjustment
LVEF	Left Ventricular Ejection Fraction
LVN	Licensed Vocational Nurse
LVRS	Lung Volume Reduction Surgery
MAC	Maximum Allowable Charge Maximum Allowable Cost
MAC III	Mission Assurance Category III
MAID	Maximum Allowable Inpatient Day
MB&RB	Medical Benefits and Reimbursement Branch
MCIO	Military Criminal Investigation Organization
MCS	Managed Care Support
MCSC	Managed Care Support Contractor
MCSS	Managed Care Support Services
MCTDP	Myelomeningocele Clinical Trial Demonstration Protocol
MD	Doctor of Medicine
MDI	Mental Developmental Index
MDR	MHS Data Repository
MDS	Minimum Data Set
MEC	Marketing and Education Committee
MEI	Medicare Economic Index
MEPS	Military Entrance Processing Station
MEPRS	Medical Expense Performance Reporting System
MFCC	Marriage and Family Counseling Center
MGCRB	Medicare Geographic Classification Review Board
MGIB	Montgomery GI Bill
MH	Mental Health
MHO	Medical Holdover
MHS	Military Health System
MHSO	Managing Health Services Organization
MHSS	Military Health Services System
MI	Myocardial Infarction
MI&L	Manpower, Installations, and Logistics
MIA	Missing In Action
MIDCAB	Minimally Invasive Direct Coronary Artery Bypass
MIRE	Monochromatic Infrared Energy
MLNT	Multisyllabic Lexical Neighborhood Test
MMA	Medicare Modernization Act
MMP	Medical Management Program

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MMSO	Military Medical Support Office
MMWR	Morbidity and Mortality Weekly Report
MNR	Medical Necessity Report
MOA	Memorandum of Agreement
MOMS	Management of Myelomeningocele Study
MOP	Mail Order Pharmacy
MOU	Memorandum of Understanding
MPI	Master Patient Index
MR	Medical Review Mentally Retarded
MRA	Magnetic Resonance Angiography
MRHFP	Medicare Rural Hospital Flexibility Program
MRI	Magnetic Resonance Imaging
MRPU	Medical Retention Processing Unit
MS	Microsoft®
MSA	Metropolitan Statistical Area
MSC	Military Sealift Command
MSIE	Microsoft® Internet Explorer
MSP	Medicare Secondary Payer
MST	Mountain Standard Time
MSUD	Maple Syrup Urine Disease
MSW	Masters of Social Work Medical Social Worker
MT	Mountain Time
MTF	Military Treatment Facility
MUE	Medically Unlikely Edits
MV	Multivisceral (transplant)
MVS	Multiple Virtual Storage
MWR	Morale, Welfare, and Recreation
N/A	Not Applicable
N/D	No Default
NAC	National Agency Check
NACI	National Agency Check Plus Written Inquiries
NACLCL	National Agency Check with Law Enforcement and Credit
NADFM	Non-Active Duty Family Member
NARA	National Archives and Records Administration
NAS	Non-Availability Statement
NATO	North Atlantic Treaty Organization
NAVMEC	Naval Medical (Form)
NBCC	National Board of Certified Counselors
NCCI	National Correct Coding Initiatives
NCF	National Conversion Factor

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NCI	National Cancer Institute
NCPAP	Nasal Continuous Positive Airway Pressure
NCPDP	National Council of Prescription Drug Program
NCQA	National Committee for Quality Assurance
NCVHS	National Committee on Vital and Health Statistics
NDAA	National Defense Authorization Act
NDC	National Drug Code
NDMS	National Disaster Medical System
NED	National Enrollment Database
NETT	National Emphysema Treatment Trial
NF	Nursing Facility
NGPL	No Government Pay List
NHLBI	National Heart, Lung and Blood Institute
NHSC	National Health Service Corps
NICHHD	National Institute of Child Health and Human Development
NIH	National Institutes of Health
NII	Networks and Information Integration
NIPRNET	Nonsecure Internet Protocol Router Network
NIS	Naval Investigative Service
NISPOM	National Industrial Security Program Operating Manual
NIST	National Institute of Standards and Technology
NLT	No Later Than
NMES	Neuromuscular Electrical Stimulation
NMOP	National Mail Order Pharmacy
NMR	Nuclear Magnetic Resonance
NMT	Nurse Massage Therapist
NOAA	National Oceanic and Atmospheric Administration
NoPP	Notice of Private Practices
NOSCASTC	National Operating Standard Cost as a Share of Total Costs
NP	Nurse Practitioner
NPDB	National Practitioner Data Bank
NPI	National Provider Identifier
NPPES	National Plan and Provider Enumeration System
NPR	Notice of Program Reimbursement
NPS	Naval Postgraduate School
NPWT	Negative Pressure Wound Therapy
NQF	National Quality Forum
NRC	Nuclear Regulatory Commission
NTIS	National Technical Information Service
NUBC	National Uniform Billing Committee
NUCC	National Uniform Claims Committee
O/ATIC	Operations/Advanced Technology Integration Center

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OASD(HA)	Office of the Assistant Secretary of Defense (Health Affairs)
OASD (H&E)	Office of the Assistant Secretary of Defense (Health and Environment)
OASD (MI&L)	Office of the Assistant Secretary of Defense (Manpower, Installations, and Logistics)
OASIS	Outcome and Assessment Information Set
OB/GYN	Obstetrician/Gynecologist
OBRA	Omnibus Budget Reconciliation Act
OCE	Outpatient Code Editor
OCHAMPUS	Office of Civilian Health and Medical Program of the Uniformed Services
OCONUS	Outside of the Continental United States
OCR	Office of Civil Rights
OCSP	Organizational Corporate Services Provider
OCT	Optical Coherence Tomograph
OD	Optical Disk
OGC	Office of General Counsel
OGP	Other Government Program
OHI	Other Health Insurance
OHS	Office of Homeland Security
OIG	Office of Inspector General
OMB	Office of Management and Budget
OP/NSP	Operation/Non-Surgical Procedure
OPD	Outpatient Department
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
OR	Operating Room
OSA	Obstructive Sleep Apnea
OSAS	Obstructive Sleep Apnea Syndrome
OSD	Office of the Secretary of Defense
OSHA	Occupational Safety and Health Act
OSS	Office of Strategic Services
OT	Occupational Therapy (Therapist)
OTC	Over-The-Counter
OUSD	Office of the Undersecretary of Defense
OUSD (P&R)	Office of the Undersecretary of Defense (Personnel and Readiness)
P/O	Prosthetic and Orthotics
P&T	Pharmacy And Therapeutics (Committee)
PA	Physician Assistant
PACAB	Port Access Coronary Artery Bypass
PACO ₂	Partial Pressure of Carbon Dioxide
PAO ₂	Partial Pressure of Oxygen
PAK	Pancreas After Kidney (transplant)
PAP	Papanicolaou

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PAT	Performance Assessment Tracking
PatID	Patient Identifier
PAVM	Pulmonary Arteriovenous Malformation
PBM	Pharmacy Benefit Manager
PC	Personal Computer Professional Component
PCA	Patient Controlled Analgesia
PCDIS	Purchased Care Detail Information System
PCI	Percutaneous Coronary Intervention
PCM	Primary Care Manager
PCMBN	PCM By Name
PCMRA	PCM Research Application
PCMRS	PCM Panel Reassignment (Application) PCM Reassignment System
PCO	Procurement (Procuring) Contracting Officer
PCP	Primary Care Physician Primary Care Provider
PCS	Permanent Change of Station
PD	Passport Division
PDA	Patent Ductus Arteriosus Personal Digital Assistant
PDDBI	Pervasive Developmental Disorders Behavior Inventory
PDDNOS	Pervasive Developmental Disorder Not Otherwise Specified
PDF	Portable Document Format
PDQ	Physicians's Data Query
PDR	Person Data Repository
PDS	Person Demographics Service
PDTS	Pharmacy Data Transaction System
PDX	Principal Diagnosis
PE	Physical Examination
PEC	Pharmacoeconomic Center
PEP	Partial Episode Payment
PEPR	Patient Encounter Processing and Reporting
PERMS	Provider Education and Relations Management System
PET	Positron Emission Tomography
PFCRA	Program Fraud Civil Remedies Act
PFP	Partnership For Peace
PFPWD	Program for Persons with Disabilities
Phen-Fen	Pondimin and Redux
PHI	Protected Health Information
PHIMT	Protected Health Information Management Tool
PHP	Partial Hospitalization Program
PHS	Public Health Service

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PI	Program Integrity (Office)
PIA	Privacy Impact Assessment (Online)
PIC	Personnel Investigation Center
PIE	Pulsed Irrigation Evacuation
PIN	Personnel Identification Number
PIP	Personal Injury Protection Personnel Identity Protection
PIT	PCM Information Transfer
PIV	Personal Identity Verification
PK	Public Key
PKE	Public Key Enabling
PKI	Public Key Infrastructure
PKU	Phenylketonuria
PLS	Preschool Language Scales
PM-DRG	Pediatric Modified-Diagnosis Related Group
PMR	Percutaneous Myocardial Laser Revascularization
PNET	Primitive Neuroectodermal Tumors
PNT	Policy Notification Transaction
POA	Power of Attorney Present On Admission
POA&M	Plan of Action and Milestones
POC	Pharmacy Operations Center Plan of Care Point of Contact
POL	May 1996 TRICARE/CHAMPUS Policy Manual 6010.47-M
POS	Point of Sale (Pharmacy only) Point of Service Public Official's Statement
POV	Privately Owned Vehicle
PPD	Per Patient Day
PPN	Preferred Provider Network
PPO	Preferred Provider Organization
PPP	Purchasing Power Parity
PPS	Prospective Payment System Ports, Protocols and Services
PPSM	Ports, Protocols, and Service Management
PPV	Pneumococcal Polysaccharide Vaccine
PQI	Potential Quality Indicator Potential Quality Issue
PR	Periodic Reinvestigation
PRC	Program Review Committee
PRG	Peer Review Group
PRO	Peer Review Organization

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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
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
PVCs	Premature Ventricular Contractions
QA	Quality Assurance
QC	Quality Control
QI	Quality Improvement Quality Issue
QII	Quality Improvement Initiative
QIO	Quality Improvement Organization
QIP	Quality Improvement Program
QLE	Qualifying Life Event
QM	Quality Management
QUIG	Quality Indicator Group
RA	Remittance Advice
RAM	Random Access Memory
RAP	Request for Anticipated Payment
RAPIDS	Real-Time Automated Personnel Identification System
RC	Reserve Component
RCN	Recoupment Case Number Refund Control Number
RCS	Report Control Symbol
RD	Regional Director
RDBMS	Relational Database Management System
RDDDB	Reportable Disease Database
REM	Rapid Eye Movement

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RFA	Radiofrequency Ablation
RFI	Request For Information
RFP	Request For Proposal
RHC	Rural Health Clinic
RHHI	Regional Home Health Intermediary
RhoGAM	RRho (D) Immune Globulin
RN	Registered Nurse
RNG	Random Number Generator
RO	Regional Office
ROC	Resumption of Care
ROFR	Right of First Refusal
ROM	Read-Only Memory Rough Order of Magnitude
ROT	Read-Only Table
ROTC	Reserved Officer Training Corps
ROVER	RHHI Outcomes and Assessment Information Set Verification
RPM	Record Processing Mode
RRA	Regional Review Authority
RTC	Residential Treatment Center
RUG	Resource Utilization Group
RV	Residual Volume
RVU	Relative Value Unit
SAAR	System Authorization Access Request
SAD	Seasonal Affective Disorder
SADMERC	Statistical Analysis Durable Medical Equipment Regional Carrier
SAFE	Sexual Assault Forensic Examination
SAO	Security Assistant Organizations
SAP	Special Access Program
SAPR	Sexual Assault Prevention and Response
SAS	Sensory Afferent Stimulation
SAT	Service Assist Team
SBCC	Service Branch Classification Code
SBI	Special Background Investigation
SCH	Sole Community Hospital
SCHIP	State Children's Health Insurance Program
SCI	Sensitive Compartmented Information Spinal Cord Injury
SCIC	Significant Change in Condition
SCOO	Special Contracts and Operations Office
SCR	Stell Cell Rescue
S/D	Security Division
SD (Form)	Secretary of Defense (Form)

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SEP	Sensory Evoked Potentials
SES	Senior Executive Service
SelRes	Selected Reserve
SF	Standard Form
SGDs	Speech Generating Devices
SHCP	Supplemental Health Care Program
SI	Sensitive Information Small Intestine (transplant) Special Indicator (code) Status Indicator
SIDS	Sudden Infant Death Syndrome
SIF	Source Input Format
SII	Special Investigative Inquiry
SI/L	Small Intestine-Live (transplant)
SIOP-ESI	Single Integrated Operational plan-Extremely Sensitive Information
SIP	System Identification Profile
SIT	Standard Insurance Table
SMC	System Management Center
SNF	Skilled Nursing Facility
SNS	Sacral Nerve Root Stimulation
SOC	Start of Care
SOFA	Status Of Forces Agreement
SOIC	Senior Officer of the Intelligence Community
SON	Submitting Office Number
SOR	Statement of Reasons
SPA	Simple Power Analysis
SPECT	Single Photon Emission Computed Tomography
SPK	Simultaneous Pancreas Kidney (transplant)
SPOC	Service Point of Contact
SPR	SECRET Periodic Reinvestigation
SQL	Structured Query Language
SRE	Serious Reportable Event
SSA	Social Security Act Social Security Administration
SSAA	Social Security Authorization Agreement
SSAN	Social Security Administration Number
SSBI	Single-Scope Background Investigation
SSL	Secure Socket Layer
SSM	Site Security Manager
SSN	Social Security Number
SSO	Short-Stay Outlier
ST	Speech Therapy
STF	Specialized Treatment Facility

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STS	Specialized Treatment Services
STSF	Specialized Treatment Service Facility
SUBID	Sub-Identifier
SUDRF	Substance Use Disorder Rehabilitation Facility
SVO	SIT Validation Office
SVT	Supraventricular Tachycardia
SWLS	Satisfaction With Life Scale
TAD	Temporary Additional Duty
TAFIM	Technical Architecture Framework for Information Management
TAMP	Transitional Assistance Management Program
TAO	TRICARE Alaska Office TRICARE Area Office
TAR	Total Ankle Replacement
TARO	TRICARE Alaska Regional Office
TB	Tuberculosis
TBD	To Be Determined
TBE	Tick Borne Encephalitis
TBI	Traumatic Brain Injury
TC	Technical Component
TCP/IP	Transmission Control Protocol/Internet Protocol
TCSRC	Transitional Care for Service-Related Conditions
TDEFIC	TRICARE Dual Eligible Fiscal Intermediary Contract
TDP	TRICARE Dental Plan
TDY	Temporary Duty
TED	TRICARE Encounter Data
TEE	Transesophageal Echocardiograph
TEFRA	Tax Equity and Fiscal Responsibility Act
TEOB	TRICARE Explanation of Benefits
TEPRC	TRICARE Encounter Pricing (Record)
TEPRV	TRICARE Encounter Provider (Record)
TET	Tubal Embryo Transfer
TF	Transfer Factor
TFL	TRICARE For Life
TFMDP	TRICARE (Active Duty) Family Member Dental Plan
TGRO	TRICARE Global Remote Overseas
TGROHC	TGRO Host Country
TIFF	Tagged Imaged File Format
TIL	Tumor-Infiltrating Lymphocytes
TIMPO	Tri-Service Information Management Program Office
TIN	Taxpayer Identification Number
TIPS	Transjugular Intrahepatic Portosystemic Shunt
TIS	TRICARE Information Service

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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
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
TPA	Third Party Administrator
TPC	Third Party Collections
TPharm	TRICARE Pharmacy
TPL	Third Party Liability
TPM	August 2002 TRICARE Policy Manual 6010.54-M February 2008 TRICARE Policy Manual 6010.57-M
TPN	Total Parenteral Nutrition
TPOCS	Third Party Outpatient Collections System
TPR	TRICARE Prime Remote
TPRADFM	TRICARE Prime Remote Active Duty Family Member
TPRADSM	TRICARE Prime Remote Active Duty Service Member
TPRC	TRICARE Puerto Rico Contract(or)
TQMC	TRICARE Quality Monitoring Contractor
TRDP	TRICARE Retiree Dental Program
TRI	TED Record Indicator
TRM	August 2002 TRICARE Reimbursement Manual 6010.55-M February 2008 TRICARE Reimbursement Manual 6010.58-M
TRO	TRICARE Regional Office
TRPB	TRICARE Retail Pharmacy Benefits
TRRx	TRICARE Retail Pharmacy
TRS	TRICARE Reserve Select
TRSA	TRICARE Reserve Select Application
TSC	TRICARE Service Center
TSF	Target of Evaluation Security Functions

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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
TTPA	Temporary Transitional Payment Adjustment
TTY	Teletypewriter
TUNA	Transurethral Needle Ablation
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
UCCI	United Concordia Companies, Inc.
UCSF	University of California San Francisco
UIC	Unit Identification Code
UIN	Unit Identifier Number
UM	Utilization Management
UMO	Utilization Management Organization
UMP	User Maintenance Portal
UPIN	Unique Physician Identification Number
UPPP	Uvulopalatopharyngoplasty
URF	Unremarried Former Spouses
URL	Universal Resource Locator
US	Ultrasound United States
USA	United States of America
USACID	United States Army Criminal Investigation Division
USAF	United States Air Force
USAO	United States Attorneys' Office
USC	United States Code
USCG	United States Coast Guard
USCO	Uniformed Services Claim Office
USD	Undersecretary of Defense
USD (P&R)	Undersecretary of Defense (Personnel and Readiness)
USDI	Undersecretary of Defense for Intelligence
USFHP	Uniformed Services Family Health Plan
USHBP	Uniformed Services Health Benefit Plan

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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
WEDI	Workgroup for Electronic Data Interchange
WIC	Women, Infants, and Children (Program)
WII	Wounded, Ill, and Injured
WLAN	Wireless Local Area Network
WORM	Write Once Read Many
WRAMC	Walter Reed Army Medical Center
WTC	World Trade Center
WTRR	Wire Transfer Reconciliation Report
WTU	Warrior Transition Unit
X-Linked SCID	X-Linked Severe Combined Immunodeficiency Syndrome
XML	eXtensible Markup Language
ZIFT	Zygote Intrafallopian Transfer

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2D	Two Dimensional
3D	Three Dimensional

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