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**CHANGE 131
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WHEN PRESCRIBED ACTION HAS BEEN TAKEN, FILE THIS TRANSMITTAL WITH BASIC DOCUMENT.

**CHANGE 131
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CHAPTER 14

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APPENDIX A

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SUMMARY OF CHANGES

CHAPTER 14

1. This change confirms that the Sole Community Hospitals End of Year Voucher process is not applicable to TRICARE Overseas Program or the TRICARE Dual Eligible Fiscal Intermediary.
EFFECTIVE DATE: 01/01/2014.

Sole Community Hospitals (SCHs)

Issue Date: November 6, 2007

Authority: [32 CFR 199.14\(a\)\(1\)\(ii\)\(D\)\(6\)](#)

1.0 APPLICABILITY

This policy is mandatory for the reimbursement of services provided either by network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the **Defense Health Agency (DHA)** and specifically included in the network provider agreement.

2.0 DESCRIPTION

A Sole Community Hospital is a hospital that is designated by the Centers for Medicare and Medicaid Services (CMS) as an SCH and meets the applicable requirements established by [32 CFR 199.6\(b\)\(4\)\(xvii\)](#).

3.0 ISSUE

How are SCHs to be reimbursed?

4.0 POLICY

4.1 Background

Under Title 10, United States Code (USC), Section 1079(j)(2), the amount to be paid to hospitals, Skilled Nursing Facilities (SNFs), and other institutional providers under TRICARE, "shall be determined to the extent practicable in accordance with the same reimbursement rules as apply to payments to providers of services of the same type under Medicare."

4.2 Payment Method For Inpatient Services

4.2.1 For admissions prior to January 1, 2014, institutional inpatient services (other than professional) provided by SCHs shall be reimbursed based on billed charges or negotiated rates.

4.2.2 Primary and Secondary Reimbursement Methodologies

4.2.2.1 For admissions on or after January 1, 2014, inpatient services that are provided by SCHs shall be reimbursed using a primary methodology referred to as a Cost-To-Charge Ratio (CCR) methodology. That is, claims shall be reimbursed by multiplying the SCH's specific Medicare overall inpatient CCR obtained from the CMS Inpatient Provider Specific File (PSF) by the hospital's billed

charges. However, during the transition period discussed in [paragraph 4.2.4](#), a modified CCR is used.

4.2.2.2 Claims shall also be priced using the secondary methodology, i.e., the Diagnosis Related Group (DRG)-based payment methodology, for accumulation and subsequent comparison to the primary methodology amount at year-end.

4.2.3 Year-End Comparison

4.2.3.1 At year-end, the contractor shall compare the aggregate allowed amount under the primary methodology, i.e., the CCR methodology (described in [paragraph 4.2.2.1](#) or [4.2.4](#) during the transition period) to the aggregate allowed amount for the same care under the secondary methodology, i.e., the DRG-based payment methodology. **The year-end comparison is not applicable to the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) contractor or the TRICARE Overseas Program (TOP) contract.**

4.2.3.2 In the event that the DRG allowed amount is the greater of the two calculations, the contractor shall reimburse the hospital the difference between the aggregate allowed amount under the primary cost-based methodology and what would have been allowed under the secondary DRG-based methodology.

4.2.3.3 The comparison shall be applied at the end of the **DHA** SCH year, based on a 12 month period after the effective date of implementation which is January 1, 2014. The first SCH year is January 1, 2014 to December 31, 2014.

4.2.3.4 **DHA** shall provide the contractor a hospital-specific capital adjustment factor in the file with the hospital specific CCR. The contractor shall adjust the DRG amount to include capital by multiplying the DRG amount by the DRG capital adjustment factor. The DRG capital adjustment factor will be equal to one plus a value equal to the capital CCR for a specific hospital divided by its operating CCR. For example, if a SCH's operating CCR is 0.35 and its capital CCR is 0.028, then the DRG capital adjustment factor would be equal to $1 + (0.028/0.35)$ which is equal to 1.08.

4.2.4 Transition Period

4.2.4.1 In the Final Rule published in the **Federal Register** on August 8, 2013, **DHA** created a multi-year transition period to buffer the impact from any potential decrease in revenue that hospitals may experience during the implementation of a revised SCH inpatient payment system. This transition period provides SCHs with sufficient time to adjust and budget for potential revenue reductions. The transition is as follows:

DHA will measure the ratio of allowed charges to billed charges during Fiscal Year 2012 (FY12) (the base year) for inpatient hospitalizations where **DHA** is the primary payer and a ratio of allowed to billed charges will be established for each SCH during FY12. This ratio will be used in calculating the modified CCR during the transition period. In the first year of the transition, the allowed amount for each claim under the modified CCR methodology shall be equal to the billed charge multiplied by the modified CCR. The modified CCR is determined separately for each SCH. For network hospitals, the modified CCR is equal to the base year ratio of the allowed to billed minus 0.10. Each year thereafter the modified CCR will decline by 0.10 until it reaches the SCH's Medicare CCR. The SCH's specific Medicare CCR is equal to the sum of the SCH's operating and

capital CCR taken from the most recently available CMS Inpatient PSF. For non-network SCHs, the base year rate will decline by 0.15 each year until the SCH reaches its specific Medicare CCR as taken from the most recently available CMS Inpatient PSF.

Example: In the case of a non-network hospital with Medicare CCR of 0.40 and a base year allowed-to-billed ratio of 1.0, payment in the first year for an inpatient hospitalization claim would be equal to the billed charges on that claim multiplied by a factor of 0.85. The factor in the second year would be 0.70, in the third year it would be 0.55, in the fourth year it would be 0.40, in the fifth year it would be 0.25, and in the sixth year it would be 0.10. In no case can the ratio in a year be less than the hospital's CCR in that year. In the case of a network hospital with a Medicare CCR of 0.40 and an allowed-to-billed base year ratio of 0.90, payment in the first year for an inpatient hospitalization claim would be equal to the billed charges on that claim multiplied by 0.80. The factors in subsequent years would be 0.70, 0.60, 0.50, 0.40, etc. until the CCR is reached.

4.2.4.2 In no year shall the modified CCR fall below the hospital's overall Medicare CCR, as measured by the most recently available inpatient Medicare CCR from the CMS inpatient PSF.

4.2.4.3 Once the hospital reaches its Medicare CCR, the transition is complete for that hospital.

4.2.5 Nursery and Labor/Delivery Adjustment (NLDA)

At the end of a SCH's transition period, i.e., when the SCH reaches its Medicare CCR, a special allowable cost shall be applied to charges for inpatient nursery and labor/delivery DRGs (610-613, 631-636, 646-651, 676-681, 765-768, 774, 775, 787-792, and 795). Instead of applying the Medicare CCR for these DRGs, DHA shall apply 130% of the Medicare CCR.

4.2.6 New SCHs and SCHs Without Inpatient Claims

DHA shall pay a new SCH using the average Medicare CCR for all SCHs calculated in the most recent year until its Medicare CCR is available in the CMS inpatient PSF. This applies to any SCH without a Medicare CCR in the inpatient PSF. DHA shall pay hospitals that have a CCR in the inpatient PSF and that change their status to an SCH using that Medicare CCR. For SCHs that had no inpatient claims from DHA immediately prior to implementation of the SCH payment reform but do have a claim after implementation of SCH payment reform, DHA shall pay them based directly on their Medicare CCR.

4.2.7 DHA Data

4.2.7.1 During the transition period, on an annual basis, DHA shall provide the contractors with modified CCRs. The overall Medicare CCR is the sum of Medicare's operating and capital inpatient CCRs for each SCH. The operating and capital CCR shall be from the most recently available CMS inpatient PSF.

4.2.7.2 Following the transition, DHA will continue to provide the contractors with the DHA SCH CCR listing by January 1 of each year.

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4.2.7.3 The DHA SCH CCR listing during the transition period and thereafter shall be effective for admissions on and after January 1 of each respective year. The contractors shall use the CCRs on the DHA SCH CCR listing for the entire DHA SCH year, i.e., January 1 through December 31.

4.2.7.4 DHA shall also provide the contractors the average Medicare CCR to use for SCHs, without a CCR in the inpatient PSF.

4.2.7.5 DHA shall also provide the contractors with a hospital-specific capital adjustment factor in the file with the hospital-specific CCR.

4.2.8 Process for SCHs Year One (Effective January 1, 2014 through December 31, 2014) and Subsequent Years

4.2.8.1 Approximately three months after the end of the DHA SCH year, the contractors shall run query reports of claims history and compare the aggregate allowed amount per SCH under the cost-based methodology during the previous DHA SCH year to the aggregate allowed amount per SCH for the same care under the DRG-based payment system methodology (that also includes the hospital-specific capital adjustment), for each SCH. **Running query reports of claims history and completing the year-end comparison is not applicable to TDEFIC and TOP contracts.**

4.2.8.2 In the event that the DRG allowed amount is the greater of the two calculations, the contractor shall process adjustment payments per the instructions in Section G of their contract under invoice and Payment Non-Underwritten - Non-TRICARE Encounter Data (TED), Demonstrations. No payments will be sent out without approval from DHA-Aurora (DHA-A), Contract Resource Management (CRM), Budget.

4.2.8.3 The year-end adjustments will be paid approximately six months following the end of the DHA SCH year.

4.2.9 General Temporary Military Contingency Payment Adjustments (GTMCPAs)

4.2.9.1 The DHA Director, or designee, may approve a GTMCPA based on the following:

- The hospital serves a disproportionate share of Active Duty Service Members (ADSMs) and Active Duty Dependents (ADDs), i.e., 10% or more of an SCH's total admissions are for ADSMs and ADDs;
- The hospital is a DHA network hospital;
- The hospital's actual costs for inpatient services exceed DHA payments or other extraordinary economic circumstance exists; and
- Without the GTMCPA, Department of Defense's (DoD's) ability to meet military contingency mission requirements will be significantly compromised.

4.2.9.2 Following is the GTMCPA Process for the first DHA SCH year (January 1, 2014 through December 31, 2014) and subsequent years.

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4.2.9.2.1 The Director, TRICARE Regional Office (DTRO), shall conduct a thorough analysis and recommend approval to the **DHA** Director of an appropriate year-end adjustment to total SCH payments for a network hospital qualifying for a GTMCPA.

4.2.9.2.2 In analyzing and recommending the appropriate year-end percentage adjustment, the DTRO shall ensure the SCH meets the four criteria listed in [paragraph 4.2.9.1](#) and the GTMCPA does not exceed a ratio of 1.15 above the hospital's costs during the previous **DHA** SCH year.

4.2.9.3 Following are the annual Data Requirements for GTMCPAs for the first **DHA** SCH year (January 1, 2014 through December 31, 2014) and subsequent years.

4.2.9.3.1 The hospital's request for a GTMCPA for the first **DHA** SCH year shall include the data requirements in [paragraph 4.2.9.4](#), and a full 12 months of claims payment data from the **DHA** SCH year the GTMCPA is requested.

4.2.9.3.2 The hospital shall submit the following information to the contractor for review and consideration:

- The total number of admissions during the previous **DHA** SCH year and the number of ADSM and ADD admissions for this same period.
- The hospital's rationale and the recommended percentage adjustment as supported by the above data requirement submissions.

4.2.9.4 Following are the annual Contractor Data Review Requirements for the first **DHA** SCH year (January 1 through December 31) and subsequent years, to evaluate network adequacy necessary to support military contingency mission requirements:

- Number of acute care hospitals and beds in the network locality;
- Availability and types of services of military acute care services in the locations or nearby;
- Efforts that have been made to create an adequate network; and
- Other cost effective alternatives and other relevant factors.

4.2.9.5 If upon initial evaluation, the contractor determines the hospital meets the disproportionate share criteria in [paragraph 4.2.9.1](#) and is deemed essential for continued network adequacy, the request from the hospital along with the supporting documentation in [paragraph 4.2.9.4](#) shall be submitted to the DTRO for review and determination.

4.2.9.6 The DTRO shall request **DHA** Medical Benefits & Reimbursement **Section** (MB&RS) run a query of claims history to determine if the network hospital qualifies for a GTMCPA, i.e., the hospital's payment-to-cost ratio is less than 1.15 for care provided to ADSMs and ADDs during the previous **DHA** SCH year (January 1 through December 31).

4.2.9.7 The DTRO shall review the supporting documentation and the report from **DHA** MB&RS to determine if the network hospital qualifies for a GTMCPA. The recommendation for approval of a

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GTMCPA shall be submitted to the MB&RS to be forwarded to the Director, DHA, or designee for review and approval. Disapprovals by the DTRO will not be forwarded to MB&RS for DHA Director review and approval.

4.2.9.8 If a hospital meets the disproportionate share criteria in [paragraph 4.2.9.1](#) and is deemed essential for network adequacy to support military contingency mission requirements, the approved hospital's GTMCPA will be set so the hospital's payment-to-cost ratio for DHA inpatient services does not exceed a ratio of 1.15. A hospital cannot be approved for a GTMCPA if it results in a hospital earning more than 15% above its costs for TRICARE beneficiaries.

4.2.9.9 Total DHA SCH payments for the qualifying hospital will be increased by the Director DHA, or designee, by way of an additional payment after the end of the DHA SCH year (January 1 through December 31). Subsequent adjustments will be issued to the qualifying hospitals for the prior DHA SCH year to ensure claims that were incurred but not reported the previous year are adjusted. The adjustment payment is separate from the application GTMCPA approved for the current DHA SCH year.

4.2.9.10 Upon approval of the GTMCPA request by the DHA Director, MB&RS shall notify the DTRO of the approval. The DTRO shall notify the Contracting Officer (CO) who shall send a letter to the contractor notifying them of the approval.

4.2.9.11 The contractors shall process the adjustment payments per the instructions in Section G of their contracts under Invoice and Payment Non-Underwritten - Non-TEDs, Demonstrations. No payments will be sent out without approval from DHA-Aurora, CRM, Budget.

4.2.9.12 DHA-Aurora shall send an approval to the contractors to issue GTMCPA payments out of the non-financially underwritten bank account based on fund availability.

4.2.9.13 GTMCPAs shall be reviewed and approved on an annual basis; i.e., they will have to be evaluated on a yearly basis by the DTRO in order to determine if the hospital continues to serve a disproportionate share of ADSMs and ADDs and whether there are any other special circumstances significantly affecting military contingency capabilities.

4.2.9.14 The Director, DHA or designee is the final approval authority. A decision by the Director DHA or designee to adopt, modify, or extend GTMCPAs is not subject to the appeal and hearing procedures in [32 CFR 199.10](#).

4.2.10 Essential Access Community Hospitals (EACHs)

The SCH reimbursement method applies to hospitals classified by CMS as EACHs.

4.2.11 Direct Medical Education

DHA will reimburse SCHs who timely file a request for their direct medical education costs as outlined in [Chapter 6, Section 8](#).

4.3 Payment Method For Outpatient Services

Outpatient services provided by a SCH are subject to DHA's Outpatient Prospective Payment

System (OPPS). Reference [Chapter 13](#).

4.4 SCH Listing

4.4.1 Prior to July 1, 2014, DHA will maintain the SCH listing on DHA's web site: <http://www.tricare.mil/hospitalclassification/>, and will update the list on a quarterly basis and notify the contractors by e-mail when the list is updated.

4.4.1.1 After June 1, 2006, and prior to January 1, 2014, if an SCH is added or dropped off of the list from the previous update, the quarterly revision date of the current listing shall be listed as the facility's effective or termination date, respectively.

4.4.1.2 Prior to July 1, 2014, if the contractor receives documentation from an SCH indicating their status is different than what is on the SCH listing on DHA's web site, the contractor shall send the information to DHA, MB&RS to review and to update the listings on the web, if appropriate.

4.4.2 Effective July 1, 2014, DHA will no longer update and maintain the SCH listing on DHA's web site. It is the contractor's responsibility to determine whether a hospital has been designated as an SCH under CMS and to reimburse them in accordance with the provisions of this policy. The contractors shall maintain accurate network status of their regional SCHs.

4.4.3 Effective July 1, 2014, the contractors shall take the steps necessary to ensure they are identifying and reimbursing SCHs appropriately. This may include referencing CMS' Inpatient Provider Specific File (IPSF) at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PropMedicareFeeSvcPmtGen/psf_text.html, contacting hospitals in their region to verify hospital status, or some other action to meet this requirement. SCHs are identified in CMS' IPSF by provider type 16 or 17 for SCHs and 21 or 22 for EACHs. CMS' IPSF is an historical file with effective dates for any change made to it, e.g., change in hospital status.

4.5 Billing And Coding Requirements

4.5.1 The contractors shall use type of institution 91 for SCHs.

4.5.2 The contractors shall use pricing rate code CR for inpatient SCH claims priced using the methodology described in [paragraphs 4.2.2.1](#) and [4.2.4](#).

5.0 EXCLUSIONS

5.1 Psychiatric and rehabilitation distinct part units are exempt from the inpatient SCH CCR methodology.

5.2 State Waivers. The DRG-based payment system provides for state waivers for states utilizing state developed rates applicable to all payers; i.e., Maryland. Psychiatric hospitals and units in these states, may also qualify for the waiver; however, the per diem may not exceed the cap amount applicable to other higher volume hospitals.

5.3 The SCH reimbursement method does not apply to any costs of physician services or other professional services provided to SCH inpatients.

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5.4 The SCH reimbursement method does not apply to hospitals in states that are paid by Medicare and **DHA** under a cost containment waiver; i.e., Maryland.

6.0 EFFECTIVE DATE

Implementation of the SCH CCR reimbursement method for inpatient services is effective for admissions on or after January 1, 2014.

- END -

Acronyms And Abbreviations

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

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Appendix A

Acronyms And Abbreviations

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

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Appendix A

Acronyms And Abbreviations

IEA	Intradiscal Electrothermal Annuloplasty
IEP	Individualized Educational Program
IFC	Interim Final Rule with comment
IFR	Interim Final Rule
IFSP	Individualized Family Service Plan
IG	Implementation Guidance
IgA	Immunoglobulin A
IGCE	Independent Government Cost Estimate
IHC	Immunohistochemistry
IHI	Institute for Healthcare Improvement
IHS	Indian Health Service
IIHI	Individually Identifiable Health Information
IIP	Implantable Infusion Pump
IM	Information Management Instant Message/Messaging Intramuscular
IMRT	Intensity Modulated Radiation Therapy
IND	Investigational New Drugs
INR	International Normalized Ratio Intramuscular International Normalized Ratio
INS	Immigration and Naturalization Service
IOC	Initial Operational Capability
IOD	Interface Operational Description
IOLs	Intraocular Lenses
IOM	Internet Only Manual
IOP	Intraocular Pressure
IORT	Intra-Operative Radiation Therapy
IP	Inpatient
IPC	Information Processing Center (outdated term, see SMC)
IPHC	Intraperitoneal Hyperthermic Chemotherapy
IPN	Intraperitoneal Nutrition
IPP	In-Person Proofing
IPPS	Inpatient Prospective Payment System
IPS	Individual Pricing Summary
IPSEC	Secure Internet Protocol
IPSF	Inpatient Provider Specific File
IQ	Intelligence Quotient
IQM	Internal Quality Management
IRB	Institutional Review Board
IRF	Inpatient Rehabilitation Facility
IRR	Individual Ready Reserve
IRS	Internal Revenue Service
IRTS	Integration and Runtime Specification

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Appendix A

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IS	Information System
ISN	Investigation Schedule Notice
ISO	International Standard Organization
ISP	Internet Service Provider
IT	Information Technology
ITSEC	Information Technology Security Evaluation Criteria
IV	Initialization Vector Intravenous
IVD	In Vitro Diagnostic Ischemic Vascular Disease
IVF	In Vitro Fertilization
JC	Joint Commission (formerly Joint Commission on Accreditation of Healthcare Organizations (JCAHO))
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
JCIH	Joint Committee on Infant Hearing
JCOS	Joint Chiefs of Staff
JFTR	Joint Federal Travel Regulations
JNI	Japanese National Insurance
JTF-GNO	Joint Task Force for Global Network Operations
JUSDAC	Joint Uniformed Services Dental Advisory Committee
JUSMAC	Joint Uniformed Services Medical Advisory Committee
JUSPAC	Joint Uniformed Services Personnel Advisory Committee
KB	Knowledge Base
KO	Contracting Officer
LAA	Limited Access Authorization
LAC	Local Agency Check
LAK	Lymphokine-Activated Killer
LAN	Local Area Network
LASER	Light Amplification by Stimulated Emission of Radiation
LCD	Local Coverage Determination
LCF	Long-term Care Facility
LCIS	Lobular Carcinoma In Situ
LDL	Low Density Lipoprotein
DLT	Living Donor Liver Transplantation
LDR	Low Dose Rate
LDT	Laboratory Developed Test
LE ESWT	Low Energy Extracorporeal Shock Wave Therapy
LGS	Lennox-Gastaut Syndrome
LH	Luteinizing Hormone
LIS	Low Income Subsidy
LLLT	Low Level Laser Therapy
LNT	Lexical Neighborhood Test
LOC	Letter of Consent

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Appendix A

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LOD	Letter of Denial/Revocation Line of Duty
LOI	Letter of Intent
LOS	Length-of-Stay
LOT	Life Orientation Test
LPA	Licensed Psychological Associate
LPC	Licensed Professional Counselor
LPN	Licensed Practical Nurse
LSIL	Low-grade Squamous Intraepithelial Lesion
LSN	Location Storage Number
LTC	Long-Term Care
LUPA	Low Utilization Payment Adjustment
LV	Left Ventricle [Ventricular]
LVEF	Left Ventricular Ejection Fraction
LVN	Licensed Vocational Nurse
LVRS	Lung Volume Reduction Surgery
LVSD	Left Ventricular Systolic Dysfunction
MAC	Maximum Allowable Charge Maximum Allowable Cost
MAC III	Mission Assurance Category III
MAID	Maximum Allowable Inpatient Day
MAP	MYH-Associated Polyposis
MB&RS	Medical Benefits and Reimbursement Section
MBI	Molecular Breast Imaging
MCIO	Military Criminal Investigation Organization
MCS	Managed Care Support
MCSC	Managed Care Support Contractor
MCSS	Managed Care Support Services
MCTDP	Myelomeningocele Clinical Trial Demonstration Protocol
MD	Doctor of Medicine
MDI	Mental Developmental Index Multiple Daily Injection
MDR	MHS Data Repository
MDS	Minimum Data Set
MEB	Medical Evaluation Board
MEC	Marketing and Education Committee
MEI	Medicare Economic Index
MEPS	Military Entrance Processing Station
MEPRS	Medical Expense Performance Reporting System
MESA	Microsurgical Epididymal Sperm Aspiration
MET	Microcurrent Electrical Therapy
MFCC	Marriage and Family Counseling Center
MGCRB	Medicare Geographic Classification Review Board

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Appendix A

Acronyms And Abbreviations

MGIB	Montgomery GI Bill
MH	Mental Health
MHCC	Maryland Health Care Commission
MHO	Medical Holdover
MHS	Military Health System
MHSO	Managing Health Services Organization
MHSS	Military Health Services System
MI	Myocardial Infarction
MI&L	Manpower, Installations, and Logistics
MIA	Missing In Action
MIAP	Multi-Host Internet Access Portal
MIDCAB	Minimally Invasive Direct Coronary Artery Bypass
mild®	Minimally Invasive Lumbar Decompression
MIRE	Monochromatic Infrared Energy
MLNT	Multisyllabic Lexical Neighborhood Test
MM	Medical Management
MMA	Medicare Modernization Act
MMEA	Medicare and Medicaid Extenders Act (of 2010)
MMP	Medical Management Program
MMPCMHP	Maryland Multi-Payer Patient-Centered Medical Home Program
MMPP	Maryland Multi-Payer Patient
MMR	Mismatch Repair
MMWR	Morbidity and Mortality Weekly Report
MNR	Medical Necessity Report
MOA	Memorandum of Agreement
MOH	Medal Of Honor
MOMS	Management of Myelomeningocele Study
MOP	Mail Order Pharmacy
MOU	Memorandum of Understanding
MPC	Medical Payments Coverage
MPI	Master Patient Index
MR	Magnetic Resonance Medical Review Mentally Retarded
MRA	Magnetic Resonance Angiography
MRHFP	Medicare Rural Hospital Flexibility Program
MRI	Magnetic Resonance Imaging
MRPU	Medical Retention Processing Unit
MRS	Magnetic Resonance Spectroscopy
MS	Microsoft® Multiple Sclerosis
MSA	Metropolitan Statistical Area
MSC	Military Sealift Command