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TRICARE
MANAGEMENT ACTIVITY

MB&RB

CHANGE 70
6010.58-M
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PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR TRICARE REIMBURSEMENT MANUAL (TRM), FEBRUARY 2008

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

CHANGE TITLE: **2012 CLARIFICATIONS - HOME INFUSION, SKILLED NURSING FACILITY (SNF), PROSTHETICS, OSTEOPOROSIS, TRICARE/MEDICARE, THERAPEUTIC SHOES, ORTHOTICS, AND APPLIED BEHAVIORAL ANALYSIS (ABA)**

CONREQ: 15911

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): See page 3.

EFFECTIVE DATE: Upon direction of the Contracting Officer.

IMPLEMENTATION DATE: Upon direction of the Contracting Officer.

This change is made in conjunction with Feb 2008 TPM, Change No. 71.

Ann N. Fazzini

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Chief, Medical Benefits and Reimbursement Branch

ATTACHMENT(S): **30 PAGE(S)**
DISTRIBUTION: **6010.58-M**

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

REMOVE PAGE(S)	**INSERT PAGE(S)**
CHAPTER 1	
Section 15, pages 1 and 2	Section 15, pages 1 and 2
CHAPTER 3	
Table of Contents, page 1	Table of Contents, page 1
Section 6, pages 1 and 2	Section 6, pages 1 and 2
★ ★ ★ ★ ★ ★	Section 7, pages 1 through 3
CHAPTER 4	
Section 4, pages 1 through 7	Section 4, pages 1 through 7
CHAPTER 8	
Section 2, pages 13 and 14	Section 2, pages 13 through 15
APPENDIX A	
pages 17 through 24	pages 17 through 24
INDEX	
pages 1 through 4	pages 1 through 4

SUMMARY OF CHANGES

CHAPTER 1

1. Section 15. Clarifies the payment of drugs provided as part of Home Infusion therapy.

CHAPTER 3

2. Table of Contents. Updated Section 6 and added Section 7.

3. Section 6. Clarifies the processing and payment of Home Infusion claims before January 30, 2012.

4. Section 7. Clarifies the processing and payment of Home Infusion claims on or after January 30, 2012.

CHAPTER 4

5. Section 4. Outlines TRICARE claims processing and reimbursement actions as a result of Medicare processing actions.

CHAPTER 8

6. Section 2. Clarifies language on Skilled Nursing Facility (SNF) enteral feedings and adds coverage of SNF ancillary services not covered under inpatient SNF Prospective Payment System (PPS).

APPENDIX A

7. Added the acronym for Mail Delivery Quality Code (MDQC).

INDEX

8. Updated Chapter 3, Section 6's reference and added Chapter 3, Section 7's reference.

Chapter 1 Section 15

Legend Drugs And Insulin

Issue Date: August 26, 1985
Authority: 32 CFR 199.4(d)(3)(vi)

1.0 APPLICABILITY

This policy is mandatory for reimbursement of services provided by either network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the TRICARE Management Activity (TMA) and specifically included in the network provider agreement.

2.0 ISSUE

How are legend drugs and insulin to be reimbursed?

3.0 POLICY

3.1 General

In addition to the military branches' pharmacies, the TRICARE Pharmacy (TPharm) benefit includes retail and mail order prescription services, medications provided by physicians and other appropriate clinicians, and medications provided in support of Home Health Care (HHC). TRICARE uses a number of contractors to administer the benefit.

3.2 Pharmacy Claims

3.2.1 TRICARE reimburses the allowable cost for covered pharmaceuticals and supplies less the applicable beneficiary deductibles and cost-shares and payments made by Other Health Insurance (OHI). Allowable costs include the pharmaceutical agent's ingredient cost, a dispensing fee, and sales tax, if applicable. The TRICARE allowable cost will be the lesser of the usual and customary price or the maximum allowable cost (MAC) or TPharm contractor's contracted rate for ingredient cost. Dispensing fees will be the lesser of the Pharmacy Benefit Manager's (PBM's) negotiated rate with individual pharmacy or the PBM's contracted rate for dispensing fees.

3.2.2 Prescription and non-prescription Insulin and related supplies may be cost-shared in accordance with the TRICARE Policy Manual (TPM), Chapter 8, Section 9.1.

3.2.3 Pharmacy reimbursements are subject to formulary requirements (prior authorizations, medical necessity, quantity limits, benefit exclusions, and non-formulary status) in accordance with the 32 CFR 199.21(i) and TPM, Chapter 8, Section 9.1.

3.3 Medical Claims That Include Drugs

3.3.1 The Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS), National Level II Medicare "J" codes are to be priced using the following.

3.3.1.1 Drugs (except for home infusion drugs) administered other than oral method, including chemotherapy drugs, are to be priced from the "J" code pricing file.

3.3.1.2 Drugs that do not appear on the "J" code pricing file will be priced at the lesser of billed charges or 95% of the Average Wholesale Price (AWP).

3.3.1.3 Home infusion drugs provided prior to January 30, 2012: Home infusion drugs will be paid the lesser of the billed amount or 95% of the AWP retroactive back to April 1, 2005. However, this retroactive coverage will not require the contractors to research their claims history and adjust previously submitted home infusion drug claims unless brought to their attention by a provider or other person with an interest in the claim. Home infusion drugs will be billed using the appropriate "J" code or any other appropriate HCPCS coding for home infusion drugs not appearing on the "J" code pricing file along with a specific National Drug Code (NDC). The unique HCPCS code will facilitate agency reporting requirements for future data analysis, while the NDC will be used in determining the drug's AWP. J-3490 (unclassified drug code) may be used in lieu of specific HCPCS coding (e.g., "J", "Q", and "S" codes) for reporting purposes as long as the drugs are U.S. Food and Drug Administration (FDA)-approved and have specific NDCs for pricing.

3.3.1.4 Home infusion drugs provided on or after January 30, 2012: Home infusion drugs must be provided in accordance with the TPM, Chapter 8, Section 20.1. Home infusion drugs will be paid the lesser of the billed amount or 95% of the AWP only in cases where the home infusion drug is not available through the TPharm, or the beneficiary is not required by the TPM, Chapter 8, Section 20.1 to obtain the drug from the TPharm. Home infusion drugs not provided through the TPharm will be billed using the appropriate "J" code or any other appropriate HCPCS coding for home infusion drugs not appearing on the "J" code pricing file along with a specific NDC. The unique HCPCS code will facilitate agency reporting requirements for future data analysis, while the NDC will be used in determining the drug's AWP. J-3490 (unclassified drug code) may be used in lieu of specific HCPCS coding (e.g., "J", "Q", and "S" codes) for reporting purposes as long as the drugs are FDA-approved and have specific NDCs for pricing.

3.3.2 Allergy preparations are custom made in a laboratory and are not considered prescription drugs. Since the cost of these allergy preparations are not found in a schedule of allowable charges based on the AWP, reimbursement will be based on the allowable charge methodology. The prevailing will include both the cost of the drug and the administrative fee. An allowance of a separate additional charge for an "office visit" would not be warranted where the services rendered did not really constitute a regular office visit.

3.3.3 A separate payment shall be made for the pharmacy compounding and dispensing services under HCPCS S9430.

- END -

Chapter 3

Operational Requirements

Section/Addendum	Subject/Addendum Title
1	Reimbursement Of Individual Health Care Professionals And Other Non-Institutional Health Care Providers
2	Hospital And Other Institutional Reimbursement
3	Discounts
4	Payment Reduction
5	Reimbursement Administration
6	Processing And Payment Of Home Infusion Claims Before January 30, 2012
7	Processing And Payment Of Home Infusion Claims On Or After January 30, 2012

Chapter 3 Section 6

Processing And Payment Of Home Infusion Claims Before January 30, 2012

Issue Date: November 9, 2009
Authority: 32 CFR 199.2 and 32 CFR 199.6(f)

1.0 ISSUE

Requirements for processing and payment of home infusion claims for home infusion services provided before January 30, 2012.

2.0 POLICY

2.1 General

Home infusion companies eligible for Corporate Services Provider (CSP) status as set forth in the TRICARE Policy Manual (TPM), Chapter 11, Section 12.1 will be paid under the CHAMPUS Maximum Allowable Charge (CMAC) reimbursement system on a fee-for-service basis for otherwise-covered professional services provided by TRICARE-authorized individual providers employed by or under contract with a freestanding corporate entity. Reimbursement of covered services, along with related drugs and supplies, will be made directly to the TRICARE-authorized corporate services provider under its own tax identification number. Payment will be allowable for services rendered in the authorized CSP's place of business, or in the beneficiary's home, under such circumstances as the contractor determines to be necessary for the efficient delivery of such in-home services. The corporate entity will not be allowed additional facility charges that are not already incorporated into the professional service structure; i.e., facility charges that are not already included in the overhead and malpractice cost indices used in establishing locally-adjusted CMAC rates. Additional expenses by providers due to travel will also not be covered.

2.2 Processing and Payment Procedures

The contractor shall use the following processing and payment procedures for adjudication of home infusion claims.

2.2.1 TRICARE has been statutorily mandated under 10 United States Code (USC) 1079(h) to pay health care professional and other non-institutional health care providers, to the extent practicable, in accordance with the same reimbursement rules as Medicare. The Agency, in compliance with the above statutory mandate adopted the Medicare Modernization Act (MMA) provisions for physician reimbursement which inadvertently reduced home infusions drug payment from 95% of the Average Wholesale Price (AWP) to Average Sales Price (ASP) plus a given percentage as part of a routine CMAC update (April 1, 2005). Since Medicare's conversion to ASP for Part B physician reimbursement mandated under MMA was not intended for coverage of homes

infusion drugs (i.e., home infusion drugs were specifically exempted from the ASP conversion), Chapter 1, Section 15, paragraph 3.3.3, was revised for payment of home infusion drugs at 95% of AWP retroactive back to April 1, 2005. As a result, home infusion drugs must be billed using an appropriate "J" code along with a specific National Drug Code (NDC) for pricing. The Healthcare Common Procedure Coding System (HCPCS) "J" code will facilitate Agency reporting requirements for future data analysis, while the NDC will be used in determining the drug's AWP. J-3490 (unclassified drug code) may be used in lieu of specific HCPCS coding for reporting purposes as long as the drugs are U.S. Food and Drug Administration (FDA) approved and have a specific NDC for pricing. Drugs that do not appear on the Medicare "J" code pricing file will also be priced using 95% of the AWP. Refer to Chapter 1, Section 15 for payment of drugs administered by other than oral method.

2.2.2 Separate payment will be allowed for supplies that are billed in association with a home infusion visit (e.g., supply codes A4221/A4222/A4223 will be paid separately from associated home infusion visits (Current Procedural Terminology (CPT)[1] procedure codes 99601 and 99602)). Claims adjustments will be retroactive back to October 1, 2008 for those providers bringing it to the attention of the contractors.

2.2.3 Infused drugs administered in an Ambulatory Infusion Suite (AIS) will not qualify for exception to Medicare drug pricing (ASP plus six percent) since they are not being administered in a home setting.

2.2.4 The TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) contractor will develop all home infusion claims with Medicare denial code PR-50 to determine whether or not the denial code was simply put on the claims because of Medicare benefit limitations or whether it was used because the services were truly not medically necessary. TRICARE should pay as primary if the services were denied because of Medicare benefit limitations (Chapter 4, Section 4, paragraph 1.3.1.3) or deny if Medicare's denial is not related to a benefit limitation (Chapter 4, Section 4, paragraph 1.3.1.2). Claims adjustments will be retroactive back to October 1, 2008 for those providers bringing it to the attention of the contractors.

3.0 EXCLUSION

"S" codes [Temporary National Codes (Non-Medicare)] are used by the Blue Cross Blue Shield Association (BCBSA) and the Health Insurance Association of America (HIAA) to report drugs, services and supplies for which there are no national codes but which are needed by the private sector to implement policies, programs or claims processing. These codes are not recognized by Medicare and are reserved solely for evolving technologies under the TRICARE program until permanent HCPCS/CPT codes can be assigned. As a CSP, home infusion companies are limited to the payment of professional services and drug and supplies provided in the direct treatment of a TRICARE eligible beneficiary. Payment is not allowed for the overall administrative charges/ expenses incorporated into the home infusion "S" code per diems.

- END -

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Chapter 3 Section 7

Processing And Payment Of Home Infusion Claims On Or After January 30, 2012

Issue Date: November 9, 2009
Authority: 32 CFR 199.2 and 32 CFR 199.6(f)

1.0 ISSUE

Requirements for processing and payment of home infusion claims for home infusion services provided on or after January 30, 2012.

2.0 POLICY

2.1 General

Effective January 30, 2012, home infusion services must be preauthorized and provided in accordance with the TRICARE Policy Manual (TPM), Chapter 8, Section 20.1. Home infusion companies eligible for Corporate Services Provider (CSP) status as set forth in the TPM, Chapter 11, Section 12.1 will be paid under the CHAMPUS Maximum Allowable Charge (CMAC) reimbursement system on a fee-for-service basis for otherwise-covered professional services provided by TRICARE-authorized individual providers employed by or under contract with a freestanding corporate entity. Reimbursement of covered services, along with related drugs and supplies, will be made directly to the TRICARE-authorized corporate services provider under its own tax identification number. Payment will be allowable for services rendered in the authorized CSP's place of business, or in the beneficiary's home, under such circumstances as the contractor determines to be necessary for the efficient delivery of such in-home services. The corporate entity will not be allowed additional facility charges that are not already incorporated into the professional service structure; i.e., facility charges that are not already included in the overhead and malpractice cost indices used in establishing locally-adjusted CMAC rates. Additional expenses by providers due to travel will also not be covered.

2.2 Processing and Payment Procedures

The contractor shall use the following processing and payment procedures for adjudication of home infusion claims.

2.2.1 In cases where the drug is not available from the TRICARE Pharmacy (TPharm), or the beneficiary is not required to obtain the drug from the TPharm, as described in the TPM, Chapter 8, Section 20.1, this paragraph describes the pricing for the home infusion drug. TRICARE has been statutorily mandated under 10 United States Code (USC) 1079(h) to pay health care professional and other non-institutional health care providers, to the extent practicable, in accordance with the same reimbursement rules as Medicare. The Agency, in compliance with the above statutory

mandate adopted the Medicare Modernization Act (MMA) provisions for physician reimbursement which inadvertently reduced home infusions drug payment from 95% of the Average Wholesale Price (AWP) to Average Sales Price (ASP) plus a given percentage as part of a routine CMAC update (April 1, 2005). Since Medicare's conversion to ASP for Part B physician reimbursement mandated under MMA was not intended for coverage of homes infusion drugs (i.e., home infusion drugs were specifically exempted from the ASP conversion), Chapter 1, Section 15, paragraph 3.3.3, was revised for payment of home infusion drugs at 95% of AWP retroactive back to April 1, 2005. As a result, home infusion drugs must be billed using an appropriate "J" code along with a specific National Drug Code (NDC) for pricing. The Healthcare Common Procedure Coding System (HCPCS) "J" code will facilitate Agency reporting requirements for future data analysis, while the NDC will be used in determining the drug's AWP. J-3490 (unclassified drug code) may be used in lieu of specific HCPCS coding for reporting purposes as long as the drugs are U.S. Food and Drug Administration (FDA) approved and have a specific NDC for pricing. Drugs that do not appear on the Medicare "J" code pricing file will also be priced using 95% of the AWP. Refer to Chapter 1, Section 15 for payment of drugs administered by other than oral method. Payment of home infusion drugs provided by the TPharm are subject to the policies and requirements of the TPharm contract.

2.2.2 Separate payment will be allowed for supplies that are billed in association with a home infusion visit (e.g., supply codes A4221/A4222/A4223 will be paid separately from associated home infusion visits (Current Procedural Terminology (CPT)[1] procedure codes 99601 and 99602)). Claims adjustments will be retroactive back to October 1, 2008 for those providers bringing it to the attention of the contractors.

2.2.3 Infused drugs administered in an Ambulatory Infusion Suite (AIS) will not qualify for exception to Medicare drug pricing (ASP plus six percent) since they are not being administered in a home setting.

2.2.4 The TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) contractor will develop all home infusion claims with Medicare denial code PR-50 to determine whether or not the denial code was simply put on the claims because of Medicare benefit limitations or whether it was used because the services were truly not medically necessary. TRICARE should pay as primary if the services were denied because of Medicare benefit limitations (Chapter 4, Section 4, paragraph 1.3.1.3) or deny if Medicare's denial is not related to a benefit limitation (Chapter 4, Section 4, paragraph 1.3.1.2). Claims adjustments will be retroactive back to October 1, 2008 for those providers bringing it to the attention of the contractors.

3.0 EXCLUSION

"S" codes [Temporary National Codes (Non-Medicare)] are used by the Blue Cross Blue Shield Association (BCBSA) and the Health Insurance Association of America (HIAA) to report drugs, services and supplies for which there are no national codes but which are needed by the private sector to implement policies, programs or claims processing. These codes are not recognized by Medicare and are reserved solely for evolving technologies under the TRICARE program until permanent HCPCS/CPT codes can be assigned. As a CSP, home infusion companies are limited to the payment of professional services and drug and supplies provided in the direct treatment of a TRICARE eligible beneficiary. Payment is not allowed for the overall administrative charges/

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expenses incorporated into the home infusion "S" code per diems.

- END -

Chapter 4 Section 4

Specific Double Coverage Actions

Issue Date:
Authority: 32 CFR 199.8

1.0 TRICARE AND MEDICARE

1.1 Medicare Always Primary To TRICARE

With the exception of services provided by a Federal Government facility, in any double coverage situation involving Medicare and TRICARE, Medicare is always primary. When services are provided by a resource sharing provider in an Military Treatment Facility (MTF) to a beneficiary age 65 years and older, reimbursement shall be in accordance with the resource sharing agreement. No TRICARE for Life (TFL) funds are available for resource sharing within an MTF.

1.2 Premium Health Insurance

Certain persons age 65 years and older who were not previously entitled to Medicare Part A, "Hospital Insurance Benefits," became eligible to enroll in Part A after June 30, 1973, under the premium Health Insurance provision of the 1972 Amendment to the Social Security Act. Entitlement to Part A secured under these circumstances does not result in a loss of TRICARE benefits.

1.3 Procedures

TRICARE beneficiaries who become entitled to Medicare Part A, based on age, do not lose TRICARE eligibility if they are enrolled in Medicare Part B. Special double coverage procedures are used for these claims in order to minimize out- of-pocket expenditures for these beneficiaries. These special procedures are used for all claims for beneficiaries who are eligible for Medicare, including active duty dependents who are age 65 and over as well as those beneficiaries under age 65 who are eligible for Medicare for any reason. (See the TRICARE Operations Manual (TOM), Chapter 20, for information on TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC)). The following sections set forth the amounts that TRICARE will pay if the beneficiary is covered by Medicare and TRICARE. If a third coverage is involved, TRICARE will be last payer and payments by the third coverage will reduce the amounts of TRICARE payment that are set forth below. In all cases where TRICARE is the primary payer, all claims processing requirements are to be followed. Additionally, when a beneficiary becomes eligible for Medicare during any part of his/her inpatient admission, the hospital claim shall be submitted to Medicare first and TRICARE payment (using non-financially underwritten funds) will be determined under the normal double coverage procedures.

1.3.1 Services That Are A Benefit Under Both Medicare And TRICARE (See paragraph 1.5 for Pharmacy Claims)

1.3.1.1 When Medicare makes a payment for benefits also covered by TRICARE, the beneficiary will generally have no out-of-pocket expense. For these claims TRICARE will resemble a Medicare supplement. That is, the allowable amount under Medicare will be used as the TRICARE allowable, and TRICARE payment will equal the remaining beneficiary liability after Medicare processes the claim without regard to any TRICARE deductible and cost-share amounts that would otherwise be assessed. For example, if it is the first claim of the year and the billed charge is $50 (which is also the amount both Medicare and TRICARE allow on the claim), Medicare will apply the entire amount to the Medicare deductible and pay nothing. In this case, TRICARE will pay the full $50 so that the beneficiary has no out-of- pocket expense. Similarly, if Medicare pays an amount that is greater than what TRICARE normally would allow for a network provider, TRICARE will still pay any Medicare deductible and cost-sharing amounts, even if that represents payments in excess of the normal TRICARE allowable amount.

Note: It is not necessary for the contractor to price these claims, since the Medicare allowable becomes the TRICARE allowable, and TRICARE payment is based on the remaining beneficiary liability. The contractor need only verify eligibility and coverage in processing the claim. Contractors will not be required to duplicate Medicare's provider certification, medical necessity, referral, authorization, and potential duplicate editing.

1.3.1.2 When Medicare makes no payment, TRICARE cannot make any payment on the claim (see exceptions in paragraphs 1.3.1.3 through 1.3.1.3.7). In such cases, the contractor is to deny the claim and the provider/ beneficiary must file an appeal with Medicare. If, during the Medicare appeals process, Medicare subsequently reverses its decision, Medicare will make payment on the claim and TRICARE can make payment on the remaining beneficiary liability. If Medicare's initial denial is upheld during the Medicare appeals process, no further consideration will be given by TRICARE.

1.3.1.3 When Medicare does not make a payment due to the following:

1.3.1.3.1 Medicare benefits have exhausted.

1.3.1.3.2 The services are received overseas (processed by the TOP contractor).

1.3.1.3.3 Medicare Part B services obtained from a beneficiary not required to purchase Part B.

1.3.1.3.4 Services are provided in a TRICARE authorized non-Department of Defense (DoD) government facility (i.e., Department of Veterans Affairs (DVA)).

1.3.1.3.5 Shingles vaccine (a Medicare Part D benefit only, if the beneficiary is not enrolled in Medicare Part D: TRICARE Pharmacy (TPharm) shall process if the services are provided at a pharmacy and TDEFIC shall process if service is provided in the provider's office).

1.3.1.3.6 Maintenance medications provided during an observation stay.

1.3.1.3.7 Home infusion claims (see Chapter 3, Section 6, paragraph 2.2.4 and Chapter 3, Section 7, paragraph 2.2.4).

TRICARE will process the claim as a primary payer, for TRICARE benefits, with any applicable deductibles and cost-shares. With the exception of paragraph 1.3.1.3.1, 1.3.1.3.6, and 1.3.1.3.7, since the contractor knows that Medicare cannot make a payment on such claims, the contractor can process the claim without evidence of processing by Medicare.

Note: In order to achieve status as a TRICARE authorized provider, DVA facilities must comply with the provisions of the TRICARE Policy Manual (TPM), Chapter 11, Section 2.1.

1.3.1.4 When Medicare does not make a payment because services were rendered by a non-Medicare provider or effective for services on or after March 1, 2007, because the provider has a private contract with the beneficiary (also referred to as "opting out" of Medicare), and the services are a TRICARE benefit, TRICARE will process the claim as a second payer. In such cases, the TRICARE payment will be the amount that TRICARE would have paid had the Medicare program processed the claim (normally 20% of the allowable charge). If there is not an available Medicare allowed amount, the TRICARE allowed amount shall be calculated and 20% of that amount will be reimbursed. Evidence of processing by Medicare for non-Medicare providers is not required; rather a statement from the provider verifying their Medicare status is sufficient for processing. Opt out providers will be identified based on the Medicare Part B carriers web sites. In cases where the beneficiary's access to medical care is limited (i.e., under served areas), the TRICARE contractor may waive the second payer status for the services of a Medicare opt-out provider and pay the claim as the primary payer. In most cases, under served areas will be identified by zip codes for Health Professional Shortage Areas (HPSAs) and Physician Scarcity Areas (PSAs) on the Centers for Medicare and Medicaid Services (CMS) web site at http://www.cms.hhs.gov/HPSAPSAPhysician Bonuses/ and will automatically be paid as primary payer. In cases where the zip code for an underserved area is not identified on the CMS web site, or in areas where there are no or limited Medicare participating providers, a written waiver request with justification identifying the county where the service was received and a copy of the provider's private contract will be required by the contractor to pay the claim as the primary payer. TRICARE contractors will identify HPSA or PSA zip codes or the county for underserved areas on the above CMS web site and identify opt out providers based on the Medicare Part B carriers web sites.

Note: Under the TRICARE Provider Reimbursement Demonstration Project for the state of Alaska, TRICARE will pay as primary payer for the services of Medicare opt-out providers.

1.3.1.5 When Medicare does not make a payment based on their Competitive Bidding Program (CBP) for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS), the TRICARE contractor shall process the claim as second payer for otherwise TRICARE covered items of DMEPOS. In such cases, the TRICARE payment shall be the amount TRICARE would have paid had Medicare processed and paid the claim. Public use files containing the competitive bid single payment amounts per Healthcare Common Procedure Coding System (HCPCS) code are posted on the CMS' competitive bidding contractor's web site: http://www.dmecompetitivebid.com/palmetto/cbic.nsf/DocsCat/Home. TRICARE contractors shall identify the competitive bid single payment amount using the above CMS web site to identify what Medicare would have allowed had the beneficiary followed Medicare's rules. Implementation of Medicare's DMEPOS CBP pricing is effective January 1, 2011.

1.3.1.6 When Medicare does not make a payment because Medicare rules were not followed or because the beneficiary failed to meet some other requirement of coverage (e.g., denied for no referral, no or untimely authorization, invalid place of service, etc.). TRICARE will process the claim

as second payer as long as the services meet TRICARE coverage rules. The TRICARE payment will be the amount that TRICARE would have paid had the Medicare program processed the claim (normally 20% of the allowed charge). If there is not an available Medicare allowed amount, the TRICARE allowed amount shall be calculated and 20% of that amount will be reimbursed. This exception does not include Medicare medical necessity denials.

1.3.1.7 Effective October 28, 2009, TRICARE beneficiaries under the age of 65 who became Medicare eligible due to a retroactive disability determination awarded upon appeal remain eligible and are considered to have coverage under the TRICARE program (see the TOM, Chapter 20, Section 1, paragraph 2.6) for the retroactive months of their entitlement to Medicare Part A, notwithstanding the gap in coverage between Medicare Part A and Part B effective dates. For previously processed claims and claims for dates of service before the beneficiary's original Medicare Part B effective date (which corresponds with the date of issuance of the retroactive determination by the Social Security Administration), jurisdiction remains with the contractor that processed the claim. Recoupment actions shall not be initiated and existing actions should be terminated. Out-of-jurisdiction rules apply to claims for dates of service on or after the original Medicare Part B effective date. These claims should be forwarded to the TDEFIC contractor for action. Medicare becomes primary payer effective as of the original Medicare Part B effective date. Eligible beneficiaries are required to keep Medicare Part B in order to maintain their TRICARE coverage for future months, but are considered to have coverage under the TRICARE program for the retroactive months of their entitlement to Medicare Part A.

1.3.2 Services That Are A Benefit Under Medicare But Not Under TRICARE

TRICARE will make no payment for services and supplies that are not a benefit under TRICARE, regardless of any action Medicare may take on the claim.

1.3.3 Services That Are A Benefit Under TRICARE But Not Under Medicare

If the service or supply is a benefit under TRICARE but never covered under Medicare, TRICARE will process the claim as the primary payer assessing any applicable deductibles and cost-shares. If the contractor has the documentation (e.g., Medicare transmittal or regulation) to support that Medicare would never cover the service or supply on the claim, the contractor can process the claim without evidence of processing by Medicare for that service or supply. These claims shall be handled in accordance with 32 CFR 199.10(a)(1)(ii). This includes services billed with the **GY** modifier (Medicare statutory exclusion or does not meet the definition of any Medicare benefit) and services provided to a beneficiary participating in Cancer Clinical Trials that are not a Medicare benefit.

1.3.4 Services Provided By A Medicare At-Risk Plan

If the beneficiary is a member of a Medicare at-risk plan (for example, Medicare Plus Choice), TRICARE will pay 100% of the beneficiaries copay for covered services. A claim containing the required information must be submitted to obtain reimbursement.

1.3.5 Beneficiary Cost-Shares

Beneficiary costs shares shall be based on the network status of the provider. Where TRICARE is primary payer, cost-shares for services received from network providers shall be TRICARE

Extra cost-shares. Services received from non-network providers shall be TRICARE Standard cost-shares. Network discounts shall only be applied when the discount arrangement specifically contemplated the TFL population.

1.3.6 Application Of Catastrophic Cap

Only the actual beneficiary out-of-pocket liability remaining after TRICARE payments will be counted for purposes of the annual catastrophic loss protection.

1.4 End Stage Renal Disease (ESRD) in TRICARE beneficiaries less than 65 years of age. Medicare is the primary payer and TRICARE is the secondary payer for beneficiaries entitled to Medicare Part A and who have Medicare Part B coverage.

1.5 Pharmacy Claims. TRICARE cost-sharing of medications through a Medicare part D prescription drug plan is subject to the double coverage provisions found in 32 CFR 199.8.

2.0 TRICARE AND MEDICAID

Medicaid is essentially a welfare program, providing medical benefits for persons under various state welfare programs (such as Aid to Dependent Children) or who qualify by reason of being determined to be "medically indigent" based on a means test. In enacting Public Law 97-377, it was the intent of Congress that no class of TRICARE beneficiary should have to resort to welfare programs, and therefore, Medicaid was exempted from these double coverage provisions. Whenever a TRICARE beneficiary is also eligible for Medicaid, TRICARE is always the primary payer. In those instances where Medicaid extends benefits on behalf of a Medicaid eligible person who is subsequently determined to be a TRICARE beneficiary, TRICARE shall reimburse the appropriate Medicaid agency for the amount TRICARE would have paid in the absence of Medicaid benefits or the amount paid by Medicaid, whichever is less. See Chapter 1, Section 20.

3.0 MATERNAL AND CHILD HEALTH PROGRAM/INDIAN HEALTH SERVICE (IHS)

Eligibility for health benefits under either of these two Federal programs is not considered to be double coverage (see Section 1).

4.0 TRICARE AND THE DVA

Eligibility for health care through the DVA for a service-connected disability is not considered double coverage. If an individual is eligible for health care through the DVA and is also eligible for TRICARE, he/she may use either TRICARE or veterans benefits. In addition, at any time a beneficiary may get medically necessary care through TRICARE, even if the beneficiary has received some treatment for the same Episode Of Care (EOC) through the DVA. However, TRICARE will not duplicate payments made by or authorized to be made by the DVA for treatment of a service-connected disability.

5.0 TRICARE AND WORKER'S COMPENSATION

TRICARE benefits are not payable for work-related illness or injury which is covered under a Worker's Compensation program. The TRICARE beneficiary may not waive his or her Worker's Compensation benefits in favor of using TRICARE benefits. If a claim indicates that an illness or

injury might be work related, the contractor will process the claim following the provisions as provided in TOM, Chapter 10, Section 5, paragraphs 5.0 and 6.0 and refer the claim to the Uniformed Service Claims Office for recovery, if appropriate.

6.0 TRICARE AND SUPPLEMENTAL INSURANCE PLANS

6.1 Not Considered Double Coverage

Supplemental plans (see Chapter 1, Section 26) or complementary insurance coverage is a health insurance policy or other health benefit plan offered by a private entity to a TRICARE beneficiary, that primarily is designed, advertised, marketed, or otherwise held out as providing payment for expenses incurred for services and items that are not reimbursed under TRICARE due to program limitations, or beneficiary liabilities imposed by law. TRICARE recognizes two types of supplemental plans, general indemnity plans and those offered through a direct service Health Maintenance Organization (HMO). Supplemental insurance plans are not considered double coverage. TRICARE benefits will be paid without regard to the beneficiary's entitlement to supplemental coverage.

6.2 Income Maintenance Plans

Income maintenance plans pay the beneficiary a flat amount per day, week or month while the beneficiary is hospitalized or disabled. They usually do not specify a type of illness, Length-Of-Stay (LOS), or type of medical service required to qualify for benefits, and benefits are not paid on the basis of incurred expenses. Income maintenance plans are not considered double coverage. TRICARE will pay benefits without regard to the beneficiary's entitlement to an income maintenance plan.

6.3 Other Secondary Coverage

Some insurance plans state that their benefits are payable only after payment by all government, Blue Cross/Blue Shield (BC/BS) and private plans to which the beneficiary is entitled. In some coverages, however, it provides that if the beneficiary has no other coverage, it will pay as a primary carrier. Such plans are double coverage under TRICARE law, regulation, and policy and are subject to the usual double coverage requirements.

7.0 SCHOOL COVERAGE - SCHOOL INFIRMARY

TRICARE benefits shall be paid for covered services provided to students by a school infirmary provided that the school imposes charges for the services on all students or on all students who are covered by health insurance.

8.0 TRICARE AND PREFERRED PROVIDER ORGANIZATIONS (PPOs)

See Chapter 1, Section 25.

9.0 DOUBLE COVERAGE AND EXTENDED CARE HEALTH OPTION (ECHO)

All double coverage rules and procedures which apply to claims under the basic program are also to be applied to ECHO claims. All local resources must be considered and utilized before

TRICARE benefits under the ECHO may be extended. If an ECHO beneficiary is eligible for other federal, state, or local assistance to the same extent as any other resident or citizen, TRICARE benefits are payable only for amounts left unpaid by the other program, up to the TRICARE maximums established in TPM, Chapter 9. The beneficiary may not waive available federal, state, or local assistance in favor of using TRICARE.

Note: The requirements of paragraph 9.0 notwithstanding, TRICARE is primary payer for medical services and items that are provided under Part C of the Individuals with Disabilities Education Act in accordance with the Individualized Family Service Plan (IFSP) and that are otherwise allowable under the TRICARE Basic Program or the ECHO.

10.0 PRIVATELY-PURCHASED, NON-GROUP COVERAGE

Privately-purchased, non-group health insurance coverage is considered double coverage.

11.0 LIABILITY INSURANCE

If a TRICARE beneficiary is injured as a result of an action or the negligence of a third person, the contractor must develop the claim(s) for potential Third Party Liability (TPL) (see the TOM, Chapter 10, Section 5). The contractor shall pursue the Government's subrogation rights under the Federal Medical Care Recovery Act (FMCRA), if the other health insurance does not cover all expenses.

12.0 TRICARE AND PRE-PAID PRESCRIPTION PLANS

If the beneficiary has a "pre-paid prescription plan," where the beneficiary pays only a "flat fee" no matter what the actual cost of the drug, the contractor shall cost-share the fee and not develop for the actual cost of the drug, since the beneficiary is liable only for the "fee."

13.0 TRICARE AND STATE VICTIMS OF CRIME COMPENSATION PROGRAMS

Effective September 13, 1994, State Victims of Crime Compensation Programs are not considered double coverage. When a TRICARE beneficiary is also eligible for benefits under a State Victims of Crime Compensation Program, TRICARE is always the primary payer over the State Victims of Crime Compensation Programs.

14.0 SURROGATE ARRANGEMENTS

Contractual arrangements between a surrogate mother and adoptive parents are considered other coverage. For pregnancies in which the surrogate mother is a TRICARE beneficiary, services and supplies associated with antepartum care, postpartum care, and complications of pregnancy may be cost-shared only as a secondary payer, and only after the contractually agreed upon amount has been exhausted. This applies where contractual arrangements for payment include a requirement for the adoptive parents to pay all or part of the medical expenses of the surrogate mother as well as where contractual arrangements for payment do not specifically address reimbursement for the mother's medical care. If brought to the contractor's attention, the requirements of TOM, Chapter 10, Section 5, paragraph 2.10 would apply.

- END -

4.4.7 As secondary payer, TRICARE will use Medicare's determination of coverage rather than performing an additional review. If Medicare denies the services as not medically necessary, TRICARE will also deny the care and the beneficiary will have appeal rights through Medicare.

5.0 MISCELLANEOUS POLICY

5.1 TMA will follow CMS policy regarding use of the default payment rate whenever the SNF does an off-schedule assessment, a late patient assessment, or in some cases, no patient assessment at all (but can prove patient eligibility). The default payment will always be equal to the lowest RUG group rate (currently, this is the payment rate for PA1).

5.2 TRICARE contractors, at their discretion, may conduct concurrent or retrospective review for Standard and Extra patients when TRICARE is the primary payer. The review required for the lower 18 RUGs (services prior to October 1, 2010) and lower 14 RUGs (services effective October 1, 2010) is a requirement for all TRICARE patients when TRICARE is primary (see paragraph 4.3.16). There will be no review for Standard and Extra patients where TRICARE is the secondary payer. The existing referral and authorization procedures for Prime beneficiaries will remain unaffected.

5.3 Effective for dates of service **June 1, 2010**, SNF care received in the U.S. and U.S. territories must be preauthorized for TRICARE dual eligible beneficiaries. The TDEFIC contractor will preauthorize SNF care beginning on day 101, when TRICARE becomes primary payer. For those beneficiaries inpatient on the effective date, a preauthorization will be required August 1, 2010. In the event that TRICARE is the primary payer for these services and preauthorization was not obtained, the contractor shall obtain the necessary information and perform a retrospective review. The payment reduction may be applied in these cases. There will be no review when TRICARE is the secondary payer.

5.4 Supplemental care benefits for ADSM will be paid according to the TRICARE SNF PPS. If the ADSM is enrolled to a Military Treatment Facility (MTF), this care must be approved by the MTF. Otherwise the care will be approved by the Service Point of Contact/Military Medical Support Office (SPOC/MMSO). TRICARE will pay the claim and the ADSM will not have any out-of-pocket expense.

5.5 SNF PPS will apply to Transitional Assistance Management Program (TAMP) beneficiaries.

5.6 SNF PPS will apply to Continued Health Care Benefit Program (CHCBP) beneficiaries.

5.7 SNF PPS claims are required to be filed sequentially at least every 30 days. Current timeliness standards will continue to apply which require claims to be filed within one year after the date the services were provided or one year from the date of discharge for an inpatient admission for facility charges billed by the facility. If a claim is not filed sequentially, the contractor may return that to the submitting SNF.

5.8 TRICARE will allow those hospital-based SNFs with medical education costs to request reimbursement for those expenses. Only medical education costs that are allowed under the Medicare SNF PPS will be considered for reimbursement. These education costs will be separately invoiced by hospital-based SNFs on an annual basis as part of the reimbursement process for hospitals (see Chapter 6, Section 8). Hospitals with SNF medical education costs will include appropriate lines from the cost report and the ratio of TRICARE days/total facility days. The product

will equal the portion that TRICARE will pay. TRICARE days do not include any days determined to be not medically necessary, and days included on claims for which TRICARE made no payment because Other Health Insurance (OHI) or Medicare paid the full TRICARE allowable amount. The hospital's reimbursement requests will be sent on a voucher to the TMA Finance Office for reimbursement as a pass through cost.

5.9 Swing Bed Providers

5.9.1 TRICARE will follow CMS policy regarding swing bed providers. To be reimbursed under SNF PPS, a hospital must be certified as a swing bed provider by CMS.

5.9.2 TRICARE will exempt CAH swing beds from the SNF PPS. Section 203 of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 [Public Law 106-554], exempted CAH swing beds from the SNF PPS. Accordingly, it will not be necessary to complete an MDS assessment for CAH swing bed SNF resident. The CAH will directly bill the claims processor for the services received. Under the TRICARE benefit, CAHs will be reimbursed for their swing bed SNF services based on the reasonable cost method, reference as provided in Section 1, paragraph 3.1. Currently, the list of current CAHs can be accessed at http://www.flexmonitoring.org.

5.9.3 The CAH swing bed claims can be identified by the Medicare provider number (CMS 1450 UB-04). There are two provider numbers issued to each CAH with swing beds. One number is all numeric and the second number is an alpha "z" in the third digit. For example, the acute beds would use 131300 and the swing beds 13z300. Other than the "z" the numbers are identical. The first two digits identifies the State code, and the 1300-1399 series identifies the CAH category.

5.10 Children under age 10 at the time of admission to a SNF will not be assessed using the MDS. TRICARE contractors will determine whether SNF services for these pediatric residents are covered based on the criteria of skilled services defined in 42 CFR 409, Subpart D and the Medicare Benefit Policy Manual, Chapter 8. The criteria used to determine SNF coverage for a child under the age of 10 will be the same whether that child is or is not Medicare-eligible. SNF benefit requirements will apply to these pediatric patients. SNF care for children under age 10 will be paid as provided in Section 1, paragraph 3.1. The TRICARE contractor will have the ability to negotiate these reimbursement rates.

5.11 The Waiver of Liability provisions in the TRICARE Policy Manual (TPM), Chapter 1, Section 4.1 apply to SNF cases.

5.12 Enteral Feedings Alone May Not Qualify For TRICARE Coverage Of SNF Services

The need for enteral feedings may not, alone, provide a sufficient basis for obtaining TRICARE coverage of care provided in a SNF. Enteral feedings are not services that can be provided only at a SNF level of care. The SNF extended care benefit covers relatively short-term care as a continuation of treatment begun in the hospital. The initiation of enteral feedings or provision of skilled care needed to manage documented difficulties or complications with the feedings may be considered skilled services that qualify for SNF care. However, once a beneficiary is stabilized for routine enteral feedings, a lower level of care may be more appropriate, such as a home care setting or assisted living facility, with non-licensed family members or facility staff trained to provide feedings and only intermittent involvement of nursing personnel needed to provide oversight. The appropriate

level of care is subject to medical necessity review.

5.13 Billing TRICARE for Outpatient SNF Services When TRICARE Has Denied Inpatient SNF PPS Or Continued Services

When no TRICARE inpatient SNF PPS program payment is possible, otherwise covered medically necessary services and supplies may be allowed under TRICARE's outpatient benefit. However, nursing care provided in a SNF setting is not billable under the TRICARE outpatient benefit. For TRICARE dual eligible beneficiaries, Medicare is primary payer for all Medicare Part B services; therefore, the SNF will need to bill CMS for these outpatient SNF services, rather than first submitting a claim to TRICARE. (See Chapter 4, Section 4.)

- END -

KO	Contracting Officer
LAA	Limited Access Authorization
LAC	Local Agency Check
LAK	Lymphokine-Activated Killer
LAN	Local Area Network
LASER	Light Amplification by Stimulated Emission of Radiation
LCF	Long-term Care Facility
LCIS	Lobular Carcinoma In Situ
LDL	Low Density Lipoprotein
LDLT	Living Donor Liver Transplantation
LDR	Low Dose Rate
LLLT	Low Level Laser Therapy
LNT	Lexical Neighborhood Test
LOC	Letter of Consent
LOD	Letter of Denial/Revocation Line of Duty
LOI	Letter of Intent
LOS	Length-of-Stay
LOT	Life Orientation Test
LPN	Licensed Practical Nurse
LSIL	Low-grade Squamous Intraepithelial Lesion
LSN	Location Storage Number
LTC	Long-Term Care
LUPA	Low Utilization Payment Adjustment
LV	Left Ventricle [Ventricular]
LVEF	Left Ventricular Ejection Fraction
LVN	Licensed Vocational Nurse
LVRS	Lung Volume Reduction Surgery
MAC	Maximum Allowable Charge Maximum Allowable Cost
MAC III	Mission Assurance Category III
MAID	Maximum Allowable Inpatient Day
MB&RB	Medical Benefits and Reimbursement Branch
MBI	Molecular Breast Imaging
MCIO	Military Criminal Investigation Organization
MCS	Managed Care Support
MCSC	Managed Care Support Contractor
MCSS	Managed Care Support Services
MCTDP	Myelomeningocele Clinical Trial Demonstration Protocol
MD	Doctor of Medicine
MDI	Mental Developmental Index Multiple Daily Injection
MDQC	Mail Delivery Quality Code

MDR	MHS Data Repository
MDS	Minimum Data Set
MEB	Medical Evaluation Board
MEC	Marketing and Education Committee
MEI	Medicare Economic Index
MEPS	Military Entrance Processing Station
MEPRS	Medical Expense Performance Reporting System
MET	Microcurrent Electrical Therapy
MFCC	Marriage and Family Counseling Center
MGCRB	Medicare Geographic Classification Review Board
MGIB	Montgomery GI Bill
MH	Mental Health
MHO	Medical Holdover
MHS	Military Health System
MHSO	Managing Health Services Organization
MHSS	Military Health Services System
MI	Myocardial Infarction
MI&L	Manpower, Installations, and Logistics
MIA	Missing In Action
MIAP	Multi-Host Internet Access Portal
MIDCAB	Minimally Invasive Direct Coronary Artery Bypass
MIRE	Monochromatic Infrared Energy
MLNT	Multisyllabic Lexical Neighborhood Test
MMA	Medicare Modernization Act
MMEA	Medicare and Medicaid Extenders Act (of 2010)
MMP	Medical Management Program
MMSO	Military Medical Support Office
MMWR	Morbidity and Mortality Weekly Report
MNR	Medical Necessity Report
MOA	Memorandum of Agreement
MOH	Medal Of Honor
MOMS	Management of Myelomeningocele Study
MOP	Mail Order Pharmacy
MOU	Memorandum of Understanding
MPI	Master Patient Index
MR	Magnetic Resonance Medical Review Mentally Retarded
MRA	Magnetic Resonance Angiography
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
NACLC	National Agency Check with Law Enforcement and Credit
NADFM	Non-Active Duty Family Member
NARA	National Archives and Records Administration
NAS	Naval Air Station Non-Availability Statement
NATO	North Atlantic Treaty Organization
NAVMED	Naval Medical (Form)
NBCC	National Board of Certified Counselors
NCCI	National Correct Coding Initiatives
NCE	National Counselor Examination
NCF	National Conversion Factor
NCI	National Cancer Institute
NCMHCE	National Clinical Mental Health Counselor Examination
NCPAP	Nasal Continuous Positive Airway Pressure
NCPDP	National Council of Prescription Drug Program
NCQA	National Committee for Quality Assurance
NCVHS	National Committee on Vital and Health Statistics
NDAA	National Defense Authorization Act
NDC	National Drug Code
NDMS	National Disaster Medical System
NED	National Enrollment Database
NETT	National Emphysema Treatment Trial
NF	Nursing Facility

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

OASIS	Outcome and Assessment Information Set
OB/GYN	Obstetrician/Gynecologist
OBRA	Omnibus Budget Reconciliation Act
OCE	Outpatient Code Editor
OCHAMPUS	Office of Civilian Health and Medical Program of the Uniformed Services
OCMO	Office of the Chief Medical Officer
OCONUS	Outside of the Continental United States
OCR	Office of Civil Rights
OCSP	Organizational Corporate Services Provider
OCT	Optical Coherence Tomograph
OD	Optical Disk
OF	Optional Form
OGC	Office of General Counsel
OGC-AC	Office of General Counsel-Appeals, Hearings & Claims Collection Division
OGP	Other Government Program
OHI	Other Health Insurance
OHS	Office of Homeland Security
OIG	Office of Inspector General
OMB	Office of Management and Budget
OP/NSP	Operation/Non-Surgical Procedure
OPD	Outpatient Department
OPM	Office of Personnel Management
OPPS	Outpatient Prospective Payment System
OR	Operating Room
OSA	Obstructive Sleep Apnea
OSAS	Obstructive Sleep Apnea Syndrome
OSD	Office of the Secretary of Defense
OSHA	Occupational Safety and Health Act
OSS	Office of Strategic Services
OT	Occupational Therapy (Therapist)
OTC	Over-The-Counter
OUSD	Office of the Undersecretary of Defense
OUSD (P&R)	Office of the Undersecretary of Defense (Personnel and Readiness)
P/O	Prosthetic and Orthotics
P&T	Pharmacy And Therapeutics (Committee)
PA	Physician Assistant
PACAB	Port Access Coronary Artery Bypass
$PACO_2$	Partial Pressure of Carbon Dioxide
PAO_2	Partial Pressure of Oxygen
PAK	Pancreas After Kidney (transplant)
PAP	Papanicolaou
PAT	Performance Assessment Tracking

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

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

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

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