APPENDIX A

ACRONYMS AND DEFINITIONS

These definitions replace the definitions in Section I of the contract. To be as specific as possible as to the intent of TRICARE Management Activity (TMA), the following acronyms and definitions have been included as part of this manual. Many of the items are general in nature and some assign meaning to relatively common terms within the health insurance industry; others are applicable only to TRICARE. However, they all appear here solely for the purposes of TRICARE. The acronyms and definitions in this appendix apply generally throughout this manual, unless otherwise specified.

1.0. ACRONYMS

ACOR - Alternate Contracting Officer's Representative

ACO - Administrative Contracting Officer

ADA - Americans with Disabilities Act

ADFM - Active Duty Family Member

ADP - Automated Data Processing

ADSM - Active Duty Service Member

AIS - Automated Information Systems

AM&S - Office of Acquisition Management and Support

ASC - Ambulatory Surgical Center

BBP - Bloodborne Pathogens Program

BPA - Bid-price Adjustment

BRAC - Base Realignment and Closure

CEIS - Corporate Executive Information System

CHAP - Community Health Accreditation Program

CHBC - Criminal History Background Check

CHCBP - Continued Health Care Benefits Program

CHCS - Composite Health Care System

CMAC - CHAMPUS Maximum Allowable Charge

COB - Coordination of Benefits

COR - Contracting Officers Representative

CPE - Contract Performance Evaluation

CPIRI - CHAMPUS Price Inflation Reimbursement Index

CPT - Current Procedural Terminology

CQMP - Clinical Quality Management Program

CRD - Chronic Renal Disease

DCAA - Defense Contract Audit Agency

DCP - Data Collection Period

D.D.S - Doctor of Dental Surgery

DEERS - Defense Enrollment Eligibility Reporting System

DHHS - Department of Health and Human Services

D.M.D - Doctor of Dental Medicine

DME - Durable Medical Equipment

DMIS - Defense Medical Information System

D.O. - Doctor of Osteopathy

DoD - Department of Defense

DP - Designated Provider

DRG - Diagnostic Related Group

DVA - Department of Veterans Affairs

EBC - Enrollment Based Capitation

EHP - Employee Health Program

EIN - Employer Identification Number

EMC - Electronic Media Claim

EOB - Explanation of Benefits

EOMB - Explanation of Medical Benefits

EPO - Exclusive Provider Organization

FAR - Federal Acquisition Regulations

FASB - Federal Accounting Standards Board

FDA - Food and Drug Administration

FEHBP - Federal Employee Health Benefit Program

FMDP - Family Member Dental Program

FMP - Family Member Prefix

FOIA - Freedom of Information Act

FRC - Federal Records Center

FY - Fiscal Year

GAF - Geographic Adjustment Factor

GPCI - Geographic Practice Cost Index

GSU - Geographically Separated Units (now known as TRICARE Prime Remote (TPR) Units)

HAC - Health Administration Center

HBA - Health Benefits Advisor

HCFA - Health Care Financing Administration

HCIL - Health Care Information Line

HCPR - Health Care Provider Record

HCSR - Health Care Service Record

HEAR - Health Enrollment Assessment Review

HEDIS - Health Plan Employer Data and Information Set

HHS - Health and Human Services

HIPAA - Health Insurance Portability and Accountability Act of 1996

HMO - Health Maintenance Organization

IC - Individual Consideration

ICD - Interface Control Document

ICD-9-CM - International Classification of Diseases, 9th Edition, Clinical Modification

ICN - Internal Control Number

ICU - Intensive Care Unit

IM/IT - Information Management/Information Technology

IPT - Integrated Product Team

IQ - Intelligence Quotient

JCAHO - Joint Commission on Accreditation of Healthcare Organizations

KO - Contracting Officer

LA - Lead Agent

L.P.N. - Licensed Practical Nurse

L.V.N. - Licensed Vocational Nurse

MCS - Managed Care Support

MCSC - Managed Care Support Contractor

M.D. - Doctor of Medicine

MDC - Major Diagnostic Category

MEI - Medicare Economic Index

MHS - Military Health System

MHSO - Office of Military Health Systems Operations

MIA - Missing in Action

MMSO - Military Medical Support Office

MSA - Metropolitan Statistical Area

MSW - Master of Social Work

MTF - Military Treatment Facility

NAS - Non-Availability Statement

NATO - North Atlantic Treaty Organization

NCF - National Conversion Factor

NDMS - National Disaster Medical System

NEDB - National Enrollment Data Base

NMOP - National Mail Order Pharmacy

NOAA - National Oceanic and Atmospheric Administration

NPDB - National Practitioner Data Bank

NQMC - National Quality Monitoring Contractor

OASD(HA) - Office of the Assistant Secretary of Defense (Health Affairs)

OHI - Other Health Insurance

OIG - Office of Inspector General

OSHA - Federal Occupational Safety and Health Act

PCM - Primary Care Manager

PCO - Procuring Contracting Officer

PCP - Primary Care Physician

PERMS - Provider Education and Relations Management System

PFPWD - Program for Persons with Disabilities

POS - Point of Service

PPO - Preferred Provider Organization

PRG - Peer Review Group

PRIMUS - Primary Care for the Uniformed Services

QM - Quality Management

R.N - Registered Nurse

RRA - Regional Review Authority

RTC - Residential Treatment Center

RVU - Relative Value Unit

SHCP - Supplemental Health Care Program

SNF - Skilled Nursing Facility

SPOC - Service Point of Contact

SSAN - Social Security Administration Number

SSN - Social Security Number

STS - Specialized Treatment Services

STSF - Specialized Treatment Service Facilities

TAMP - Transitional Assistance Management Program

TED - TRICARE Encounter Data

TMA - TRICARE Management Activity

TFL - TRICARE For Life

TPL - Third Party Liability

TPR - TRICARE Prime Remote

TSC - TRICARE Service Center

UM - Utilization Management

USC - Uniformed Service Clinics

USFHP - Uniformed Services Family Health Plan

USPHS - United States Public Health Service

WC - Workers Compensation

2.0. DEFINITIONS

These definitions replace the definitions found in Section I of the contract.

ABORTION: The intentional termination of a pregnancy by artificial means done for a purpose other than that of producing a live birth. A spontaneous, missed, or threatened abortion or termination of an ectopic (tubal) pregnancy are not included within the term "abortion" as used herein,

ABSENT TREATMENT: Services performed by Christian Science practitioners for a person when the person is not physically present.

NOTE: Technically, "Absent Treatment" is an obsolete term. The current Christian Science terminology is "treatment through prayer and spiritual means," which is employed by an authorized Christian Science practitioner either with the beneficiary being present or absent. However, to be considered for coverage under TRICARE, the beneficiary must be present physically when a Christian Science service is rendered, regardless of the terminology used.

ABUSE: For the purposes of TRICARE, abuse is defined as any practice that is inconsistent with accepted sound fiscal, business, or professional practice which results in a TRICARE claim, unnecessary cost, or TRICARE payment for services or supplies that are: (1) not within the concepts of medically necessary and appropriate care, as defined in this Regulation, or (2) that fail to meet professionally recognized standards for health care providers. The term "abuse" includes deception or misrepresentation by a provider, or any person or entity acting on behalf of a provider in relation to a TRICARE claim.

NOTE: Unless a specific action is deemed gross and flagrant, a pattern of inappropriate practice will normally be required to find that abuse has occurred. Also, any practice or action that constitutes fraud, as defined by this Regulation, would also be abuse

ACCESS, HEALTH CARE: The ability to receive necessary health care services of high quality within the timeframes, at the locations and from the providers that satisfy patient needs and desires.

ACCESS, INFORMATION:

1. The availability of or the permission to consult records, archives, or manuscripts.

2. The ability and opportunity to obtain sensitive, classified, or administratively controlled information or records.

ACCIDENTAL INJURY: Physical bodily injury resulting from an external force, blow or fall, or the ingestion of a foreign body or harmful substance, requiring immediate medical treatment. Accidental injury also includes animal and insect bites and sunstrokes. For the purpose of TRICARE, the breaking of a tooth or teeth does not constitute a physical bodily injury.

ACTION PLAN: A contractor's plan for achieving a goal through the use of specific resources based on a time-oriented schedule of activities.

ACTIVE DUTY: Full-time duty in the Uniformed Services of the United States. It includes duty on the active list, full-time training duty, annual training duty, and attendance while in the active Military Service, at a school designated as a Service school by law or by the Secretary of the Military Department concerned.

ACTIVE DUTY CLAIMS PROGRAM: A program established to price certain active duty claims according to TRICARE rules of reimbursement.

ACTIVE DUTY MEMBER: A person on active duty in a Uniformed Service under a call or order that does not specify a period of thirty days or less.

ACTUAL HEALTH CARE SERVICE COSTS: (In the application of the risk sharing corridors) The sum of incurred contractor non-capitated costs recorded on HCSRs adjusted to completion using CHAMPUS national completion rates and corrected based upon the results of the adjudication audit, plus audited capitated costs and audited Category 8 costs. If the audit of Category 12 costs has not been accomplished at the time of the first risk sharing adjustment for a given option period, the results of the audits shall be incorporated in the second and final risk sharing adjustment for the option period.

1. A net error rate percentage shall be determined from the adjudication audit of a sample of non-capitated HCSRS, as described in Section F of the contract. The actual net payment error rate for institutional HCSRs and for non-institutional HCSRs shall be the amount of overpayment (positive amount) or underpayment (negative amount) divided by total payments for institutional HCSRs and non-institutional HCSRs.

2. In the case of a net overpayment, the total non-capitated HCSR claims dollars (adjusted to completion) shall be multiplied by one (1) - net payment error rate, and the result shall be used to represent actual costs for categories of care 1 through 7. For example, if the audit determines that the audited HCSR sample reflects a two percent overpayment, total non-capitated HCSR claims dollars adjusted to completion shall be multiplied by 98, and the result shall be added to audited capitated costs and audited Category 8 costs to reflect actual health care costs for the purposes of risk sharing.

3. In the case the HCSR adjudication audit identifying net underpayments, the total HCSR claims dollars (adjusted to completion) shall reflect any actual additional payments made by the contractor as a result of the audit. The contractor must submit the additional HCSRs resulting from the reconciliation payments made in these instances.

ACUPUNCTURE: The practice of inserting needles into various body parts to pierce specific peripheral nerves for the production of counter-irritation to relieve the discomfort of pain, induce surgical anesthesia, or for other treatment purposes.

NOTE: Acupuncture is not covered by TRICARE.

ADEQUATE MEDICAL DOCUMENTATION, MEDICAL TREATMENT RECORDS: Adequate medical documentation contains sufficient information to justify the diagnosis, the treatment plan, and the services and supplies furnished. Under TRICARE, it is required that adequate and sufficient clinical records be kept by the health care provider(s) to substantiate that specific care was actually and appropriately furnished, was medically necessary and appropriate (as defined by 32 CFR 199), and to identify the individual(s) who provided the care. All procedures billed must be documented in the records. In determining whether medical records are adequate, the records will be reviewed under generally acceptable standards such

as the applicable Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards, the Peer Review Organization (PRO) standards (and the provider's state or local licensing requirements) and other requirements specified by this Regulation. In general, the documentation requirements for a professional provider are not less in the outpatient setting than the inpatient setting.

ADEQUATE MEDICAL DOCUMENTATION, MENTAL HEALTH RECORDS: Adequate medical documentation provides the means for measuring the type, frequency, and duration of active treatment mechanisms employed and progress under the treatment plan. Under TRICARE, it is required that adequate and sufficient clinical records be kept by the provider to substantiate that specific care was actually and appropriately furnished, was medically or psychologically necessary (as defined by 32 CFR 199), and to identify the individual(s) who provided the care. Each service provided or billed must be documented in the records. In determining whether medical records are adequate, the records will be reviewed under generally acceptable standards (e.g., the applicable JCAHO standards and the provider's state or local licensing requirements) and other requirements specified by this Regulation. It must be noted that the psychiatric and psychological evaluations, physician orders, the treatment plan, integrated progress notes (and physician progress notes if separate from the integrated progress notes), and the discharge summary are the more critical elements of the mental health record. However, nursing and staff notes, no matter how complete, are not a substitute for the documentation of services by the individual professional provider who furnished treatment to the beneficiary. In general, the documentation requirements of a professional provider are not less in the outpatient setting than the inpatient setting. Furthermore, even though a hospital that provides psychiatric care may be accredited under the JCAHO manual for hospitals rather than the consolidated standards manual, the critical elements of the mental health record listed above are required for TRICARE claims.

ADJUNCTIVE DENTAL CARE: Dental care that is medically necessary in the treatment of an otherwise covered medical (not dental) condition, is an integral part of the treatment of such medical condition, and is essential to the control of the primary medical condition; or, is required in preparation for or as the result of dental trauma which may be or is caused by medically necessary treatment of an injury or disease (iatrogenic).

ADJUSTMENT: A correction to the information in the Health Care Service Record (HCSR) and/or Beneficiary History Files (Hard Copy Files and Automated Beneficiary History and Deductible Files) related to a claim previously processed to completion by the current contractor. Adjustments include any recoupments, additional payment(s), all cancellations (total or partial), and corrections to statistical data, whether or not the changes result in changes to the financial data.

ADJUSTMENT, IDENTIFICATION OF (RECEIPT): An adjustment may be generated by a telephonic, written or personal inquiry, appeal decision, or as the result of a contractor's internal review. The adjustment is identified when the contractor's staff determines the issue requires an additional payment, cancellation, or a change to the Beneficiary History and Deductible Files (see definition) or when notice is received from TMA that an adjustment is required. In the case of recoupments, the adjustment is "identified" for reporting purposes, with receipt of the payment into the contractor's custody.

ADMISSION: The formal acceptance by a TRICARE authorized institutional provider of a TRICARE beneficiary for the purpose of diagnosis and treatment of illness, injury, pregnancy, or mental disorder.

ADOPTED CHILD: A child taken into one's own family by legal process and treated as one's own child. In case of adoption, TRICARE eligibility begins as of 12:01 a.m. of the day of the final adoption decree.

NOTE: A child who is placed in legal custody of a member or former member by a court or who is placed in the home of a member or former member by a recognized placement agency in anticipation of the legal adoption of the child is TRICARE eligible beginning 12:01 a.m. of the day of such placement.

ALL-INCLUSIVE PER DIEM RATE: The TMA-determined rate that encompasses the daily charge for inpatient care and, unless specifically excepted, all other treatment determined necessary and rendered as part of the treatment plan established for a patient.

ALLOWABLE CHARGE: The TRICARE-determined level of payment to physicians and other categories of individual professional providers based on one of the approved reimbursement methods set forth in Chapter 10. As used by TRICARE, the allowable charge shall be the lowest of the billed charge, the prevailing charge, or the maximum allowable prevailing charge. For network/contracted providers, the allowable charge shall be the contracted amount.

NOTE: Under a program approved by the Director, TMA, where a non-network provider has agreed to discount his or her charges, the discounted charge shall be used in place of the billed charge in allowable charge calculations unless the discounted amount is above the billed charge. When the discounted amount is above the billed charge, the actual billed charge shall be used in the allowable charge calculations.

ALLOWABLE CHARGE COMPLAINT: A request for review of a contractor determination of allowable charge for covered services and supplies furnished under TRICARE. The allowable charge complaint does not fall within the meaning of an "appeal", in the technical sense, but does require a careful contractor review of the claim processing to ensure accuracy of the allowance made.

ALLOWABLE CHARGE REDUCTION: The difference between the reimbursement determination made by a contractor and the amount billed by the provider of care (prior to determination of applicable cost-shares and deductibles).

ALLOWABLE COST: The TRICARE-determined level of payment to hospitals or other institutions, based on one of the approved reimbursement methods described in 32 CFR 199.14. Allowable cost may also be referred to as the TRICARE-determined reasonable cost.

AMBULANCE: A specially designed vehicle for transporting the sick or injured that contains a stretcher, linens, first aid supplies, oxygen equipment, and such lifesaving equipment required by state and local law, and that is staffed by personnel trained to provide first aid treatment.

AMBULATORY SURGERY: Surgery provided to the patient on an outpatient, walk-in, same day basis in an appropriately equipped and staffed health facility with surgery usually conducted under general anesthesia with no overnight stay in the hospital required. Also called same day surgery.

AMOUNT IN DISPUTE: The amount of money, determined under 32 CFR 199, that TRICARE would pay for medical services and supplies involved in an adverse determination being appealed if the appeal were resolved in favor of the appealing party. See 32 CFR 199.10 for additional information concerning the determination of "amount in dispute" under the Regulation.

ANESTHESIA SERVICES: The administration of an anesthetic agent by injection or inhalation, the purpose and effect of which is to produce surgical anesthesia characterized by muscular relaxation, loss of sensation, or loss of consciousness when administered by or under the direction of a physician or dentist in connection with otherwise covered surgery or obstetrical care, or shock therapy. Anesthesia services do not include hypnosis or acupuncture.

APPEAL: A formal written request by a beneficiary, a participating provider, a provider denied authorized provider status under TRICARE, or a representative, to resolve a disputed question of fact. See the 32 CFR 199 and the Operations Manual 6010.49-M.

APPEALABLE ISSUE: Disputed question of fact which, if resolved in favor of the appealing party, would result in the authorization of TRICARE benefits, or approval as an authorized provider in accordance with the 32 CFR 199. There is no appealable issue if no facts are in dispute, if no TRICARE benefits would be payable, or if there is no authorized provider, regardless of the resolution of any disputed facts. 32 CFR 199.10 provides additional information concerning the determination of "appealable issue."

APPEALING PARTY: Any party to the initial determination who files an appeal of an adverse determination or requests a hearing under the provisions of 32 CFR 199.

APPROPRIATE MEDICAL CARE:

1. Services performed in connection with the diagnosis or treatment of disease or injury, pregnancy, mental disorder, or well-baby care which are in keeping with the generally accepted norms for medical practice in the United States;

2. The authorized individual professional provider rendering the medical care is qualified to perform such medical services by reason of his or her training and education and is licensed or certified by the state where the service is rendered or appropriate national organization or otherwise meets TRICARE standards; and

3. The services are furnished economically. "Economically" means that the services are furnished in the least expensive level of care or medical environment adequate to provide the required medical care regardless of whether or not that level of care is covered by TRICARE.

APPROVED TEACHING PROGRAMS: For purposes of TRICARE, an approved teaching program is a program of graduate medical education which has been duly approved in its respective

specialty or subspecialty by the Accreditation Council for Graduate Medical Education of the American Medical Association, by the Committee on Hospitals of the Bureau of Professional Education of the American Osteopathic Association, by the Council on Dental Education of the American Dental Association, or by the Council on Podiatry Education of the American Podiatry Association.

ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS): An authority of the Assistant Secretary of Defense (Health Affairs) includes any person designated by the Assistant Secretary to exercise the authority involved.

ATTENDING PHYSICIAN: The physician who has the primary responsibility for the medical diagnosis and treatment of the patient. A consultant or an assistant surgeon, for example, would not be an attending physician. Under very extraordinary circumstances, because of the presence of complex, serious, and multiple, but unrelated, medical conditions, a patient may have more than one attending physician concurrently rendering medical treatment during a single period of time. An attending physician also may be a teaching physician.

AUTHORIZATION FOR CARE: The determination that the requested treatment is medically necessary, delivered in the appropriate setting, a TRICARE benefit, and that the treatment will be cost-shared by DoD through its MCS contract. (All NAS issuances need to be prior authorized.)

AUTHORIZED PROVIDER: A hospital or institutional provider, physician, or other individual professional provider, or other provider of services or supplies specifically authorized to provide benefits under TRICARE in 32 CFR 199.6. *Any physician listed in the 32 CFR 199.6 who holds a valid license to practice medicine in the state where he/she practices shall be an authorized provider. Providers not specifically listed in 32 CFR 199.6 are not considered authorized providers unless they are included in a TRICARE demonstration program.*

AUTOMATED DATA PROCESSING (ADP): A system for recording and processing data on magnetic media, ADP cards, or any other method for mechanical/electronic processing and manipulation or storage of data.

AUTOMATED DATA PROCESSING AND REPORTING MANUAL (6010.50): A TMA manual which provides ADP instructions and requirements for contractors who use the Health Care Service Records (HCSRs) system for reporting data to TMA.

BACKUP HOSPITAL: A hospital that is otherwise eligible as a TRICARE institutional provider and that is fully capable of providing emergency care to a patient who develops complications beyond the scope of services of a given category of TRICARE-authorized freestanding institutional provider and which is accessible from the site of the TRICARE-authorized freestanding institutional provider within an average transport time acceptable for the types of medical emergencies usually associated with the type of care provided by the freestanding facility.

BACKUP SYSTEM: A separate, off-site automated data processing system with similar operating capabilities which will be activated/used in case of a major system failure, damage, or destruction. This includes back-up data sets, software and hardware requirements, and trained personnel.

BALANCE BILLING: The practice of a provider billing a beneficiary the difference between the TRICARE allowed amount and the billed charges on a claim. Participating providers and network providers may not collect from all sources an amount which exceeds the TRICARE allowed amount. Non-participating providers may not collect an amount which exceeds the balance billing limit (115% of the allowed charge). If the billed charge is less than the balance billing limit, then the billed charge is the maximum amount that can be collected by the non-participating provider.

BASIC PROGRAM: The primary medical benefits authorized under Chapter 55 of Title 10, United States Code, and set forth in 32 CFR 199.4.

BENCHMARK: A TRICARE clerical and automated systems test using claims and other documents created or approved by TMA and processed by the contractor. The contractor's output is compared to predetermined results prepared or approved by TMA to determine the accuracy, completeness and operational characteristics of the contractor's clerical and automated systems components. The purpose of the benchmark is to identify clerical and automated systems deficiencies which must be corrected before claims can be processed in accordance with TMA requirements. The comprehensiveness of the benchmark will vary depending on the number and type of conditions tested.

BENEFICIARY HISTORY FILE: A system of records consisting of any record or subsystem of records, whether hard copy, microform or automated, which reflects diagnosis, treatment, medical condition, or any other personal information with respect to any individual, including all such records acquired or utilized by the contractor in delivery of health care services, in the development and processing of claims, or in performing any other functions under this contract.

1. **HARD COPY CLAIM AND MICROFORM FILES**. These files may include but are not limited to:

   a. Claim forms (TRICARE or other claim form approved by TMA)

   b. DD Form 1251, Nonavailability Statement

   c. Reports and related documentation pertaining to professional review of treatment

   d. Powers of Attorney

   e. Other Statements of Legal Guardianship

   f. Receipts (Itemized Bills)

   g. Other Insurance Payment Information (or EOB)

   h. Medical Reports (Mental illness case files, DME, Medical Necessity Statement, Emergency Admission Statement, progress reports, nursing notes, operative reports, test results, etc.).

i. Deductible Certificate (if claimant indicates that deductible has been satisfied or partially satisfied via claims processed by a different contractor).

j. Timely Filing Waiver

k. Claim-Related Correspondence

l. Appeals Case File

m. Any other contractor developed documentation which is used for recording and documenting care and payment for care by network providers of care.

2. **AUTOMATED HISTORY FILES**. The electronically maintained record of a beneficiary's medical care and related administrative data, including such data on charges, payments, deductible status, services received, diagnoses, adjustments, etc. (See Chapter 8 and 9.)

BENEFICIARY LIABILITY: The legal obligation of a beneficiary, his or her estate, or responsible family member to pay for the costs of medical care or treatment received. Specifically, for the purposes of services and supplies covered by TRICARE, beneficiary liability includes any annual deductible amount, cost-sharing amounts, or, when a provider does not submit a claim on a participating basis on behalf of the beneficiary, amounts above the TRICARE-determined allowable cost or charge. Beneficiary liability also includes any expenses for medical or related services and supplies not covered by TRICARE.

BENEFIT: The TRICARE benefit consists of those services, payment amounts, cost-shares and co-payments authorized by Public Law 89-614, 32 CFR 199 and the Policy Manual.

BEST VALUE: The expected outcome of an acquisition that, in the Government's estimation, provides the greatest overall benefit in response to the requirement.

BIRTHING CENTER: A health care provider that meets the applicable requirements established by 32 CFR 199.6.

BIRTHING ROOM: A room and environment designed and equipped to provide care, to accommodate support persons, and within which a woman with a low-risk, normal, full-term pregnancy can labor, deliver and recover with her infant.

BRACE: An orthopedic appliance or apparatus (an orthosis) used to support, align, or hold parts of the body in correct position. For the purposes of TRICARE, it does not include orthodontic or other dental appliances.

CAPABILITY OF A PROVIDER: This term applies to the scope of services the provider is both capable of performing and willing to perform under this contract. For example, a neurologist who only performs sleep studies may not be considered to have capability to perform as a general neurology specialist.

CAPACITY OF A PROVIDER: This term applies to the amount of time or number of services a provider is able to perform in conjunction with this contract. For example, a primary care physician whose practice is full has no available capacity for services.

CAPITATED CLAIMS/ENCOUNTERS/RESOURCE SHARING SERVICES: Claims, encounters, or resource sharing services that are paid (usually monthly) based on a predetermined fee per individual/family assigned to a network provider. Payments are not determined by the number of services or types of procedures rendered.

CAPPED RATE: The maximum per diem or all-inclusive rate that TRICARE will allow for care.

CASE MANAGEMENT: A collaborative process which assesses, plans, implements, coordinates, monitors and evaluates the options and services to meet an individual's health care needs using resources available to provide quality and cost-effective outcomes. Case Management is not restricted to catastrophic illnesses and injuries.

CATCHMENT AREAS: Geographic areas determined by the Assistant Secretary of Defense (Health Affairs) that are defined by a set of five digit zip codes, usually within an approximate 40 mile radius of military inpatient treatment facility. Beneficiaries not enrolled in TRICARE Prime residing in these areas are required to receive all inpatient care from the military treatment facility or obtain a Nonavailability Statement (NAS) (see definition) that authorizes civilian inpatient care for a particular inpatient service.

CERTIFICATION FOR CARE: The determination that the provider's request for care (level of care, procedure, etc.) is consistent with preestablished criteria. (Note: This is NOT synonymous with authorization for care).

CERTIFIED PROVIDER: *A hospital or institutional provider, physician, or other individual professional provider of services or supplies specifically authorized by 32 CFR 199.6. Certified providers have been verified by TMA or a designated contractor to meet the standards of 32 CFR 199.6, and have been approved to provide services to TRICARE beneficiaries and receive government payment for services rendered to TRICARE beneficiaries.*

CERTIFIED NURSE MIDWIFE: An individual who meets the applicable requirements established by 32 CFR 199.6.

CERTIFIED PSYCHIATRIC NURSE SPECIALIST: A licensed, registered nurse who meets the criteria in 32 CFR 199.6.

CHAMPUS MAXIMUM ALLOWABLE CHARGE (CMAC): CMAC is a nationally determined allowable charge level that is adjusted by locality indicies and is equal to or greater than the Medicare Fee Scheduled amount.

CHAMPUS PRICE INFLATION REIMBURSEMENT INDEX (CPIRI): The percentage change from the DCP of a contractor for 12 prices or update factors, and a weight for each of these values. The weights are fixed throughout the contract, and will sum to 100% (as in the U.S. Government's measurement of the CPI).

CHAMPVA: The Civilian Health and Medical Program of the Veterans Administration. This is a program of medical care for spouses and dependent children of disabled or deceased disabled veterans who meet the eligibility requirements of the Veterans Administration.

CHAMPVA CENTER (CVAC): It is the component within the Department of Veterans Affairs, Health Administration Center (HAC) which processes all CHAMPVA claims.

CHANGE ORDER: A written directive from the TMA Contracting Officer to the contractor directing changes within the general scope of the contract, as authorized by the "changes clause."

CHEMOTHERAPY: The administration of approved antineoplastic drugs for the treatment of malignancies (cancer) via perfusion, infusion, or parenteral methods of administration.

CHILD: An unmarried legitimate child, adopted child, stepchild, or illegitimate child, who otherwise meets the requirements (including age requirements) set forth in 32 CFR 199.3.

CHIROPRACTOR: A practitioner of chiropractic (also called chiropraxis); essentially a system of therapeutics based upon the claim that disease is caused by abnormal function of the nerve system. It attempts to restore normal function of the nerve system by manipulation and treatment of the structures of the human body, especially those of the spinal column.

NOTE: Services of chiropractors are not covered by TRICARE, except under specific demonstration authority.

CHRISTIAN SCIENCE NURSE: An individual who has been accredited as a Christian Science Nurse by the Department of Care of the First Church of Christ, Scientist, Boston, Massachusetts, and listed (or eligible to be listed) in the Christian Science Journal at the time the service is provided. The duties of Christian Science nurses are spiritual and are nonmedical and nontechnical nursing care performed under the direction of an accredited Christian Science practitioner. There are two levels of Christian Science nurse accreditation:

1. **GRADUATE CHRISTIAN SCIENCE NURSE**. This accreditation is granted by the Department of Care of the First Church of Christ, Scientist, Boston, Massachusetts, after completion of a three year course of instruction and study.

2. **PRACTICAL CHRISTIAN SCIENCE NURSE**. This accreditation is granted by the Department of Care of the First Church of Christ, Scientist, Boston, Massachusetts, after completion of a one year course of instruction and study.

CHRISTIAN SCIENCE PRACTITIONER: An individual who has been accredited as a Christian Science Practitioner for the First Church of Christ, Scientist, Boston, Massachusetts, and listed (or eligible to be listed) in the Christian Science Journal at the time the service is provided. An individual who attains this accreditation has demonstrated results of his or her healing through faith and prayer rather than by medical treatment. Instruction is executed by an accredited Christian Science teacher and is continuous.

CHRISTIAN SCIENCE SANATORIUM: A sanatorium either operated by the First Church of Christ, Scientist, or listed and certified by the First Church of Christ, Scientist, Boston, Massachusetts.

CHRONIC MEDICAL CONDITION: A medical condition that is not curable, but which is under control through active medical treatment. Such chronic conditions may have periodic acute episodes and may require intermittent inpatient hospital care. However, a chronic medical condition can be controlled sufficiently to generally permit continuation of some activities of persons who are not ill (such as work and school).

CHRONIC RENAL DISEASE (CRD): The end stage of renal disease which requires a continuing course of dialysis or a kidney transplantation to ameliorate uremic symptoms and maintain life.

CLAIM: Any request for payment for services rendered related to care and treatment of a disease or injury which is received from a beneficiary, a beneficiary's representative, or a network or non-network provider by a contractor on any TRICARE-approved claim form or approved electronic medium. If two or more forms for the same beneficiary are submitted together, they shall constitute one claim unless they qualify for separate processing under the claims splitting rules. (It is recognized that services may be provided in situations in which no claims, as defined here, are generated. This does not relieve the contractor from collecting the data necessary to fulfill the requirements of the health care service record for all care provided under the contract.)

CLAIM FILE: The collected records submitted with or developed in the course of processing a single claim. It includes the approved TRICARE claim form and may include attached bills, medical records, record of telephone development, copies of correspondence sent and received in connection with the claim, the EOB, and record of adjustments to the claim. It may also include the record of appeals and appeal actions. The claim file may be in microcopy, hard copy, or in a combination of media.

CLAIM FORM: A fixed arrangement of captioned spaces designed for entering and extracting prescribed information, including ADP system forms.

CLAIM FORMS, AUTHORIZED:

1. **UB-92, HCFA-1450**. The national standard claim form (except for New York where the UB-F-1 is authorized for TRICARE) used by institutional providers for submission of claims for inpatient and outpatient institutional services. The UB-92 may be used by institutional providers and Home Health Care Agencies to bill for professional services. The UB-92 must include all the required information needed to process the professional services and reimburse the services using the allowable charge payment methodology to include any negotiated rates. Contractors shall contact any Home Health Care Agency that has requested to bill for professional services on the UB-92 to assist them with the proper billing requirements, e.g., CPT procedure codes, name of the actual provider, etc.

2. **FORM HCFA-1500**. A claim form used for the submission of claims for non-institutional services by physicians and all other individual providers of care. This form is accepted from beneficiaries although it is not designed for beneficiary use.

3. **DD FORM 2520**. A form used for submitting a claim requesting payment for inpatient or outpatient medical services or supplies when provided by civilian sources of medical care. This form is authorized for use only outside the United States. Beneficiaries or providers may use this form. Beneficiaries complete this form and attach bills and/or receipts for any service where a provider will not complete a claim form for him/her.

4. **DD FORM 2642**. A form used for submitting a claim requesting payment for civilian inpatient or outpatient medical services or supplies. This form is authorized for use

both inside and outside the United States. Only beneficiaries may use this form. When a civilian provider of care will not complete a claim form, the beneficiary completes this form, attaches bills and/or receipts, and files the claim with the appropriate TRICARE claims processing contractor.

CLAIMS CYCLE TIME: That period of time, recorded in calendar days, from the receipt of a claim into the possession/custody of the contractor to the completion of all processing steps including, when required, printing of the check and EOB.

CLAIMS PAYMENT DATA: The record of information contained on or derived from the processing of a claim or encounter.

CLEAN CLAIMS: Deleted. Refer to "Retained Claims."

CLINICAL PSYCHOLOGIST: A psychologist, certified or licensed at the independent practice level in his or her state, who meets the criteria in 32 CFR 199.6.

CLINICAL SOCIAL WORKER: An individual who is licensed or certified as a clinical social worker and meets the criteria listed in 32 CFR 199.6.

COINSURANCE: See the definition for "cost-share."

COLLATERAL VISITS: Sessions with the patient's family or significant others for purposes of information gathering or implementing treatment goals.

COMBINED DAILY CHARGE: A billing procedure by an inpatient facility that uses an inclusive flat rate covering all professional and ancillary charges without any itemization.

COMMITMENT: An unequivocal written statement that the contractor will accomplish a task(s), achieve an outcome, or produce a product meeting or exceeding Government or contractor established standards.

COMMUNITY HEALTH ACCREDITATION PROGRAM (CHAP): An evaluating body for home and community health care organizations. CHAP is an independent subsidiary of the National League for Nursing.

COMPLAINT: A verbal, written, or electronic expression of dissatisfaction, resentment, or discontent.

COMPLICATIONS OF PREGNANCY: One of the following, when commencing or exacerbating during the term of the pregnancy:

1. Cesarean delivery; hysterectomy
2. Pregnancy terminating before expiration of twenty-six (26) weeks, except a voluntary abortion.
3. False labor or threatened miscarriage.
4. Nephritis or pyelitis of pregnancy.

5. Hyperemesis gravidarum.

6. Toxemia.

7. Aggravation of a heart condition or diabetes.

8. Premature rupture of membrane.

9. Ectopic pregnancy.

10. Hemorrhage.

11. Other conditions as may be determined by the Director, TMA, or a designee.

CONCURRENT REVIEW/CONTINUED STAY REVIEW: Evaluation of a patient's continued need for treatment and the appropriateness of current and proposed treatment, as well as the setting in which the treatment is being rendered or proposed. Concurrent review applies to all levels of care (including outpatient care).

CONFIDENTIALITY REQUIREMENTS: The procedures and controls that assure the confidentiality of medical information in compliance with the Freedom of Information Act, the Comprehensive Alcohol Abuse and Alcoholism Prevention and Rehabilitation Act, and the Privacy Act.

CONFINEMENT: That period of time from the day of admission to a hospital or other institutional provider, to the day of discharge, transfer, or separation from the facility, or death. Successive admissions also may qualify as one confinement provided not more than 60 days have elapsed between the successive admissions, except that successive admissions related to a single maternity episode shall be considered one confinement, regardless of the number of days between admissions.

CONFLICT OF INTEREST: Includes any situation where an active duty member (including a reserve member while on active duty) or civilian employee of the United States Government, through an official federal position, has the apparent or actual opportunity to exert, directly or indirectly, any influence on the referral of MHS beneficiaries to himself or herself or others with some potential for personal gain or appearance of impropriety. Individuals under contract to a Uniformed Service may be involved in a conflict of interest situation through the contract position.

CONGENITAL ANOMALY: A condition existing at or from birth that is a significant deviation from the common form or norm and is other than a common racial or ethnic feature. For purposes of TRICARE, congenital anomalies do not include anomalies relating to teeth (including malocclusion or missing tooth buds) or structures supporting the teeth, or to any form of hermaphroditism or sex gender confusion. Examples of congenital anomalies are harelip, birthmarks, webbed fingers or toes, or such other conditions that the Director, TMA, or a designee, may determine to be congenital anomalies.

CONSULTATION: A deliberation with a specialist physician or dentist requested by the attending physician primarily responsible for the medical care of the patient, with respect to the diagnosis or treatment in any particular case. A consulting physician or dentist may perform a limited examination of a given system or one requiring a complete diagnostic

history and examination. To qualify as a consultation, a written report to the attending physician of the findings of the consultant is required.

NOTE: Staff consultations required by rules and regulations of the medical staff of a hospital or other institutional provider do not qualify as consultation.

CONSULTING PHYSICIAN OR DENTIST: A physician or dentist, other than the attending physician, who performs a consultation.

CONTINUED HEALTH CARE BENEFIT PROGRAM: The Continued Health Care Benefit Program (CHCBP) was established by the National Defense Authorization Act for FY 1993, and provides temporary continued TRICARE benefits for certain former TRICARE beneficiaries. Coverage under the CHCBP is purchased on a premium basis.

CONTINUUM OF CARE: All patient care services provided from "pre-conception to grave" across all types of settings. Requires integrating processes to maintain ongoing communication and documentation flow between the direct care system and network.

CONTRACT PERFORMANCE EVALUATION (CPE): The review by TMA, of a contractor's level of compliance with the terms and conditions of its contract. Usually, an operational audit performed by TMA staff focuses on timeliness, accuracy, and responsiveness of the contractor in performing all aspects of the work required by the contract.

CONTRACT PHYSICIAN: A physician who has made contractual arrangements with a contractor to provide care or services to TRICARE beneficiaries. A contract physician is a network provider who participates on all TRICARE claims.

CONTRACTING OFFICER: A Government employee having authority vested by a Contracting Officer's Warrant to execute, administer, and terminate contracts and orders, and modifications thereto, which obligate Government funds and commit the Government to contractual terms and conditions.

CONTRACTOR: An organization with which TMA has entered into a contract for delivery of and/or processing of payment for health care services through contracted providers and for processing of claims for health care received from non-network providers and for performance of related support activities.

CONTROL OF CLAIMS: The ability to identify individually, locate, and count all claims in the custody of the contractor by location, including those that may be being developed by physical return of a copy of the claim, and age including total age in-house and age in a specific location.

CONTROLLED DEVELOPMENT: The retention of a claim by the contractor in pending inventory, during the time the claim is being completed by investigation, telephone contact, or written contact or return of a copy for information needed to enable the accurate processing and adjudication of the claim.

CONVICTION: "Conviction" or "convicted" means that (1) a judgment of conviction has been entered, or (2) there has been a finding of guilt by the trier of fact, or (3) a plea of guilty or a

plea of nolo contendere has been accepted by a court of competent jurisdiction, regardless of whether an appeal is pending.

COORDINATION OF BENEFITS: A system to require collection of other health insurance benefits before making any TRICARE benefit payment, except for Medicaid, in compliance with requirements specified in the 32 CFR 199 and the Operations Manual.

COPAYMENT: See the definition for "cost-share."

COPY: A reproduction of the contents of an original document, prepared simultaneously or separately, usually identified by function or by method of creation. Copies identified by function may include action copy, comeback copy, file or record copy, information or reference copy, official copy, and tickler copy. Copies identified by method of creation include carbon copy, mimeograph copy, ribbon copy, microcopy, and electrostatic copy.

CORRESPONDENCE: Written requests for information, claims status, benefit coverage, and other inquiries of a general nature. A single inquiry may contain a request for the status of several different claims. In this case, a single inquiry shall be counted as one piece of correspondence even though there may be multiple claims attached to the one inquiry. This does not include grievances or appeals.

COSMETIC, RECONSTRUCTIVE, OR PLASTIC SURGERY. Surgery that can be expected primarily to improve physical appearance of a beneficiary, or that is performed primarily for psychological purposes, or that restores form, but does not correct or improve materially a bodily function.

COST EFFECTIVE PROVIDER NETWORK AREAS: Areas in which provider networks can be developed where the discounts received from providers and the effects of Utilization Management activities are greater than or equal to the administrative costs associated with maintaining the Provider Network and accomplishing all additional marketing, education, enrollment, and related administrative activities.

COST-SHARE: The amount a beneficiary must pay for covered inpatient and outpatient services (other than the deductible, the annual TRICARE Prime enrollment fee, the balance billing amount, or disallowed amounts) as set forth in 32 CFR 199.4, 199.5, and 199.17. Active duty service members have no financial liability for the authorized health care services they receive. They do not pay cost-shares, deductibles, enrollment fees, or balance billed amounts. The contractor shall reimburse the full amount that a provider can collect, including any amount over CMAC up to the balance billing limit. Under TRICARE, cost-shares are expressed in one of two ways:

1. **COINSURANCE:** The beneficiary's cost-share expressed as a percentage of allowed charges.

   EXAMPLE 1: TRICARE STANDARD: Family members of active duty sponsors pay 20% of the allowed charges for outpatient services. All other beneficiaries (retirees, family members of retirees, survivors, etcetera) pay 25% of the allowed charges for both inpatient and outpatient services.

EXAMPLE 2: **TRICARE EXTRA**: Family members of active duty sponsors usually pay 15% of the allowed charges for outpatient services. All other beneficiaries (retirees, family members of retirees, survivors, etcetera) usually pay 20% of the allowed charges for both inpatient and outpatient services.

EXAMPLE 3: **TRICARE PRIME POINT OF SERVICE (POS)**: All TRICARE Prime enrollees who receive care under the POS option pay 50% of the allowed charges for inpatient care and, after meeting the outpatient deductible ($300 for an individual, $600 for a family), 50% of the allowed charges for outpatient care.

2. **COPAYMENT.** The beneficiary's cost-share expressed as a predetermined, fixed amount.

EXAMPLE 1: **TRICARE STANDARD**: For each inpatient admission, active duty family members pay the first $25 of allowed institutional charges or a per diem rate for the total number of inpatient days—whichever is greater.

EXAMPLE 2: **TRICARE PRIME**: Except for family members of active duty for each covered visit or service, enrolled members pay a specific dollar amount which is usually collected at the time of the visit or service. For specific information on TRICARE Prime copayments, see the TRICARE Reimbursement Manual, Chapter 2, Addendum A, Table 1.

EXAMPLE 3: **PROGRAM FOR PERSONS WITH DISABILITIES (PFPWD)**: The beneficiary (or responsible person) pays a fixed amount each month during which the active duty family member receives services under PFPWD. The copayment schedule is based on the sponsor's rank.

See 32 CFR 199.4 and 199.17, for beneficiary liability requirements under TRICARE Standard, 32 CFR 199.17 for TRICARE Extra and Prime liability requirements, and 32 CFR 199.5 for Program for Persons with Disabilities liability requirements.

COVERED CHARGES: Billed charges for services, supplies, and equipment furnished by an authorized provider that have been determined to be benefits of the program and that have been properly submitted to a contractor on or attached to, an approved TRICARE claim form.

CPT: The acronym for Current Procedural Terminology published by the American Medical Association. CPT is the required TRICARE procedural coding system for medical procedures for all contracts becoming effective on and after October 1, 1981.

CREDENTIALING: The process by which providers are allowed to participate in the network. This includes a review of the provider's training, educational degrees, licensure, practice history, etc.

CREDENTIALS PACKAGE: Credentials packages are required for all clinical personnel supplied by the contractor who will be working in an MTF. Similar packages may be required for non-clinical personnel. The credentials package shall contain the following information.

1. All documents, verified per regulation/directive/instruction/policy, which are needed in order for the individual to provide the proposed services at the involved facility. This will include licensure from the jurisdiction in which the individual will be practicing and a National Practitioner Data Bank (NPDB) query as specified by the facility.

2. Credentials files for all personnel required by law to have a Criminal History Background Check (CHBC) will contain documentation showing that the required CHBC has been completed prior to awarding of privileges or the delivery of services.

   a. If a CHBC has been initiated, but not completed, the MTF commander has the authority to allow awarding of privileges and initiation of services if delivered under clinical supervision.

   b. The mechanism for accomplishing the CHBC may vary between MTFs and should be determined during phase-in/transition and be agreed to by the MTF Commander.

   c. Regardless of the mechanism for initiating and completing a CHBC, the cost is to be borne by the contractor.

3. TRICARE Provider ID number when provider is of a type which is recognized by TRICARE. Medicare Provider ID number when provider is of a type recognized by Medicare.

4. Evidence of compliance (or scheduled compliance) with the MTF specific requirements including all local Employee Health Program (EHP), Federal Occupational Safety Act and Health Act (OSHA), and Bloodborn Pathogens Program (BBP) requirements.

CURRENT PROCEDURAL TERMINOLOGY (CPT): The CPT is published by the American Medical Association and is the required TRICARE procedural coding system for medical procedures for all contracts becoming effective on and after October 1, 1981.

CUSTODIAL CARE PRIOR TO DECEMBER 28, 2001: Care rendered to a patient (1) who is disabled mentally or physically and such disability is expected to continue and be prolonged, and (2) who requires a protected, monitored, or controlled environment whether in an institution or in the home, and (3) who requires assistance to support the essentials of daily living, and (4) who is not under active and specific medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored, or controlled environment. A custodial care determination is not precluded by the fact that a patient is under the care of a supervising or attending physician and that services are being ordered and prescribed to support and generally maintain the patient's condition, or provide for the patient's comfort, or ensure the manageability of the patient. Further, a custodial care determination is not precluded because the ordered and prescribed services and supplies are being provided by an R.N., L.P.N., or L.V.N.

NOTE: The determination of custodial care in no way implies that the care being rendered is not required by the patient; it only means that it is the kind of care that is not covered under TRICARE. A program of physical and mental rehabilitation which is designed to reduce a

disability is not custodial care as long as the objective of the program is a reduced level of care.

CUSTODIAL CARE ON OR AFTER DECEMBER 28, 2001: The treatment or services, regardless of who recommends such treatment or services or where such treatment or services are provided, that can be rendered safely and reasonably by a person who is not medically skilled or is or are designed mainly to help the patient with the activities of daily living. Refer to the TRICARE Policy Manual, Chapter 7, Section 13.1A.

CUSTODY: The guardianship of documents/claims or funds which includes both physical possession (protective responsibility) and legal title (legal responsibility).

CYCLE TIME: The elapsed time, as expressed in calendar days (including any part of the first and last days counted as two days), from the date a claim, piece of correspondence, grievance, or appeal case was received by a contractor through the date processed to completion. (See claims cycle time for added detail.)

DATA REPOSITORY: A single point of electronic storage, established and maintained by the contractor, that enables the Government to electronically access all data maintained by the contractor relative to this contract. This includes all claims/encounter data, provider data, authorization, enrollment, and derived data collected in relation to this contract.

DATE OF DETERMINATION (APPEALS): The date of completion appearing on the reconsideration determination, formal review determination, or hearing final decision.

DAYS: Calendar days unless otherwise indicated.

DECEASED SERVICE MEMBER: A person who, at the time of his or her death, was an active duty member of a Uniformed Service under a call or order that did not specify a period of 30 days or less; or a retiree of a Uniformed Service.

DEDUCTIBLE: The statutory requirement for payment by the beneficiary of an initial specified dollar amount of the TRICARE-determined allowable costs or charges for covered outpatient services or supplies provided in any one fiscal year.

EXAMPLE 1: Under TRICARE Standard and TRICARE Extra, the deductible is $50 (for family members of sponsors in pay grade E-4 and below) or $150.00 (for family members of sponsors in pay grades above E-4, and retirees and their family members) For a family, the aggregate payment of $100 (for family members of sponsors in pay grade E-4 and below) or $300.00 (for family members of sponsors in pay grades above E-4, and retirees and their family members) by two or more beneficiaries will satisfy the deductible requirement.

EXAMPLE 2: For TRICARE Prime enrollees, under the Point-of-Service option, the deductible is $300 for individuals, $600 for a family.

DEDUCTIBLE CERTIFICATE: A statement issued to the beneficiary (or sponsor) by a Managed Care Support Contractor certifying to deductible amounts satisfied by a TRICARE beneficiary for any applicable fiscal year.

DEERS/TRICARE/CLAIMS DEVELOPMENT SYSTEM: A realtime data system which will provide some sponsor/beneficiary identification information that can assist in claims development. Data available include sponsor's paygrade, sponsor's branch of service, status of sponsor, patient's name, patient's date of birth, patient's sex, and patient's Prime enrollment status.

DEFENSE ENROLLMENT ELIGIBILITY REPORTING SYSTEM (DEERS): The computer-based enrollment/ eligibility system for verifying entitlement to health care services. See the 32 CFR 199 definition and the Automated Data Processing and Reporting Manual (6010.50-M), for specific information concerning DEERS.

DEFICIENCY: (For the purpose of evaluating past performance) a certain level of the offeror's performance under a contract, either with a government agency or commercial business, that fails to satisfy a contract requirement. (Also see FAR 15.306).

DEMAND MANAGEMENT: A comprehensive integrated system to empower beneficiaries to participate actively in their health management, strengthen the physician/patient relationship, make intelligent health care decisions, and use services effectively and efficiently. Triage and medical education support systems are included.

DEMONSTRATION: A study or test project with respect to alternative methods of payment for health and medical services, cost-sharing by eligible beneficiaries, methods of encouraging efficient and economical delivery of care, innovative approaches to delivery and financing services and prepayment for services provided to a defined population. Following completion and evaluation of the test project, it may or may not become part of the program.

DENIAL OF AUTHORIZATION: The determination that the proposed treatment or already-provided treatment will not be reimbursed by DoD.

DENIAL OF CERTIFICATION: The determination that the proposed treatment or already provided treatment does not conform to preestablished utilization criteria or the professional opinion of a second level medical/psychiatric reviewer.

DENTAL CARE: Services relating to the teeth and their supporting structures.

DENTISTS: Doctor of Dental Medicine (D.M.D.) or Doctor of Dental Surgery (D.D.S.) who is licensed to practice dentistry by an appropriate authority.

DESERTER OR DESERTION STATUS: A service member is a deserter, or in a desertion status, when the Uniformed Service concerned has made an administrative determination to that effect, or the member's period of unauthorized absence has resulted in a court-martial conviction of desertion. Administrative declarations of desertion normally are made when a member has been an unauthorized absentee for over 30 days, but particular circumstances may result in an earlier declaration. Entitlement to TRICARE benefits ceases as of 12:01 a.m. on the day following the day the desertion status is declared. Benefits are not to be authorized for treatment received during a period of unauthorized absence that results in a court-martial conviction for desertion. Family member eligibility for benefits is reestablished when a deserter is returned to military control and continues, even though the member may be in confinement, until any discharge is executed. When a deserter status is later found to have been determined erroneously, the status of deserter is considered never to have existed, and

the member's family members will have been eligible continuously for benefits under TRICARE.

DESK INSTRUCTIONS: Detailed procedures and action requirements which are peculiar to a specific work station or set of work stations which perform the same function. They should be so designed and so adequately detailed that a reasonably qualified person could follow the procedures and accomplish the work at the station without detailed training.

DEVELOPMENT OF A CLAIM (CONTROLLED): Controlled development of a claim occurs when an originally submitted claim (and all attached documents) is suspended under control by a contractor during the time that efforts are initiated to acquire missing information. Information can be obtained from sources such as DEERS, the Contractor's Beneficiary History and Deductible File, the beneficiary, or provider.

DIAGNOSIS RELATED GROUPS (DRGS): A categorization of hospital patients into clinically coherent groups based on their consumption of resources. Patients are assigned to the groups based on their principal diagnosis (the reason for admission, determined after study), secondary diagnoses, procedures performed, and the patient's age, sex, and discharge status. A reimbursement system using DRGs assigns payment levels to each DRG based on the average cost of treating all patients in a given DRG.

DIAGNOSTIC ADMISSION: An admission to a hospital or other authorized institutional provider, or an extension of a stay in such a facility, primarily for the purpose of performing diagnostic tests, examinations, and procedures.

DISEASE MANAGEMENT: The application and translation of evidenced-based medical guidelines to a population known to have a chronic condition(s). Although variously implemented, Disease Management core competencies include patient assessment and identification according to specific criteria, education, and intervention on behalf of physician-patient plans of care. Disease Management programs feature, at a minimum, population identification, condition assessment, severity stratification with leveled intervention, longitudinal severity tracking and adjustment, on-demand self-management education, triage advice, and provision for referral to appropriate care options.

DOCTOR OF DENTAL MEDICINE (D.M.D.): A person who has received a degree in dentistry, that is, that department of the healing arts which is concerned with the teeth, oral cavity, and associated structures.

DOCTOR OF MEDICINE (M.D.): A person who has graduated from a college of allopathic medicine and who is entitled legally to use the designation M.D.

DOCTOR OF OSTEOPATHY (D.O.): A practitioner of osteopathy, that is, a system of therapy based on the theory that the body is capable of making its own remedies against disease and other toxic conditions when it is in normal structural relationship and has favorable environmental conditions and adequate nutrition. It utilizes generally accepted physical, medicinal, and surgical methods of diagnosis and therapy, while placing chief emphasis on the importance of normal body mechanics and manipulative methods of detecting and correcting faulty structure.

DOMICILIARY CARE: Care provided to a patient in an institution or home-like environment because - (A) providing support for the activities for daily living in the home is not available or is unsuitable; or (B) members of the patient's family are unwilling to provide the care.

NOTE: The terms "domiciliary" and "custodial care" represent separate concepts and are not interchangeable. Domiciliary care is not covered under either the TRICARE Standard Program or the Program for Persons with Disabilities (PFPWD).

DONOR: An individual who supplies living tissue or material to be used in another body, such as a person who furnishes a kidney for renal transplant.

DOUBLE COVERAGE: Enrollment by a TRICARE beneficiary in another insurance, medical service, or health plan that duplicates all or part of a beneficiary's TRICARE benefits.

DOUBLE COVERAGE PLAN: The specific insurance, medical service, or health plan under which a TRICARE beneficiary has entitlement to medical benefits that duplicate TRICARE benefits in whole or in part. Double coverage plans do not include:

1. Medicaid.
2. Coverage specifically designed to supplement TRICARE benefits.
3. Entitlement to receive care from the Uniformed Services medical care facilities; or
4. Entitlement to receive care from Veterans Administration medical care facilities; or
5. Entitlement to receive care from Indian Health Services medical care facilities; or
6. Services and items provided under Part C (early intervention services) of the Individual With Disabilities Education Act.

DSM III: A technical reference, Diagnostic and Statistical Manual of Mental Disorders, Third Edition.

DSM IV: A technical reference, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.

DUAL COMPENSATION: Federal law (5 U.S.C. 5536) prohibits active duty members or civilian employees of the United States Government from receiving additional compensation from the Government above their normal pay and allowances. This prohibition applies to TRICARE cost-sharing of medical care provided by active duty members or civilian government employees to TRICARE beneficiaries.

DURABLE MEDICAL EQUIPMENT (DME): Equipment for which the allowable charge is over $100 and which:

1. Is medically necessary for the treatment of a covered illness or injury;
2. Improves the function of a malformed, diseased, or injured body part, or retards further deterioration of a patient's physical condition;

3. Is used primarily and customarily to serve a medical purpose rather than primarily for transportation, comfort, or convenience;

4. Can withstand repeated use;

5. Provides the medically appropriate level of performance and quality for the medical condition present (that is, nonluxury and nondeluxe); and

6. Is other than spectacles, eyeglasses, contact lenses, or other optical devices, hearing aids, or other communication devices.

7. Is other than exercise equipment, spas, whirlpools, hot tubs, swimming pools or other such items.

EDIT ERROR (HCSRS ONLY). Errors found on HCSRs (initial submissions, resubmissions, and adjustments/cancellation submissions) which result in nonacceptance of the records by TMA. These require correction of the error by the contractor and resubmission of the corrected HCSR to TMA for acceptance.

EMERGENCY INPATIENT ADMISSION: An unscheduled, unexpected, medically necessary admission to a hospital or other authorized institutional provider for treatment of a medical condition meeting the definition of medical emergency and which is determined to require immediate inpatient treatment by the attending physician.

EMERGENCY SERVICES: Medical services provided for a sudden and unexpected onset of a medical or psychiatric condition or the acute exacerbation of a chronic condition that is threatening to life, limb, or sight and requires immediate medical treatment or which manifests painful symptomatology requiring immediate palliative efforts to alleviate suffering. See the Policy Manual for further clarification of emergency services.

ENROLLMENT FEES: The amount required to be paid by some categories of MHS beneficiaries to enroll in and receive the benefits of TRICARE Prime or other special TRICARE programs.

ENROLLMENT PLAN: A plan established by the Contractor to inform beneficiaries of the availability of the TRICARE Prime enrollment program, facilitate enrollment in the program, and maintain enrollment records. The plan must be approved by the government.

ENROLLMENT RECORDS: The official record of a beneficiary's enrollment in TRICARE Prime and maintained on the DEERS System.

ENROLLMENT TRANSFER: A transfer of TRICARE Prime enrollment from one location or contractor to another:

1. **OUT-OF-CONTRACT ENROLLMENT TRANSFER.** An enrollment transfer requiring information exchange between contractors or, for a managed care area administered by a Lead Agent (e.g., overseas, Alaska, etc.), between a contractor and a Lead Agent. The term "contractors" includes designated providers under the Uniformed Services Family Health Plan (USFHP). See Chapter 6, Section 3, paragraph 1.0.

2. **WITHIN-CONTRACT ENROLLMENT TRANSFER.** An enrollment transfer within a Managed Care Area which involves a change of address and possibly a change of Primary Care Managers but does not require information exchange between contractors (e.g., an enrollee transfers from Los Angeles, CA, to San Francisco, CA; from Memphis, TN, to Tallahassee, FL; from Denver, CO, to Phoenix, AZ; from Austin, TX, to Abilene, TX; etc.).

ENTITY: Includes a corporation, trust, partnership, sole proprietorship or other kind of business enterprise that is or may be eligible to receive reimbursement either directly or indirectly from TRICARE.

ESSENTIALS OF DAILY LIVING: Care that consists of providing food (including special diets), clothing, and shelter; personal hygiene services; observation and general monitoring; bowel training or management; safety precautions; general preventive procedures (such as turning to prevent bedsores); passive exercise; companionship; recreation; transportation; and such other elements of personal care that reasonably can be performed by an untrained adult with minimal instruction or supervision.

EXCLUSION: Exclusion from participation as a provider or entity under TRICARE means that items, services, and/or supplies furnished will not be reimbursed under TRICARE. This term may be used interchangeably with "suspension."

EXCLUSIVE PROVIDER ORGANIZATION (EPO): The set of contract providers from whom, as a rule, TRICARE Prime enrollees must receive services to receive TRICARE Prime benefits and have services cost-shared by the contractor. Members of the EPO may also be PPO members for non-Prime TRICARE beneficiaries.

EXPLANATION OF BENEFITS (EOB): The document prepared by insurance carriers, health care organizations, and TRICARE to inform beneficiaries of the actions taken with respect to a claim for health care coverage.

EXTRAMEDICAL INDIVIDUAL PROVIDERS OF CARE: Individuals who do counseling or nonmedical therapy and whose training and therapeutic concepts are outside the medical field, as specified in 32 CFR 199.6.

FAMILY MEMBER: A person who bears any of the following relationships to an active duty member (under a call or order that does not specify a period of 30 days or less), or deceased active duty member or retiree, of a Uniformed Service, that is, lawful spouse, former spouse (in certain circumstances), unremarried widow or widower, or child; or a spouse and child of an active duty member of the armed forces of foreign North Atlantic Treaty Organization (NATO) nations (refer to 32 CFR 199.3).

FEDERAL HEALTH CARE PROGRAM: Section 1128B of the Social Security Act, defines the term "Federal Health Care Program" to encompass any plan or program providing health care benefits, whether directly through insurance or otherwise, which is funded directly, in whole or in part, by the United States Government (other than the Federal Employees Health Benefits Program).

FEDERAL RECORDS CENTER (FRCS): Centers established and maintained by the General Services Administration at locations throughout the United States for the storage, processing, and servicing of noncurrent records for Federal agencies.

FILE:

1. An accumulation of records maintained in a predetermined physical arrangement. Used primarily in reference to current records, the term in archival usage may refer to either a series or a file unit, such as a folder or dossier.

2. To place documents in a predetermined location according to an overall plan of classification.

3. In machine-readable records/archives, two or more data records of identical layout treated as a unit. The unit is larger than a data record but smaller than a data system and is sometimes known as a data set.

4. Storage equipment, such as a filing cabinet.

FILE BREAK: The termination of a file at regular periodic intervals to facilitate continuous disposal or transfer of the file series.

FILES: A term usually applied collectively to all records.

FILES ADMINISTRATION: The application of records management techniques to filing practices to maintain records easily and to retrieve them rapidly, to ensure their completeness, and to facilitate the disposition of noncurrent records.

FISCAL INTERMEDIARY (FI) SERVICES: Services related to the adjudication and processing of selected TRICARE claims and the performance of related support activities in an administrative services only (ASO) environment.

FISCAL YEAR (FY): The Federal Government's 12 month accounting period which currently runs from October 1 through September 30 of the following year.

FORMER SPOUSE: A former husband or wife of a Uniformed Service member or former member who meets the criteria as set forth in 32 CFR 199.3.

FRAGMENTED BILLING: (See "Unbundled Billing")

FRAUD: Fraud is defined as 1) a deception or misrepresentation by a provider, beneficiary, sponsor, or any person acting on behalf of a provider, sponsor, or beneficiary with the knowledge (or who had reason to know or should have known) that the deception or misrepresentation could result in some unauthorized TRICARE benefit to self or some other person, or some unauthorized TRICARE payment, or 2) a claim that is false or fictitious, or includes or is supported by any written statement which asserts a material fact which is false or fictitious, or includes or is supported by any written statement that (a) omits a material fact and (b) is false or fictitious as a result of such omission and (c) is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact. It is presumed that, if a deception or misrepresentation is established and a TRICARE

claim is filed, the person responsible for the claim had the requisite knowledge. This presumption is rebuttable only by substantial evidence. It is further presumed that the provider of the services is responsible for the actions of all individuals who file a claim on behalf of the provider (for example, billing clerks); this presumption may only be rebutted by clear and convincing evidence.

FREEDOM OF CHOICE: The right to obtain medical care from any TRICARE-authorized source available, including TRICARE Prime, the direct care system (military treatment facility system), or obtain care from a provider not affiliated with the contractor and seek reimbursement under the terms and conditions of the TRICARE Standard Program (see definition). Beneficiaries who voluntarily enroll in TRICARE Prime must be informed of any restrictions on freedom of choice that may be applicable to enrollees as a result of enrollment. Except for any limitations on freedom of choice that are fully disclosed to the beneficiaries at the time of enrollment, freedom of choice provisions applicable to the TRICARE Standard Program shall be applicable to TRICARE Prime.

FREEDOM OF INFORMATION ACT (FOIA): A law enacted in 1967 as an amendment to the "Public Information" section of the Administrative Procedures Act, establishing provisions making information available to the public. TMA and contractors are subject to these provisions.

FREESTANDING: Not "institution-affiliated" or "institution-based."

FULL MOBILIZATION: When the President recommends and the Congress orders full mobilization. Full mobilization requires passage by the Congress of a public law or joint resolution declaring war and involves the mobilization of all reserve component units.

FULL-TIME COURSE OF HIGHER EDUCATION: A complete, progressive series of studies to develop attributes such as knowledge, skill, mind, and character, by formal schooling at a college or university, and which meets the criteria set out in 32 CFR 199.3. To qualify as full-time, the student must be carrying a course load of a minimum of 12 credit hours or equivalent each semester.

GAG CLAUSE: A gag clause is any clause included in a professional provider's agreement or contract with a managed care organization (such as a PPO network or HMO network) or third party payer that directly or indirectly limits the ability of the health care professional provider to provide treatment information and options to their patients in particular limitations on advice regarding the patient's health status, medical care, and treatment options, the risks, benefits and consequences of treatment or non-treatment, or the opportunity for the individual to refuse treatment and to express preferences about future treatment options.

GANTT CHART: A chart which depicts a task, its intermediate steps, and beginning and ending dates for accomplishing the task and its intermediate steps.

GENERAL STAFF NURSING SERVICE: All nursing care (other than that provided by private duty nurses) including, but not limited to, general duty nursing, emergency room nursing, recovery room nursing, intensive nursing care, and group nursing arrangements performed by nursing personnel on the payroll of the hospital or other authorized institution.

GEOGRAPHIC ADJUSTMENT FACTOR (GAF): Adjustment(s) to the national standardized Medicare Fee Schedule relative value components required by law (OBRA 1989) to account for differences in the cost of practicing medicine in different geographic areas of the country. The GAF is based on the GPCI - the Geographic Practice Cost Index.

GEOGRAPHIC PRACTICE COST INDEX (GPCI): An index developed to measure the differences in resource costs among fee schedule areas compared to the national average in the three (3) components of the relative value units - physician work, practice expenses excluding malpractice and, malpractice.

GOOD FAITH PAYMENTS: Those payments made to civilian sources of medical care who provided medical care to persons purporting to be eligible beneficiaries but who are determined later to be ineligible for TRICARE benefits. (The ineligible person usually possesses an erroneous or illegal identification card.) To be considered for good faith payments, the civilian source of care must have exercised reasonable precautions in identifying a person claiming to be an eligible beneficiary.

GRIEVANCE: A written complaint on a non-appealable issue which deals primarily with a perceived failure of a network provider, the health care finder, or Contractor or subcontractor, to furnish the level or quality of care expected by a beneficiary.

GRIEVANCE PROCESS: A Contractor developed and managed system for resolving beneficiary grievances.

HEALTH BENEFITS ADVISORS (HBAS): Those individuals located at Uniformed Services medical facilities (on occasion at other locations) and assigned the responsibility for providing TRICARE information, information concerning availability of care from the Uniformed Services direct medical care system, and generally assisting beneficiaries (or sponsors). The term also includes "Health Benefits Counselor."

HEALTH CARE FINDER (HCF): The person who manages and performs the duties necessary to operate the Health Care Finder System.

HEALTH CARE FINDER SYSTEM: A system or mechanism established by the contractor in each catchment area in the region to facilitate referrals of beneficiaries to military and/or civilian health care services.

HEALTH CARE PROVIDER (HCP): An individual or institution licensed or otherwise authorized to practice medicine or deliver health care services, supplies, or equipment.

HEALTH CARE SERVICE RECORD (HCSR): A data set of information required for all care received/delivered under the contract and provided by the contractor in a government-specified format and submitted to TMA via a telecommunication network. The information in the data set can be described in the following broad categories:

1. Beneficiary identification (including service affiliation)

2. Provider identification (including type/specialty)

3. Health information:

a. Place and type of service

b. Diagnosis and treatment-related data

c. Units of service (admissions, days, visits, etc.)

4. Related financial information

HEALTH CARE SERVICE RECORD TRANSMITTAL SUMMARY: A single record which identifies the submitting contractor and summarizes, for transmittal purposes, the number of records and the financial information contained within the associated "batch" of health care records.

HEALTH CARE SERVICES COST: Those amounts paid, or to be paid, by the contractor to individual or institutional providers of authorized health care to TRICARE-eligible beneficiaries, including payments to hospitals for capital and direct medical education, to resource sharing health care providers, and to others for resource sharing equipment.

HIGH-RISK PREGNANCY: A pregnancy is high-risk when the presence of a currently active or previously treated medical, anatomical, physiological illness or condition may create or increase the likelihood of a detrimental effect on the mother, fetus, or newborn and presents a reasonable possibility of the development of complications during labor or delivery.

HOSPICE CARE: Hospice care is a program which provides an integrated set of services and supplies designed to care for the terminally ill. This type of care emphasizes palliative care and supportive services, such as pain control and home care, rather than cure-oriented services provided in institutions that are otherwise the primary focus under TRICARE. The benefit provides coverage for a humane and sensible approach to care during the last days of life for some terminally ill patients.

HOSPITAL, ACUTE CARE (GENERAL AND SPECIAL): An institution that meets the criteria as set forth in 32 CFR 199.6.

HOSPITAL DAY: An overnight stay at a hospital. Normally if the patient is discharged in less than 24 hours it would not be considered an inpatient stay; however, if the patient was admitted and assigned to a bed and the intent of the hospital was to keep the patient overnight, regardless of the actual length of stay, the stay will be considered an inpatient stay and, therefore, a hospital day. For hospital stays exceeding 24 hours, the day of admission is considered a hospital day; the day of discharge is not.

HOSPITAL, LONG-TERM (TUBERCULOSIS, CHRONIC CARE, OR REHABILITATION): An institution that meets the criteria as set forth in 32 CFR 199.6.

HOSPITAL, PSYCHIATRIC: An institution that meets the criteria as set forth in 32 CFR 199.6.

ICD-9-CM: A technical reference, International Classification of Diseases, 9th Edition, Clinical Modification. It is a required reference and coding system for diagnoses in processing TRICARE claims for medical care and claims processing contracts becoming effective on and after October 1, 1981.

ILLEGITIMATE CHILD: A child not recognized as a lawful offspring; that is, a child born of parents not married to each other.

IMMEDIATE FAMILY: The spouse, natural parent, child and sibling, adopted child and adoptive parent, stepparent, stepchild, grandparent, grandchild, stepbrother and stepsister, father-in-law, mother-in-law of the beneficiary, or provider, as appropriate. For purposes of this definition only, to determine who may render services to a beneficiary, the step-relationship continues to exist even if the marriage upon which the relationship is based terminates through divorce or death of one of the parents.

INDEPENDENT LABORATORY: A freestanding laboratory approved for participation under Medicare and certified by the Health Care Financing Administration (HCFA).

INDIVIDUAL CONSIDERATION (IC) PROCEDURE: An individual consideration procedure is one that is not routinely provided, is unusual, variable, or new. These procedures will require additional information from the provider of care, including an adequate definition or description of the nature, extent and need for the procedure; and the time, effort, and necessary equipment required. Any complexities related to the service should also be identified.

INDIVIDUAL PRICING SUMMARY (IPS): A document that a contractor provides to the originating MTF/Claims Office which indicates the contractor's actions in pricing active duty claims.

INFIRMARIES: Facilities operated by student health departments of colleges and universities to provide inpatient or outpatient care to enrolled students. When specifically approved by the Director, TMA, or a designee, a boarding school infirmary also is included.

INITIAL DETERMINATION: A formal written decision (including an EOB) regarding a TRICARE claim, a request for benefit authorization, a request by a provider for approval as an authorized TRICARE provider, or a decision sanctioning a TRICARE provider. Rejection of a claim or a request for benefit or provider authorization for failure to comply with administrative requirements, including failure to submit reasonably requested information, is not an initial determination. Responses to general or specific inquiries regarding TRICARE benefits are not initial determinations.

INITIAL PAYMENT: The first payment on a continuing claim, such as a long-term institutional claim.

INPATIENT CARE: Care provided to a patient who has been admitted to a hospital or other authorized institution for bed occupancy for purposes of receiving necessary medical care, with the reasonable expectation that the patient will remain in the institution at least 24 hours, and with the registration and assignment of an inpatient number or designation. Institutional care in connection with in and out (ambulatory) surgery is not included within the meaning of inpatient whether or not an inpatient number or designation is made by the hospital or other institution. If the patient has been received at the hospital, but death occurs before the actual admission occurs, an inpatient admission exists as if the patient had lived and had been formally admitted.

INQUIRY: Requests for information or assistance made by or on behalf of a beneficiary, provider, the public, or the Government. Written inquiries may be made in any format (letter,

memorandum, note attached to a claim, etc.). Allowable charge complaints, grievances, and appeals are excluded from this definition.

INSTITUTION-AFFILIATED: Related to a TRICARE authorized institutional provider through a shared governing body but operating under a separate and distinct license or accreditation.

INSTITUTION-BASED: Related to a TRICARE authorized institutional provider through a shared governing body and operating under a common license and shared accreditation.

INSTITUTIONAL PROVIDER: A health care provider which meets the applicable requirements established by 32 CFR 199.6.

IN-SYSTEM CARE: See "Network Care."

INTEGRATED PRODUCT TEAM (IPT): A work group with the authority to represent the individual member's organizations convened to develop and/or review a proposed program change. The Integrated Product Team (IPT) consists of all of the representatives of each organization necessary to provide the expertise required to develop and/or review a program change.

INTENSIVE CARE UNIT (ICU): A special segregated unit of a hospital in which patients are concentrated by reason of serious illness, usually without regard to diagnosis. Special lifesaving techniques and equipment regularly and immediately are available within the unit, and patients are under continuous observation by a nursing staff specially trained and selected for the care of this type patient. The unit is maintained on a continuing rather than an intermittent or temporary basis. It is not a postoperative recovery room nor a postanesthesia room. In some large or highly specialized hospitals, the ICUs may be further refined for special purposes, such as for respiratory conditions, cardiac surgery, coronary care, burn care, or neurosurgery. For the purposes of TRICARE, these specialized units would be considered ICUs if they otherwise conformed to the definition of an ICU.

INTERN: A graduate of a medical or dental school serving in a hospital in preparation to being licensed to practice medicine or dentistry.

INTERNAL CONTROL NUMBER (ICN): The unique number assigned to a claim by the contractor to distinguish it in processing, payment, and filing procedures. It is the number affixed to the face of each claim received and will, at a minimum, include the Julian date of receipt and a five digit sequence number assigned by the contractor. Each health care service record must have a unique internal control number. For records generated from claims, it will be the internal control number of the claim from which it was generated. For health care service records which are not generated from claims, it will be a unique number assigned by the contractor which will include the Julian date of the record's creation and a five digit sequence number.

ITEM, SERVICE, OR SUPPLY: Includes (1) any item, device, medical supply, or service claimed to have been provided to a beneficiary (patient) and listed in an itemized claim for TRICARE payment or a request for payment, or (2) in the case of a claim based on costs, any entry or omission in a cost report, books of account, or other documents supporting the claim.

LABORATORY AND PATHOLOGICAL SERVICES: Laboratory and pathological examinations (including machine diagnostic tests that produce hard-copy results) when necessary to, and

rendered in connection with medical, obstetrical, or surgical diagnosis or treatment of an illness or injury, or in connection with well-baby care.

LEAD AGENT: The uniformed services "individual" responsible for supporting TRICARE contract administration in a specific region.

LEAD AGENT OFFICE: The responsible organizational entity and designated focal point for Tri-Services health services development and planning for a single, integrated healthcare network within an identified Health Service Region (HSR).

LEGITIMIZED CHILD: A formerly illegitimate child who is considered legitimate by reason of qualifying actions recognized in law.

LICENSE: A grant of permission by an official agency of a State, the District of Columbia, a Commonwealth, territory, or possession of the United States to provide healthcare independently within the scope of practice for a discipline.

1. **CURRENT**. Active--not revoked, suspended, or lapsed in registration.

2. **VALID**. The issuing authority accepts, investigates and acts upon quality assurance information such as provider professional performance, conduct, ethics of practice, regardless of the practitioner's status or residency.

3. **UNRESTRICTED**. Not subject to limitations on the scope of practice ordinarily granted all other applicants of similar specialty in the granting jurisdiction.

LICENSED PRACTICAL NURSE (L.P.N.): A person who is prepared specially in the scientific basis of nursing; who is a graduate of a school of practical nursing; whose qualifications have been examined by a state board of nursing; and who has been authorized legally to practice as an L.P.N.

LICENSED VOCATIONAL NURSE (L.V.N.): A person who specifically is prepared in the scientific basis of nursing; who is a graduate of a school of vocational nursing; whose qualifications have been examined by a state board of nursing; and who has been authorized legally to practice as a L.V.N.

LINE ITEM:

1. Each distinct occurrence, with the attendant charge, separately identified on a claim.

2. With respect to Health Care Service Records, up to 50 occurrences submitted on the same record.

NOTE: For purposes of (2), contractors have the option of restricting "line item" occurrences to those received in a single month. Also, for mental health services, each separate occurrence may be listed as a line item.

LONG-TERM HOSPITAL CARE: Any inpatient hospital stay that exceeds 30 days.

LOW-RISK PREGNANCY: A pregnancy is low-risk when the basis for the ongoing clinical expectation of a normal uncomplicated birth, as defined by reasonable and generally accepted criteria of maternal and fetal health, is documented throughout a generally accepted course of prenatal care.

MACHINE-READABLE RECORDS/ARCHIVES: The records and archives whose informational content is usually in code and has been recorded on media, such as magnetic disks, drums, tapes, punched paper cards, or punched paper tapes, accompanied by finding aids known as software documentation. The coded information is retrievable only by machine.

MAJOR DIAGNOSTIC CATEGORY (MDC): A grouping of Diagnosis Related Groups (DRG's) aggregated on the basis of clinical similarity.

MANAGEMENT PLAN, PFPWD: A detailed description of the medical history of and proposed therapy for a TRICARE beneficiary seeking benefits under the PFPWD as set forth in 32 CFR 199.5. A management plan must include, at a minimum, a diagnosis (either in the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) or the Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III)); detailed reports of prior treatment, family history, social history, history of handicapping condition, and physical examination; diagnostic test results; consultants (if any) reports; proposed therapeutic approach and modality (including anticipated length of time the proposed modality will be required); prognosis; problem list; and all inclusive current or anticipated monthly charges related to the proposed management plan. If the management plan involves the transfer of a beneficiary from a hospital or another inpatient facility, medical records related to that inpatient stay also are required as a part of the management plan documentation.

MARRIAGE AND FAMILY THERAPIST, CERTIFIED: An extramedical individual provider who meets the requirements outlined in 32 CFR 199.6.

MATERNITY CARE: Care and treatment related to conception, delivery, and abortion, including prenatal and postnatal care (generally through the 6th post-delivery week), and also including treatment of the complications of pregnancy.

MAXIMUM ALLOWABLE PREVAILING CHARGE: The TRICARE state prevailing charges adjusted by the Medicare Economic Index (MEI) according to the methodology as set forth in Chapter 10.

MEDICAID: The medical benefits program authorized under Title XIX of the Social Security Act as administered by state agencies in the various states.

MEDICAL: The generally used term which pertains to the diagnosis and treatment of illness, injury, pregnancy, and mental disorders by trained and licensed or certified health professionals. For purposes of TRICARE, the term "medical" should be understood to include "medical, psychological, surgical, and obstetrical," unless it is specifically stated that a more restrictive meaning is intended.

MEDICAL CLAIMS HISTORY FILE: (Refer to Beneficiary History File.)

MEDICAL EMERGENCY: A condition that would lead a "prudent layperson" (someone with average knowledge of health & medicine), to believe that the sudden and unexpected onset

of a medical condition or the acute exacerbation of a chronic condition that is threatening to life, limb, or sight, and requires immediate medical treatment or which manifests painful symptomatology requiring immediate palliative efforts to alleviate suffering. Medical emergencies include heart attacks, cardiovascular accidents, poisoning, convulsions, kidney stones, and such other acute medical conditions as may be determined to be medical emergencies by the Director, TMA, or a designee. In the case of a pregnancy, a medical emergency must involve a sudden and unexpected medical complication that puts the mother, the baby, or both, at risk. Pain would not, however, qualify a maternity case as an emergency, nor would incipient birth after the thirty-fourth (34th) week of gestation, unless an otherwise qualifying medical condition is present. Examples of medical emergencies related to pregnancy or delivery are hemorrhage, ruptured membrane with prolapsed cord, placenta previa, abruptio placenta, presence of shock or unconsciousness, suspected heart attack or stroke, or trauma (such as injuries received in an automobile accident).

MEDICAL SUPPLIES AND DRESSINGS (CONSUMABLES): Necessary medical or surgical supplies (exclusive of durable medical equipment) that do not withstand prolonged, repeated use and that are needed for the proper medical management of a condition for which benefits are otherwise authorized under TRICARE, on either an inpatient or outpatient basis. Examples include disposable syringes for a diabetic, colostomy sets, irrigation sets, and ace bandages.

MEDICALLY OR PSYCHOLOGICALLY NECESSARY: The frequency, extent, and types of medical services or supplies which represent appropriate medical care and that are generally accepted by qualified professionals to be reasonable and adequate for the diagnosis and treatment of illness, injury, pregnancy, and mental disorders or that are reasonable and adequate for well-baby care.

MEDICARE: Those medical benefits authorized under Title XVIII of the Social Security Act provided to persons 65 or older, certain disabled persons, or persons with chronic renal disease, through a national program administered by the DHHS, Health Care Financing Administration, Medicare Bureau.

MEDICARE ECONOMIC INDEX (MEI): An index used in the Medicare program to update physician fee levels in relation to annual changes in the general economy for inflation, productivity, and changes in specific health sector practice expenses factors including malpractice, personnel costs, rent, and other expenses.

MEMBER PHARMACY: A pharmacy that is a member of the contractor's or a subcontractor's provider network.

MENTAL DISORDER: For purposes of the payment of TRICARE 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 DSM-III.

MENTAL HEALTH COUNSELOR: An extramedical individual provider who meets the requirements outlined in 32 CFR 199.6.

MENTAL HEALTH THERAPEUTIC ABSENCE: A therapeutically planned absence from the inpatient setting. The patient is not discharged from the facility and may be away for periods of several

hours to several days. The purpose of the therapeutic absence is to give the patient an opportunity to test his or her ability to function outside the inpatient setting before the actual discharge.

MENTAL RETARDATION: Subnormal general intellectual functioning associated with impairment of either learning and social adjustment or maturation, or both. The diagnostic classification of moderate and severe mental retardation relates to intelligence quotient (IQ) as follows:

1. **MODERATE**. Mental retardation IQ 36-51.

2. **SEVERE**. Mental retardation IQ 35 and under.

MICROCOPY: A photographic reproduction so much smaller than the object photographed that optical aid is necessary to read or view the image. The usual range of reduction is from eight to 25 diameters. Also called microphotography.

MICROFICHE: Miniaturized images arranged in rows that form a grid pattern on card-size transparent sheet film.

MICROFILM: A negative or a positive microphotograph on film. The term is usually applied to a sheet of film or to a long strip or roll of film that is 16mm, 35mm, 70mm, or 105mm in width and on which there is a series of microphotographs.

MICROFORM: Any miniaturized form containing microimages, such a microcards, microfiche, microfilm, and aperture cards.

MILITARY HEALTH SYSTEM (MHS) BENEFICIARY: Any individual who is eligible to receive treatment in a Military Treatment Facility (MTF). The categories of Military Health System (MHS) beneficiaries shall be broadly interpreted unless otherwise specifically restricted. (For example: Authorized parents and parents-in-law are not eligible for TRICARE purchased care, but may receive treatment in an MTF (on a space available basis) and may access the TRICARE Health Care Information Line (HCIL)).

MILITARY MEDICAL SUPPORT OFFICE (MMSO): The joint services organization responsible for reviewing specialty and inpatient care requests and claims for impact on fitness-for-duty. MMSO is also responsible for approving certain medical services not covered under TRICARE that are necessary to maintain fitness for duty and/or retention on active duty. The Service Points of Contact (SPOCs) for Army, Navy, Marine Corps, and Air Force active duty service members (ADSMs) are assigned to the MMSO. See also Service Point of Contact definition.

MILITARY TREATMENT FACILITY (MTF): A military hospital or clinic.

MILITARY TREATMENT FACILITY (MTF)-REFERRED CARE: When Military Treatment Facility (MTF) patients require medical care that is not available at the MTF, the MTF will refer the patient to civilian medical care, and the contractor shall process the claim ensuring that discounts, cost-shares, copayments and/or deductibles are applied when appropriate.

MISSING IN ACTION (MIA): A battle casualty whose whereabouts and status are unknown, provided the absence appears to be involuntary and the service member is not known to be in a status of unauthorized absence.

NOTE: Claims for eligible TRICARE beneficiaries whose sponsor is classified as MIA are processed as dependents of an active duty service member.

MOBILIZATION PLAN - TRICARE: A plan designed to ensure the government's ability to meet the medical care needs of the TRICARE-eligible beneficiaries in the event of a military mobilization that precludes use of all or parts of the military direct care system for provision of care to TRICARE-eligible beneficiaries.

MONTHLY PRO-RATING: The process for determining the amount of the enrollment fee to be credited to a new enrollment period. For example, if a beneficiary pays their annual enrollment fee, in total, on January 1, (the first day of their enrollment period) and a change in status occurs on February 15. The beneficiary will receive credit for ten months of the enrollment fee. The beneficiary will lose that portion of the enrollment fee that would have covered the period from February 15 through February 28.

MORBID OBESITY: The body weight is 100 pounds over ideal weight for height and bone structure, according to the most current Metropolitan Life Table, and such weight is in association with severe medical conditions known to have higher mortality rates in association with morbid obesity; or, the body weight is 200% or more of the ideal weight for height and bone structure according to the most current Metropolitan Life Table. The associated medical conditions are diabetes mellitus, hypertension, cholecystitis, narcolepsy, pickwickian syndrome (and other severe respiratory diseases), hypothalamic disorders, and severe arthritis of the weight-bearing joints.

MOST-FAVORED RATE: The lowest usual charge to any individual or third-party payer in effect on the date of the admission of a TRICARE beneficiary.

NATIONAL APPROPRIATE CHARGE LEVEL: The charge level established from a 1991 national appropriate charge file developed from July 1986 - June 1987 claims data, by applying appropriate Medicare Economic Index (MEI) updates through 1990, and prevailing charge cuts, freeze or MEI updates for 1991 as discussed in the September 6, 1991, final rule.

NATIONAL CONVERSION FACTOR (NCF): A mathematical representation of what is currently being paid for similar services nationally. The factor is based on the national allowable charges actually in use.

NATIONAL DISASTER MEDICAL SYSTEM (NDMS): A system designed to ensure that the United States is prepared to respond medically to all types of mass casualty emergency situations, whether from a natural or man-made disaster in the country or from United States military casualties being returned from an overseas conventional conflict. This system involves private sector hospitals located throughout the United States that will provide care for victims of any incident that exceeds the medical care capability of any affected state, region, or federal medical care system.

NATIONAL PREVAILING CHARGE LEVEL: The level that does not exceed the amount equivalent to the eightieth (80th) percentile of billed charges made for similar services during a twelve (12) month base period.

NATIONAL QUALITY MONITORING CONTRACT (NQMC): A national-level contractor responsible to DoD and TRICARE Management Activity (TMA) that performs second level reconsiderations for payment denials and focused retrospective quality of care reviews.

NATURAL CHILDBIRTH: Childbirth without the use of chemical induction or augmentation of labor or surgical procedures other than episiotomy or perennial repair.

NATUROPATH: A person who practices naturopathy, that is, a drugless system of therapy making use of physical forces such as air, light, water, heat, and massage.

NOTE: Services of a naturopath are not covered by TRICARE.

NAVCARE CLINICS: Contractor owned, staffed, and operated primary clinics exclusively serving Uniformed Services beneficiaries pursuant to contracts awarded by a Military Department.

NEGOTIATED (DISCOUNTED) RATE: The negotiated or discounted rate, under a program approved by the Director, TMA, is the reimbursable amount that the provider agrees to accept in lieu of the usual TRICARE reimbursement, the DRG amount, the mental health per diem, or any other TRICARE payment determined through a TMA-approved reimbursement methodology.

NETWORK: The network of contractor-operated providers and facilities (owned, leased, arranged) that link the providers or facilities with the prime contractor as part of the total contracted delivery system. The agreements for health care delivery made by the contractor with the MTFs are also included in this definition.

NETWORK CARE: Care provided by the network of contractor-operated providers and facilities (owned, leased, arranged) that link the providers or facilities with the prime contractor as part of the total contracted delivery system. Thus a "network provider" is one who serves TRICARE beneficiaries by agreement with the prime contractor as a member of the TRICARE Prime network or of any other preferred provider network or by any other contractual agreement with the contractor. "Network care" includes any care provided by a "network provider" or any care provided to a TRICARE Prime enrollee under a referral from the contractor, whether by a "network provider" or not. A "network claim" is a claim submitted for "network care." (See the definition for "Non-Network Care.")

NETWORK PROVIDER: An individual or institutional provider that is a member of a contractor's provider network.

NONAPPEALABLE ISSUE: The issue or basis upon which a denial of benefits was made based on a fact or condition outside the scope of responsibility of TMA and the contractor. For example, the establishment of eligibility is a Uniformed Service responsibility and if the service has not established that eligibility, neither TMA nor a contractor may review the action. Similarly, the need for a Nonavailability Statement, late claim filing, late appeal filing, amount of allowable charge (the contractor must verify it was properly applied and calculated), and services or

supplies specifically excluded by law or regulation, such as routine dental care, clothing, routine vision care, etc., are matters subject to legislative action or regulatory rule making not appealable under TRICARE. Contractors will not make a determination that an issue is not appealable except as specified in Chapter 13 and 32 CFR 199.10.

NONAVAILABILITY STATEMENT (NAS): A statement issued by a commander (or designee) of a Uniformed Services medical treatment facility that needed medical care being requested by a TRICARE beneficiary cannot be provided at the facility concerned because the necessary resources are not available. Requirement for a non-availability statement is currently limited to inpatient treatment, but may, at the direction of the Assistant Secretary of Defense (Health Affairs), be extended to specific types of outpatient care. TRICARE Prime enrollees are exempt from NAS requirements, even under the Point-of-Service option.

NON-CLAIM HEALTH CARE DATA: That data captured by the contractor to complete the required Health Care Service Record information for care rendered to TRICARE beneficiaries in those contractor owned, operated and/or subcontracted facilities where there is no claim submitted by the provider of care.

NONCURRENT RECORDS: Records that are no longer required in the conduct of current business and therefore can be retrieved by an archival repository or destroyed.

NON-DOD TRICARE BENEFICIARIES: These are TRICARE-eligible beneficiaries sponsored by non-Department of Defense uniformed services (the Commissioned Corps of the Public Health Service, the United States Coast Guard and the Commissioned Corps of the National Oceanic and Atmospheric Administration).

NON-NETWORK CARE: Any care not provided by "network providers" (see definition of "Network Care"), except care provided to a TRICARE Prime enrollee by a "non-network provider" upon referral from the contractor. A "non-network provider" is one who has no contractual relationship with the prime contractor to provide care to TRICARE beneficiaries. A "non-network claim" is one submitted for "non-network care."

NON-PARTICIPATING PROVIDER: A hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider that furnished medical services or supplies to a TRICARE beneficiary, but who did not agree on the TRICARE claim form to participate or to accept the TRICARE-determined allowable cost or charge as the total charge for the services. A nonparticipating provider looks to the beneficiary or sponsor for payment of his or her charge, not TRICARE. In such cases, TRICARE pays the beneficiary or sponsor, not the provider.

NON-PRIME TRICARE BENEFICIARIES: These are TRICARE-eligible beneficiaries who are not enrolled in the TRICARE Prime program. These beneficiaries remain eligible for all services specified in 32 CFR 199 and are subject to deductible and cost-share provisions of the TRICARE Standard Program.

NORTH ATLANTIC TREATY ORGANIZATION (NATO) MEMBER: A military member of an armed force of a foreign NATO nation who is on active duty and who, in connection with official duties, is stationed in or passing through the United States. The foreign NATO nations are Belgium, Canada, Czech Republic, Denmark, France, Federal Republic of Germany, Greece, Hungary,

Iceland, Italy, Luxembourg, the Netherlands, Norway, Poland, Portugal, Spain, Turkey, and the United Kingdom.

NOTICE OF AWARD: A communication by the Contracting Officer formally notifying the incoming contractor by letter, wire, or telephone of the contract award.

OBJECTIVE: The Government's broad goal for the contract.

OFFICIAL FORMULARIES: A book of official standards for certain pharmaceuticals and preparations that are not included in the U.S. Pharmacopoeia.

OPERATIONS MANUAL (6010.49-M): The manual which provides the instructions and requirements for claims processing and health care delivery under TRICARE when these services are delivered under fixed-price, at-risk contracts for benefits and administration.

OPTOMETRIST (DOCTOR OF OPTOMETRY): A person trained and licensed to examine and test the eyes and to treat visual defects by prescribing and adapting corrective lenses and other optical aids, and by establishing programs of exercises.

ORAL SURGEON (D.D.S. OR D.M.D.): A person who has received a degree in dentistry and who limits his or her practice to oral surgery, that is, that branch of the healing arts that deals with the diagnosis and the surgical correction and adjunctive treatment of diseases, injuries, and defects of the mouth, the jaws, and associated structures.

ORTHOPEDIC SHOES: Shoes prescribed by an orthopedic surgeon to effect changes in foot or feet position and alignment and which are not an integral part of a brace.

OTHER ALLIED HEALTH PROFESSIONALS: Individual professional providers other than physicians, dentists, or extramedical individual providers, as specified in 32 CFR 199.6.

OTHER SPECIAL INSTITUTIONAL PROVIDERS: Certain special institutional providers, either inpatient or outpatient, other than those specifically defined, that provide courses of treatment prescribed by a doctor of medicine or osteopathy; when the patient is under the supervision of a doctor of medicine or osteopathy during the entire course of the inpatient admission or the outpatient treatment; when the type and level of care and services rendered by the institution are otherwise authorized in 32 CFR 199; when the facility meets all licensing or other certification requirements that are extant in the jurisdiction in which the facility is located geographically; which is accredited by the Joint Commission on Accreditation if an appropriate accreditation program for the given type of facility is available; and which is not a nursing home, intermediate facility, halfway house, home for the aged, or other institution of similar purpose.

OTHERWISE AUTHORIZING DOCUMENT:

1. Mechanisms, such as registration and certification, by which a State, the District of Columbia, a Commonwealth, territory, or possession of the United States grants authority to provide healthcare independently in a specified discipline; or

2. In specialties not licensed, or where the requirements of the granting authority for registration or certification are highly variable, a validation (provided by national

organizations based on professional qualifications) to provide healthcare services independently in a specified discipline; or,

3. In the case where healthcare is provided in a foreign country by any person who is not a national of the United States, a grant of permission by an official agency of that foreign country for that person to provide healthcare independently in a specified discipline.

OUT-OF-AREA CARE: Urgent care received by Prime enrollees traveling outside the drive time access standard. These enrollees are not required to return to their PCM for urgent care.

OUT-OF-REGION BENEFICIARIES: TRICARE-eligible beneficiaries who reside outside of the region for which the Contractor has responsibility, but who receive care within the region.

OUT-OF-SYSTEM CARE: See "Non-Network Care."

OUTPATIENT: A patient who has not been admitted to a hospital or other authorized institution as an inpatient.

OWNERSHIP OR CONTROL INTEREST: A "person with an ownership or control interest" is anyone who:

1. Has directly or indirectly a five percent or more ownership interest in the entity; or

2. Is the owner of a whole or part interest in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the entity or any of the property or assets thereof, which whole or part interest is equal to or exceeds five percent of the total property and assets of the entity; or

3. Is an officer or director of the entity if the entity is organized as a corporation; or

4. Is a partner in the entity if the entity is organized as a partnership.

PARTIAL HOSPITALIZATION: 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. Such programs must enter into a participation agreement with TRICARE, and be accredited and in substantial compliance with the standards of the Mental Health Manual of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (formerly known as the Consolidated Standards).

PARTICIPATING PROVIDER: A hospital or other authorized institutional provider, a physician or other authorized individual professional provider, or other authorized provider who furnishes services or supplies to a TRICARE beneficiary and has agreed, by act of signing and submitting a TRICARE claim form and indicating participation in the appropriate space

on the claim form, to accept the TRICARE-determined allowable cost or charge as the total charge (even though less than the actual billed amount), whether paid for fully by the TRICARE allowance or requiring cost-sharing by the beneficiary or sponsor. All network providers MUST be participating providers.

PARTY TO A HEARING: An appealing party or parties and the Director, TMA.

PARTY TO THE INITIAL DETERMINATION: Includes TRICARE and also refers to a TRICARE beneficiary and a participating provider of services whose interests have been adjudicated by the initial determination. In addition, a provider who has been denied approval as an authorized TRICARE provider is a party to that initial determination, as is a provider who is disqualified or excluded as an authorized provider under TRICARE, unless the provider is excluded based on a determination of abuse or fraudulent practices or procedures under another federal or federally funded program. See 32 CFR 199.10, for additional information concerning parties not entitled to administrative review under the TRICARE appeals and hearing procedures.

PASTORAL COUNSELOR: An extramedical individual provider who meets the requirements outlined in 32 CFR 199.6.

PEER REVIEW GROUP (PRG): A group of professional reviewers contracted with by the government to perform external peer review of the care provided under TRICARE. See the definition for "provider network."

PENDING CLAIM, CORRESPONDENCE, OR APPEAL: The claim/correspondence/appeal case has been received but has not been processed to final disposition.

PHARMACIST: A person who is trained specially in the scientific basis of pharmacology and who is licensed to prepare and sell or dispense drugs and compounds and to make up prescriptions ordered by a physician.

PHYSICAL HANDICAP: A physical condition of the body that meets the following criteria:

1. **DURATION**. The condition is expected to result in death, or has lasted, or with reasonable certainty is expected to last, for a minimum period of 12 months; and

2. **EXTENT**. The condition is of such severity as to preclude the individual from engaging in basic productive activities of daily living expected of unimpaired persons of the same age group.

PHYSICAL MEDICINE SERVICES OR PHYSIATRY SERVICES: The treatment of disease or injury by physical means such as massage, hydrotherapy, or heat.

PHYSICAL THERAPIST: A person who is trained specially in the skills and techniques of physical therapy (that is, the treatment of disease by physical agents and methods such as heat, massage, manipulation, therapeutic exercise, hydrotherapy, and various forms of energy such as electrotherapy and ultrasound), who has been authorized legally (that is, registered) to administer treatments prescribed by a physician and who is entitled legally to use the designation "Registered Physical Therapist." A physical therapist also may be called a physiotherapist.

PHYSICIAN: A person with a degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is licensed to practice medicine by an appropriate authority.

PHYSICIAN IN TRAINING: Interns, residents, and fellows participating in approved postgraduate training programs and physicians who are not in approved programs but who are authorized to practice only in a hospital or other institutional provider setting, e.g., individuals with temporary or restricted licenses, or unlicensed graduates of foreign medical schools.

PODIATRIST (DOCTOR OF PODIATRY OR SURGICAL CHIROPODY): A person who has received a degree in podiatry (formerly called chiropody), that is, that specialized field of the healing arts that deals with the study and care of the foot, including its anatomy, pathology, and medical and surgical treatment.

POINT-OF-SERVICE (POS) OPTION: Option under TRICARE Prime that allows enrollees to self-refer for non-emergent health care services to any TRICARE authorized civilian provider, in or out of the network. When Prime enrollees choose to use the POS option, i.e., to obtain non-emergent health care services from other than their PCMs or without a referral from their PCMs, all requirements applicable to TRICARE Standard apply except the requirement for an NAS. Point-of-Service claims are subject to deductibles and cost-shares (refer to definitions in this appendix) even after the Fiscal Year catastrophic cap has been met.

PREAUTHORIZATION: A decision issued in writing by the Director, TMA, or a designee, that TRICARE benefits are payable for certain services that a beneficiary has not yet received.

PREFERRED PROVIDER ORGANIZATION (PPO): An organization of providers who, through contractual agreements with the contractor, have agreed to provide services to TRICARE beneficiaries at reduced rates and to file TRICARE claims on behalf of the beneficiaries and accept TRICARE assignment on all TRICARE claims. The preferred provider agreements may call for some other form of reimbursement to providers, but in no case will an eligible beneficiary receiving services from a preferred provider be required to file a TRICARE claim or pay more than the allowable charge cost-share for services received.

PRESCRIPTION DRUGS AND MEDICINES: Drugs and medicines which at the time of use were approved for commercial marketing by the U.S. Food and Drug Administration (FDA), and which, by law of the United States, require a physician's or dentist's prescription, except that it includes insulin for known diabetics whether or not a prescription is required. Drugs grandfathered by the Federal Food, Drug and Cosmetic Act of 1938 may be covered under TRICARE as if FDA approved.

NOTE: The fact that the U.S. Food and Drug Administration has approved a drug for testing on humans would not qualify it within this definition.

PREVAILING CHARGE: The charges submitted by certain non-institutional providers which fall within the range of charges that are most frequently used in a state for a particular procedure or service. The top of the range establishes the maximum amount TRICARE will authorize for payments of a given procedure or service, except where unusual circumstances or medical complications warrant an additional charge. The calculation methodology and use is determined according to the instructions in Chapter 10.

PREVENTIVE CARE: Diagnostic and other medical procedures not related directly to a specific illness, injury, or definitive set of symptoms, or obstetrical care, but rather performed as periodic health screening, health assessment, or health maintenance.

PRIMARY CARE: Those standard, usual and customary services rendered in the course of providing routine ambulatory health care required for TRICARE beneficiaries. Services are typically, although not exclusively, provided by internists, family practitioners, pediatricians, general practitioners and obstetricians/gynecologists. It may also include services of non-physician providers (under supervision of a physician to the extent required by state law). These services shall include appropriate care for acute illness, accidents, follow-up care for ongoing medical problems and preventive health care. These services shall include care for routine illness and injury, periodic physical examinations of newborns, infants, children and adults, immunizations, injections and allergy shots, and patient education and counseling (including family planning and contraceptive advice). Such services shall include medically necessary diagnostic laboratory and x-ray procedures and tests incident to such services.

PRIMARY CARE MANAGER (PCM): An MTF provider or team of providers or a network provider to whom a beneficiary is assigned for primary care services at the time of enrollment in TRICARE Prime. Enrolled beneficiaries agree to initially seek all non-emergency, non-mental health care services from their PCMs.

PRIMARY CARE PHYSICIAN: A physician who provides primary care services to patients, but who is not a network physician performing Primary Care Manager functions under TRICARE Prime.

PRIMARY PAYER: The plan or program whose medical benefits are payable first in a double coverage situation.

PRIME CONTRACTOR: The single entity with which the Government will contract for the specified services.

PRIME ENROLLEE: An MHS beneficiary enrolled in TRICARE Prime.

PRIMUS CLINICS: These are civilian-operated clinics that are designated as satellite clinics of military treatment facilities. They are under individual contract to the uniformed services and are funded directly by the services. They are not associated with the TRICARE program. The Navy has a similar civilian-operated clinic program under the heading of NavCare.

PRIORITY CORRESPONDENCE: Correspondence received by the contractor from the Office of the Assistant Secretary of Defense (Health Affairs), TMA, and Members of Congress, or any other correspondence designated for priority status by the contractor's management.

PRIVACY ACT, TITLE 5, UNITED STATES CODE, SECTION 552A: A law intended to preserve the personal privacy of individuals and to permit an individual to know what records pertaining to him or her are collected, maintained, used, or disseminated, and to have access to and to have copied at the requestor's expense, all or any portion of such records, and to correct or amend such records. Concomitantly, it requires government activities which collect, maintain, use or disseminate any record of an identifiable personal nature in a manner that assures that such action is necessary and lawful; that any information collected is accurate, relevant, timely, and as complete as is reasonably possible and necessary to assure fairness to

the individual, and that adequate safeguards are provided to prevent misuse or unauthorized release of such information.

PRIVATE DUTY (SPECIAL) NURSING SERVICES: Skilled nursing services rendered to an individual patient requiring intensive medical care. Such private duty (special) nursing must be by an actively practicing registered nurse (RN) or licensed practical or vocational nurse (LPN or LVN) only when the medical condition of the patient requires intensive skilled nursing services (rather than primarily providing the essentials of daily living) and when such skilled nursing care is ordered by the attending physician.

PRIVATE ROOM: A room with one bed that is designated as a private room by the hospital or other authorized institutional provider.

PROCESSED TO COMPLETION (OR FINAL DISPOSITION):

1. **CLAIMS**. Claims are processed to completion, for workload reporting and payment record coding purposes, when all claims received in the current and prior months have been processed to the point where the following actions have resulted:

   a. All services and supplies on the claim have been adjudicated, payment has been determined on the basis of covered services/supplies and allowable charges applied to deductible and/or denied, and checks and EOBs have been prepared for mailing to providers and beneficiaries, and

   b. Payment, deductible application or denial action has been posted to ADP history.

2. **CORRESPONDENCE**. Correspondence is processed to completion when the final reply is mailed to the individual(s) submitting the written inquiry or when the inquiry is fully answered by telephone.

3. **TELEPHONIC INQUIRY**. A telephonic inquiry is processed to completion when the final reply is provided by either telephone or letter.

4. **APPEALS**. Final disposition of an appeal case occurs when the previous decision by the contractor is either reaffirmed, reversed, or partially reversed and the decision is mailed.

PROFILED AMOUNT: The profiled amount is the lower of the prevailing charge or the maximum allowable prevailing charge.

PROGRAM FOR PERSONS WITH DISABILITIES (PFPWD): The special program set forth in 32 CFR 199.5, through which family members of active duty members receive supplemental benefits for the moderately or severely mentally retarded and the seriously physically disabled over and above those medical benefits available under the TRICARE Standard Program.

PROGRAM INTEGRITY SYSTEM: A system required of the contractor by the government for detecting overutilization or fraud and abuse.

PROGRESS NOTES: Progress notes are an essential component of the medical record wherein health care personnel provide written evidence of ordered and supervised diagnostic tests, treatments, medical procedures, therapeutic behavior and outcomes. In the case of mental health care, progress notes must include: the date of the therapy session; length of the therapy session; and a narrative of the care provided during the session. Collectively, the progress notes must also include, where appropriate, a notation of the patient's signs and symptoms, the issues, pathology and therapeutic interventions attempted during the treatment, the response to significant others, and summaries of the patient's degree of progress toward the treatment goals. Progress notes do not need to repeat all that was said during a therapy session but must document a patient contact and be sufficiently detailed to allow for both peer review and audits to substantiate the quality and quantity of care rendered.

PROSPECTIVE REVIEW: Evaluation of a provider's request for treatment of a patient before the treatment is delivered. This typically involves a provider requesting admission (non-emergent) or requesting selected procedures that require pretreatment certification and authorization for reimbursement.

PROSTHETIC DEVICE (PROSTHESIS): An artificial substitute for a missing body part.

PROVIDER: A hospital or other institutional provider of medical care or services, a physician or other individual professional provider, or other provider of services or supplies in accordance with the 32 CFR 199.

PROVIDER EXCLUSION AND SUSPENSION: The terms "exclusion" and "suspension", when referring to a provider under TRICARE, both mean the denial of status as an authorized provider, resulting in items, services, or supplies furnished by the provider not being reimbursed, directly or indirectly, under TRICARE. The terms may be used interchangeably to refer to a provider who has been denied status as an authorized TRICARE provider based on 1) a criminal conviction or civil judgment involving fraud, 2) an administrative finding of fraud or abuse under TRICARE, 3) an administrative finding that the provider has been excluded or suspended by another agency of the Federal Government, a state, or a local licensing authority, 4) an administrative finding that the provider has knowingly participated in a conflict of interest situation, or 5) an administrative finding that it is in the best interests of TRICARE or TRICARE beneficiaries to exclude or suspend the provider.

PROVIDER NETWORK: An organization of providers with which the contractor has made contractual or other arrangements. These providers must accept assignment of claims and submit claims on behalf of the beneficiary.

PROVIDER TERMINATION: When a provider's status as an authorized TRICARE provider is ended, other than through exclusion or suspension, based on a finding that the provider does not meet the qualifications, as set forth in 32 CFR 199.6 to be an authorized TRICARE provider.

PSYCHIATRIC EMERGENCY: A psychiatric inpatient admission is an emergency when, based on a psychiatric evaluation performed by a physician (or other qualified mental health care professional with hospital admission authority), the patient is at immediate risk of serious harm to self or others as a result of a mental disorder and requires immediate continuous skilled observation at the acute level of care.

QUALITY ASSURANCE PROGRAM: A system-wide program established and maintained by the contractor to monitor and evaluate the quality of patient care and clinical performance.

RADIATION THERAPY SERVICES: The treatment of diseases by x-ray, radium, or radioactive isotopes when ordered by the attending physician.

RECEIPT OF CLAIM, CORRESPONDENCE OR APPEAL: Delivery of a claim, correspondence, or appeal into the custody of the contractor by the post office or other party.

RECONSIDERATION: An appeal to a contractor of an initial determination issued by the contractor.

RECORDS: All books, papers, maps, photographs, machine readable materials, or other documentary materials, regardless of physical form or characteristics, made or received by an agency of the United States Government under Federal law or in connection with the transaction of public business or appropriate for presentation by that agency or its legitimate successor as evidence of the organization, functions, policies, decisions, procedures, operations, or other activities of the government.

RECORDS MANAGEMENT: The area of general administrative management concerned with achieving economy and efficiency in the creation, use and maintenance, and disposition of records. Included in the fulfilling of archival requirements and ensuring effective documentation.

REFERENCE MATERIAL: Such items as the 32 CFR 199, Operations Manual, Policy Manual, Procedural Code manuals, Diagnostic Code manuals, TMA Instructions, drug books, medical dictionaries and other materials, as appropriate to the needs of the operating unit.

REFERRAL: The process of the contractor directing an MHS beneficiary to a network or non-network provider.

REFERRAL MANAGEMENT: Referral Management is the process by which primary care managers (PCMs) determine if they need to refer a member either to a specialist or for services to be performed outside of the PCM's office (diagnostic tests, outpatient surgery, home health care, etc.). If a referral is necessary, the PCM also needs to decide to whom the referral is made, for how long, and for what services.

REGION: A geographic area determined by the government for civilian contracting of medical care and other services for TRICARE/CHAMPUS-eligible beneficiaries.

REGIONAL LEAD AGENT: The designated major military medical center shall act as the regional lead agent, having tri-service responsibility for the development and execution of a single, integrated health care network.

REGIONAL REVIEW AUTHORITY (RRA): The entity performing PRO functions. The MCS contractor performs the duties of the RRA.

REGISTERED NURSE (R.N.): A person who is prepared specially in the scientific basis of nursing, who is a graduate of a school of nursing, and who is registered for practice after examination

by a state board of nurse examiners or similar regulatory authority, who holds a current, valid license, and who is entitled legally to use the designation R.N.

RELATIVE VALUE UNIT (RVU): Valuation or rating of physician services on the basis of relative physician resource inputs (work and other practice costs) to provide medical services. Specifically refers to relative physician work values developed by the Harvard University RBS study. (Only for Medicare RVUs given to contractors as part of the CMAC file for use in CMAC pricing.)

RELIABLE EVIDENCE: 1) Well controlled studies of clinically meaningful end points, published in refereed medical literature; 2) Published formal technology assessments; 3) The published reports of national professional medical associations; 4) Published national medical policy organization positions; and 5) The published reports of national expert opinion organizations.

REPRESENTATIVE: Any person who has been appointed by a party to the initial determination as counsel or advisor and who is otherwise eligible to serve as the counsel or advisor of the party to the initial determination, particularly in connection with a hearing.

RESIDENCE: For purposes of TRICARE, "residence" is the dwelling place of the beneficiary for day-to-day living. A temporary living place during periods of temporary duty or during a period of confinement, such as a residential treatment center, does not constitute a residence. In the case of minor children, the residence of the custodial parent(s) or the legal guardian shall be deemed the residence of the child. In the case of incompetent adult beneficiaries, the residence of the legal guardian shall be deemed the residence of such beneficiary. Under split enrollment, when a dependent resides away from home while attending school, their residence shall be where they are domiciled.

RESIDENT (MEDICAL): A graduate physician or dentist who has an M.D. or D.O. degree, or D.D.S. or D.M.D. degree, respectively, is licensed to practice, and who chooses to remain on the house staff of a hospital to get further training that will qualify him or her for a medical or dental specialty.

RESIDENTIAL TREATMENT CENTER (RTC): A facility (or distinct part of a facility) which meets the criteria in 32 CFR 199.6.

RESIDUAL CLAIM: A claim for health care services rendered in an at-risk region to a patient who is not a resident of that region.

RESOURCE SHARING AGREEMENT: This is an agreement between the Contractor and individual military treatment facility commanders to provide or share equipment, supplies, facilities, physicians, nurses, or other trained staff who are under contract with, or employed by, the contractor for work in MTFs for the purpose of enhancing the capabilities of MTFs to provide needed patient care to beneficiaries.

RESOURCE SUPPORT: Contractor provided personnel based on the MTF's demand for care in the MTF. This service is funded from the MTF's normal operating funds.

RESPITE CARE: Respite care is short-term care for a patient in order to provide rest and change for those who have been caring for the patient at home, usually the patient's family.

RESUBMISSIONS: A group of Health Care Service Records (HCSR) submitted to TMA to correct those Health Care Service Record claims and adjustments which generated edit errors when originally processed by TMA. These groups of records will be identified by the batch number and resubmission in the HCSR Header Record.

RETAINED CLAIMS: Claims retained by the contractor for processing to completion or development. Contractors shall retain all claims that contain sufficient information to allow processing and all claims for which missing information may be developed from in-house sources, including DEERS and contractor-operated or -maintained electronic, paper, or film files.

RETENTION PERIOD: The time period for particular records (normally a series) to be kept.

RETIREE: A member or former member of a Uniformed Service who is entitled to retired, retainer, or equivalent pay based on duty in a Uniformed Service.

RETROSPECTIVE REVIEW: Evaluation of care already delivered to determine appropriateness of care and conformance to pre-established criteria for utilization. The purpose for this type of review may be to validate utilization decisions made during the review process and/or to validate payment made for care provided (by examining the actual record of treatment).

RETURNED CLAIM: Any TRICARE claim, with attached documentation, containing less than sufficient information for processing to completion; a copy, or the original of, which must be sent back for completion of required data, rather than retaining and developing by letter request, alone. A "Returned Claim" will normally be retained under contractor control in the "pending" claim inventory. A Coordination of Benefits claim returned to the claimant when OHI is known to exist, or other claims authorized for return "not under control", are not included as a "returned claim."

RISK SHARING: A contractual agreement between the government and the Contractor for sharing the financial burden or risk associated with the delivery of medical care services.

ROUTINE CORRESPONDENCE: Any correspondence which is not designated as Priority Correspondence.

ROUTINE EYE EXAMINATIONS: The services rendered in order to determine the refractive state of the eyes.

SANCTION: A provider exclusion, suspension, or termination.

SECONDARY PAYER: The plan or program whose medical benefits are payable in double coverage situations only after the primary payer has adjudicated the claim.

SEMIPRIVATE ROOM: A room containing at least two beds. If a room is designated publicly as a semiprivate accommodation by the hospital or other authorized institutional provider and contains multiple beds, it qualifies as a semiprivate room for the purposes of TRICARE.

SERVICE POINT OF CONTACT (SPOC): The uniformed services office or individual responsible for coordinating civilian health care for active duty service members (ADSMs) who receive care under the Supplemental Health Care Program and the TRICARE Prime Remote

Program. The SPOC reviews requests for specialty and inpatient care to determine impact on the ADSM's fitness for duty; determines whether the ADSM shall receive care related to fitness for duty at a military medical treatment facility (MTF) or with a civilian provider; initiates/coordinates medical evaluation boards; arranges transportation for hospitalized service members when necessary; and provides overall health care management for the ADSMs. The SPOC is also responsible for approving certain medical services not covered under TRICARE that are necessary to maintain fitness-for duty and/or retention on active duty. SPOCs for the Army, Navy/Marines, and Air Force are assigned to the Military Medical Support Office (MMSO). [See "Military Medical Support Office (MMSO)."] See Chapter 20, Addendum B, for information on contacting the SPOCs for all services.

SKILLED NURSING FACILITY (SNF): An institution (or a distinct part of an institution) that meets the criteria as set forth in 32 CFR 199.6.

SKILLED NURSING SERVICE: A service that can only be furnished by an R.N., or L.P.N. or L.V.N., and is required to be performed under the supervision of a physician to ensure the safety of the patient and achieve the medically desired result. Examples of skilled nursing services are intravenous or intramuscular injections, levin tube or gastrostomy feedings, or tracheotomy aspiration and insertion. Skilled nursing services are other than those services that provide primarily support for the essentials of daily living or that could be performed by an untrained adult with minimum instruction or supervision.

SPECIAL CHECKS: Checks issued outside the normal processing workflow for the purpose of expediting payment of a claim for benefits.

SPECIAL INQUIRIES: Freedom of Information Act requests; Privacy Act requests; information requests by the news media; surveys, audits, and requests by Government agencies (including Department of Defense agencies and entities other than TMA) and Congressional Committees.

SPECIAL TUTORING: Teaching or instruction provided by a private teacher to an individual usually in a private or separate setting to enhance the educational development of an individual in one or more study areas.

SPECIALIZED TREATMENT SERVICE FACILITIES (STSFS): Health care facilities designated by the Assistant Secretary of Defense (Health Affairs) to have catchment areas for specified services exceeding the standard 40 mile radius. These services are high-cost procedures for which the STSF has special capabilities. One example of an STSF is Wilford Hall Medical Center, San Antonio, Texas, which is designated as an STSF for bone marrow transplants. Refer to Chapter 19, for information on STSFs.

SPECIALTY CARE: Specialized medical services provided by a physician specialist.

SPECTACLES, EYEGLASSES, AND LENSES: Lenses, including contact lenses, that help to correct faulty vision.

SPLIT ENROLLMENT: Refers to multiple family members enrolled in TRICARE Prime under different Lead Agents/contractors, including Managed Care Support (MCS) contractors and Uniformed Services Family Health Plan (USFHP) designated providers.

SPONSOR: An active duty member, retiree, or deceased active duty member or retiree, of a Uniformed Service upon whose status his or her family members' eligibility for TRICARE is based.

SPOUSE: A lawful wife or husband regardless of whether or not dependent upon the active duty member or retiree.

STAKEHOLDERS: Any party who has an interest in the success of the contract. Stakeholders include the Department of Defense, the Lead Agents, MTF Commanders, the TRICARE Management Activity, The Military Health System (MHS), and all employees thereof, MCS contractors, elected officials, and MHS beneficiaries.

START WORK DATE: The date the incoming Contractor officially begins delivery of health care services, processing claims, and delivery of other services in a production environment, as specified in the contract.

STUDENT STATUS: A dependent of a member or former member of a Uniformed Service who has not passed his or her 23rd birthday, and is enrolled in a full-time course of study in an institution of higher learning.

SUBCONTRACTORS: Includes, but is not limited to, enrolled program health benefits business entities at whatever level of the contract organization they exist and institutional and non-institutional providers of health care under agreement or contract to the prime contractor. It does not include institutional or non-institutional providers of health care under agreement or contract to subcontracted enrolled program health benefits business entities.

Institutional and non-institutional providers are those hospitals, physicians, laboratories, pharmacies or other entities as defined by 32 CFR 199.6 that provide care or services directly related to delivery of health or mental health care to TRICARE-eligible beneficiaries.

In determining whether a business entity is a network first tier subcontractor, consideration is given as to whether or not the entity providing the designated services acts as a broker of care; i.e., the entity itself obtains the medical coverage needed by in turn contracting with institutional and non-institutional providers. Implicit in the determination is size of the offered network; i.e., does this entity provide a large number of contracted providers for a large geographical area?

This definition does not exclude business entities that are not specifically addressed herein but whose legal status within the contract organization establishes them as subcontractors because that term may be otherwise defined in the FAR.

SUBCONTRACTS: The contractual assignment of elements of requirements to another organization or person for purposes of TRICARE. Unless otherwise specified in the contract, the term also includes purchase orders, with changes and/or modifications thereto.

SUPPLEMENTAL CARE: Medical care received by Active Duty Service Members (ADSMs) of the Uniformed Services and other designated patients pursuant to an MTF referral (MTF Referred Care). Supplemental Health Care also includes specific episodes of ADSM non-referred civilian care, both emergent and authorized non-emergent care (non-MTF Referred Care).

SUPPLEMENTAL FUNDS: Funds used to pay for supplemental care.

SUPPLEMENTAL INSURANCE: Health benefit plans that are specifically designed to supplement TRICARE Standard benefits. Unlike other health insurance (OHI) plans that are considered primary payers, TRICARE supplemental plans are always secondary payers on TRICARE claims. These plans are frequently available from military associations and other private organizations and firms.

SUPPLIERS OF PORTABLE X-RAY SERVICES: A supplier that meets the conditions of coverage of the Medicare program, set forth in the Medicare regulations, or the Medicaid program in the state in which the covered service is provided.

SURGERY: Medically appropriate operative procedures, including related preoperative and postoperative care; reduction of fractures and dislocations; injection and needling procedures of the joints; laser surgery of the eye; and those certain procedures listed in 32 CFR 199.4.

SURGICAL ASSISTANT: A physician (or dentist or podiatrist) who assists the operating surgeon in the performance of a covered surgical service when such assistance is certified as necessary by the attending surgeon, when the type of surgical procedure being performed is of such complexity and seriousness as to require a surgical assistant, and when interns, residents, or other house staff are not available to provide the surgical assistance services in the specialty area required.

SUSPENSION OF CLAIMS PROCESSING: The temporary suspension of processing (to protect the government's interests) of claims for care furnished by a specific provider (whether the claims are submitted by the provider or beneficiary) or claims submitted by or on behalf of a specific TRICARE beneficiary pending action by the Director, TMA, or a designee, in a case of suspected fraud or abuse. The action may include administrative remedies or any other Department of Defense issuance (e.g. DoD issuances implementing the Program Fraud Civil Remedies Act), case development or investigation by TMA, or referral to the Department of Defense-Inspector General or the Department of Justice for action within their cognizant jurisdictions.

TEACHING PHYSICIAN: A teaching physician is any physician whose duties include providing medical training to physicians in training within a hospital or other institutional provider setting.

TERMINATION: Termination is the removal of a provider as an authorized TRICARE provider based on a finding that the provider does not meet the qualifications established by 32 CFR 199.6 to be an authorized TRICARE provider. This includes those categories of providers who have signed specific participation agreements.

THIRD PARTY LIABILITY (TPL) CLAIMS: Third party liability (TPL) claims are claims in favor of the government that arise when medical care is provided to an entitled beneficiary for treatment or injury or illness caused under circumstances creating tort liability legally requiring a third person to pay damages for that care. The government pursues repayment for the care provided to the beneficiary under the provisions and authority of the Federal Medical Care Recovery Act (42 U.S.C. paragraphs 2651-2653).

THIRD PARTY LIABILITY (TPL) RECOVERY: The recovery by the government of expenses incurred for medical care provided to an entitled beneficiary in the treatment of injuries or illness caused by a third party who is liable in tort for damages to the beneficiary. Such recoveries can be made from the liable third party directly or from a liability insurance policy (e.g., automobile liability policy or homeowners insurance) covering the liable third party. Third party liability recoveries are made under the authority of the Medical Care Recovery Act (42 U.S.C. Paragraph 2651 et sec. Other potential sources of recovery in favor of the government in third party liability situations include, but are not limited to, no fault or uninsured motorist insurance, medical payments provisions of insurance policies, and workers compensation plans. Recoveries from such other sources are made under the authority of 10. U.S.C. paragraphs 10790, 1086(g), and 1095b.)

THIRD PARTY PAYER: An entity that provides an insurance, medical service, or health plan by contract or agreement, including an automobile liability insurance or no fault insurance carrier and a workers compensation program or plan, and any other plan or program (e.g., homeowners insurance, etc.) that is designed to provide compensation or coverage for expenses incurred by a beneficiary for medical services or supplies.

TIMELY FILING: The filing of TRICARE claims within the prescribed time limits as set forth in 32 CFR 199.7.

TOLL-FREE TELEPHONES: All telephone calls are considered toll-free for the purposes of measuring the standards contained in Chapter 1, Section 3, paragraph 5.3., except for those telephone calls to a TRICARE Service Center.

TRANSFER CLAIMS: A claim received by a contractor which is for services received and billed from another contractor's jurisdiction. TRICARE claims and attendant documentation must be referred to the appropriate contractor for processing. Notification must be sent to the claimant explaining the action taken, including the name and address of the correct contractor. Claims for active duty members which are sent to the appropriate Uniformed Service are not considered to be "transfer claims."

TRANSITION: The process of changing Contractors who serve a particular area or areas. Transition begins with the Notice of Award to the incoming contractor and is formally completed with the close out procedures of the outgoing contractor, several months after the start work date.

TRANSITIONAL ASSISTANCE MANAGEMENT PROGRAM: The Transitional Assistance Management Program (TAMP) was established to provide short-term transitional TRICARE and MTF benefits to certain former TRICARE beneficiaries.

TRANSITIONAL PATIENTS OR CASES: Patients for whom active care is in progress on the date of a Contractor's start work date. If the care being provided is for covered services, the Contractor is financially responsible for the portion of care delivered on or after the Contractor's start work date.

TREATMENT ENCOUNTER: The smallest meaningful unit of health care utilization: One provider rendering one service to one beneficiary.

TREATMENT PLAN: A detailed description of the medical care being rendered or expected to be rendered a TRICARE beneficiary seeking approval for inpatient benefits for which preauthorization is required as set forth in 32 CFR 199.4. A treatment plan must include, at a minimum, a diagnosis (either ICD-9-CM or DSM-III); detailed reports of prior treatment, medical history, family history, social history, and physical examination; diagnostic test results; consultant's reports (if any); proposed treatment by type (such as surgical, medical, and psychiatric); a description of who is or will be providing treatment (by discipline or specialty); anticipated frequency, medications, and specific goals of treatment; type of inpatient facility required and why (including length of time the related inpatient stay will be required); and prognosis. If the treatment plan involves the transfer of a TRICARE patient from a hospital or another inpatient facility, medical records related to that inpatient stay also are required as a part of the treatment plan documentation.

TRIAGE: A method of assessing the urgency of need for medical care using the patient's complaints and medical algorithms or other appropriate methods for analysis and then arranging for care. Medically qualified contractor personnel on 24 hour telephone coverage will perform the function.

TRICARE: The Department of Defense's managed health care program for active duty service members, service families, retirees and their families, survivors, and other TRICARE-eligible beneficiaries. TRICARE is a blend of the military's direct care system of hospitals and clinics and civilian providers. TRICARE offers three (3) options: TRICARE Standard Plan, TRICARE Extra Plan, and TRICARE Prime Plan (see definitions below).

TRICARE BENEFICIARY: An individual who has been determined to be eligible for TRICARE benefits, as set forth in 32 CFR 199.3.

TRICARE CONTRACTOR: An organization with which TMA has entered into a contract for delivery of and/or processing of payment for health care services through contracted providers and for processing of claims for health care received from non-network providers and for performance of related support activities.

TRICARE/CHAMPUS POLICY MANUAL (6010.47-M): A TMA manual which provides the description of program benefits, adjudication guidance, policy interpretations, and decisions implementing the TRICARE Program.

TRICARE DRG-BASED PAYMENT SYSTEM: A reimbursement system for hospitals which assigns prospectively-determined payment levels to each DRG based on the average cost of treating all TRICARE patients in a given DRG.

TRICARE EXTRA:A PPO-like option, provided as part of the TRICARE program under 32 CFR 199.17, where MHS beneficiaries may choose to receive care in facilities of the uniformed services, or from special civilian network providers (with reduced cost sharing), or from any other TRICARE-authorized provider (with standard cost sharing).

TRICARE FOR LIFE: : Benefit for Medicare eligibles, based on age. TRICARE is secondary payor when service is a benefit of both Medicare and TRICARE.

TRICARE PLUS: An enrollment option for TRICARE beneficiaries not enrolled in Prime. Beneficiaries are enrolled with a primary care coordinator (PCC) at a MTF. Enrollees are to

receive primary care appointments within the TRICARE Prime access standards. TRICARE Plus 'enrollment' will be annotated in DEERS and CHCS. For care from civilian providers, TRICARE Standard/Extra rules will apply. For services payable by Medicare, Medicare rules will apply, with TRICARE as second payer for TRICARE covered services and supplies. Specialty care in the MTF will be on referrals from the primary care provider or on a self-referral basis. Enrollees are not guaranteed specialty care appointments within the TRICARE Prime access standards. There is no lock-in and no enrollment fee. MTFs may limit enrollment based on capability and capacity.

TRICARE PRIME: An HMO-like option, provided as part of the TRICARE program under 32 CFR 199.17, where MHS beneficiaries elect to enroll in a voluntary enrollment program, which provides TRICARE Standard benefits and enhanced primary and preventive benefits with nominal beneficiary cost-sharing. TRICARE Prime requires beneficiaries to use a Primary Care Manager located at either the MTF or from the contractor's network except when beneficiaries are exercising their freedom of choice under the Point of Service Option.

TRICARE PRIME REMOTE PROGRAM (TPR) (GEOGRAPHICALLY SEPARATED UNIT PROGRAM): The program designed to provide health care services to active duty service members assigned to remote locations in the United States and the District of Columbia.

TRICARE PRIME REMOTE (TPR) WORK UNIT: A uniformed services work unit whose members are eligible to enroll in the TRICARE Prime Remote (TPR) Program as designated by the Military Services.

TRICARE PROGRAM: A DoD managed health care program operated under the authority of 32 CFR 199.17(d).

TRICARE REGULATION. 32 CFR 199. This regulation prescribes guidelines and policies for the administration of the TRICARE Program for the Army, Navy, Air Force, Marine Corps, Coast Guard, Commissioned Corps of the U.S. Public Health Service (USPHS) and the Commissioned Corps of the National Oceanic and Atmospheric Administration (NOAA). It includes the guidelines and policies for the administration of the TRICARE Program.

TRICARE REPRESENTATIVE: A highly qualified service representative serving within a defined part of a contractor's region, providing information and assistance to providers, whether network or non-network, to Health Benefit Advisors (HBAs) in the service area and to congressional offices.

TRICARE STANDARD: A health care option, provided as part of the TRICARE program under 32 CFR 199.17, where MHS beneficiaries may choose to receive care in facilities of the uniformed services, or from any TRICARE authorized providers (with standard cost sharing).

UNBUNDLED (OR FRAGMENTED) BILLING: A form of procedure code manipulation which involves a provider separately billing the component parts of a procedure instead of billing only the single procedure code which represents the entire comprehensive procedure.

UNCLEAN CLAIM: A claim received by the contractor that lacks any required documentation or authorization.

UNIFORM HMO BENEFIT: The health care benefit established by 32 CFR 199.18.

UNIFORMED SERVICES: The Army, Navy, Air Force, Marine Corps, Coast Guard, Commissioned Corps of the USPHS, and the Commissioned Corps of the NOAA.

UNIFORMED SERVICES CLINIC (USC): A Military Health System clinic that delivers primary care to active duty service members (ADSMs).

UNIFORMED SERVICES FAMILY HEALTH PLAN (USFHP): A government-contracted health plan that offers enrollment in TRICARE Prime to individuals who reside in the geographic service area of a USFHP designated provider who are eligible to receive care in military medical treatment facilities (except active duty service members). This includes those individuals over age 65 who, except for their eligibility for Medicare benefits, would have been eligible for TRICARE benefits. Designated providers under the USFHP were previously known as "Uniformed Services Treatment Facilities" (USTFs) and are former Public Health Service Hospitals. The service areas of the USFHP designated providers are listed at "http://www.usfhp.org" on the world wide web and under "USTF" in the Catchment Area Directory.

UNITED STATES: "United States" means the 50 states and the District of Columbia.

UNITED STATES PUBLIC HEALTH SERVICE (USPHS): An agency within the U.S. Department of Health and Human Services which has a Commissioned Corps which are classified as members of the "Uniformed Services."

UNPROCESSABLE HEALTH CARE SERVICE RECORDS (HCSRS): Health care service records transmitted by the contractor to TMA and received in such condition that the basic record identifier information is not readable on the TRICARE data system, i.e., header incorrect, electronic records garbled, etc.

UNPROVEN DRUGS, DEVICES, AND MEDICAL TREATMENTS OR PROCEDURES: Drugs, devices, medical treatments or procedures are considered unproven if 1) FDA approval is required and has not been given; 2) If the device is a FDA Category A Investigational Device Exemption (IDE); 3) If there is no reliable evidence which documents that the treatment or procedure has been the subject of well-controlled studies of clinically meaningful endpoints which have determined its maximum tolerated dose, its toxicity, its safety, and its efficacy as compared with the standard means of treatment or diagnosis; 4) If the reliable evidence shows that the consensus among experts regarding the treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its safety, or its effectiveness as compared with the standard means of treatment or diagnosis. For further clarification see 32 CFR 199.4(g)(15).

URGENT CARE: Medically necessary treatment that is required for illness or injury that would not result in further disability or death if not treated immediately. The illness or injury does require professional attention, and should be treated within 24 hours to avoid development of a situation in which further complications could result if treatment is not received.

UTILIZATION CRITERIA: Specific conditions that must be met in order to provide appropriate treatment. DoD-approved criteria to use for screening medical/surgical care and for mental health care as outlined in Chapter 7.

UTILIZATION MANAGEMENT: A set of techniques used to manage health care costs by influencing patient care decision-making through case-by-case assessment of the appropriateness and medical necessity of care either prior to, during, or after provision of care. Utilization management also includes the systematic evaluation of individual and group utilization patterns to determine the effectiveness of the employed utilization management techniques and to develop modifications to the utilization management system designed to address aberrances identified through the evaluation.

UTILIZATION REVIEW: A process of case-by-case examination for consistency of the provider's request for specific treatment(s) (e.g., level of care, procedures, etc.) with preestablished criteria. Specific types of review include (but are not limited to) prospective review, concurrent review, and retrospective review. For the purposes of this contract, utilization review will be mandatory for enumerated conditions and treatments in order to generate certification and authorization for care provided.

VENDOR PHARMACY: A participating provider pharmacy not under contract with the contractor as a member pharmacy.

VETERAN: A person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.

NOTE: Unless the veteran is eligible for "retired pay," "retirement pay," or "retainer pay," which refers to payments of a continuing nature and are payable at fixed intervals from the government for military service neither the veteran nor his or her family members are eligible for benefits under TRICARE.

VISIT:

1. **CIVILIAN CARE SETTING**. Those medical care procedures characterized by the professional examining and/or evaluating a patient and delivering or prescribing a care regimen. Professional visit procedures include CPT procedure codes[1] 90000 - 90499, 90571 - 97799, 99175 - 99195, 99155 - 99156, each range inclusive except 90596, 90597, and 90599; and including emergency room visit procedure codes 90500 - 90570 and 90599.

2. **MILITARY MEDICAL AND DENTAL TREATMENT FACILITIES**. The definition of a visit as used in the Medical Expense and Performance Reporting System for Fixed Military Medical and Dental Treatment Facilities Manual, DoD 6010.13-M (MEPRS Manual) applies. "Each time an eligible beneficiary presents himself to a separate organized clinic or specialty service for examination, diagnosis, treatment, evaluation, consultation, counseling, medical advice; or is treated or observed in his quarters; and a signed and dated entry is made in the patient's health record or other record of medical treatment, then a visit is considered to have been completed and is countable; however, with the exception that consecutive clinic visits to specialty clinics, i.e., physical therapy and occupational therapy, will not require a signed and dated entry at each visit, unless there is a change in the prescribed treatment, or significant physical finding is evident. In all instances, however, an acceptable record audit trail

[1] *CPT codes, descriptions and other data only are copyright 2004 American Medical Association. All rights reserved. Applicable FARS/DFARS Restrictions Apply to Government use.*

will be maintained. For example, a clinic log or treatment card may be maintained as a source document to support an audit trail. Classification of a service as a visit will not be dependent on the professional level of the person providing the service (includes physicians, nurses, physician's assistants, medical specialists, and medical technicians)." The MEPRS Manual definition contains added instructions related to the MTF counting of a "Visit." See Appendix B for detail.

WIDOW OR WIDOWER: A person who was a spouse at the time of death of the active duty member or retiree and who has not remarried.

WORKDAY: A day on which full-time work is performed.

WORKER'S COMPENSATION BENEFITS: Medical benefits available under any worker's compensation law (including the Federal Employees Compensation Act), occupational disease law, employers liability law, or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure.

X-RAY SERVICES: An x-ray examination from which an x-ray film or other image is produced, ordered by the attending physician when necessary and rendered in connection with a medical or surgical diagnosis or treatment of an illness or injury, or in connection with maternity or well-baby care.