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DEFENSE
HEALTH AGENCY

HPOSD

CHANGE 2
6010.59-M
MAY 17, 2017

PUBLICATIONS SYSTEM CHANGE TRANSMITTAL FOR TRICARE OPERATIONS MANUAL (TOM), APRIL 2015

The Defense Health Agency has authorized the following addition(s)/revision(s).

CHANGE TITLE: **INCORPORATING T-3 PUBLISHED CHANGES INTO T2017 MANUALS**

CONREQ: 18514

PAGE CHANGE(S): See page 2.

SUMMARY OF CHANGE(S): This change brings the T2017 Manuals current with the T-3 Manuals, by incorporating T-3 changes published from December 20, 2016 through March 28, 2017 and adds revisions and administrative updates.

EFFECTIVE DATE: Thirty (30) days prior to healthcare delivery.

IMPLEMENTATION DATE: Thirty (30) days prior to healthcare delivery.

This change is made in conjunction with Apr 2015 TPM, Change No. 2, Apr 2015 TRM, Change No. 2, and Apr 2015 TSM, Change No. 2.

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

CHANGE 2
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Chapter 1 Section 1

Organization Of The Defense Health Agency (DHA)

Revision: C-2, May 17, 2017

Chapter 55, Title 10, of the United States Code (USC), provides that the Secretary of Defense and the Secretary of Health and Human Services (HHS) shall jointly prescribe regulations for the administration of TRICARE. Department of Defense Directive (DoDD) 5136.13 (The DHA Charter) established DHA as an agency under the policy guidance and direction of the Assistant Secretary of Defense (Health Affairs) (ASD(HA)).

- END -

2.8 Service members, who have sustained an amputation, shall be considered for transfer or admission to an appropriate MTF/eMSM Center of Excellence. Prior to authorizing rehabilitative treatment to a purchased care sector provider or facility, the contractor (Managed Care Support Contractor (MCSC), DP and TOP), in coordination with the respective TRICARE Regional Office (TRO)/ TRICARE Area Office (TAO) and the assigned MTF/eMSM (or DHA-Great Lakes (DHA-GL) for TRICARE Prime Remote (TPR) enrollees), shall determine whether care is available from any Department of Defense (DoD) Advanced Rehabilitation Center (ARC). The DoD ARCs include the Center for the Intrepid (CFI); San Antonio Military Medical Center (SAMMC), San Antonio, Texas; Military Advanced Training Center (MATC); Walter Reed National Military Medical Center (WRNMMC), Bethesda, Maryland; and the Comprehensive Combat and Complex Casualty Care (C5), Naval Medical Center, San Diego, California. The assigned MTF (or DHA-GL for TPR enrollees) and the ARC will determine appropriateness of the transfer/referral. If care is available and appropriate in one of these facilities, the contractor shall facilitate the transfer or admission of the Service member as soon as practical based on the patient's condition. The contractor shall coordinate with the respective TRO/TAO or DHA-GL for any issues or concerns. See Section J of the contract for reporting requirements.

3.0 FAILURE TO COMPLY WITH PREAUTHORIZATION - PAYMENT REDUCTION

During claims processing, provider payments shall be reduced for failure to comply with the preauthorization requirements for certain types of care. See the TRM, Chapter 1, Section 28, for more information.

4.0 PSYCHIATRIC RESIDENTIAL TREATMENT CENTERS (RTCs)

4.1 All RTC care requires preauthorization review, regardless of the setting (see Chapter 7, Section 2). Before any claims for RTC care may be paid, an authorization must be on file. The dates of service on the claim form and the name of the facility plus the Employer Identification Number (EIN) with suffix must correspond with the dates of the approval and the facility indicated on the authorization. If the beneficiary resides outside of the contractor's region, the contractor responsible for payment shall pay the claims at the rate determined by Defense Health Agency (DHA). When the contractor issues an RTC authorization, it shall flag its files to preclude payment of any family or collateral therapy that is billed in the name of the RTC patient. That cost is the responsibility of the RTC, unless, as part of its negotiated agreement, the contractor agrees to a separate payment for such care. Under the DHA-determined rates, family therapists may bill separately from the RTC (outside the all-inclusive rate) only if the therapy is provided to one or both of the parents residing a significant distance from the RTC. In the case of residents of a region, geographically distant family therapy must be certified by the contractor in order for cost-sharing to occur.

4.2 If a claim for admission or extension is submitted and no authorization form is on file, the claim shall not be paid. For network claims, the contractor may deny or develop in accordance with its agreements with network providers. For non-network claims, the contractor shall deny the claim.

4.3 For any claims submitted for inpatient care at other than the RTC, the contractor shall pay the claim if the care was medically necessary. Claims for RTC care during the period of time the beneficiary was receiving care from another inpatient facility shall be denied. If the RTC has been paid and a claim for inpatient hospital care is received and the care was medically necessary, the contractor must pay the inpatient hospital claim and recover the payment from the RTC.

5.0 GRANDFATHERED CUSTODIAL CARE CASES

A list of the beneficiaries who qualified for custodial care benefits prior to June 1, 1977, has been furnished to the contractor with instructions to flag the file for those beneficiaries on the list who are within its region. Claims received for those beneficiaries, for which no authorization is on file, are to be suspended and the contractor shall notify the appropriate TRICARE Regional Office (TRO). Refer to 32 CFR 199.4.

6.0 REFERRAL AND AUTHORIZATION PROCESS

The contractor shall process referrals in accordance with the following:

6.1 Referrals From The MTF/eMSM To The Contractor

Referral Management Suite (RMS) is the Department of Defense's (DoD's) system to transmit referrals and authorizations between the Military Health System (MHS) MTFs/eMSMs and contractors. RMS captures and stores the referral and authorization information allowing for the tracking of referrals from the time it is created to the time the referral results are provided to the referring provider or closed for non-use by the patient. RMS is able to transmit Health Insurance Portability and Accountability Act (HIPAA) compliant 278 Health Care Services Review Request for Review and Response transactions. The RMS supports reporting of referral authorization processing times, rejected referrals, and referrals awaiting contractor response, among others. Faxing shall be used only in situations when electronic means is temporarily unavailable (with the exception of transmission of ROFRs and the Coast Guard which does not use the RMS). Referrals from the MTF/eMSM will include the information in the chart below, at a minimum, unless otherwise specified. The MTF/eMSM is not required to provide diagnosis or procedure codes. The contractor shall translate the narrative descriptions into standard diagnosis and procedure codes. The contractor shall ensure that care received outside the MTF/eMSM and referred by the MTF/eMSM (for MTF/eMSM enrollees) is properly entered into the contractor's claims processing system to ensure the appropriate adjudication of claims. To facilitate adjudication of claims, the contractor's claims system shall utilize the UIN, at a minimum, to match claims with referral authorizations.

REQUIRED DATA ELEMENT*	DESCRIPTION/PURPOSE/USE
Request Date/Time	DD MMM YY hhmm
Request Priority	STAT/24-hour/ASAP/Today/72-hour/Routine
Requester	
Referring Provider Name	Name of PCM/MTF/eMSM individual provider making request
Referring Provider NPI	Health Insurance Portability and Accountability Act (HIPAA) NPI - Type 1 (Individual)
Referring MTF/eMSM	Name of MTF/eMSM
PATIENT INFORMATION	
Sponsor Social Security Number (SSN)	Only if the Electronic Data Interchange Patient Number (EDI_PN) (from DEERS is not available)
Patient ID	EDI_PN
Patient Name	Full Name of Patient (if no EDI_PN available)
Patient Date of Birth (DOB)	DOB (required if patient not in DEERS)
Patient Gender	

REQUIRED DATA ELEMENT*	DESCRIPTION/PURPOSE/USE
Patient Address	Full Address of Beneficiary (including zip)
Patient Telephone Number	If available - Telephone Number (including area code)
CLINICAL INFORMATION	
Patient Primary Provisional Diagnosis	Description
Reason for Request	Sufficient Clinical Info to Perform Medical Necessity Report (MNR)
SERVICE	
Service 1 - Provider	Specialty of Service Provider
Service 1 - Provider Sub-Specialty	Additional Sub-Specialist Info if Needed (Free Text Clarifying Info Entered with Reason for Request) e.g., Pediatric Nephrologist
Service 1 - By Name Provider Request if Applicable - First and Last Name	Optional Info Regarding Preferred Specialist Provider (Free Text)
Service 1 - Service Type	Inpatient, Specialty Referral, Durable Medical Equipment (DME) Purchase/Rental, Other Health Service, et al DME Provider to do Certificates of Medical Necessity (CMN)
Service 1 - Service Quantity	Evaluate or Evaluate and Treat
CHCS Generated Order Number (DMIS-YYMMDD-XXXXX)	UIN. The UIN is the DMIS (of the referring facility identified in the "Referring MTF/eMSM" field on this request) --Date in format indicated--Consult Order Number from CHCS.
Special Instructions:	
Note 1: *Above data elements are required unless otherwise noted as "Optional."	
Note 2: Use of the NPI is required in accordance with Health and Human Services (HHS) NPI Final Rule of May 23, 2007 or upon service direction and/or direction of the Contracting Officer (CO). Implementation requirements may be found at Chapter 19, Section 4.	
Note 3: When issuing a preauthorization for a Service member while in terminal leave status to obtain medical care from the Department of Veterans Affairs (DVA), as required by Chapter 17, Section 1, paragraph 4.5, the MTF/eMSM shall make special entries for data elements as follows:	
Patient Primary Provisional Diagnosis	Condition of a routine or urgent nature as specified by the patient at a future date.
Reason for Request	Provide preauthorization for outpatient treatment by the DVA for routine or urgent conditions while the active duty patient is in a terminal leave status.
Service 1 - Provider	Any DVA provider.
Service 1 - By Name Provider Request if Applicable - First and Last Name	DVA provider only.
Note 4: When issuing an authorization for the DVA to provide a Compensation and Pension (C&P) examination for a Service member as required by Chapter 17, Section 2, paragraph 3.2.2, the MTF/eMSM shall make special entries for data elements as follows:	
Patient Primary Provisional Diagnosis	V68.01 - Disability Examination or Z02.71 - Disability Examination
Reason for Request	DVA only: Integrated Disability Evaluation System (IDES) C&P Examinations for Fitness for Duty Determination
Service 1 - Provider	Any DVA Provider
Service 1 - By Name Provider Request if Applicable - First and Last Name	DVA Provider Only
Service 1 - Service Quantity	Number of C&P Examinations Authorized

REQUIRED DATA ELEMENT*	DESCRIPTION/PURPOSE/USE
This blanket preauthorization is only for routine and urgent outpatient primary medical care provided by the DVA while the patient is in a terminal leave status and/or for C&P examinations through IDES. Terminal leave for this patient concludes at midnight on DD MM YY. The referral in Note 4 shall be considered a blanket authorization for any DVA to conduct the authorized number of C&P exams and ancillary services.	

6.1.1 Using the UIN, the contractor shall locate related referrals, authorizations, and claims. Contractor generated MTF/eMSM reports shall be modified to accommodate the UIN and NPI. The UIN shall also be used for all related customer service inquiries. UINs and NPIs will be attached to all MTF/eMSM referrals and will be portable across all regions of care. The UIN will be used to match claims to an MTF/eMSM generated referral. The contractor shall provide the MTF/eMSM a monthly adjudicated referral claim report which shall include the UIN against each claim. The contractor shall capture the NPIs from the referral transmission report and forward the NPI and corresponding UIN to the referred to provider on all referrals.

6.1.2 The contractor where care is rendered shall apply their best business practices when authorizing care for referrals to their network and shall retain responsibility for managing requests for additional services or inpatient concurrent stay reviews associated with the original referral as well as changes to the specialty provider identified to deliver the care. The contractor authorizing the care shall forward the referral/authorization information, including the range of codes authorized (i.e., Episode Of Care (EOC)) and the name, the NPI, and demographic information of the specialty provider to the contractor for the region to which the patient is enrolled. If the patient is enrolled overseas, the contractor shall provide the same service and information required above to the TOP contractor. If a CONUS Prime retiree/retiree family member receives authorization to obtain care overseas from a contractor, the contractor shall forward the authorization information to the TOP contractor to ensure appropriate adjudication of the claim. Claims submitted by the provider shall be processed by the contractor or the TOP contractor according to Chapter 8, Section 2.

6.1.3 The contractor shall screen the information provided and return incomplete requests within one business day to the MTF/eMSM by HIPAA-compliant 278 response. If the contractor's system is temporarily not available, then the contractor shall send the information to the MTF's/eMSM's single POC via fax or other electronic means acceptable to the MTF/eMSM and the contractor. The return of a referral to the MTF/eMSM is considered processed to completion.

6.1.4 The contractor shall verify that the services are a TRICARE benefit through appropriate medical review and screening to ensure that the service requested is reimbursable through TRICARE. The contractor's medical review shall be in accordance with the contractor's best business practices. This process does not alter the TRICARE Operations Manual (TOM), TRICARE Policy Manual (TPM), or TRICARE Systems Manual (TSM) provisions covering active duty personnel or TRICARE For Life (TFL) beneficiaries.

6.1.5 The contractor shall advise the patient, referring MTF/eMSM, and receiving provider of all approved referrals. The MTF/eMSM single Point of Contact (POC) shall be advised via HIPAA-compliant 278 response. (The MTF/eMSM single POC may be an individual or a single office with more than one telephone number.) The notice to the beneficiary shall contain the UIN and information necessary to support obtaining ordered services or an appointment with the referred to provider within the access standards. The notice shall also provide the beneficiary with instructions on how to change their provider, if desired. If the contractor is informed that the beneficiary changed the provider listed on the referral, the contractor shall make appropriate modifications to MTF/eMSM issued referral (to revise the

provider the beneficiary was referred to by the MTF/eMSM). The revised referral shall contain the same level of data as the initial MTF/eMSM referral. The revised referral shall be issued to the current provider, with an updated HIPAA-compliant 278 response to the MTF/eMSM. If the contractor's system is temporarily not available, then the contractor shall send the information to the MTF's/eMSM's single POC via fax or other electronic means acceptable to the MTF/eMSM and the contractor. For same day, 24-hour, and 72-hour referrals, no beneficiary notification shall be issued. The contractor shall notify the provider to whom the beneficiary is being referred of the approved services, to include clinical information furnished by the referring provider.

6.1.6 If services are denied, the contractor shall notify the patient and shall advise the patient of their right to appeal consistent with the TOM. The contractor shall also notify the referring single MTF/eMSM POC by HIPAA-compliant 278 response of the initial denial. If the contractor's or the MTF's/eMSM's system is temporarily not available, then the contractor shall send the information to the MTF's/eMSM's single POC via fax or other electronic means acceptable to the MTF/eMSM and the contractor.

6.1.7 For services beyond the initial authorization, the contractor shall use its best practices in determining the extent of additional services to authorize. The contractor shall not request a referral from the MTF/eMSM but shall provide the MTF/eMSM, by HIPAA-compliant 278 response, the updated authorization and clinical information that served as the basis for the new authorization. If the contractor's or the MTF's/eMSM's system is temporarily not available, then the contractor shall send the information to the MTF's/eMSM's single POC via fax or other electronic means acceptable to the MTF/eMSM and the contractor.

6.1.8 Directed Referrals (CONUS Only)

6.1.8.1 The contractor shall establish and maintain an adequate network (Chapter 5, and TRM, Chapter 1, Section 1) to produce the best quality and outcome for TRICARE beneficiaries. MTF/eMSM-directed referrals could impede the contractor's ability to maintain and manage the network. Directed referrals are any provider generated by-name requests for services. Directed referrals are expected to be rare; however, a description of appropriate circumstances is outlined in the MOU and the process for submitting directed referrals for services within the PSA will be contained within the MOUs between the MTFs/eMSMs, TROs, and contractor.

6.1.8.2 MTF/eMSM directed referrals for initial services to a non-network provider greater than 100 miles from the MTF/eMSM where specialized treatment, surgical procedure, and/or inpatient admission is expected or being requested require justification from the MTF/eMSM to the contractor and coordination between the contractor and TRO prior to approval by the contractor. This coordination process is contained within the MOUs between the MTFs/eMSMs, TRO, and contractor. The MOU will also contain guidance on types of MTF/eMSM directed referrals excluded from this policy. The contractor shall accomplish benefit review and medical necessity review as required by policy and then coordinate with the TRO prior to completing the referral/authorization. The contractor may ask the TRO for guidance on any MTF/eMSM or network provider-directed referral that meets the intent of this policy.

6.1.8.3 The contractor shall make and document appropriate determinations considering the justification provided by the MTF/eMSM for directed referrals to non-network providers. The contractor shall track and report MTF/eMSM-directed referrals to the TRO as specified in Section J of the contract.

6.2 Referrals From The Contractor To The MTF/eMSM

Referrals subject to the ROFR provision from the civilian sector shall be processed in accordance with the following procedures.

6.2.1 The contractor shall send ROFRs to the MTF/eMSM via a HIPAA-compliant 278, or other process as identified by the Government. The request shall contain the minimum data set described in paragraph 6.1 (with the exception of the UIN) plus the referring civilian provider's fax number, telephone number, and mailing address. This data set shall be provided to the MTF/eMSM in plain text with or without diagnosis or procedure codes. This transmission shall take place within 90 minutes from date/time of receipt of referral for "urgent priority" ROFRs and within two business days from date/time of receipt for "routine priority" ROFRs. If the contractor's system is temporarily not available, then the contractor shall send the information to the MTF's/eMSM's single POC via fax or other electronic means acceptable to the MTF/eMSM and the contractor.

6.2.2 The MTF/eMSM will respond to the contractor via HIPAA-compliant 278, or other process as identified by the Government, within 90 minutes from receipt of the request for "urgent priority" ROFRs and two business days, as defined in paragraph 6.2.1, from receipt of the request for "routine priority" ROFRs. When no response is received from the MTF/eMSM in response to the ROFR request as defined above, the contractor shall process the referral request as if the MTF/eMSM declined to see the patient. The contractor shall provide each MTF/eMSM with a report of the number and specialty types of ROFR referrals forwarded to the MTF/eMSM, the number of accepted and declined ROFRs by the MTF/eMSM, and the accuracy of the types of ROFRs forwarded to the MTF/eMSM compared to the MTF's/eMSM's capability and capacity report. All referrals for care indicated on the MTF/eMSM capabilities table shall be forwarded to the MTF/eMSM by the contractor. The only exception will be for continuity of care. Continuity of care is operationally defined as follow on care from a specific specialist as part of a specific procedure or service that was performed within the previous six months.

6.2.3 The ROFR will be forwarded for Prime beneficiaries for whom the MTF/eMSM has indicated the desire to receive referral requests based on specialty or selective diagnosis codes or procedure codes, and/or enrollment category. ROFR requests shall be provided prior to the contractor's medical necessity and covered benefit review to afford the MTF/eMSM the opportunity to see the patient prior to any decision.

6.2.4 In instances where the MTF/eMSM elects to accept the patient, the MTF/eMSM will advise the contractor from date/time of receipt for "routine priority" ROFRs, as defined in paragraph 6.2.1. The contractor shall notify the beneficiary of the MTF's/eMSM's acceptance and provide instructions for contacting the MTF/eMSM to obtain an appointment. The contractor shall enforce the POS if the patient chooses to not go to the MTF/eMSM once the MTF/eMSM has accepted the ROFR.

6.3 The contractor shall provide reports on unactivated behavioral health referrals, referrals received by specialty, and purchased care MTF/eMSM Prime enrolled inpatients, according to Contract Data Requirement List (CDRL) requirements.

- END -

Chapter 11 Section 9

Collection Actions Against Beneficiaries

Revision: C-2, May 17, 2017

1.0 GENERAL

1.1 No patient, family member or sponsor shall be subjected to ongoing collection action undertaken by or on behalf of a provider of services or supplies, as a result of the inappropriate non-payment of claims for services which should have been covered under TRICARE. When the Government becomes aware that such collection action has been initiated, it will intervene on behalf of the party against whom the collection action has been taken.

1.2 While the Government will assist in the resolution of collection matters brought to their attention, the ultimate responsibility for resolving collection actions lies with the patient, family member, or sponsor. The Government will not provide legal representation to resolve these issues and will not pay attorneys' fees, court costs, collection agency fees, accrued interest, late charges, etc. TRICARE can only assume responsibility for collection assistance for medically necessary supplies and services as authorized for coverage under the TRICARE regulation.

2.0 DEBT COLLECTION ASSISTANCE INTERVENTION

Upon notification of a problem, Department of Defense (DoD) will investigate and, when appropriate, resolve and/or assist in the clarification of collection issues for TRICARE beneficiaries.

3.0 CONTRACTOR RESPONSIBILITIES

3.1 Research Assistance

The contractor shall provide immediate assistance to the Government in support of the debt collection assistance function. In addition to identifying specific underpayments, the contractor shall also:

3.1.1 Designate specific individuals and provide resources to work collection issues with Government representatives during normal weekday business hours.

3.1.2 Provide Web-site access and/or e-mail addresses, mailing addresses, fax numbers and direct phone number(s) of specialized collections research and support staff to the Government.

3.1.3 Maintain records and processing statistics on collection activity. The records to be maintained shall include a detailed chronological record of all actions taken, including names and telephone numbers of all parties contacted in the course of the actions taken, as well as copies of all correspondence sent and received.

3.1.4 When violation of the participation agreement or balance billing is not at issue, issue letters to providers and conduct provider education when the provider was at fault.

3.1.5 The contractor shall furnish reports of all completed collection cases.

3.1.6 In newsletters and other materials, publicize and educate beneficiaries and providers on the Debt Collection Assistance Program. This shall include informing providers of the availability of the contractor's support services to assist in resolution of claims problems, and encourage providers to contact the contractor's priority unit for assistance prior to initiating any collection action. If the contractor is asked to participate in beneficiary, sponsor or provider training, workshops or briefings at Military Treatment Facilities (MTFs)/Enhanced Multi-Service Markets (eMSMs) or elsewhere in the Region in accordance with specific regional requirements, the contractor shall ensure the Debt Collection Assistance Program is a topic.

3.2 Expedited Payment

All requests for expedited payment will be coordinated through the TRICARE contractor for the region. When research reveals a processing error by the contractor or subcontractor, any additional payment due shall be processed on an expedited basis, and the contractor's response to the Government shall reflect an expected date of payment.

3.3 Referrals to Program Integrity, Defense Health Agency (DHA)

When it has been determined that balance billing or violation of the participation agreement is at issue, the matter will continue to be handled in accordance with the existing program integrity guidelines contained in Chapter 13, Section 2.

- END -

2.3 Time Limitations On Filing Service member Claims

The claims filing deadline outlined in Chapter 8, Section 3, paragraph 1.1, does not apply to any Service member claims.

3.0 CLAIM REIMBURSEMENT

3.1 For network providers, the contractor shall pay TPR medical claims at the CHAMPUS allowable charge or at a lower negotiated rate.

3.2 No deductible, cost-sharing, or copayment amounts shall be applied to Service member claims.

3.3 If a non-participating provider requires a TPR enrollee to make an "up front" payment for health care services, in order for the enrollee to be reimbursed, the enrollee must submit a claim to the contractor with proof of payment and an explanation of the circumstances. The contractor shall process the claim according to the provisions in this chapter. If the claim is payable without SAS review, the contractor shall allow the billed amount and reimburse the enrollee for the charges on the claim. If the claim requires SAS review the contractor shall pend the claim to the SAS for determination. If the SAS authorizes the care, the contractor shall allow the billed amount and reimburse the enrollee for charges on the claim.

3.4 If the contractor becomes aware that a civilian provider is trying to collect "balance billing" amounts from a TPR enrollee or has initiated collection action for emergency or authorized care, the contractor shall follow contract procedures for notifying the provider that balance billing is prohibited. If the contractor is unable to resolve the situation, the contractor shall pend the file and forward the issue to the SAS for determination. The SAS will issue an authorization to the contractor for payments in excess of the applicable TRICARE payment ceilings provided the SAS has requested and has been granted a waiver from the Deputy Director, DHA, or designee.

3.5 If required services are not available from a network or participating provider within the medically appropriate time frame, the contractor shall arrange for care with a non-participating provider subject to the normal reimbursement rules.

3.5.1 The contractor initially shall make every effort to obtain the provider's agreement to accept, as payment in full, a rate within the 100% of CMAC limitation. If this is not feasible, the contractor shall make every effort to obtain the provider's agreement to accept, as payment in full, a rate between 100% and 115% of CMAC. If the latter is not feasible, the contractor shall determine the lowest acceptable rate that the provider will accept.

3.5.2 The contractor shall then request a waiver of CMAC limitation from the Director, TRICARE Regional Offices (TROs), as the designee of the Deputy Director, DHA, before patient referral is made to ensure the patient does not bear any out-of-pocket expense. The waiver request shall include the patient name, TPR location, services requested (Current Procedural Terminology, 4th Edition [CPT-4] codes), CMAC rate, billed charge, and anticipated negotiated rate. The contractor shall obtain approval from the RD before the negotiation can be concluded. The contractors shall ensure that the approved payment is annotated in the authorization/claims processing system, and that payment is issued directly to the provider, unless there is information presented that the Service member has personally paid the provider.

4.0 ADVANCED REHABILITATION CENTERS

See Chapter 8, Section 5, paragraph 2.8.

5.0 THIRD PARTY LIABILITY (TPL)

TPL processing requirements (Chapter 10) apply to all claims covered by this chapter. However, the contractor shall not delay adjudication action on a claim while awaiting completion of the TPL questionnaire and compilation of documentation. Instead, the contractor shall process the claim(s) to completion. When the contractor receives a completed TPL questionnaire and/or other related documentation, the contractor shall forward the documentation as directed in Chapter 10.

6.0 END OF PROCESSING

The contractor shall issue Explanations of Benefits (EOBs) and provider summary vouchers for TPR claims according to TRICARE Prime claims processing procedures.

7.0 TED VOUCHER SUBMITTAL

The contractor shall report the TPR Program claims on vouchers according to TRICARE Systems Manual (TSM), Chapter 2, Section 2.3. The TED for each claim must reflect the appropriate data element values.

8.0 STANDARDS

All TRICARE Program claims processing standards apply to TPR claims, see Chapter 1, Section 3.

- END -

2.5.5.2 Where a beneficiary has had clinical evaluation(s)/tests performed in order to determine eligibility for Section 1637 program coverage and has paid for those clinical evaluation(s)/tests out-of-pocket, the contractor shall process any claim(s) received for such clinical evaluation(s)/tests and shall pay any such claim as if the Service member were an active duty Service member.

2.5.5.3 Service members with multiple service-related conditions will have multiple Section 1637 enrollments. Each condition may have the same or different begin and end dates.

2.5.5.4 Jurisdiction rules for Section 1637 program coverage shall be in accordance with Chapter 8, Section 2.

2.5.5.5 The contractors shall pay all claims submitted for the specific service-related condition in the same manner as other active duty claims. There shall be no application of catastrophic cap, deductibles, cost-shares, copayments or coordination of benefits for these claims. Claims paid for the specific service-related condition under this change should be paid from non-financially underwritten funds.

2.5.5.6 Claims paid for medical care under the 180 day TAMP program, for other than the service-related condition, shall continue to be paid as an ADFM beneficiary under TRICARE with application of appropriate cost-shares and deductibles for these claims. The Section 1637 benefit does not extend the duration of the TAMP period beyond 180 days.

2.5.5.7 If the contractor is unable to determine if the care received is covered by the Section 1637 diagnosis, the claim is to be pended while the contractor obtains further clarification from SAS.

2.5.5.8 Pharmacy transactions at retail network pharmacies are processed on-line using the HIPAA data transaction standard of the National Council for Prescription Drug Programs (NCPDP). Under this standard, claims are adjudicated real time for eligibility along with clinical and administrative edits at the Point Of Service (POS) which includes cost-share determinations based on the Service member's primary HCDP code.

2.5.5.8.1 Enrolled Service members determined to be eligible for pharmacy services based on their primary HCDP code will pay appropriate cost-shares as determined by their primary HCDP code and will submit a paper claim to the pharmacy contractor to seek reimbursement of these costs shares. Enrollment documentation that includes the specific condition for Section 1637 enrollment shall be submitted with their claim. The pharmacy contractor shall verify eligibility in DEERS and determine coverage of the prescription based on the specific condition detailed in the supporting documentation.

2.5.5.8.2 Enrolled Service members determined to not be eligible for pharmacy services based on their primary HCDP code will pay out-of-pocket for the total cost of the prescription and then submit a paper claim to the pharmacy contractor for reimbursement. The pharmacy contractor shall verify eligibility in DEERS and determine coverage of the prescription based on the specific condition detailed in the supporting documentation.

2.5.5.8.3 In situations where the supporting document submitted by the former Service member to the pharmacy contractor does not provide sufficient detail of their covered condition, the pharmacy contractor shall contact SAS to obtain appropriate documentation of their covered condition needed to make a coverage determination and process the claim.

2.6 Provisions Of Reproductive Services For The Benefit Of Seriously or Severely Ill Or Injured Service Members Under The SHCPs

Assisted reproductive services, including sperm retrieval, oocyte retrieval, IVF, artificial insemination, and blastocyst implantation, are available for seriously or severely ill/injured female and male Service members (Category II and III). This is a benefit offered based on the condition of the seriously or severely ill/injured Service member not the spouse; therefore, the use of the SHCP is authorized.

2.7 Advanced Rehabilitation Centers

See Chapter 8, Section 5, paragraph 2.8.

3.0 ENROLLMENT STATUS EFFECT ON CLAIMS PROCESSING

3.1 Active duty claims shall be processed without application of a cost-share, copayment, or deductible. These are SHCP claims.

3.2 Claims for TRICARE Prime enrollees who are in MTF/eMSM inpatient status shall be processed without application of a cost-share, copayment, or deductible. These are SHCP claims.

3.3 Claims for services provided under the current MOU between the DoD (including Army, Air Force, and Navy/Marine Corps facilities) and the DHHS (including the Indian Health Service, Public Health Service, etc.) are not SHCP claims. They shall be adjudicated under the claims processing provisions applicable to those specific agreements.

3.4 Claims for services provided under any local MOU between the DoD (including the Army, Air Force, and Navy/Marine Corps facilities) and the DVA are not SHCP claims. They shall be adjudicated under the claims processing provisions applicable to those specific agreements. (Claims for services provided under the current national MOA for SCI, TBI, and Blind Rehabilitation are covered, see Section 2, paragraph 3.1.)

3.5 Claims for participants in the CCEP shall be processed for payment solely on the basis of MTF/eMSM authorization. There will not be a cost-share, copayment, or deductible applied to these claims. These are SHCP claims.

3.6 Claims for non-TRICARE eligibles shall be processed for payment solely on the basis of MTF/eMSM or SAS authorization. There will not be a cost-share, copayment, or deductible applied to these claims. These are SHCP claims.

3.7 Outpatient claims for non-TRICARE Medicare eligibles will be returned to the submitting party for filing with the Medicare claims processor. These are not SHCP or TRICARE claims.

3.8 Claims for TDRL participants shall be processed for payment in accordance with DoD/HA Policy Letter dated March 30, 2009, Subject: Policy Guidance for Use of Supplemental Health Care Program Funds to Pay for Required Physical Examinations for Members on the Temporary Disability Retirement List. There will not be a cost-share, copayment, or deductible applied to these claims. These are SHCP claims. SHCP funds will only be applied to the exam. SHCP funds shall not be used to treat the condition which caused Service member to be placed on the TDRL or for conditions discovered during the exam.

3.9 Claims from Service members enrolled in the FRCP shall be processed without application of a cost-share, copayment, or deductible. These are SHCP claims.

4.0 MEDICAL RECORDS

The current contract requirements for medical records shall also apply to Service members in this program, with the additional requirement that Service members must also be given copies directly. Narrative summaries and other documentation of care rendered (including laboratory reports and X-rays) shall be given to the Service member for delivery to his/her PCM and inclusion in his/her military health record. The contractor shall be responsible for all administrative/copying costs. Under no circumstances will the Service member be charged for this documentation. Network providers shall be reimbursed for medical records photocopying and postage costs incurred at the rates established in their network provider participation agreements. Participating and non-participating providers shall be reimbursed for medical records photocopying and postage costs on the basis of billed charges. Service members who have paid for copied records and applicable postage costs shall be reimbursed for the full amount paid to ensure they have no out-of-pocket expenses. All providers and/or patients must submit a claim form, with the charges clearly identified, to the contractor for reimbursement. Service member's claim forms should be accompanied by a receipt showing the amount paid.

5.0 REIMBURSEMENT

5.1 Allowable amounts are to be determined based upon the TRICARE payment reimbursement methodology applicable to the services reflected on the claim, (e.g., DRGs, mental health per diem, CMAC, Outpatient Prospective Payment System (OPPS), or TRICARE network provider discount). Reimbursement for services not ordinarily covered by TRICARE and/or rendered by a provider who cannot be a TRICARE authorized provider shall be at billed amounts unless a CMAC/DRG exists. Cost-sharing and deductibles shall not be applied to supplemental health care claims.

5.2 Claims with codes on the TRICARE inpatient only list performed in an outpatient setting will be denied, except in those situations where the beneficiary dies in an emergency room prior to admission. Reference the TRM, Chapter 13, Section 2, paragraph 3.4. Professional providers may submit with modifier **CA**. No bypass authority is authorized for inpatient only procedure editing.

5.3 Pending development and implementation of recently enacted legislative authority to waive CMACs under TRICARE, the following interim procedures shall be followed when necessary to assure adequate availability of health care to Service members under SHCP. If required services are not available from a network or participating provider within the medically appropriate time frame, the contractor shall arrange for care with a non-participating provider subject to the normal reimbursement rules. The contractor initially shall make every effort to obtain the provider's agreement to accept, as payment in full, a rate within the 100% of CMAC limitation. If this is not feasible, the contractor shall make every effort to obtain the provider's agreement to accept, as payment in full, a rate between 100% and 115% of CMAC. If the latter is not feasible, the contractor shall determine the lowest acceptable rate that the provider will accept and communicate the same to the referring MTF/eMSM. A waiver of CMAC limitation must be obtained by the MTF/eMSM from the Director, TROs, as the designee of the Chief Operating Officer (COO), DHA, before patient referral is made to ensure that the patient does not bear any out-of-pocket expense. Upon approval of a CMAC waiver by the Director, TROs, the MTF/eMSM will notify the contractor who shall then conclude rate negotiations, and notify the MTF/eMSM when an agreement with the provider has been reached. The contractor shall ensure that the approved payment is annotated in the authorization/claims processing system, and that

payment is issued directly to the provider, unless there is information presented that the Service member has personally paid the provider. In the case of non-MTF/eMSM referred care, the contractor shall submit the waiver request to the Director, TROs.

5.4 Eligible uniformed Service members and/or referred patients who have been required by the provider to make "up front" payment at the time services are rendered will be required to submit a claim to the contractor with an explanation and proof of such payment. For eligible uniformed Service members, if the claim is payable without SAS review the contractor shall allow the billed amount and reimburse the Service member for charges on the claim. If the claim requires SAS review the contractor shall pend the claim to the SAS for determination. If the SAS authorizes the care the contractor shall allow the billed amount and reimburse the Service member for charges on the claim.

- Supplemental health care claims for uniformed Service members and all MTF/eMSM inpatients receiving referred civilian care while remaining in an MTF/eMSM inpatient status shall be promptly reimbursed and the patient shall not be required to bear any out-of-pocket expense. If such payment exceeds normally allowable amounts, the contractor shall allow the billed amount and reimburse the patient for charges on the claim. As a goal, no such claim should remain unpaid after 30 calendar days.

5.5 In no case shall a uniformed Service member be subjected to "balance billing" or ongoing collection action by a civilian provider for referred, emergency or authorized care. If the contractor becomes aware of such situations that they cannot resolve they shall pend the file and forward the issue to the referring MTF/eMSM or SAS, as appropriate, for determination. The referring MTF/eMSM or SAS will issue an authorization to the contractor for payments in excess of CMAC or other applicable TRICARE payment ceilings, provided the referring MTF/eMSM or SAS has requested and has been granted a waiver from the COO, DHA, or designee.

6.0 END OF PROCESSING

6.1 EOB

An EOB shall be prepared for each supplemental health care claim processed, and copies sent to the provider and the patient in accordance with normal claims processing procedures. For all SHCP claims, the EOB will include the statement that this is a supplemental health care claim, not a TRICARE claim. The EOB will also indicate that questions concerning the processing of the claim must be addressed to the contractor or SAS, as appropriate. Any standard TRICARE EOB messages which are applicable to the claim are also to be utilized, e.g., "No authorization on file."

6.2 Appeal Rights

6.2.1 For supplemental health care claims, the appeals process in Chapter 12, applies, as limited herein. If the care is still denied after completion of a review to verify that no miscoding or other clerical error took place and the MTF/eMSM/SAS will not authorize the care in question, then the notification of the denial shall include the following statement: "If you disagree with this decision, please contact **(insert MTF/eMSM name/SAS here)**." TRICARE appeal rights shall pertain to outpatient claims for treatment of TRICARE eligible patients. The SAS will handle only those issues that involve SAS denials of authorization or authorization for reimbursement. The contractor shall handle allowable charge issues, grievances, etc.

6.2.2 If the Service member disagrees with a denial of authorization, rendered by SAS, the first level of appeal will be through the SAS who will coordinate the appeal as appropriate. The Service member may initiate the appeal by contacting his/her SAS. If the SAS upholds the denial, the SAS will notify the Service member of further appeal rights with the appropriate Surgeon General's office. If the denial is overturned at any level, the SAS will notify the contractor and the Service member.

6.2.3 The contractor shall forward all written inquiries and correspondence related to the SAS or MTF/eMSM denials of authorization or authorization for reimbursement to the appropriate SAS or MTF/eMSM. The contractor shall refer telephonic inquiries related to SAS denials to the appropriate SAS or MTF/eMSM.

7.0 TRICARE ENCOUNTER DATA (TED) SUBMITTAL

The TED for each claim must reflect the appropriate data element values. The appropriate codes published in the TSM are to be used for supplemental health care claims.

8.0 CONTRACTOR'S RESPONSIBILITY TO RESPOND TO INQUIRIES

8.1 Telephonic Inquiries

Inquiries relating to the SHCP need not be tracked nor reported separately from other inquiries received by the contractor. Most SHCP inquiries to the contractor should come from MTFs/eMSMs/claims offices, the Service Project Officers, DHA, or the SAS. In some instances, inquiries may also come from Congressional offices, patients, or providers. To facilitate responsiveness to SHCP inquiries, the contractor shall provide MTFs/eMSMs/claims offices, the Service Project Officers, DHA, and the SAS a specific telephone number, different from the public toll-free number, for inquiries related to the SHCP Claims Program. The line shall be operational and continuously staffed according to the hours and schedule specified in the contract for toll-free and other service phone lines. It may be the same line as required in support of TPR under Chapter 16. The telephone response standards of Chapter 1, Section 3, shall apply to SHCP telephonic inquiries.

8.1.1 Congressional Telephonic Inquiries

The contractor shall refer any Congressional telephonic inquiries to the referring MTF/eMSM or the SAS, as appropriate, if the inquiry is related to the authorization or non-authorization of a specific claim or episode of treatment. If it is a general Congressional inquiry regarding the SHCP claims program, the contractor shall respond or refer the caller as appropriate.

8.1.2 Provider And Other Telephonic Inquiries

The contractor shall refer any other telephonic inquiries it receives, including calls from the provider, Service member or the MTF/eMSM patient, to the referring MTF/eMSM or the SAS, as appropriate, if the inquiry pertains to the authorization or non-authorization of a specific claim. The contractor shall respond as appropriate to general inquiries regarding the SHCP.

8.2 Written Inquiries

8.2.1 Congressional Written Inquiries

For MTF/eMSM-referred care, the contractor shall refer written Congressional inquiries to the Service Project Officer of the referring MTF's/eMSM's branch of service if the inquiry is related to the authorization or non-authorization of a specific claim. For non-MTF/eMSM referred care, the inquiry shall be referred to the SAS. When referring the inquiry, the contractor shall attach a copy of all supporting documentation related to the inquiry. If it is a general Congressional inquiry regarding the SHCP, the contractor shall refer the inquiry to the Director, DHA. The contractor shall refer all Congressional written inquiries within 72 hours of identifying the inquiry as relating to the SHCP. When referring the inquiry, the contractor shall also send a letter to the Congressional office informing them of the action taken and providing them with the name, address and telephone number of the individual or entity to which the Congressional correspondence was transferred.

8.2.2 Provider And Service Member (Or MTF/eMSM Patient) Written Inquiries

The contractor shall refer provider and Service member or MTF/eMSM patient written inquiries to the referring MTF/eMSM or the SAS, as appropriate, if the inquiry pertains to the authorization or non-authorization of a specific claim. The contractor shall respond as appropriate to general written inquiries regarding the SHCP.

8.2.3 MTF/eMSM Written Inquiries

8.2.3.1 The contractor shall provide a final written response to all written inquiries from the MTF/eMSM within 10 work days of the receipt of the inquiry, or if appropriate, refer the inquiry to the SAS upon receipt of the inquiry.

8.2.3.2 The Government intends to take action on all referrals to the SAS as quickly as possible. To support this objective, the SAS must be kept apprised of those claims by telephone, e-mail or fax on which the contractor cannot take further action until the SAS has completed its reviews and approvals.

- END -

Chapter 18

Demonstrations And Pilot Projects

Revision: C-2, May 17, 2017

Chapter 18 Section 2

Reserved

Revision: C-2, May 17, 2017

- END -

4.2.2 Addition Of Family Members to TRS Member and Family Coverage

TRS members/survivors may request to add eligible family members to an existing TRS member and family coverage plan at any time, once eligibility for the family is established. Eligibility is established by going to a military personnel office with RAPIDS capability to appropriately update DEERS. The effective date of coverage for the added family member(s) shall follow procedures specified in paragraphs 4.1.2 or 4.1.3. The TRS request must be either received by the contractor/TOP contractor or postmarked no later than 60 days after that date.

4.2.3 TRS Newborn/New Child Policy

4.2.3.1 A newborn/new child will be covered from the date of birth/custody only if, (a) the TRS member registers the newborn/new child in DEERS within 60 days of birth/custody, and (b) the TRS request is either received by the contractor/TOP contractor or postmarked no later than 60 days after the date of birth/custody. The contractor shall handle claims associated with the newborn/new child as specified in paragraph 6.2.

4.2.3.2 TRS members who reside overseas may have difficulty in obtaining the documentation required to register a newborn/new child in DEERS. As with all other late submissions of enrollment requests, the TRS member may submit a request for reconsideration to the appropriate Director, TRICARE Regional Offices (TROs), the TRICARE Area Office (TAO) Director, or their designee, consistent with paragraph 4.5.1.

4.3 Processing

4.3.1 The contractor shall process all TRS transactions through the Government furnished web-based system/application for members or survivors with a DEERS residential address in the contractor's region. The contractor shall process TRS requests received along with the initial premium payment (see paragraph 4.1) no later than 10 calendar days after receipt.

4.3.2 If the contractor is unable to enroll the member/survivor in the Government furnished web-based system/application due to (a) a 90-day future enrollment limitation; (b) DEERS not reflecting eligibility; (c) the application being incomplete; (d) a missing initial premium payment; or (e) the initial premium payment not being in the correct amount.

4.3.3 The contractor shall return a copy of the original application and any incorrect premium payments to the member, within 10 business days, with an explanation of what is needed for the contractor to accept the application for processing.

4.4 Suspension of TRS Coverage

The contractor shall initiate return of any excess premium amounts paid prorated to the day as indicated no later than 10 business days after the effective date of the suspension or after receipt of a Policy Notification Transaction (PNT) notifying the contractor of a suspension, whichever is later. The contractor shall also update DEERS with any premium amount refunded within 30 calendar days. The contractor shall include an explanation for the premium refund.

4.4.1 Loss of TRS Eligibility

The effective date of suspension for a member covered under TRS shall be the effective date of the loss of their qualification for TRS coverage. The contractor shall place the TRS member, their family members, and/or survivors in a suspended status from the last paid-through date by "applying a lockout" in the Government furnished web-based system/application. While the Government furnished web-based system/application will apply a "lockout" status, the TRS member, family members, and/or survivors are considered to be in a "suspended" status, subject to reinstatement in certain circumstances, for the period of 12 months from the last paid-through date and will not incur a lockout when coverage is terminated due to a loss of TRS eligibility (i.e., member no longer qualifies to purchase TRS due to status change of Active Duty or FEHBP).

4.4.1.1 Sponsor Loss of Eligibility

When a sponsor's eligibility is terminated at a date other than the anticipated end date, DEERS will send the contractor an unsolicited PNT advising the contractor of the suspended coverage. If a sponsor's eligibility is restored within 90 days from loss of eligibility, DEERS will automatically reinstate the TRS coverage previously in effect and send an unsolicited PNT to the appropriate contractor notifying them of the reinstated TRS coverage. Upon notification of the reinstated TRS coverage, the contractor shall contact the sponsor within 10 business days from receipt of unsolicited PNT and collect all required premiums owed through the current month (see paragraphs 5.2.2 through 5.2.4). When a sponsor's eligibility is terminated at the anticipated end date, DEERS will not send the contractor an unsolicited PNT advising the contractor of the suspended coverage. The contractor shall suspend coverage for the sponsor as appropriate (see paragraph 4.4.1).

4.4.1.2 Individual Family Member or Survivor Loss of Eligibility

In the case of a family member or survivor losing eligibility at a date other than an anticipated end date, DEERS will send the contractor an unsolicited PNT advising the contractor to suspend coverage for that individual. When an individual family member's or survivor's eligibility is terminated at the anticipated end date, DEERS will not send the contractor an unsolicited PNT advising the contractor of the suspended coverage. The contractor shall suspend coverage for the family member(s) or survivor(s) as appropriate (see paragraph 4.4.1).

4.4.1.3 Sponsor Involuntarily Removed

When a Selected Reserve member's service has recorded in DEERS that the member is being involuntarily removed from the Selected Reserve under other than adverse conditions, and the member was covered by TRS on the last day of his or her Selected Reserve membership, DEERS will terminate TRS coverage 180 days after the date on which the member is removed from the Selected Reserve. DEERS will send the contractor an unsolicited PNT advising the contractor of the adjusted anticipated end date. The contractor shall continue to collect monthly premiums until the adjusted anticipated end date (see paragraph 5.2) unless the coverage is otherwise suspended/terminated earlier. This extended TRS coverage provision expires December 31, 2018.

4.4.2 Member or Survivor Gains Other TRICARE Coverage

No lockout shall be applied for suspension due to the gain of other TRICARE coverage.

4.4.2.1 If a TRS member gains other TRICARE coverage for a period of 30 days or less, TRS coverage will continue unchanged.

4.4.2.2 If a TRS member or survivor gains other TRICARE coverage for a period of more than 30 days, DEERS will suspend TRS coverage in accordance with paragraph 4.4.1.1. The contractor must be aware of the fact that DEERS may reflect Service member and ADFM TRICARE coverage before the member actually reports for active duty.

4.4.2.3 If a TRS member gains other TRICARE coverage via a family member, the member and family members may suspend coverage under TRS without incurring a lockout.

4.4.3 Failure to Make Payment

4.4.3.1 Failure to pay monthly premiums in accordance with the procedures in this chapter shall result in suspension of coverage. The effective date of suspension is the first day following the paid-through date. The contractor shall automatically suspend coverage of the TRS member, all covered family members and survivors, if the monthly premium payment is not received by the last day of the month of coverage. After the last day of the month, the contractor shall suspend coverage up to 12 months from the last paid-through date. DMDC will provide written notification to the TRS member or survivor of the suspension along with the reason, noting the suspension may become a retroactive termination and 12 month lockout from the last paid-through date. During a suspension, the contractor may pend any claims received for health care furnished to the TRS member, family members, and/or survivors during the period for which premiums have yet to be paid, to avoid creating recoupment of health care costs for ineligible beneficiaries. The TRS member, family members, and/or survivors will be responsible for the cost of any health care received after the termination date following retroactive termination of coverage. If claims are not pended, the contractor shall initiate recoupment of health care costs following the procedures in Chapter 11, Section 3.

4.4.3.2 Upon failure of a TRS member or survivor to pay monthly premiums in accordance with paragraph 4.4.3, a contractor shall place the TRS member, family members, and/or survivors in a suspended status for a period of 12 months from the last paid-through date by "applying a lockout" in the Government furnished web-based system/application. The DMDC written notification of suspension (see paragraph 4.4.3.1) includes notice that the suspended coverage shall be considered to become terminated coverage retroactive to the last paid-through date.

4.4.4 Member/Survivor Request for Voluntary Suspension

A contractor shall place the TRS member, family members, and/or survivors in a suspended status for a period of 12 months from the last paid-through date by "applying a lockout" in the Government furnished web-based system/application. While the Government furnished web-based system/application will apply a "lockout" status, the TRS member, family members, and/or survivors are considered to be in a "suspended" status, subject to reinstatement in certain circumstances, for the period of 12 months from the last paid-through date. When the 12 month suspension expires, the suspended coverage shall be considered to become terminated coverage retroactive to the last paid-through date.

4.4.4.1 Suspension of Existing Plan(s)

The contractor shall accept requests for suspension of coverage from TRS members or

survivors at any time. The effective date of suspension is either (a) the last day of the month in which the request was postmarked or received by the contractor/TOP contractor or (b) the last day of a future month as specified in the request given that the request was postmarked or received by the contractor/TOP contractor in the month preceding the requested month of suspension. The contractor shall place the TRS member, family members and/or survivors in a suspended status for a period of 12 months from the terminations last paid-through-date by "applying a lockout" in the Government furnished web-based system/application. The DMDC written notification of the suspension (see paragraph 4.4.3.1) includes notice that the suspended coverage shall be considered to become terminated coverage retroactive to the last paid-through date.

4.4.4.2 Suspension of an Individual's Coverage

The contractor shall accept requests for suspension of coverage from individual family members of TRS members or survivors at any time. The effective date of suspension is either (a) the last day of the month in which the request was postmarked or received by the contractor/TOP contractor or (b) the last day of a future month as specified in the request, if the request was postmarked or received by the contractor/TOP contractor in the month preceding the requested month of suspension. The contractor shall apply a suspension to individual family members or survivors whose TRS coverage was suspended upon request for a period of 12 months from the effective date of suspension initiated by the TRS member or survivor. The DMDC written notification of the suspension (see paragraph 4.4.3.1) includes notice that the suspended coverage shall be considered to become terminated coverage retroactive to the last paid-through date.

4.4.4.3 Cancelled Eligibility and Enrollment

When the contractor receives a PNT for a cancelled enrollment, the contractor will generate a letter notifying the covered member of the cancellation and refund any unused portion of the premium payment. The contractor shall update DEERS with any premium amount refunded within 30 calendar days. No lockout shall be applied for a cancelled enrollment. The contractor shall include an explanation for the premium refund.

4.4.5 TRS Survivor Coverage Suspension

If TRS coverage is continued as described in paragraph 4.1.4.1 and the survivors do not wish to keep the coverage, the survivors must submit a request in writing, in accordance with procedures described in paragraph 4.1.4.1, to be received by the contractor no later than 60 days after the date of death in order to suspend coverage retroactive to the day after the member's death. Alternatively, the survivor may request to suspend coverage in accordance with paragraph 4.4.4. Otherwise, DEERS will terminate TRS survivor coverage six months after the date of the member's death. Refunds of premiums will be handled as specified in paragraph 4.4.

4.5 Exceptions

4.5.1 Reconsiderations of Member's and Survivor's Request to Enroll

The contractor shall advise TRS members/survivors that all reconsideration requests for a refusal of a late submission of a request to enroll shall be submitted to the appropriate Director, TRO, the TAO Director, or their designee, for determination. The Director, TRO, the TAO Director, or their designee will issue decisions for all reconsideration requests. If changes are to be made to a member's/

survivor's coverage as a result of a reconsideration determination, the Director, TRO, the TAO Director, or their designee will send instructions to the contractor. The contractor shall carry out such instructions no later than 10 calendar days after receipt from the Director, TRO or the TAO Director, or their designee. Additionally, the Director, TRO, the TAO Director, or their designee may extend the TRS enrollment period for a newborn/adopted child up to 120 days, on a case-by-case or regional basis.

4.5.2 Administrative Issues Regarding Requests to Enroll

The TRO, the TAO, or their designee will notify the contractor when the Government determines that an administrative situation occurred that prevented a member's or survivor's request to enroll from being accepted for processing according to submission deadlines specified in this section.

4.5.3 Lifting Suspension of TRS Coverage

The contractor shall lift suspension of TRS coverage before 12 months has elapsed from the paid-through date as specified below. If a suspension is not lifted by 12 months from the paid-through date, the termination and lock out become final for the time period ending 12 months from the paid-through date.

4.5.3.1 Reinstatement of Suspended TRS Coverage (Retroactive Coverage)

4.5.3.1.1 While a 12 month suspension is in force, a TRS member/survivor may submit a request to the contractor to retroactively reinstate TRS coverage with no justification needed. The contractor shall lift the suspension and process the appropriate transaction to reinstate coverage effective the first day after the last paid-through date if the request meets all of the following conditions:

- The request is received by the contractor or postmarked no later than the first business day of the fourth month after the paid-through date;
- Payment of all premiums from the last paid-through date through the current month, plus the amount for the following two months is included (to include any administrative fees); and
- Information is provided to establish recurring electronic premium payments as specified in paragraph 5.2.2.

4.5.3.1.2 The contractor shall reject the request to reinstate coverage retroactively if any of the conditions above are not met and inform the member/survivor of their option to purchase new coverage specified under paragraph 4.5.3.2. The contractor shall issue a response to the member/survivor within 10 calendar days of receipt for all reinstatement requests. The response is either a rejection of the request with reason specified or notification that the TRS coverage has been reinstated retroactively.

4.5.3.2 Reinstatement of Suspended TRS Coverage (No Retroactive Coverage)

4.5.3.2.1 While a 12 month suspension is in force, a TRS member/survivor may submit a request to the contractor for new TRS coverage with no justification needed. The contractor shall lift the suspension and process the appropriate transaction for new TRS coverage effective the first day of the

following month the request is received, with no new application (DD Form 2896-1) required if the request meets all of the following conditions:

- The request is received by the contractor or postmarked after the first business day of the fourth month (but less than one year) after the paid-through date;
- Payment of two months of the appropriate premium payment in full is included (to include any administrative fees); and
- Information is provided to establish recurring electronic premium payments as specified in paragraph 5.2.2.

4.5.3.2.2 The contractor shall reject the request for new coverage if any of the conditions above are not met. The contractor shall issue a response to the member/survivor within 10 calendar days of receipt for all new coverage requests. The response is either a rejection of the request with reason specified or notification that new TRS coverage has been established.

5.0 PREMIUM COLLECTION

The contractor shall perform all premium collection functions required for TRS. Service members or survivors are responsible for all premium payments for the type of coverage elected (i.e., TRS member-only or TRS member and family). After enrollment, only monthly premium payments are permitted. Premium related transactions shall be reported through the enrollment fee payment interface or Catastrophic Cap and Deductible (CC&D) Fee Web (see the TSM, Chapter 3, Section 4.2).

5.1 Jurisdiction for Premium Collection

5.1.1 The particular contractor servicing the residential address for the TRS member or survivor shall perform premium collection functions for the TRS member or survivor. The contractor shall identify the financially responsible individual for survivor plans from the survivors actually covered by TRS in descending order of precedence:

- Spouse.
- Oldest Enrolled Child (or Legal Guardian as applicable).

5.1.2 Any time the servicing contractor notices that a new residential address is in the servicing area of another TRICARE contractor, the losing contractor shall notify the TRS member or survivor within 10 calendar days that they need to contact the servicing contractor in their new area to transfer their coverage to the new area. A TRS member or survivor may elect to provide an alternate mailing address, but the servicing contractor shall be based on the TRS member's or financially responsible survivor's residential, not alternate mailing address. Any TRS member/financially responsible survivor may transfer regions at any time. The gaining contractor shall perform the premium collections for future payments.

5.1.3 All unsolicited PNTs for TRS members or survivors will be evaluated to determine if residential address changes require a notification to the TRS member or survivor (see paragraph 5.1.2).

5.2 Premium Collection Processes

5.2.1 The contractor shall credit the TRS member or survivor for premium payments received. In the case of a start date of coverage at any time other than the first of a month, the first payment collected by the contractor shall include the prorated amount on a daily basis necessary to synchronize billing to the last day of the month. The daily prorated amount shall be equal to 1/30th of the appropriate premium (rounded to the penny) regardless of how many days are actually in the month. DEERS will automatically prorate the premium due for mid-month enrollments from the effective date of coverage to the end of that first enrollment month, e.g., from the 18th of the month to the 31st.

5.2.2 The contractor shall collect monthly premium payments from TRS members or survivors as appropriate and shall report the premium amount paid for those payments to DEERS (see the TSM, Chapter 3), including any overpayments that are not refunded to the TRS member or survivor. In the event that there are insufficient funds to process a premium payment, the contractor may assess the account holder a fee of up to 20 U.S. dollars ($20.00) which is retained by the contractor. The contractor shall provide commercial payment methods for TRS premiums that best meet the needs of beneficiaries while conforming to paragraphs 5.2.3 through 5.2.8.

5.2.3 Monthly premiums must be paid-through an automated, recurring electronic payment through Electronic Funds Transfer (EFT) or Recurring Credit/Debit Card (RCC) (i.e., Visa/MasterCard) from a designated financial institution. These are the only acceptable payment methods for the recurring monthly premiums. An EFT payment or a RCC payment shall be processed within the first five business days of the month of coverage. The contractor shall advise TRS members or survivors at the time of EFT/RCC election that an insufficient funds fee of up to $20 U.S. may be assessed, if sufficient funds are not available.

5.2.4 TRS members or survivors must make the required initial payment (as specified in paragraph 4.1) at the time the TRS application is submitted to allow time for the EFT/RCC to be established for subsequent monthly premium payments.

5.2.5 The contractor shall establish recurring monthly EFTs/RCCs and is responsible for obtaining and verifying the information necessary to do so.

5.2.6 The contractor shall initiate action to modify EFT/RCC payment amounts to support premium changes.

5.2.7 When an administrative issue arises that stops or prevents an automated monthly payment from being received by the contractor (e.g., incorrect or transposed number provided by the beneficiary, credit card expired, bank account closed, etc.), the contractor shall grant the TRS member or survivor 30 days after the paid-through date to provide information for a new automated monthly payment method. The contractor may accept payment in accordance with paragraph 4.1 during this 30 day period in order to preserve the TRS member's or survivor's enrollment status.

5.2.8 The contractor shall directly bill the TRS member or survivor only when a problem occurs in setting up or maintaining the EFT or RCC payment; to include a fee of up to $20 U.S. due to insufficient funds. Bills may be sent to the residential or alternate mailing address designated by the TRS member or survivor. All bills shall specify that the premium payment is due for receipt by the contractor no later than the last business day of the month. Premium payments shall be made payable to the contractor servicing the member's or survivor's coverage as specified in paragraph 5.1. The contractor shall

terminate billing once the problem with EFT/RCC payment is resolved.

5.3 Annual Premium Adjustment

5.3.1 Contractors shall notify current TRS members or survivors in writing of any annual premium adjustments no later than 30 days after the contractors receive notification of the updated premiums.

5.3.2 For premium adjustments that go into effect at any time other than January the first, the Government will provide instructions about notification of TRS members or survivors.

5.4 Premium Adjustments from Changes Associated with QLEs

5.4.1 When a QLE is processed that changes the premium, the effective date of the premium change shall be the date of the QLE.

5.4.2 If the change from a QLE results in an increase in the premium, the contractor shall notify the TRS member or survivor of the increase and adjust the next premium amount due, to include any underpaid amount (prorated to the day as specified in paragraph 5.2), to the effective date of the change.

5.4.3 If the change from a QLE results in a decrease in the premium, the contractor shall retain any overpaid amount and apply it to subsequent electronic payments until all of the overpayment is exhausted.

5.5 Suspensions/Terminations

The contractor shall initiate the process to refund any premium amounts applied for coverage after the date of suspension/termination as specified in paragraph 4.4.

5.6 Online Transactions

In addition to requirements specified in paragraph 5.0 and its subordinate paragraphs, the contractor may provide on-line capability for TRS members or survivors to conduct business related to premium collection and other applicable administrative services through secure access to the contractor's web site.

6.0 CLAIMS PROCESSING

6.1 The contractor shall process TRS claims under established TRICARE Standard and TRICARE Extra ADFM cost-sharing rules and guidance. Normal TRICARE Other Health Insurance (OHI) processing rules apply to TRS.

6.2 The contractor shall pend all claims for health care provided to a newborn/new child of a TRS member until the member completes the process specified in paragraph 4.2.3.1. If the contractor becomes aware that a TRS member has an unregistered newborn/new child, the contractor shall notify the TRS member of the requirement to register the newborn/new child in DEERS and submit a TRS request form for the newborn/new child no later than 60 days after birth/custody. When the member completes the process specified in paragraph 4.2.3.1, the contractor shall process any claims associated with the newborn/new child's health care. If the member fails to complete the process as specified in

paragraph 4.2.3.1, the contractor shall deny any claims associated with the newborn/new child's health care.

6.3 Premium payments made for TRS coverage shall not be applied to the fiscal year deductible or catastrophic cap limit.

6.4 Medicare is the primary payer for TRICARE beneficiaries who are eligible for Medicare. Claims under the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) will be adjudicated under the rules set forth in the TRICARE Reimbursement Manual (TRM), Chapter 4, Section 4. The contractors shall follow procedures established in Chapter 8, Section 2, regarding claims jurisdiction for dual eligibles.

6.5 If the contractor receives a PNT notifying them of a retroactive TRS disenrollment the contractor shall initiate recoupment of claims paid, if appropriate, as specified in Chapter 10.

6.6 If at any time the contractor discovers that the Selected Reserve member may be eligible for or enrolled in the FEHBP, the contractor shall report the discovery to the appropriate TRO, or the TAO, or their designee no later than one business day after discovery. As applicable, the contractor shall follow paragraph 4.4.1 and its subordinate paragraphs for loss of TRS qualification.

7.0 BENEFICIARY EDUCATION AND SUPPORT (BE&S)

In addition to BE&S functions specified throughout this chapter, the contractor shall perform BE&S functions to the same extent as they do for TRICARE Standard and TRICARE Extra.

7.1 Customer Education

The contractor shall distribute information materials relevant to TRS as specified in Chapter 2, Section 5, paragraph 4.0 and Chapter 11, Section 1, paragraph 4.0. Upon start of coverage under TRS, the DMDC-generated enrollment notification will include information on how purchasers can obtain TRS-specific and other TRICARE plan materials over the Internet.

7.2 Customer Service

The contractor shall provide all customer service support in a manner equivalent to that provided TRICARE Standard beneficiaries. When the contractor receives an inquiry involving TRS qualifications, the contractor shall refer the individual to the appropriate RC.

8.0 PAYMENTS FOR CONTRACTOR SERVICES RENDERED

8.1 Claims Reporting

The contractor shall report TRS program claims according to Chapter 3. The contractor shall process payments on a non-financially underwritten basis for the health care costs incurred for each TRS claim processed to completion according to the provisions of Chapter 3.

8.2 Fiduciary Responsibilities

8.2.1 The contractor shall act as a fiduciary for all funds acquired from TRS premium collections, which are Government property. The contractor shall develop strict funds control processes for its

collection, retention and transfer of premium funds to the Government. All premium collections received by the contractor shall be maintained in accordance with these procedures.

8.2.2 Either a separate non-interest bearing account shall be established for the collection and disbursement of TRS premiums or the account used for TRICARE Retired Reserve (TRR) premium collections, when established, shall be used for TRS premiums as well. The contractor shall deposit premium collections to the established account within one business day of receipt.

8.2.3 The contractor shall wire-transfer the premium collections and net of refund payments monthly to a specified Government account as directed by the Defense Health Agency (DHA) Contract Resource Management (CRM) Office. The Government will provide the contractor with information for this Government account. The contractor shall notify the DHA CRM, by e-mail, within one business day of the deposit specifying, the date and amount of the deposit, as well as its purpose (i.e., TRS premiums). Premiums for TRS and TRR, when established, may be sent as a single wire as long as CRM is notified of the amounts of each type of premium. Collections for delinquency cases that have been transferred to DHA Office of General Counsel (OGC) shall be wire-transferred separately. The contractor shall notify DHA CRM F&AO and DHA OGC by e-mail within one business day of the day of deposit, specifying the sponsor name, sponsor Social Security Number (SSN) (last four digits), payment amount, payment date, date case was transferred to DHA OGC and the date and amount of the deposit.

8.2.4 The contractor shall maintain a system for tracking and reporting premium billings, collections, and starts of coverage. The system is subject to Government review and approval.

9.0 DELINQUENT PREMIUMS

9.1 The contractor shall no longer collect delinquent premiums with two exceptions:

- Contractors shall continue to collect delinquent premiums in cases in which TRS members and/or family members have entered into installment payment agreements.

- Contractors shall continue to collect delinquent premiums in cases in which TRS members and/or family members received health care services during the grace period.

9.2 The contractor shall be responsible for coordinating with DEERS to ensure coverage dates for all TRS members and/or family members are correct. The coverage dates in DEERS will not be changed for those members and/or family members who have entered into installment payment agreements or for cases in which TRS members and/or family members obtained medical services during the grace period. OGC will provide the premium paid-through dates to the contractor for cases for which the premiums were not collected by OGC so that DEERS can be updated accordingly.

- END -

Chapter 23 Section 1

General

Revision: C-2, May 17, 2017

1.0 GENERAL

1.1 The TRICARE Pharmacy (TPharm) Benefits Program offers worldwide services through:

- Direct Care (DC) pharmacies located at Military Treatment Facilities (MTFs)/Enhanced Multi-Service Markets (eMSMs);
- Retail network pharmacies;
- A Mail Order Pharmacy (MOP) program including specialty pharmacy services; and
- Retail non-network pharmacies.

1.2 The requirements/guidelines in this chapter apply only to the TPharm contractor.

2.0 ELIGIBILITY

2.1 The TPharm Benefits Program is available to all TRICARE eligible beneficiaries, including Uniformed Service members, TRICARE Prime Remote (TPR) enrollees, TRICARE Dual Eligibles, and TRICARE Reserve Select (TRS) members. Eligible beneficiaries need not enroll in order to use the pharmacy program. The contractor shall use the Defense Enrollment Eligibility Reporting System (DEERS) to verify TRICARE eligibility prior to dispensing pharmaceuticals (or paying any claim) for all beneficiaries.

2.2 Foreign Force Members (FFMs) and their dependents from countries that are party to a North Atlantic Treaty Organization (NATO), Status of Forces Agreement (SOFA), or Partnership For Peace (PFP) SOFA may be eligible to receive pharmaceuticals or Durable Medical Equipment (DME) dispensed through retail pharmacies. If eligible, coverage will be subject to the same rules regarding adjudication and payment as applicable to U.S. active duty members and dependents of active duty members using the TRICARE Standard/CHAMPUS program. Refer to http://tricare.mil/CoveredServices/Pharmacy/Eligibility.aspx for information on potential coverage.

2.3 Guard or Service members who are injured or become ill while serving on active duty or performing official drills with their unit may be eligible for continued care/treatment associated with the specific episode of care once their active duty or drill status has terminated. Documentation from Specified Authorization Staff (SAS) will serve as proof of eligibility and pharmaceutical claims will be processed for reimbursement. SAS, per Chapter 17, Section 2, paragraph 1.2, has authority to approve claims for drugs not covered under standard benefit guidelines.

3.0 PERFORMANCE/PROCESSING STANDARDS

Performance standards for the TPharm Benefits Program are located in Section C of the TPharm contract. Additionally, the contractor shall comply with the TRICARE Encounter Data (TED) timeliness and TED accuracy standards included in Chapter 1, Section 3.

4.0 SPECIALTY PHARMACEUTICALS

Specialty pharmaceuticals may be obtained at retail or mail order. Some specialty pharmaceuticals are eligible for specialty care services at mail order. Pharmaceuticals eligible for specialty care services under the pharmacy contract are listed http://health.mil/SpecialtyDrugList.

- END -

catastrophic cap has not been met, the contractor shall apply and collect the appropriate copayment amount (or portion thereof if application of the full copayment amount would result in the catastrophic cap total being exceeded). After a copayment has been collected, the contractor must submit a transaction to update the catastrophic cap amount on DEERS. If during this update, CCDD file shows that the cap is now met (due to an intervening transaction that occurred from the time between the initial eligibility inquiry and the update transaction), the following actions will be taken. The contractor will proceed with the update transaction and apply the copayment amount to the CCDD file catastrophic cap totals (which will result in the cap being exceeded). The contractor shall initiate a refund of the copayment amount (or appropriate portion thereof which exceeds the cap amount) to the beneficiary. Once the refund has been sent, the contractor will adjust (i.e., correct) the CCDD file totals to reflect the refunded copayment amount. This correction action should result in the CCDD file total reflecting that the cap has been met, but not exceeded. (If a TED record has been previously submitted, it will be necessary to submit an adjustment to the TED to correct the copayment amount.)

3.2 Continued Health Care Benefits Program (CHCBP) CC&D

CHCBP CC&D totals are maintained by the CHCBP contractor. The CHCBP contractor and pharmacy contractor will develop an automated exchange process at least once a month for sharing current CHCBP CC&D totals. This automated process allows both the CHCBP contractor and pharmacy contractor to reimburse beneficiaries for any overpayments after the date the CHCBP catastrophic cap or deductible is met and to prevent future overpayments from occurring during that fiscal year. The corrections should be completed prior to next automated file exchange. If the CHCBP CC&D totals change and the result is underpayments, the contractors will also be responsible for recoupments.

4.0 MEDICAL NECESSITY AND PRIOR AUTHORIZATION

4.1 Medical Necessity Reviews

When a drug is designated as non-formulary, the contractor shall check to see if a medical necessity determination for the non-formulary drug has previously been completed for a Direct Care (DC) dispensing. If a medical necessity determination has not previously been completed, the contractor shall apply the non-formulary copayment to the dispensed prescription. At the request of the beneficiary or provider, the contractor shall conduct a medical necessity review using Government-provided review criteria. If the contractor establishes medical necessity, the prescription shall be dispensed with the formulary copayment amount applied.

4.1.1 The contractor will be given at least a 30-day notice before a drug is moved to a non-formulary status. Non-formulary drugs, medical necessity forms, and review criteria can be found at http://www.tricare.mil/CoveredServices/Pharmacy/Drugs/NonFormulary.

4.1.2 In general, in order to establish medical necessity for a pharmaceutical agent designated non-formulary under the Uniform Formulary Rule, one or more of the following criteria must be met for ALL of the available formulary alternatives:

4.1.2.1 The use of the formulary alternative is contraindicated;

4.1.2.2 The patient experiences, or is likely to experience, significant adverse effects from the formulary alternative, and the patient is reasonably expected to tolerate the non-formulary medication;

4.1.2.3 The formulary alternative results in therapeutic failure, and the patient is reasonably expected to respond to the non-formulary medication;

4.1.2.4 The patient previously responded to a non-formulary medication, and changing to a formulary alternative would incur unacceptable clinical risk; or

4.1.2.5 There is no formulary alternative.

4.2 Prior Authorizations

Some medications require prior authorization before being dispensed. Medications requiring prior authorization include, but may not be limited to, those established by the Government such as brand name medications with a generic equivalent, medications with age limitations, and medications requiring a quantity limit override. Before a prescription is dispensed, the contractor shall check to see if a prior authorization for the medication in question currently exists. If a valid authorization exists, the contractor shall dispense the prescription. If a prior authorization has previously not been completed, the contractor shall complete a prior authorization review before the prescription can be dispensed. Drugs requiring prior authorization, prior authorization forms, and review criteria can be found at http://www.tricare.mil/CoveredServices/Pharmacy/Drugs/PriorAuth.aspx.

Note: Government review criteria are not available for all circumstances requiring prior authorization. If Government review criteria are not available, the contractor shall develop review criteria for these circumstances. For example, there is no Government-provided review criteria for quantity limit overrides.

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Appropriate Medical Care (Defined in 32 CFR 199.2)

Services that are:

1. 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 U.S.;

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

3. Furnished economically. For the purposes of TRICARE, "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.

Authorization For Care

The determination that requested treatment is medically necessary, delivered in the appropriate setting, a TRICARE benefit, and that the treatment will be cost-shared by the DoD through its TRICARE contract. In managed care environments, this is most often accomplished prior to health care delivery, but can be accomplished concurrently in some circumstances and retroactively in rarer circumstances.

Authorized Provider (Defined in 32 CFR 199.2)

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.

Note: Providers not specifically listed in 32 CFR 199.6 or defined in 32 CFR 199.2 are not considered authorized providers unless they have been included in a TRICARE demonstration program.

Authorized Supplies, Pharmacy

Non-drug items (usually used in conjunction with the administration of a drug) approved by the DoD Pharmacy and Therapeutic (P&T) [Committee] for inclusion in the formulary, and appearing on the formulary web site at http://www.tricare.mil/CoveredServices/Pharmacy/Drugs/OTCDrugsSupplies.aspx.

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 (ADP) Backup System

A separate, off-site ADP 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 (Defined in 32 CFR 199.2)

A provider seeking any payment, other than any payment relating to applicable deductible and cost-sharing amounts, from a beneficiary for TRICARE covered services for any amount in excess of the applicable TRICARE allowable cost or charge.

Basic Program (Defined in 32 CFR 199.2)

The primary medical benefits authorized under Chapter 55 of Title 10, United States Code (USC), and set forth in 32 CFR 199.4.

Benchmark, Drug Price

The Average Wholesale Price (AWP) has long been the drug price benchmark for establishing reimbursement payment terms between payers, Pharmacy Benefit Managers (PBMs), and pharmacies. AWP as a benchmark has been going away. AWP is by no means the only price type available. Listed here, with brief descriptions, are others that are available and may be used by the industry for reimbursement purposes as AWP is being phased out:

- Actual Acquisition Cost (AAC) - Final price paid by the pharmacy after subtraction of all discounts;
- Average Manufacturer Price (AMP) - Manufacturer reported price for Medicaid drug rebate program;
- Average Sales Price (ASP) - Center for Medicare and Medicaid Service (CMS) calculated price for Medicate Part B drugs;
- Estimated Acquisition Cost (EAC) - Estimated cost of the product or the pharmacies' usual and customary charge;
- Federal Upper Limit (FUL) - CMS calculation for the upper amount to be paid in aggregate for multi-source products;
- Maximum Allowable Cost (MAC) - Defined by each payer for multi-source drugs;
- Manufacturer List Price (MLP) - Price listed by the drug company;
- Wholesale Acquisition Cost (WAC) - List price for a drug sold by a manufacturer to wholesaler, not including discounts.

Beneficiary Counseling and Assistance Coordinators (BCACs)

Formerly referred to as Health Benefit Advisors (HBAs), BCACs are individuals located at Uniformed Services medical facilities or on occasion at other locations and assigned the responsibility for providing TRICARE information, information concerning availability of care from the Uniformed Services Direct Care (DC) or Purchased Care Systems, and generally assisting beneficiaries or sponsors. The term also includes "Health Benefits Counselor."

Catastrophic Cap

The National Defense Authorization Act (NDAA) for Fiscal Years (FYs) 1988 and 1989 (Public Law 100-180) amended Title 10, USC, and established catastrophic loss protection for TRICARE beneficiary families on a Government fiscal year basis. The law placed fiscal year limits or catastrophic caps on beneficiary liabilities for deductibles and cost-shares under the TRICARE Basic Program. Specific guidance may be found in the TRM, Chapter 2, Section 2.

Catchment Areas

Geographic areas determined by the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) that are defined by a set of five digit zip codes, usually within an approximate 40 mile radius of military inpatient treatment facility.

Centers of Excellence

See definition for Defense Centers of Excellence (CoE).

Certification and Accreditation (C&A) Process

A process that ensures the trust requirement is met for Information Systems (IS)/networks. Certification is the determination of the appropriate level of protection required for IS/networks. Certification also includes a comprehensive evaluation of the technical and non-technical security features and countermeasures required for each IS/network. Accreditation is the formal approval by the Government to operate the contractor's IS/networks in a particular security mode using a prescribed set of safeguards at an acceptable level of risk. In addition, accreditation allows IS/networks to operate within the given operational environment with stated interconnections; and with appropriate level-of-protection for the specified period. The C&A requirements apply to all DoD IS/networks and contractor IS/networks that access, manage, store, or manipulate electronic IS data. Specific guidance may be found in the TSM, Chapter 1.

Certification For Care

The determination that the provider's request for services (level of care, procedure, etc.) is consistent with pre-established health care criteria. Pre-certification is the process performing a certification for care prior to rendering the care.

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 verified by DHA, or a designated contractor, to meet the provider standards outlined in 32 CFR 199.6, and have been approved to provide services to TRICARE beneficiaries and receive Government payment for services rendered to TRICARE beneficiaries.

CHAMPUS Maximum Allowable Charge (CMAC)

A CMAC is a nationally determined allowable charge level that is adjusted by locality indices and is equal to or greater than the Medicare Fee Scheduled amount.

Civilian Health and Medical Program of the Veterans Administration (CHAMPVA)

A program of medical care for spouses and dependent children of disabled or deceased disabled veterans who meet the eligibility requirements of the Department of Veterans Affairs (DVA).

Civilian Health and Medical Program of the Veterans Administration (CHAMPVA) Center (CVAC)

A component within the DVA, Health Administration Center (HAC) that processes all CHAMPVA claims.

Change Order

A written directive from the DHA Procuring Contracting Officer (PCO) to the contractor directing modifications, within the general scope of the contract, as authorized by the "changes clause" at FAR 52.243-1, Changes--Fixed Price.

Christian Science Nurse (Defined in 32 CFR 199.2)

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 (Defined in 32 CFR 199.2)

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 (Defined in 32 CFR 199.2)

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

Claim

Any request for reimbursement for health care services rendered, 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.

Data Condition (HIPAA Definition)

The circumstances under which a covered entity must use a particular data element or segment as defined by HIPAA of 1996.

Data Content (HIPAA Definition)

All the data elements and code sets inherent to a transaction, and not related to the format of the transaction. Data elements that are related to the format are not data content as defined by HIPAA of 1996.

Data Element (HIPAA Definition)

The smallest named unit of information in a transaction defined by HIPAA of 1996.

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 a TRICARE contract. This includes all claims/encounter data, provider data, authorization, enrollment, and derived data collected in relation to a TRICARE contract.

Data Set (HIPAA Definition)

A semantically meaningful unit of information exchanged between two parties to a transaction as defined by HIPAA of 1996.

Date Of Determination (Appeals)

The date of completion appearing on the reconsideration determination, formal review determination, or hearing final decision.

Days (Defined in 32 CFR 199.2)

Calendar days.

Days Supply (Pharmacy)

The length of time a dispensed quantity of drug should last, based on directions for use with a limit as the First Data Bank recommended maximum daily dose (unless specifically altered by DoD).

Deductible (Defined in 32 CFR 199.2)

Payment by the beneficiary of the first $50 of the CHAMPUS determined allowable costs or charges for covered outpatient services or supplies provided in any one fiscal year; aggregate payment by two or more beneficiaries who submit claims for the first $100.

Note: Deductible application examples:

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 (POS) option, the deductible is $300 for individuals, $600 for a family.

Note: For additional information on deductibles refer to the TRM.

Defense Centers of Excellence (COEs)

CoEs focus on an associated group of clinical conditions and create value by achieving improvement in outcomes through clinical, educational, and research activities.

- CoEs develop pathways of care covering the clinical spectrum from prevention through reintegration or transition.
- Products of pathway of care development include:
  - Guidance regarding structured documentation (electronic health record);
  - Clinical practice guidelines;
  - Process and outcome measures;
  - Educational materials;
  - Innovation and identification of research priorities; and,
  - Strategies for improving access to care.

Defense Enrollment Eligibility Reporting System (DEERS) (Defined in 32 CFR 199.2)

An automated system maintained by the DoD for the purposes of:

1. Enrolling members, former members and their dependents; and

2. Verifying members', former members', and their dependents' eligibility for health care benefits in the direct facilities and for TRICARE.

De-Identified Data

Health information that has been rendered not individually identifiable by removal of specific identifiers, such as, individual or relatives or household members, names, addresses, employers, name or addressee, or geographic subdivisions smaller than a State, and all elements of dates (except year) for dates directly related to an individual, telephone numbers, Social Security Numbers (SSNs), etc., as outlined in HIPAA of 1996.

Demonstration

A study or test project for the purpose of trying 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.

Descriptor (HIPAA Definition)

The text defining a code as defined in HIPAA of 1996.

Designated Record Set

A group of records maintained by or for a covered entity that is:

1. The medical records and billing records about individuals maintained by or for a covered HCP;

2. The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or

3. Used, in whole or in part, by or for the covered entity to make decisions about individuals.

For purposes of this definition, the term record means any item, collection, or grouping of information that includes PHI and is maintained, collected, used, or disseminated by or for a covered entity as described in HIPAA of 1996.

Designated Standard Maintenance Organization (DSMO)

An organization designated by the Secretary of HHS under HIPAA of 1996 §162.910(a).

Diagnosis Related Groups (DRGs) (Defined in 32 CFR 199.2)

A method of dividing 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. See the TRM for more specific information on DRGs.

Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM III) or Fourth Edition (DSM IV)

A classification system of codes for mental illness developed by the American Psychiatric Association (APA).

Direct Data Entry (HIPAA Definition)

The direct entry of data (for example, using dumb terminals or web browsers) that is immediately transmitted into a health plan's computer, as defined in HIPAA of 1996.

Direct Treatment Relationship (HIPAA Definition)

A treatment relationship between an individual and a HCP that is not an indirect treatment relationship as defined under HIPAA of 1996. See also the definition of Indirect Treatment Relationship.

Director, TRICARE Regional Offices (TROs)

An individual responsible for:

1. Overseeing and ensuring there is an integrated health care delivery system for TRICARE beneficiaries in the region; and

2. Oversight of the management/monitoring of the daily administration of the TRICARE contract/ contractor(s) in the region; and

3. Managing the daily activities of the TRO.

Discharge Planning

The development of an individualized discharge health care plan for the patient prior to leaving an institution to follow at home, with the aim of improving patient outcomes, reducing the chance of unplanned readmission to an institution, and containing costs.

Disclosure (HIPAA Definition)

The release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information as defined in HIPAA of 1996.

DoD Information

Information that is provided by the DoD to a non-DoD entity, or that is collected, developed, received, transmitted, used, or stored by a non-DoD entity in support of an official DoD activity, where that information has not been cleared for public release.

Domiciliary Care (Defined in 32 CFR 199.2)

Care provided to a patient in an institution or home-like environment because:

1. Providing support for the ADLs in the home is not available or is unsuitable; or

2. 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. Custodial care and domiciliary care are not covered under the TRICARE Prime, Extra, or Standard programs or the Extended Care Health Option (ECHO).

Donor (Defined in 32 CFR 199.2)

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 (Defined in 32 CFR 199.2)

When a TRICARE beneficiary also is enrolled in another insurance, medical service, or health plan that duplicates all or part of a beneficiary's TRICARE benefits.

Double Coverage Plan (Defined in 32 CFR 199.2)

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 DVA 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 (Infants and Toddlers with Disabilities) of the Individuals With Disabilities Education Act (IDEA).

Dual Compensation (Defined in 32 CFR 199.2)

Federal law (5 USC 5536) prohibits active duty members or civilian employees of the U.S. 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.

Edit Error (TEDs Only)

Errors found on TEDs (initial submissions, resubmissions, and adjustments/cancellation submissions) which result in non-acceptance of the records by DHA. These require correction of the error by the contractor and resubmission of the corrected TED to DHA for acceptance.

Electronic Media (HIPAA Definition)

A mode of transferring/storing information that includes:

1. Electronic storage material on which data may be recorded electronically, including for example devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, or digital memory card.

2. Transmission media used to exchange information already in electronic storage media. Transmission media includes, for example, the Internet (the Extranet leased lines, dial-up lines, private networks, and the physical movement of removable and transportable electronic storage media. Certain transmissions, including paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media if the information being exchanged did not exist in electronic form immediately before the transmission.

Employment Records (Defined in DoD 5400.11-R, DoD Privacy Program)

Any item collection or grouping of information, whatever the storage media (paper, electronic, etc,) about an individual that is maintained by an entity subject to the DoD Privacy Program Regulation including but not limited to an individual's education, financial transactions, medical history, criminal or employment history, and that contains his or her name, or the identifying number, symbol, or other identifying particular assigned to the individual, such as a finger or voice print or a photograph. For more specific information refer to the DoD Privacy Program Regulation.

Enhanced Multi-Service Markets (eMSM)

Concept which integrates health care among the Uniformed Services by providing increased authority including funding allocation, policy, and better maximization of staff skill sets. The concept is employed in geographic areas where at least two medical hospitals or clinics from different Uniformed Services have overlapping service areas. They are considered enhanced because of several factors, including overall size, medical mission, and graduate medical education capacity and because they allow for the movement of workload and workforce between or among the medical treatment facilities.

Enrollment Fees

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

Enrollment Plan

A process established by the contractor to inform beneficiaries of the availability of the TRICARE Prime program, facilitate enrollment in the program, and maintain enrollment records. The contractor process must be approved by the Government.

Enrollment Records

Official documentation of a beneficiary's registration (enrollment) for TRICARE Prime and maintained on the DEERS.

Enrollment Transfer

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

1. Out-Of-Contract Enrollment Transfer. An enrollment transfer between contractors, to include the Continental United States (CONUS) to CONUS, CONUS to Outside of the Continental United States (OCONUS), and OCONUS to CONUS. The term "contractors" also includes Designated Providers (DPs) under the Uniformed Services Family Health Plan (USFHP).

2. Within-Contract Enrollment Transfer. An enrollment transfer within a TRICARE region, which involves a change of address and possibly a change of Primary Care Managers (PCMs), but not a change of contractors.

Entity (Defined in 32 CFR 199.2)

An 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.

Episodes of Care (EOC)

Referrals are normally processed as "Episodes of Care." An EOC is defined as "A treatment period that begins with the initial assessment, follow up interventions and reassessments necessary to provide reasonable medical services related to a specific condition." The episode includes associated lab, radiology, Durable Medical Equipment (DME), and ancillary therapies (Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST)), all of which are subject to the Right of First Refusal (ROFR) process. An episode of care generally involves evaluation and/or treatment of one disease or condition and may allow for specialist to specialist (secondary) referrals. Episodes are generally categorized as "evaluate (only)" or "evaluate and treat."

Exclusion

Services and/or supplies not reimbursable under TRICARE. This includes otherwise covered services and supplies provided to a TRICARE eligible beneficiary by a non-authorized provider/entity or a provider placed on "suspension" by a contractor.

Explanation Of Benefits (EOB)

An electronic or paper document prepared by insurance carriers, health care organizations, and TRICARE contractors to inform beneficiaries of the actions taken with respect to a claim for health care coverage.

Extraordinary Physical Or Psychological Condition

A complex physical or psychological clinical condition of such severity which results in the dependents of a Service member being homebound. See TPM, Chapter 9 for additional information.

Federal Records Center (FRCs)

Locations established and maintained by the General Services Administration (GSA) at areas throughout the U.S. for the storage, processing, and servicing of non-current records for Government agencies.

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 Year (FY)

The Federal Government's 12 month accounting period which currently runs from October 1 through September 30 of the following year.

Format (HIPAA Definition)

Those data elements that provide or control the enveloping or hierarchical structure, or assist in identifying data content of, a transaction, as defined in HIPAA of 1996.

Formulary

A listing of pharmaceuticals and other authorized supplies to be dispensed with appropriate prescriber's order from a particular POS. The formulary for any TRICARE contract will be managed by the DoD Pharmacy and Therapeutics (P&T) Committee with clinical guidance from the DoD Pharmacoeconomic Center (PEC). Applicable formulary information may be viewed on the TRICARE web site at: http://www.health.mil/formulary.

Freedom Of Choice

The right to obtain medical care from any TRICARE-authorized source available, including TRICARE Prime, the DC and/or the MTF/eMSM systems, 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).

Note: 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. DHA and TRICARE contractors are subject to these provisions.

Freestanding (Defined in 32 CFR 199.2)

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

Full Mobilization (DoD Definition)

Expansion of the Active Armed Forces resulting from action by Congress and the President to mobilize all Reserve Component (RC) units and individuals in the existing approved force structure, as well as retired military personnel, and the resources needed for their support to meet the requirements of a war or other national emergency involving an external threat to the national security. Reserve personnel can be placed on active duty for the duration of the emergency plus six months.

Gag Clause

A provision that is included in a professional provider's agreement or contract with a managed care organization; such as a Preferred Provider Organization (PPO) network or a Health Maintenance Organization (HMO) network, or third-party payer that directly or indirectly prevents limits the ability of the HCP from being open with his/her patients about the terms of the patient's coverage and therapeutic treatment options, including, 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.

Good Faith Payments (Defined in 32 CFR 199.2)

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 (HCF), 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.

Group Health Plan (GHP)

An employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income and Security Act of 1974 (ERISA), 29 USC 1002(1)), including insured and self-insured plans, to the extent that the plan provides medical care (as defined in section 2791(a)(2) of the Public Health Service Act (PHS Act), 42 USC 300gg-91(a)(2)), including items and services paid for as medical care, to employees or their dependents directly or through insurance, reimbursement, or otherwise, that:

1. Has 50 or more participants (as defined in section 3(7) of ERISA, 29 USC 1002(7)); or

2. Is administered by an entity other than the employer that established and maintains the plan.

Health Care

The prevention, treatment and management of illness and the preservation of mental and physical well being by qualified medical professionals. This includes but is not limited to, preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and the sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription. As described in HIPAA of 1996.

Health Care Clearinghouse (HIPAA Definition)

A public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches, that does either of the following functions.

1. Processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.

2. Receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity. As defined in HIPAA of 1996.

Health Care Common Procedure Coding System (HCPCS)

Set of health care procedure codes based on the American Medical Association's (AMA's) Current Procedural Terminology (CPT).

Health Care Finder (HCF)

A person who manages and performs the duties necessary to operate an HCF system.

Health Care Finder (HCF) System

A system or mechanism, established by the contractor in each Prime Service Area (PSA) in the region, to facilitate referrals and other customer service functions to assist beneficiaries in accessing health care to the DC system and/or civilian providers.

Health Care Provider (HCP) (HIPAA Definition)

A provider of medical or health services, institutional or individual professional provider, and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business as defined in HIPAA of 1996.

Health Information (HIPAA Definition)

Any information, including genetic information, whether oral or recorded, in any form or medium that:

1. Is created or received by a HCP, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and

2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

As defined in HIPAA of 1996.

Health Insurance Issuer (HIPAA Definition)

An insurance company, insurance service, or insurance organization (including an HMO) that is licensed to engage in the business of insurance in a State and is subject to State Law that regulates insurance. Such term does not include a group health plan.

Health Maintenance Organization (HMO) (HIPAA Definition)

A federally qualified HMO, an organization recognized as an HMO under State law, or a similar organization regulated for solvency under State law in the same manner and to the same extent as such an HMO as defined in HIPAA of 1996.

Health Oversight Agency (HIPAA Definition)

An agency or authority of the U.S., a State, a territory, a political subdivision of a State or territory, or an Indian tribe, or a person or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or persons or

entities to whom it has granted authority, that is authorized by law to oversee the health care system (whether public or private) or Government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which health information is relevant as defined in HIPAA of 1996.

Note: The term "health oversight agency" includes any DoD Component authorized under applicable DoD Regulation to oversee the MHS, including with respect to matters of quality of care, risk management, program integrity, financial management, standards of conduct, or the effectiveness of the MHS in carrying out its mission.

Health Plan (HIPAA Definition)

An individual or group plan that provides or pays the cost of medical care. For a more detailed definition refer to HIPAA of 1996.

HIPAA Breach

An incident that satisfies the definition of a breach in 45 CFR 164.402 (HIPAA Breach Rule).

Homebound (Defined in 32 CFR 199.2)

A beneficiary's condition is such that there exists a normal inability to leave home, and consequently, leaving home would require considerable and taxing effort. Any absence of an individual from the home attributable to the need to receive health care treatment including regular absences for the purpose of participating in rehabilitative, therapeutic, psychosocial, or medical treatment in an adult daycare program that is licensed or certified by a state, or accredited to furnish adult daycare services in the state shall not disqualify an individual from being considered to be confined to home. Any other absence of an individual from the home shall not disqualify an individual if the absence is infrequent or of relatively short duration. For the purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. Also, absences from the home for non-medical purposes, such as an occasional trip to the barber, a walk around the block or a drive, would not necessarily negate the beneficiary's homebound status if the absences are undertaken on an infrequent basis and are of relatively short duration. An exception is made to the above homebound definitional criteria for beneficiaries under the age of 18 and those receiving maternity care. The only homebound criteria for these special beneficiary categories is written certification from a physician attesting to the fact that leaving home would place the beneficiary at medical risk. In addition to the above absences, whether regular or infrequent, from the beneficiary's primary home for the purpose of attending an educational program in a public or private school that is licensed and/or certified by a state, shall not negate the beneficiary's homebound status. See also TPM, Chapter 9 for additional information.

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 (LOS), 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.

Immediate Family (Defined in 32 CFR 199.2)

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 (Defined in 32 CFR 199.2)

A freestanding laboratory approved for participation under Medicare and certified by the CMS.

Indirect Treatment Relationship (HIPAA Definition)

A relationship between an individual and a HCP in which:

1. The HCP delivers health care to the individual based on the orders of another HCP; and

2. The HCP typically provides services or products, or reports the diagnosis or results associated with the health care, directly to another HCP, who provides the services or products or reports to the individual.

As defined in HIPAA of 1996.

Individual

The person who is the subject of PHI as defined in HIPAA of 1996.

Individual Consideration (IC) Procedure

A service/treatment not routinely provided, is unusual, variable, or new and, as such, will require additional information from the provider of care, including an adequate definition or description of the nature, extent and need for the unusual service/treatment including the time, effort, and necessary equipment required. Any complexities related to the service should also be identified.

Individually Identifiable Health Information (IIHI) (HIPAA Definition)

Information that is a subset of health information, including demographic information collected from an individual, and:

1. Is created or received by a HCP, health plan, employer, or health care clearinghouse; and

2. Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

3. That identifies the individual; or

4. With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

As defined in HIPAA of 1996.

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

A technical reference, ICD-9-CM. Volumes 1 and 2 are a required reference and coding system for diagnoses and Volume 3 is required as a coding system for procedures in processing TRICARE claims for medical care with dates of service for outpatient services or dates of discharge for inpatient services before the mandated date, as directed by HHS, for ICD-10 implementation.

International Classification of Diseases, 10th Edition, Clinical Modification (ICD-10-CM)

A technical reference, ICD-10-CM. It is a required reference and coding system for diagnoses in processing TRICARE claims for medical care with dates of service for outpatient services or dates of discharge for inpatient services on or after the mandated date, as directed by HHS, for ICD-10 implementation.

International Classification of Diseases, 10th Edition, Procedure Coding System (ICD-10-PCS)

A technical reference, ICD-10-PCS. It is a required reference and coding system for procedures in processing TRICARE claims for medical care with dates of discharge for inpatient services on or after the mandated date, as directed by HHS, for ICD-10 implementation.

Intervention, Pharmacy

A change in therapy resulting from the prospective drug utilization review process and contact with the prescriber and/or the beneficiary because of allergy, clinically significant interactions, duplicative therapy, or other reasons.

Intervention Report, Pharmacy

A formal account of prescriptions not dispensed or changes in therapy as a result of contact with prescriber's and/or beneficiaries because of allergies, clinically significant interactions, duplicative therapy, or other reasons. The formal account shall also contain the resultant change in cost due to the intervention, if possible.

Initial Determination (Defined in 32 CFR 199.2)

A formal written decision on a TRICARE claim, a request for benefit authorization, a request by a provider for approval as an authorized TRICARE provider, or a decision disqualifying or excluding a provider as an authorized provider under TRICARE. 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 (Defined in 32 CFR 199.2)

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.

Inpatient Care

Services/treatment provided to a person who has been admitted to a hospital or other authorized institution.

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 (Defined in 32 CFR 199.2)

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

Institution-Based (Defined in 32 CFR 199.2)

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

Institutional Provider

A HCP who meets the applicable requirements established by 32 CFR 199.6.

Internal Control Number (ICN)

The unique number assigned to a claim by the contractor to distinguish the claim during 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 TED must have a unique ICN. For records generated from claims, it will be the ICN of the claim from which it was generated. For a TED which is 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.

Investigational Drugs

New medicines or other substances which have a physiological effect when ingested or otherwise introduced into the body, that have not been approved for general use by the Food and Drug Administration (FDA) but is under investigation and clinical trial regarding its safety and efficacy first by clinical investigators and then by practicing physician using subjects who have given informed consent to participate.

Laboratory And Pathological Services (Defined in 32 CFR 199.2)

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.

Law Enforcement Official (HIPAA Definition)

An officer or employee of any agency or authority of the U.S., a State, a territory, a political subdivision of a State or territory, or an Indian tribe, who is empowered by law to:

1. Investigate or conduct an official inquiry into a potential violation of law; or

2. Prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.

For further details, refer to HIPAA of 1996.

Legacy Identifier

A number used to identify unique providers. These number include the six-digit Medicare ID number, Unique Physician Identification Number (UPIN), 10-digit Ambulatory Surgery Center (ASC) number, Supplier Clearinghouse (NSC) number, Online Survey Certification and Reporting (OSCAR) number, and DME supplier number. A legacy identification number is other than the unique NPI required by HIPAA of 1996 to be issued to each physician, supplier and other provider of health care and the Federal Tax Identification Number (TIN). A Federal TIN is not considered a legacy identifier for health care purposes as it's primary purpose is to support IRS 1099 reporting.

Limited Data Set (HIPAA Definition)

A semantically meaningful unit of information exchanged between two parties to a transaction that excludes direct identifiers of the individual or of relatives, employers, or household members of the individual which is considered to be PHI as defined in HIPAA of 1996.

Long-Term Hospital Care (Defined in 32 CFR 199.2)

Any inpatient hospital stay that exceeds 30 days.

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.

Maintain Or Maintenance (HIPAA Definition)

Activities necessary to support the use of a standard adopted by the Secretary of HHS, including technical corrections to an implementation specification, and enhancements, or expansion of a code set. This term excludes the activities related to the adoption of a new standard or implementation specification, or modification to an adopted standard or implementation specification.

Major Diagnostic Category (MDC)

A group of similar DRGs, such as all those effecting a given organ system of the body formed by dividing all possible principal diagnoses from (ICD-9-CM) into 25 mutually exclusive diagnosis areas. MDC codes, like DRG codes, are primarily a claims and administrative data element unique to the U.S. medical care reimbursement system. DRG codes are also mapped, or grouped, into the MDC codes.

Managed Care Support Contractor (MCSC)

Civilian contractor, under contract with the DoD, to work with, help support and augment health care services available at the MTFs/eMSMs resulting in the establishment of an integrated system of health care delivery that influences utilization of services, cost of services while measuring performance. The contractor is required to assist military personnel in the combining of the resources of the military's direct medical care system, the TRICARE program and the contractor's managed care provider network and other services outlined in the contract to ensure a system that delivers value by giving TRICARE eligible beneficiaries access to quality, cost-effective health care.

Marketing (HIPAA Definition)

Communication about a product or service to encourage recipients of the communication to purchase or use the product or service as defined in HIPAA of 1996. See also DoD 6025.18R, DoD Health Information Privacy Regulation, for a list of specific exclusions to this definition.

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 16.

Maximum Defined Data Set (HIPAA Definition)

All required data elements for a particular standard based on a specific implementation specification.

Medicaid (Defined in 32 CFR 199.2)

Those medical benefits authorized under Title XIX of the Social Security Act provided to welfare recipients and the medically indigent through programs as administered by the various states.

Medical (Defined in 32 CFR 199.2)

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/Dental Claims History File

Refer to Beneficiary History File definition.

TRICARE Standard (Defined in 32 CFR 199.2)

A health care option, provided as part of the TRICARE program under 32 CFR 199.17, under which beneficiaries are eligible for care in facilities of the Uniformed Services and TRICARE under standard rules and procedures.

TRICARE Systems Manual (TSM) (7950.3-M)

A DHA authored book which provides ADP instructions and requirements for contractors who use the TEDs system for reporting data to DHA.

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.

Uniform Formulary

A list of brand name and generic drugs and supplies available for dispensing.

Note: PL 106-65, NDAA for FY 2000, Section 701, mandated that the DoD develop a uniform formulary to be applied across all POSs within the TRICARE system. Pharmaceuticals and other supplies authorized for dispensing will be in accordance with TRICARE policy and the Uniform Formulary. Recommendations for the design, structure and composition of the Uniform Formulary are developed by the DoD P&T Committee, with comments by the Uniform Formulary Beneficiary Advisory Panel, and provided to the Executive Director, DHA for approval and implementation.

Uniform HMO Benefit (Defined in 32 CFR 199.2)

The health care benefit established by 32 CFR 199.18.

Uniformed Services (Defined in 32 CFR 199.2)

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)

An MHS clinic that delivers primary health care to Service members.

Uniformed Services Family Health Plan (USFHP)

A DoD health plan option that offers TRICARE Prime to individuals who reside in the geographic service area of a USFHP DP who are eligible to receive care in medical MTFs/eMSMs (except Service members). This includes those individuals over age 65 who, except for their eligibility for Medicare benefits, would have been eligible for TRICARE benefits. DPs under the USFHP were previously known as "Uniformed Services Family Treatment Facilities" (USTFs) and are former USPHS hospitals. The service areas of the USFHP DPs are listed at http://usfhp.net on the world wide web and in the Catchment Area Directory.

United States (U.S.)

Territory made up of the 50 federated states, American Samoa, the District of Columbia, Johnston Island, Guam, Wake, Midway Islands, Northern Marianas and the U.S. Virgin Islands.

United States Public Health Service (USPHS)

An agency within the DHHS which has a Commissioned Corps which are classified as members of the "Uniformed Services."

Unprocessable TRICARE Encounter Data (TED)

TED records transmitted by the contractor to DHA 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.

Urgent Care

Medically necessary treatment that is required for a sudden illness or injury that is not life threatening, but does require immediate professional attention to avoid further complications resulting from non-treatment. Treatment is usually performed outside an Emergency Room (ER) setting.

Use (HIPAA Definition)

IIHI which involves sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information."

Utilization Criteria

Specific guidelines that must be met in order to ensure that medically necessary and appropriate treatment is being provided. Criteria to use for screening.

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